Assessment of the Gender Responsiveness of Measures for COVID-19 Prevention, Response and Recovery in Ethiopia

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Final Assessment Report

Submission Date: December 15, 2020
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LIST OF ABBREVIATIONS

COVID-19	Coronavirus disease of 2019
CSO	Civil Society Organisation
ECC	Emergency Coordination Center (MOP)
EDFA	Ethiopian Drug and Food Administration
EOC	Emergency Operation Center (MOH)
EPHI	Ethiopian Public Health Institute
FAGE	Federal Attorney General Office of Ethiopia
FGD	Focus Group Discussion
GBV	Gender-Based Violence
HDR	Human Development Report
IFPRI	International Food Policy Research Institute
ILO	International Labour Organisation
IO	International Organisation
IOM	International Organization for Migration
KII	Key Informant Interviews
MOH	Ministry of Health
MOLSA	Ministry of Labour and Social Affairs
MOP	Ministry of Peace
MoWCY	Ministry of Women, Children and Youth
NDRMC	National Disaster Risk Management Commission
PWD	Persons with Disabilities
SRH	Sexual and Reproductive Health
UN	United Nations
WB	World Bank
WEAMS	Women's Empowerment and Market Systems
WHO	World Health Organisation

EXECUTIVE SUMMARY

Ethiopia has done well in terms of COVID-19 prevention and containment. The pandemic itself has not had the huge impact on loss of life that is witnessed in other countries, including wealthier countries with more developed healthcare systems in Africa, Europe and North America. However, COVID-19 has heightened awareness and the negative impacts resulting from gender disparities, particularly for women with intersectional identities and multiple vulnerabilities, who are impacted by the social and economic fallout of the pandemic. From girls staying out of school and marrying young (a generational loss in educational outcomes for girls is a genuine fear globally), to women with disabilities closeted in their homes, or marginalised labour migrants without status, the consequences and suffering are immeasurable.

UN Women Ethiopia has been supporting initiatives which alleviate the negative impacts of COVID-19 on women and girls throughout the pandemic. This report—*Assessment of the Gender-Responsiveness of Measures for COVID-19 Prevention, Response and Recovery in Ethiopia*—is an extension of that work. Commissioned by UN Women Ethiopia in collaboration with the Ministry of Women, Children and Youth (MoWCY), the report documents the gender-responsiveness of government ministries and agencies, civil society organisations (CSOs) and international organisations (IOs) across health, social and economic sectors, highlighting the successes achieved, the gaps and constraints that remain, and the priorities that will assist in the process of recovery in Ethiopia.

The study takes a gendered research approach with specific references to gender analysis, engagement of women in the research process, and consultation to hear a range of voices across sectors, organisations and target groups. The research methodology incorporates an inclusive mixed-methods and gender-analytical approach combining existing sex-disaggregated data and information as available while gathering new quantitative and qualitative information. The study therefore draws on both secondary and primary sources including a survey and a series of key informant interviews and focus group discussions.

The study was not without its challenges given the relatively short timeframe since COVID-19 became a global pandemic, the rapidly evolving situation, the lack of sex-disaggregated data, gender-blindness of policies, strategies and reports, and the need to rely more than usual on preliminary stakeholder reports along with investigative journalism over academic research and analysis.

This report details the findings of stakeholder mapping, desk review and primary research, leading to six overarching recommendations:

1. The national government must lead on a coordinated cross-sectoral response for COVID-19 gender-responsiveness
2. A national gender-responsive strategy needs to establish the collection of sex-disaggregated data as a minimum requirement for evidence-based and gender-responsive decision-making
3. A national gender-responsive strategy requires gender-budgeting across ministries and agencies at all levels of government (and provide the capacity support for this to be carried out)
4. Gendered capacity and leadership for gender-responsiveness has to be integrated across all relevant government ministries, agencies and other organisations including CSOs and IOs
5. Strategies, policies and initiatives must serve the needs of vulnerable women by recognising, funding, and promoting awareness of intersectional identities and the increased challenges faced by excluded groups
6. Empowered, connected and resourced ministries, agencies and other organisations, need to develop and support gender-responsive sector strategies including in the non-COVID health sector, social sector and economic sector.

Ethiopia has the opportunity to build on its significant success in COVID-19 prevention and containment, and its recent years of strong economic growth, to emerge from the pandemic with a focus on greater equality and resilience, especially with regard to the inclusion of more vulnerable populations, especially women and girls.

1. INTRODUCTION

UN Women Ethiopia has been supporting initiatives which alleviate the negative impacts of COVID-19 on women and girls throughout the pandemic. This report—*Assessment of the Gender-Responsiveness of Measures for COVID-19 Prevention, Response and Recovery in Ethiopia*—is an extension of that work. Commissioned by UN Women Ethiopia in collaboration with the Ministry of Women, Children and Youth Affairs (MoWCY), the report documents the gender-responsiveness of government ministries and agencies, civil society organisations (CSOs) and international organisations (IOs) across health, social and economic sectors, highlighting the successes achieved, the gaps that remain, and the priorities for response and recovery going forward.

The study—including desk review, stakeholder mapping, gender-responsiveness survey, key informant interviews and focus group discussions—was carried out from September 16 to December 15, 2020. This study complements a second survey, also spearheaded by UN Women Ethiopia, along with MoWCY and UN Women Eastern and Southern Africa Regional Office. This other survey is aimed at assessing the *impacts* of COVID-19 on women and men in areas of income, sanitation, health and safety, and domestic responsibilities, whereas this study including its own survey examines the *gender-responsiveness* of COVID-19 policy and implementation of government, civil society and IOs.

Strategic Objectives of the Assessment

To respond to the specific and intersectional needs of the most vulnerable populations of women and girls, a strong gender dimension is necessary to guide strategic policies and interventions at the national and local levels. Based on this assumption, the strategic outcomes of the assessment (as guided by UN Women and MoWCY) are to:

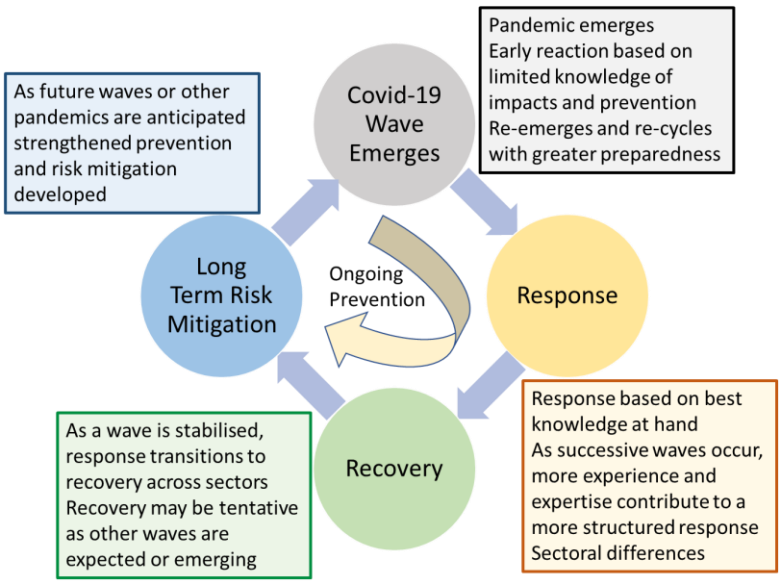
1. Analyse the effectiveness of COVID-19 measures regarding gender considerations and their mainstreaming into prevention, recovery and response by government, CSOs and international organizations.
2. Identify and map key actors and assess the scale and quality of responses with regards to COVID-19 in the country and the number of institutions and individuals that have been reached, where possible disaggregated by sex and age.
3. Make recommendations to guide gender responsiveness in strategic interventions at the National level taking into consideration the specific and intersectional needs of the most vulnerable populations of women and girls.
4. Serve as the basis for a training module and manual on gender responsive humanitarian prevention, response and recovery from a COVID 19 perspective.
5. Contribute to the successful testing and delivery of training to key stakeholders.

These strategic outcomes informed the breadth of the research, selection of stakeholders, design of research tools, analysis and recommendations, and the creation of the training module and manual.

Defining the COVID-19 Prevention, Response and Recovery Cycle

The COVID-19 cycle is characterized by a series of phases that are iterative over successive waves of COVID-19. Prevention is relevant at all phases, focusing on the containment of the pandemic including long-term risk mitigation (such as a vaccine). Response and recovery, while inclusive of health, also incorporate issues related to social issues (e.g., gender-based violence) and economic concerns (e.g., loss of income). While policies, interventions and activities are integral to all phases, it is still useful to understand the phases separately and visualise how gender-responsiveness may vary for prevention, response, recovery and eventually risk mitigation as illustrated in Figure 1. Much of the focus in Ethiopia (and indeed globally), as we set out in the following sections, has been on health issues and prevention, with a lower emphasis to date on the response to other health, economic and social challenges and recovery efforts addressing the broader impacts of the pandemic on the lives of women and girls.

Figure 1: COVID-19 Prevention, Response, Recovery Cycle



Contents of the Assessment Report

The following sections of the Assessment Report present and explain the study process and contents as follows:

- The research methodology section explains the gendered approach to the collection and analysis of data and information from multiple sources using a mixed-method approach (qualitative and quantitative). Specifics are provided about the various primary and secondary sources, numbers of respondents, tools and timeline.
- The global, African and Ethiopian situations are described in detail based on in-depth desk review, offering a comparison across regions and countries to contextualize Ethiopia's gender-responsiveness, and to provide the critical background information and statistics relevant to primary research, analysis, findings and recommendations.
- Primary research builds on secondary research to provide first-hand accounts and knowledge of COVID-19 gender-responsiveness in Ethiopia. The two combined, with a focus on lived experience, contributed to the report findings outlining gaps, constraints and opportunities.
- The recommendations section responds to the research questions, analysis and findings to propose key opportunities and needs for gender-responsiveness of government, civil society and international organisations going forward.
- A brief conclusion summarizes Ethiopia's gender-responsiveness and opportunity to advance its capacities and support for women and other vulnerable people.

This Assessment Report includes a set of Annexes to further illustrate the methodology and document the results of primary research.

2. RESEARCH APPROACH AND METHODOLOGY

This section describes the gendered research approach applied in this study with specific references to gender analysis, engagement of women in the research process, and the consultative approach to hear voices across sectors, organisations and target groups. It also outlines the research methodology which incorporates an inclusive mixed-methods and gender-analytical approach combining existing sex-disaggregated data and information as available while gathering new quantitative and qualitative information through the secondary and primary research described below.

GENDERED RESEARCH APPROACH

The study team mainstreamed a gendered approach across all aspects of the research, analysis, reporting and training such as: respondent selection, design of research tools and questions, gendered research and analysis techniques, and production of fully gendered reports and training manual/module. This is described more in the gender analysis section below. The gendered research approach incorporates several gender elements:

Assessment of Gender-Responsiveness: The mandate of the study was to assess the COVID-19 gender-responsiveness of government ministries and agencies, CSOs and IOs. This meant reviewing and analysing the gender-responsiveness of policies/regulations and implementation across sectors and stakeholders as well as at different stages of the COVID-19 prevention, response and recovery. This required adopting a gender analysis lens in preparing the research tools and in the subsequent analysis and recommendations.

Gender Analysis: Gender analysis is a socio-economic approach that is used as the basis for gender mainstreaming. Gender analysis allows us to identify, understand, and explain gaps between women and men in households, communities and countries, as well as to determine the underlying root causes of inequalities such as prescribed gender norms and asymmetrical power relations. As a result, we can better assess a range of issues that impact the disparities between women and men's status, roles and opportunities such as: access to assets, resources, opportunities and services; the division of labour in paid employment, unpaid work (including both subsistence production and care for family members), and volunteer activities; gendered leadership roles and decision-making; constraints, opportunities, and entry points for narrowing gender gaps and empowering women; and potential differential impacts of development policies and programs on women and men.

By utilizing a gender analysis lens, it is possible to integrate gender across all aspects of research taking into account: i) the type of stakeholder – government, CSO, international organisation; ii) the phases of prevention, response, recovery; and iii) the target sector – health, social and economic sectors. Available gender analysis frameworks, such as Jhpiego's Gender Analysis Framework[1] and Jones' WEAMS Framework[2] will be instrumental in informing the current exercise. These frameworks provided insights for gendered primary data collection methods, review of secondary data, analysis of qualitative and quantitative information, reporting and training.

Engagement of Women in Research Processes: For gendered research, it is imperative that women engage in all aspects of the research process. Women were central to this assessment as subjects of the research as well as contributors to the process as researchers, survey respondents, key informants, and advisors at UN Women and MoWCY. In particular, we targeted vulnerable women in focus group discussions to better understand the lived experience of low-income women, women labour migrants, women operating micro to small businesses and women with disabilities.

Inclusive Consultation and Collaboration: A consultative and collaborative approach ensured expectations were aligned and research was coordinated with existing information, while also delving into the experiences, challenges and opportunities of UN Women and its government, civil society and international partners in Ethiopia. Consultation and collaboration with the National Partner (MoWCY) were also critical for

[1] See https://resources.jhpiego.org/resources/gender-analysis-toolkit-health-systems#:~:text=The%20Jhpiego%202016%20Gender%20Analysis,newborn%2C%20child%20and%20adolescent%20health.
[2] See https://beamexchange.org/uploads/filer_public/0d/50/0d5009be-faea-4b8c-b191-c40c6bde5394/weams_framework.pdf

a successful and responsive assessment. Finally, but very importantly, through primary research, we consulted with a wide range of women, heard their opinions and concerns directly, and incorporated their voices into the research findings and recommendations.

Guiding Research Questions

A set of overarching research questions were agreed upon with UN Women and MoWCY:

1. What policies / strategies / interventions have been developed and implemented (by sector: health, social (especially gender-based violence), economic
2. To what degree have gender considerations been integrated into the assessments and approaches?
3. To what extent were national women's machineries (NWMs) and gender specialists involved in the design of the response and recovery plan?
4. What types of gender factors have been considered in assessments and approaches: transactional (e.g., availability, access, uptake) and/or root causes (e.g., agency, social norms, gender bias and discrimination)?
5. Which policies/ strategies/ initiatives were successful according to gender outreach and impact metrics?
6. What were the gaps, constraints, opportunities, negative, positive of these approaches and activities?
7. What are the resulting recommendations of those surveyed and interviewed?

These research questions drove the content of the research and also guided the form and substance of the research tools, constraints and opportunity analysis, and the development of recommendations.

Gendered Research Methodology

The mixed-methods research consists of secondary research, primary research, analysis and recommendations. A training manual and training module will follow on from the research and therefore be evidence-based and tailored to the needs of the targeted stakeholders.

Secondary Research

Secondary research comprised of two tools: desk review and stakeholder mapping.

Desk Review: An extensive desk review laid the foundation for the development of the other tools as well as for the background analysis. Desk review was then used iteratively to triangulate primary research findings and provide additional perspectives for discussion and recommendations. Consisting of both quantitative data and qualitative information as available, the desk review drew from a range of sources: international bodies' reports, newsletters and dashboards; government reports, project briefs and reports; Ethiopian CSO and international non-governmental organisations' reports and briefs; academic publications; journalistic investigative reporting and analysis; available statistics; and information on existing laws, plans, regulations and directives. Sources are referenced as footnotes throughout the document according to the UN Women standard method of citation.

Stakeholder Mapping: Stakeholder mapping was utilized to identify key actors in Ethiopia's fight against the pandemic. The mapping describes the landscape of COVID-19 response, cataloguing **58 stakeholders**—21 government ministries and agencies, 10 international bodies (e.g.., UN agencies, WB), 9 international NGOs, 3 foreign government/donors, 15 Ethiopian CSOs/associations—and their role, activities and approaches to Ethiopia's COVID-19 gender-responsiveness. The mapping exercise ensured that research is comprehensive without unnecessary gaps, recognizing data and reporting challenges described below. The identified stakeholders were all encouraged to respond to the survey and share with other potential respondents. A sub-set of stakeholders were prioritized for key informant interviews. The relevant stakeholders included in this inception report are government organizations, CSOs, IOs and to a lesser extent the private sector. A table summarizing the stakeholder mapping is appended as Annex One.

Primary Research

Primary data collection for the gender analysis of COVID-19 prevention, response and recovery was conducted using a quantitative and qualitative mixed-method approach including a largely quantitative survey tool and qualitative key informant interviews (KIIs) and focus group discussions (FGDs).

Gender-Responsiveness Survey: The survey assessed the overall experiences, perceptions and general trends in Ethiopia's gender-responsiveness to COVID-19 from **the perspective of 78 respondents (75% female)**—25 international NGOs or contractors, 23 government, 14 Ethiopian CSOs/associations, 9 international bodies (e.g., UN, ILO), 4 foreign government/donor and 3 private sector stakeholders. The majority of the respondents (71 out of 78) identified as mid-level manager/expert/consultant or more senior, while half have over six years' experience of which 21 respondents have greater than 10 years. The survey was directly distributed to approximately 120 representatives of organizations identified through stakeholder mapping and mailing lists shared by UN Women and other organizations. Respondents were encouraged to share the survey with others in their organisations. The survey was distributed in the form of an online questionnaire in Google Forms (an online application that is used and accessible in Ethiopia). The survey did not aim to be statistically representative (given timeframe and budget that would have been required to reach a representative sample) but was meant to reach a diverse set of experienced constituents with varying experiences and perspectives. Nevertheless, key trends emerged, supported by key informant interviews and literature review.

Key Informant Interviews (KIIs): The **40 key informants—**19 government ministries or agencies, 6 international NGOs, 10 Ethiopian CSOs / networks, and 5 international bodies**—**reached allowed the researchers to gain a more nuanced perspective of COVID-19 gender-responsiveness in Ethiopia while triangulating and exploring findings of secondary research and the survey. KIIs ensured direct engagement with informed stakeholders (in person or remotely) with either/both a general knowledge of what is happening in Ethiopia and/or an in-depth knowledge of a target sector or theme. Over the course of four weeks, we completed the interviews, drawing from the stakeholder mapping and prioritisation of respondents, identified in discussion with UN Women and MoWCY

Focus Group Discussions: Given the COVID situation, we had to limit the number of FGDs as well as the number in attendance at any one FGD since these needed to be carried out in person due to technology constraints at the locations of the discussions. Despite these restrictions, we were able to meet with **15 low-income/vulnerable women** including five microentrepreneurs, five migrant returnees, and four women with disability through three separate FGDs. This provided the opportunity to gain a greater understanding of vulnerable populations. FGDs were carried out with the support of the Association of Women in Self-Employment (WISE) and Ethiopian Women with Disability National Association (EWDNA), both of which have deep connections and experiences working with marginalized women.

ANALYSIS AND RECOMMENDATIONS

All data and information have been analysed and synthesized to produce recommendations that are evidence-based, well-defined and actionable. A gender analysis of the various responses to COVID-19 in Ethiopia have enabled the researchers to identify gaps as well as the concrete opportunities for gender-responsiveness going forward.

As information came available from desk research, the survey, key informant interviews and focus group discussions, it was documented and translated into English as needed. Interviews and FGDs were recorded in audio and writing to ensure a backup source. The survey collected data at the individual level and also collated it by response (percentages and numbers of response to each question and sub-question). Desk research was cited and referenced in footnotes with links to all original sources. All raw information and data have been maintained for evidence and future review.

Data and information were sorted around the overarching research questions to facilitate a comprehensive response to those questions. Stakeholder mapping and key informant interviews were organised and summarised in tabular form to facilitate this analysis. Focus group discussions were highlighted by topic area

to offer quick review of the relevant information. Responses to the survey were consolidated as graphs, charts and matrices, and also kept in a detailed excel spreadsheet.

Utilizing a gender analytical lens as described in the methodology section, the sex of all respondents was maintained, and questions were clearly gendered or declared 'gender-neutral'.

The consolidated data was utilised to derive recommendations. Recommendations emerged from desk review and informant responses to the overarching research questions. For example, there was no overarching research question about the quality and availability of sex-disaggregated data, but the research made evident that this is a gap that needs to be filled at the country and global level to inform gender-responsiveness across the board.

3. GENDER AND THE DATA CHALLENGE

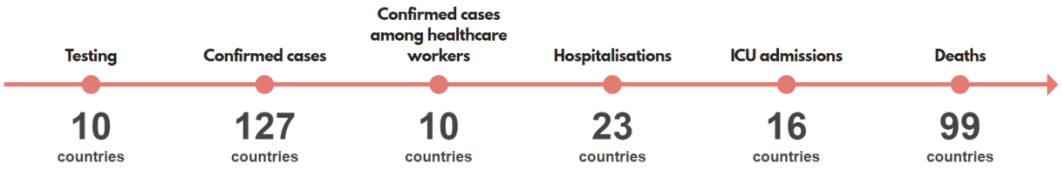
The mandate of this consultancy was not to review COVID-19 strategies, policies, reports, in general, but to assess gender-responsiveness. While carrying out primary and secondary research, it became apparent that there are pervasive data gaps and information challenges around conducting and reporting on COVID-19 gender-responsiveness: lack of sex-disaggregated data tracking and reporting; gender-blind policies and strategies; and constantly-changing information in the wake of the fast-moving COVID-19 pandemic. Each of these areas is discussed in this section.

Lack of Sex-Disaggregated Data

The availability of sex-disaggregated data on COVID-19 impacts and the outcomes of actions is patchy globally across health, social and economic sectors. While in the case of health outcomes, datasets are collected and tabulated daily on the WHO dashboard among others,[3] statistics are generally not sex-disaggregated. Although there is sex-disaggregated information on specific health, economic and social topics in various reports, these datasets are often predictive or extrapolated and not based on comprehensive data collection. This study incorporates data from both desk review and primary research, as it is available, to support analysis and findings. However, the need for improved collection of sex-disaggregated data will be a key recommendation of this report.

COVID-19 **health statistics** (testing, confirmed cases, hospitalisation, ICU admission, death) are the most widely reported data national, regional and global levels. However, sex-disaggregated statistics are not readily available for most countries, including Ethiopia. For example, the daily updated WHO dashboard (with supporting datasets) does not offer sex-disaggregated data. In an effort to redress this shortcoming, Global Health 50/50, the African Population and Health Research Center, and the International Center for Research on Women (ICRW) have collaborated to produce a Sex-Disaggregated Data Tracker[4]--the world's most comprehensive sex-disaggregated dataset on COVID-19.

The Sex-Disaggregated Data Tracker provides the following numbers for countries reporting sex-disaggregated data at the different stages of the COVID-19 infection life cycle:

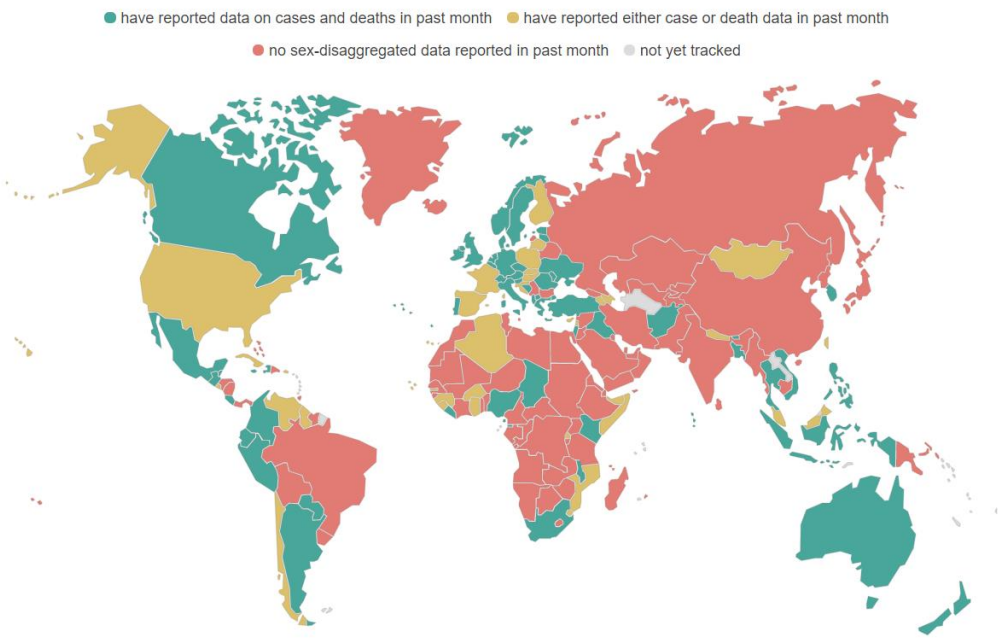


Source: Sex-Disaggregated Data Tracker

An interactive map, presented as Figure 2, shows that despite the recognition that there are gender differences in the impacts of COVID-19, sex-disaggregated statistics are reported by very few countries.

[3] See WHO Coronavirus Disease (COVID-19) Dashboard | WHO Coronavirus Disease (COVID-19) Dashboard
[4] See https://globalhealth5050.org/the-sex-gender-and-covid-19-project/

Figure 2: Countries Reporting Sex Disaggregated Data[5]



The only nationwide sex-disaggregated health data reported in the tracker for Ethiopia are confirmed cases (reported in the tracker to the end of June 2020 as approximately 5000 confirmed cases of which two thirds are men). Similar sex-disaggregated national statistics are not available for testing, hospitalisation or deaths.

All treatment centers across Ethiopia reportedly enter data online. However, key informant interview respondents reported that while the Ministry of Health (MOH) and Ethiopian Public Health Institute (EPHI) had well-established and sex-disaggregated data related to COVID-19, it is no longer disseminated. This was further confirmed by a review of the MoH Facebook page[6] and EPHI epidemiological weekly bulletin[7] neither of which provide sex-disaggregated data on their public sites. As explained in the findings section below, as the numbers increased, it became more difficult to maintain sex-disaggregated data.

In terms of **social and economic sectors**, there are even fewer statistics at global and national levels – although there are narrative reports, generalized data projections and targeted studies which report some data (e.g., number of subjects), there is little hard numeric evidence.

In an attempt to collate gender-responsive information, UNDP with technical and advisory support from UN Women launched a COVID-19 Global Gender Response Tracker.[8] The UN tracker monitors national and sub-national government initiatives that aim to deal with the pandemic and indicates where these initiatives are gender-responsive. Globally, the tracker has identified 2,517 measures taken in response to COVID-19. These measures fall into four main policy categories: social protection, labour markets, fiscal and economic policies and measures to address violence against women and girls. Data are reported by UNDP and UN Women country offices and are based on publicly available information, including media coverage, official documents, and other COVID-19 policy trackers.

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[5] See https://globalhealth5050.org/the-sex-gender-and-covid-19-project/
[6] See https://www.facebook.com/EthiopiaFMoH/photos/coronaviruscovid-19-report-cases-in-ethiopiasocialdistancing-safehandsethiopiafm/1480375942133204/
[7] See https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/ethiopian_weekly_epidemiological_bulletin_wk_42_2020.pdf
[8] See COVID-19 Global Gender Response Tracker - UNDP Covid

The UN tracker reports on government initiatives and does not include information on civil society or international aid initiatives; data are only consolidated at the level of 'number of initiatives' and 'gender-sensitive initiatives', and many of the initiatives are small, with limited data and are often not sex-disaggregated or gender-sensitive. It also seems likely that due to the method of data collection and reporting, many government initiatives are overlooked, or not updated. For example, just the following 10 initiatives are reported for Ethiopia, of which half are considered gender-sensitive.

Table 1: Ethiopia COVID-19 Government Initiatives

Focus of initiative	Description of imitative / link to further information
Social protection In-kind support	Amhara Regional State: food security, started providing flour, oil and sugar to "the poorest of the poor" in city of Bahir Dar;
Social protection; Utility, housing/financial support	Tigray State: rent support; a moratorium on evictions and reduction of rents by half
Social protection Public works	Beneficiaries of the Urban Productive Safety Net Project (UPSNP) will receive an advance 3-months payment while on leave from their public works obligations. UPSNP partly targets female-headed households.
Social protection Public works	Ethiopia Rural Productive Social Net Program, which partly targets female-headed households, foresees the provision of community-based childcare services and reduced working time for women with children.
Social protection Paid sick leave	Government employees in Harari State who are at higher risk of COVID-19 (elderly, pregnant women, those with underlying conditions) stay home while receiving salaries.
Labour market: Labour regulatory adjustment	Ethiopia prohibited companies from laying off workers and terminating employment in measures introduced as part of a state of emergency to stop the spread of the coronavirus.
Economic, financial and fiscal support for entrepreneurs	National Bank of Ethiopia to avail Birr 15 Billion liquidity for private banks to enable them to provide debt relief and additional loans to their customers in need.
Economic support for entrepreneurs; Taxation	Ethiopia initially announced a Br 300 million package to bolster healthcare spending through allowing a tax deferral.
Violence against women; Police and justice responses	The country has continued to hear domestic violence cases with minimal interruption.
Violence against women; Awareness raising campaigns	In Hawassa City, Ethiopia, safe city messages on prevention and response to domestic violence and sexual violence have been shared with religious authorities for community outreach.

Source: COVID-19 Global Gender Response Tracker [9]

Gender-Blind Policies and Strategies

In most of the world, including in Ethiopia, COVID-19 policies, strategies and reports are often gender-blind with little or no reference to women, girls, gender, intersectional identities. There is a growing awareness that this is a gap, and there are statements, projections, thoughts on the matter of gender-inclusion. However, a review of existing guidance documents reveals a lack of gender-mainstreaming in general documents, with attention paid in targeted documents on vulnerable populations. Still these policies and strategies have not impacted the majority of Ethiopians, regardless of gender (as reported in the Primary Research Findings section).

The following table analyses key documents to illustrate the limited mainstreaming of gender-responsiveness of COVID-19 policies and strategies.

[9] See COVID-19 Global Gender Response Tracker - UNDP Covid

Policy/ Strategy/ Report	Ministry or Agency	Date of Publication	Document Contents	Gender-Responsiveness
COVID-19: National Emergency Response Plan	National Government	April 4, 2020	The document provides an overview of the situation of COVID19 in Ethiopia as of April 2020, its current and expected health, social and economic impacts as well as outlines multi-sectoral emergency response plans.	Gender is not mainstreamed although the report recognizes vulnerability of poor women and children in a few places such as lactating and pregnant women in need of food baskets; women and girls identified at risk as frontline care givers at home and in the workplace; access to services for GBV and SRH are identified. In the planning section, women are not referenced and gender-responsiveness of delivery is not included.
COVID19: Economic Impact Responses Assessment and Policy	National Government	April 2020	Description of the expected direct and indirect impacts of COVID-19 on the Ethiopian economy across sectors; policy guidance	Gender is not mainstreamed, and in the 24-page document, there are two sentences on the economic impact on women. Gender / women are not referenced in the response plan.
COVID-19 Workplace Protocol	Ministry of Labour and Social Affairs (MoLSA)	March 2020	Two-fold objective of protecting people in the workplace and minimizing the impact on the Ethiopian economy	Gender is not mainstreamed, and the document is gender blind. There is no reference to gender or to women but only to 'workers' generally.
COVID-19 Emergency Preparedness and Response Plan for protection of special need population group	Ministry of Health (MoH) and Ethiopian Public Health Institute (EPHI)	April 2, 2020	Plan to protect vulnerable persons which includes pregnant, women, lactating mothers, victims of gender-based violence and many others without specific reference to gender (e.g., persons with disabilities, commercial sex workers, prisoners, geriatric centers, street dwellers/homeless etc.)	Strong intention of gender-inclusion: Ensure that community engagement teams are gender-balanced and promote women's leadership within these; Provide specific advice for people - usually women - who care for children, the elderly and other vulnerable groups in quarantine, and who may not be able to avoid close contact; Design online and in-person surveys and other engagement activities so that women in unpaid care work can participate; Take into account provisions for childcare, transport, and safety for any in-person community engagement activities; Ensure frontline medical personnel are gender-balanced and health facilities are culturally and gender sensitive
COVID-19 Response Standard Operating Procedure for Returning Migrants	Emergency Coordination Center (ECC) in collaboration with International	May 13, 2020	Guidance for management of labour migrants recognizing Ethiopia as a migration hub as well as deportation of migrants	Focuses on issue of quarantine that takes into account a range of gendered needs: lactating and pregnant women, menstruation, care of children.

	Organization for Migration (IOM)		from the Gulf back to Ethiopia.	
ETHIOPIA: COVID-19 Humanitarian impact Situation Update No. 15	National Emergency Coordination Center (ECC), led by the National Disaster Risk Management Commission (NDRMC)	October 21, 2020	A four-page update on Ethiopia's humanitarian situation and response vis a vis COVID-19.	Gender is not mainstreamed, and data is not sex-disaggregated. Throughout the document, there is no reference to women, gender-based violence is mentioned twice, and there is one phrase commenting on early marriage.
Safe Schools Operational Guideline	Ministry of Education (MoE)	September 25, 2020	A strategy and operational guideline for the safe re-opening of schools in Ethiopia. It provides for the different preconditions that have to be met before opening schools.	Gender is not mainstreamed in the document. The issue of girls not returning to school and their susceptibility to early marriage and gender-based violence is mentioned in passing and not incorporated into planning. Although the document tries to address students of both genders there is no particular initiative, plan, problem statement or activity for girls' return to. Gendered needs of girl students are not considered in this document.
Child Protection During COVID-19 Pandemic Guide	Ministry of Health (MoH) and Ethiopian Public Health Institute (EPHI)	2020 (no month)	Interim guideline for child protection at quarantine, isolation, and treatment centers during COVID-19 pandemic to prevent separation of children from parents/caregivers and siblings and protect children from violence, exploitation and abuse including gender-based violence.	Specific reference of girl child is made in the document. As well as mainstreaming gender in the entire document, there is a specific section on prevention of, risk mitigation for and response to gender-based violence. Particular gendered needs have been given due consideration. Staff training on gender-based violence and referral systems are included in the document. Background checks on staff to ensure no history of violence, exploitation and abuse is discussed.
Environmental and Social Management for Ethiopia COVID-19 Emergency Response Project	Ministry of Health (MoH) and Ethiopian Public Health Institute (EPHI)	June 2020	The document provides for a framework for identification, mitigation, monitoring and reporting environmental and social risks associated with Ethiopia COVID-19 Emergency Response Project.	Strong gender and social inclusion in different focus areas of the document such as in recognizing the vulnerabilities of women and girls associated with the Emergency Response projects; these include potential for increase in gender-based violence and exploitation in quarantine facilities. Provision of risk mitigation measures and availability of resources catering to gendered needs. Taking gender into consideration in the respectful and courteous treatment of quarantined persons;

				provision of gender sensitive infrastructures such as segregated toilets and enough water and light in quarantine and isolation centers. Specific budget allocated for mitigation of gender-based risks.

As further explained in the Primary Research Findings section, key informants reported that even when policies or strategies exist, they are not usually gender-responsive, and there is limited knowledge of these initiatives, with at times conflicting guidance from ministries.

Constantly Changing Information

COVID-19 was declared a global pandemic on March 12, just nine months before the writing of this report. Since that time, we have repeatedly heard from officials all over the world that "we live in unprecedented times;" "the situation is rapidly evolving"; "as new information is available;" etc. Data and information change daily, new impacts (health and other) are recorded on a regular basis, and experts disagree on the best strategies to deal with COVID-19 and the societal fallout. Much of this is happening in real time in the media, becoming obsolete almost as soon as it is published. Therefore, for this study, wherever possible, there is a preference for sources that were published from mid-October onward including scientific and academic sources as available.

It is important to underline, that this fast-moving pandemic has had consequences far beyond the health sector which has been the primary area of focus for many countries. The global community of government, CSOs, IOs, research institutes and academics has been especially challenged to conduct robust research and deliver meaningful reports on non-COVID health outcomes, social issues and economic challenges, let alone to consider the impacts and respond to the needs of vulnerable women. This hampered the report in terms of identifying and referencing more robust research sources around social and economic issues in both response and recovery. However, as available, sources have been reviewed and cited.

In response to this informational maelstrom, this study has sorted through stakeholder reports, media articles, press releases, dashboards, investigative journalism, documents from international bodies (such as the UN, World Economic Forum, World Bank etc.) and academic papers as available. We have searched for information to assess gender-responsiveness, the mandate of this study, identifying gaps, constraints and opportunities in Ethiopia.

While a challenge for the study, the end result is that the study itself is additive, contributing to the consolidation and assessment of existing data, providing insights based on primary research (largely qualitative), offering triangulation for desk research, and making recommendations for improved gender-responsive data collection and reporting.

4. COVID-19 BACKGROUND ANALYSIS: GLOBAL, AFRICA, ETHIOPIA

COVID-19 is a global pandemic, and therefore information and learning across regions and countries is relevant to understanding a specific context and its successes and challenges. While ultimately the goal has been to understand the gender-responsiveness of policy and implementation in Ethiopia, full understanding depends on the broader context, illustrating where Ethiopia is doing well and underlining where improvements are possible and desirable. This assessment report therefore draws on international and African experiences, particularly those of stakeholders such as UN Women, UNFPA, WB, bilateral donors and CSOs, to name a few.

Scale Of Covid-19 Cases – Prevention and Loss

The new strain of coronavirus, COVID-19, emerged in Wuhan, China in January 2020, and was declared a global pandemic by the World Health Organization (WHO) on March 11, 2020. COVID-19 has spread rapidly around the globe, with some countries now experiencing their second, third or even fourth wave. By the writing of this report, November 26, 2020. the impact of the virus was as follows.

- Worldwide, 217 countries had been infected with over 60 million confirmed cases and 1,378,000 reported deaths (WHO Dashboard; sex-disaggregated data not available).[10]
- Africa had a total of 1.5 million confirmed cases with deaths at 33,000 (WHO Dashboard), accounting for only 2.5 percent of global infections and 2.4 percent of deaths despite being the home to 17 percent of the world's people.
- Ethiopia reached total confirmed cases of 107,109 and 1664 deaths (WHO Dashboard). In the Africa context, this translates to about 7 percent of the continent's cases and 5 percent of its deaths, despite being Africa's second most populated country at 115 million inhabitants and accounting for 8.5 percent of Africa's population.
- The above results are skewed by high death rates in South Africa as well as relatively high rates in North Africa (Egypt, Morocco, Tunisia and Algeria). [11] Ethiopia has the highest rate of infection in Sub-Saharan Africa outside of South Africa.[12]

A Snapshot: Ethiopia, Development & Gender

Rapid economic growth, a booming population and urbanization hold the promise of Ethiopia's graduation to middle-income status by 2030. Ethiopia is the fourth fastest growing economy in Africa in 2020 with projected annual growth of 7.2 percent (WB). In the most recent UN Human Development Report (2019), Ethiopia ranked 173 out of 189 countries placing it at the upper end of the low human development category. However, despite this growth, 61.5 percent of the population still live in severe multi-dimensional poverty, characterized by a low standard of living with few assets, poor educational outcomes, inadequate nutrition and high rates of child mortality (UN, 2019).

The UN Gender Inequality Index places Ethiopia at 123 out of 162 countries (UN, 2019), relatively higher than many countries in the region. Due to root causes of entrenched social norms, practices and beliefs as well as pressures of poverty, one in three women experience physical, emotional or sexual violence, two thirds have undergone FGM, and only 50 percent of girls complete grade five (USAID, 2020). Women also suffer from low levels of literacy and skills, weak social networks, and workplace disparities earning less than male counterparts while carrying out unpaid family labour including care work (UN Women). This is especially complex in Ethiopia with the varying customs of ethnic groups and the movement of groups due to internal conflict, natural disasters and economic hardship.

Existing economic pressures on low-income communities have been heightened by COVID-19, with over 30,000 female and male workers (mainly from Gulf States) forced to return to Ethiopia in recent months (NYT). Urban centers are also under increased pressure due to conflict and natural disasters resulting in 1.7 million internally displaced persons (IOM) which is compounded by an influx of almost 800,000 refugees from poorer countries in the region (UNHCR) due to Ethiopia's progressive refugee policies including granting of work permits and enrolment in all levels of education.

[10] See See WHO Coronavirus Disease (COVID-19) Dashboard | WHO Coronavirus Disease (COVID-19) Dashboard
[11] See https://www.bbc.com/news/world-africa-53181555
[12] See https://pandemic.internationalsos.com/reports/covid-19-in-ethiopia-july-jul-02-2020

These statistics provide evidence of Africa and Ethiopia's comparatively low infection and death rates which set the continent apart from the startling trends in developed countries (including South Africa), where the top 20 countries for per capita deaths include the United States, the United Kingdom and eight European countries (with the remainder in Latin America). However, as noted above – sex-disaggregated data is not available.

Among African countries, South Africa has the highest per capita death rate, but still ranks 32 in the world, while Ethiopia ranks 132 globally. In real terms, Belgium's death rate is 120 per 100,000 population, South Africa's is 35 and Ethiopia has suffered fewer than two deaths per 100,000. To illustrate this in another way, the United Kingdom and Spain have the same combined population as Ethiopia but account for over 3 million cases and 106,792 deaths (WHO Dashboard). Not all developed countries share these death rates; for example, Norway's death rate is currently around six per 100,000 and Germany's is less than 20. Developed island states such as Taiwan and New Zealand exhibit extremely low death rates of less than 1 per 100,000 population as reported by John Hopkins COVID Resource Center in November, 2020.[13]

There are a range of proposed reasons for this country-by-country variation in prevention of infection and death. On the one hand, national governments have taken different measures to prevent and respond to the pandemic, ranging from Sweden's controversial hands-off herd immunity model (with high rates of infection and death) to Vietnam's early closure of borders and schools, lockdown of the entire country and government quarantine of returnees (with low rates of infection and death). A range of factors come into play with some countries imposing lockdowns early combined with extensive testing and tracing—e.g., Norway, South Korea, Taiwan, and New Zealand—resulting in fewer deaths and lower economic impact. Others locked down later, if at all, opened up early, and had less effecting testing, tracing and quarantine protocols—e.g., Brazil, Netherlands, Spain, the US and the UK—and have typically fared worse in terms of infection and death.[14]

But Africa and Ethiopia's prevention success stories are more complex, and we turn to them next.

AFRICA AND ETHIOPIA'S COVID-19 PREVENTION AND PREPAREDNESS

Early on, John Nkengasong, Director of the Africa Centers for Disease Control and Prevention (Africa CDC)[15] insisted that Africa could stand up to COVID-19 if given a chance. Faced with forecasts that a high number of Africans would die, Dr. Nkengasong reviewed the data and the assumptions himself, and was not convinced they were correct. With this conclusion, the Africa CDC decided not to issue existing dire projections,[16] and Nkengasong's analysis has since proven correct.

While some reports point to the low median age in Africa as the main factor in its successful COVID-19 outcomes, there is a growing consensus that Africa's success story is more complex.[17] Evidence reveals that while age is undoubtedly a factor in low death rates, Mormina and Nsofor report that there is an overemphasis on age by those who have not fully understood the successful deployment of Africa's collaborative systems, early action in the face of COVID-19 and experience with past pandemics.[18] Reflective of this debate, BBC's Senior Africa Correspondent, Anne Soy, has summarized five reasons for Africa's overall successful response to COVID-19.[19] First, African governments took immediate and drastic measures to try and slow the spread of the virus stemming in part from fears that health systems would be overwhelmed. This included regulation and guidance on lockdowns, hand-washing, social distancing and wearing of masks. In addition, African leaders have not only responded fast and well, but they have collaborated with one another, a legacy of the Ebola crisis which recognised that pandemics do not respect borders which led to

[13] See John Hopkins Coronavirus Resource Center https://coronavirus.jhu.edu/data/mortality
[14] See Why the Swedish Model for Fighting COVID-19 Is a Disaster | Time
[15] See About Us – Africa CDC
[16] See As U.S. struggles, Africa's COVID-19 response is praised | CTV News
[17] See Coronavirus: What's happening to the numbers in Africa? - BBC News
[18] See What developing countries can teach rich countries about how to respond to a pandemic (theconversation.com)
[19] See Coronavirus in Africa: Five reasons why Covid-19 has been less deadly than elsewhere - BBC News

the establishment of the Africa Centers for Disease Control and Prevention.[20] Ethiopia has been especially recognized for its rapid response, widespread testing, public awareness raising, maintaining economic activity and shared responsibility for combating the impacts of the pandemic.[21] Second, a high percentage of the population in Africa (85% in 18 countries surveyed) [22] exhibit strong compliance with guidance and regulation. In Ethiopia, 80 percent of the population is very satisfied or somewhat satisfied with the government's response,[23] while also noting concerns about health services (especially reproductive health) and the economic situation. Third, the relatively young age of Africans is a significant factor (but not the only or even the key reason) for a low death rate. Ethiopia fits within this scenario, with 43 percent of the population 14 years old and under, and an additional 20 percent 15-24 years of age.[24] Fourth, the seasonality of viruses, including those of the coronavirus strain, is often ascribed to the weather,[25] meaning that much of Africa would inhibit spread due to higher temperatures and levels of humidity. Finally, while hospital infrastructure may be less developed in Africa than in other regions, there are established community health systems that have arisen in response to other diseases from polio to HIV to Ebola. It has long been recognized that community health systems are an effective means to deliver health care and promote change in behaviour, vaccination rates, child mortality and more. Nevertheless, while there are excellent anecdotal examples of community activists, networks of clinics, etc., the systems are not consistently operational within and across countries.[26] The Ethiopian example of women health extension workers shows how Ethiopia's primary healthcare system has been strengthened. Unlike many other countries, these extension workers are paid, have adequate training, and are accorded the status to influence community members and their leaders.

Ethiopia's Health Extension Workers

Ethiopia has deployed an "army of community health workers" to fight the spread of COVID-19. Now 40,000 strong, this "army" was originally formed of women who worked to reduce maternal mortality in the 2000s. Now, the community health extension workers have taken on new roles to improve hygiene, monitor infections, and debunk myths about the virus.
Source: Emeline Wuilbercq, Reuters

GENDERED IMPACTS IN HEALTH, SOCIAL AND ECONOMIC SECTORS

Despite success in prevention, Africa and Ethiopia have experienced challenges in terms of response and recovery on par with other regions/countries globally. Moreover, there is indisputable evidence that COVID-19 has disproportionately affected vulnerable populations, and that women suffer more from negative health, social and economic impacts than their male counterparts. Winnie Byanyima, Executive Director of UNAIDS reminds us that "just as HIV has held up a mirror to inequalities and injustices, the COVID-19 pandemic has put a spotlight on the discrimination that women and girls battle against every day of their lives."[27] Byanyima concludes that that such epidemics can only be defeated by putting gender equality at the center of the response.

Health Impacts on Women

The OECD reported in 2020 that almost half of aid in the area of health does not yet focus on gender equality and women's empowerment.[28] Particularly relevant given the current COVID-19 emergency is that only 24 percent of aid in the sub-sector of infectious disease control integrates gender equality and women's empowerment on average per year in 2017-18. Similarly, it is not surprising then that the health of women is impacted in diverse ways by the pandemic. The desk review revealed that the most notable areas of women's health impacted by COVID-19 (beyond the direct impacts of the pandemic and with implications

[20] See What developing countries can teach rich countries about how to respond to a pandemic (theconversation.com)
[21] See https://www.weforum.org/agenda/2020/06/ethiopia-covid19-response/
[22] See PERC | Prevent Epidemics
[23] See PERC_RespondingtoCovidData.pdf (preventepidemics.org)
[24] See https://www.unfpa.org/data/adolescent-youth/ET
[25] See http://dx.doi.org/10.2139/ssrn.3550308
[26] See doi: http://dx.doi.org/10.2471/BLT.12.109660
[27] See https://www.unaids.org/en/resources/presscenter/featurestories/2020/june/20200615_gender-equality-at-the-center-of-covid-19-responses
[28] See http://www.oecd.org/development/gender-development/Aid-Focussed-on-Gender-Equality-and-Women-s-Empowerment-2020.pdf

COVID-19 and Maternal Healthcare Services in Ethiopia

COVID-19 has similarly impacted maternal and reproductive health care services in Ethiopia. For example, in governmental health institutions in Dessie town, a study determined six percent of antenatal care attendees, eighteen percent of delivery care attendees and nearly half of postnatal care attendees reported inappropriate service delivery due to fear of health care providers, shortage of medical supplies and staff workload. In addition, the uptake of services by clients was decreased due to fear of infection at health institutions.

Source: Kassa et al

for recovery) are: i) intersectionality of gender and poverty or other vulnerabilities (e.g., age, disability, minority group, etc.); ii) reallocation of health resources away from other needed healthcare services; and iii) women's role as essential workers in healthcare and other frontline services. These are described in the following sub-sections.

i) Deeper poverty among women with intersectional identities results in higher rates of infection and death from COVID-19 worldwide. Intersectionality ranges across a range of identities—for example, age, level of education, type of employment, disability, marital status and family size, and affiliation with a minority or otherwise disadvantaged group. However, since identities are social and political constructs, while there are some global similarities, there can be significant variations from one society to the next. For example, in developed countries, COVID-19 has taken its toll on **older women**, with the highest death rates among those who live in long-term care facilities. In many countries, over 40 percent of deaths take place in these facilities, with national death rates as high as 80 percent in some high-income countries such as Canada,[29] where women represent more than two-thirds of residents. An equally harsh example from developed countries is the disproportionate impact on people of colour, which extends to South Africa where there is a higher risk of Black or mixed-race patients dying of COVID-19 in the country's hospitals than white patients. With Ethiopia's low death rate, and limited reliance on long-term care facilities, higher incidence rates and death from COVID-19 for the elderly appears to be connected to underlying health issues and in some cases poverty and neglect.[30]

Globally, there are approximately one billion **persons with disabilities (PWD**) who, even before COVID-19, had lower access appropriate healthcare services, as well as being more likely to suffer from violence or neglect.[31] Out of this one billion people, 80 percent live in developing countries.[32] In Africa, as access to healthcare services and incomes has decreased during the pandemic, this is especially true for women and girls with disabilities (WWD). Moreover, with increased gender-based violence (GBV) at this time, WWD are at a higher risk for experiencing harm. The Ethiopian Women with Disabilities National Association has identified the risk of starvation for women with disabilities due to both the closure of critical support organisations and the loss of income from micro-businesses in which many of them engage.[33]

ii) The reallocation of health service resources to COVID-19 priorities contributes to reductions in critical services across the spectrum with a notable impact on sexual and reproductive health (SRH) services including restricted prenatal, perinatal and postpartum health care. The World Health Organization (WHO)'s survey on the impact of COVID-19 on health systems collected data from 105 countries across five regions finding that almost every country (90%) experienced disruption to its health services, with low- and middle-income countries reporting the greatest difficulties. For example, routine and elective services have been suspended, while critical care - such as cancer treatments and HIV therapy – resulted in significant interruptions in low-income countries.[34] Dr Matshidiso Moeti, World Health Organization (WHO) Regional Director for Africa indicated in "We are already seeing that the impact of COVID-19 on women and girls is profound. Women are disproportionately affected by lockdowns and this is resulting in a reduced access to

[29] See Long-Term Care Homes in Canada – The Impact of COVID-19 - HillNotes

[30] See https://www.deccanherald.com/international/mixed-race-covid-19-patients-dying-more-than-white-patients-in-south-africa-says-report-873801.html

[31] See https://www.un.org/en/coronavirus/disability-inclusion

[32] See https://www.un.org/sites/un2.un.org/files/sg_policy_brief_on_persons_with_disabilities_final.pdf

[33] See https://www.womankind.org.uk/covid-19-and-womens-rights-in-ethiopia/

[34] See Pulse survey on continuity of essential health services during the COVID-19 pandemic: interim report, 27 August 2020 (who.int)

health services.[35] That is, access to critical health services have been disrupted across Africa as a result of the COVID-19 response effort. For example, in Zimbabwe, SRH services have shown declines in a range of services: caesarean sections down 42 percent between January and April 2020, 21 percent fewer delivery of infants in healthcare facilities, and a 90 percent reduction in new clients on combined birth control pills.[36]

iii) Women's role as frontline healthcare workers and caregivers in the home put them at greater risk than male counterparts. The International Council of Nurses reports that there had been 1,500 confirmed deaths of nurses across 44 countries as of October 28, 2020.[37] The Council extrapolated that since an estimated 10 percent of infections are among healthcare workers more generally (predominantly women), the total is likely to be 20,000 deaths worldwide. As of September, Amnesty International reported the countries with the highest estimated numbers of health workers who have died from COVID-19 include Mexico (1,320), USA (1,077), UK (649), Brazil (634), Russia (631), India (573), South Africa (240), Italy (188), Peru (183), Indonesia (181), Iran (164) and Egypt (159)—aligned with countries that have overall high death rates.[38] In Africa, both in formal and informal settings, the burden of caring for the sick and elderly is largely borne by women.[39] Moreover, women healthcare workers report high incidence of abuse and harassment. Midwives and specialist primary care nurses often work night-shifts by themselves in patient's homes, and female health workers, particularly community and other field health workers, are responsible for outreach services or are based in remote locations, which also exposes them to violence.[40] In Kenya, community health workers report threats of violence from husbands of women in their care, as well as cases of rape. Another key concern for healthcare workers is appropriate levels of preparedness as well as adequate personal protective equipment. Moreover, women make up 70 percent of workers in health and social sectors, but there is a gender pay gap of about 11 percent for women healthcare workers.[41] The box above provides an interesting illustration of the situation in Ethiopia.

Frontline COVID-19 Healthcare Workers
Recent studies in Ethiopia have determined that safeguards for healthcare workers are insufficient in the formal hospital setting, putting healthcare workers and patients at risk. found In Amhara, out of 404 hospital healthcare workers, over 74 percent felt unsafe in their workplace, 64 percent were anxious working with patients with a fever, and less than one third had consistent access to gloves, masks, goggles, shoes and aprons in the workplace. Similarly, across six hospitals in Addis Ababa where over 1100 healthcare workers were surveyed, the majority reported that their hospital did not have adequate PPE, and almost 72 percent of the respondents were dissatisfied with the situation.
Source: Mulu et al (2020)

Social Impacts on Women

Due to **social** factors such as gender discrimination, the pandemic results in negative social impacts on women and girls. Key areas of concern reported in the literature include GBV, increased unpaid care work, and girls' being out of school—challenges that will negatively affect recovery if adequate resources are not available to mitigate long-term impacts.

Due to entrenched social norms and gender inequities, **gender-based violence** is on the rise with many countries reporting an increase in the number of gender-based violence incidents especially domestic violence, sexual exploitation and harmful traditional practices such as child marriage. For example, France logged an increase in domestic violence reports of 30 percent in the first few months of the pandemic; Argentina experienced a 25 percent increase in emergency calls regarding domestic abuse; and Singapore

[35] See https://www.afro.who.int/news/who-concerned-over-covid-19-impact-women-girls-africa
[36] See https://www.afro.who.int/news/who-concerned-over-covid-19-impact-women-girls-africa)
[37] See https://www.ctvnews.ca/health/coronavirus/1-500-nurses-dead-from-covid-19-across-44-countries-international-council-of-nurses-1.5165352
[38] See https://www.amnesty.org/en/latest/news/2020/09/amnesty-analysis-7000-health-workers-have-died-from-covid19/
[39] See https://www.ohchr.org/Documents/Events/COVID-19_and_Women_Rights_7_Possible_Actions.pdf
[40] See https://doi.org/10.1136/bmj.m3546
[41] See ICRW https://www.icrw.org/wp-content/uploads/2020/04/cweee_covid_and_wee_brief_final.pdf

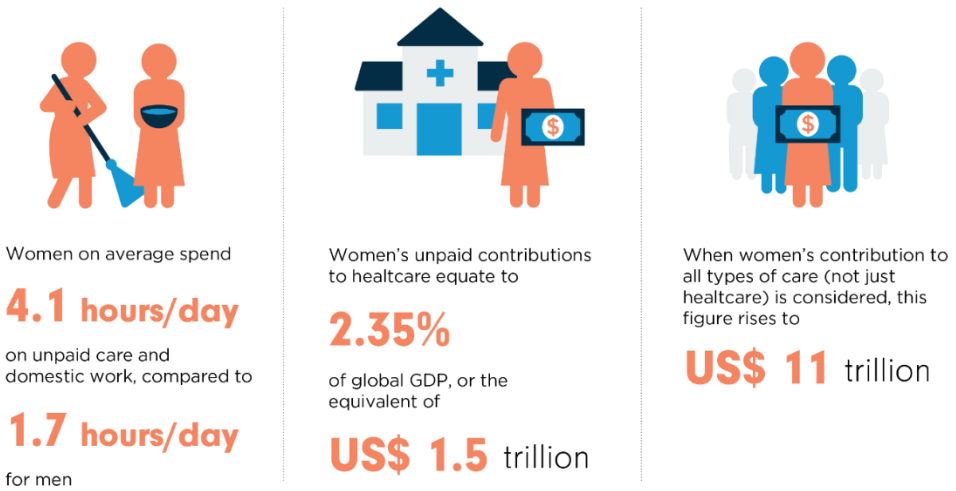
reported a 33 percent rise in helpline calls.[42] African countries have experienced the same alarming surge in GBV. For example:[43]

- Liberia recorded a 50 per cent increase in gender-based violence in the first half of this year.
- Nigeria saw an increase of sexual violence during the curfews.
- In Kenya, local media reported almost 4,000 schoolgirls becoming pregnant when schools were closed during the lockdown (allegedly been raped by relatives or police officers).
- The UN's MINUSCA mission in the Central African Republic reported a 27 percent increase in rape, and 69 percent more cases of physical harm to women and children.[44]

Similarly, UN Women Ethiopia found that measures introduced to prevent the spread of COVID-19 have in fact been putting women and girls at increased risk of a range of gender-based violence: domestic violence, intimate partner violence, sexual assault/rape, sexual exploitation and harassment, abuse from male-dominated security forces and other state/community officials; and illegally forced into underage unions/marriages in some regions of Ethiopia.[45]

Women's responsibility for **unpaid care work** in the domestic realm is much greater than men's and contributes significant value to the communities and economies as illustrated in Figure 4.

Figure 3: Women's Unpaid Care Work



Source: UN Secretary General: policy-brief-the-impact-of-covid-19-on-women-en.pdf (unwomen.org)

In Ethiopia, even before the pandemic, women spent much more time on unpaid household work than men; for example, compare the amount of time women spent collecting water and firewood (71% and 54% respectively) which was double that of men (29% and 28%).[46] However, it does appear from early reports that women who have or had paid employment do not see childcare and household responsibilities as a

[42] See https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/issue-brief-covid-19-and-ending-violence-against-women-and-girls-en.pdf?la=en&vs=5006
[43] See https://www.dw.com/en/africa-pandemic-violence-rape-women/a-55174136
[44] See In CAR, violence against women is surging amid COVID-19 pandemic, study finds | UNDP
[45] See https://www2.unwomen.org/-/media/field%20office%20africa/attachments/publications/2020/policy-brief_evawg%20covid_ethiopia.pdf?la=en&vs=2540

[46] See https://www.oecd.org/dev/development-gender/Unpaid_care_work.pdf

major issue standing in the way of employment – it is rather the job loss due to COVID-19 itself which is the bigger concern.[47]

The **social impacts on girls** are also significant, particularly with school closures and the resulting effects on education and social issues. These include a permanent end to schooling, loss of opportunities and life choices, increased care work, need to take up precarious or unsafe work, more exposure to GBV in the home, greater rates of early pregnancy (often through rape), and early marriage.[48] These concerns are evident across Africa, where evidence from the Ebola crisis demonstrated that once girls were taken out of school, they often did not return,[49] and where during the first wave, more than 120 million school girls were out of school.[50] Ethiopia was one of the 20 out of 21 countries in East and Southern Africa that faced school closures,[51] which re-opened in October after six months. Those most at risk not to return were students from low-income families, girls, rural students, and low-performing students according to a survey conducted by Research on Improving Systems of Education (RISE), Ethiopia.[52]

Economic Impacts on Women

The global economic impacts on women due to COVID-19 are extreme as illustrated by statistics collated by the Coalition for Women's Economic Empowerment and Equality.

- The International Labour Organization estimates that 195 million jobs could be eliminated globally due to the pandemic with a majority in sectors predominated by women.
- Over 740 million women around the world work in the informal sector and as low-wage workers employment that is vulnerable to elimination due to COVID-19 and which often lacks protections against exploitation and harassment.
- Globally women earn 24 percent less than men do, with women's wages being lower than men's and women experiencing wage gaps for both identical roles and different occupations of equal value.
- Women comprise on average 43 percent of the agricultural workforce in developing countries and are estimated to account for two-thirds of the world's 600 million poor livestock keepers.
- On average, women are 14 percent less likely to own mobile phones than their male counterparts and 43 percent less likely to engage online. This will result in women's inability to access critical cash transfers and other financial services via digital platforms currently being prioritized by governments in light of social distancing measures.

Source: Consortium for Women's Economic Empowerment and Equality Brief[53]

Low-Income Workers at the Margins

The reduced global demand for clothing during the pandemic has affected the welfare of garment workers in Ethiopia's largest industrial park. Although local cases of COVID-19 remain low, women have seen significant job loss, migration back to rural areas, and high levels of food insecurity.
Source: ILO, 2020

Negative **economic** outcomes for women are compounded by the pandemic due to the fact that women often have lower levels of education and skills development, earn less than men even in the same jobs, do not have the same amounts of savings as male counterparts, and are more likely to be employed in the informal sector with reduced job security and more precarious workplaces. In fact, estimates indicate that while women make up 39 percent of global employment, they account for 54 percent of overall job losses during the pandemic.[54] This is especially the case in developing countries where women are mainly employed in the informal economy. As informal jobs disappear, the outcomes are catastrophic for

[47] See http://documents1.worldbank.org/curated/en/836531600754494664/pdf/COVID-19-Impacts-on-Women-Factory-Workers-in-Ethiopia-Results-from-High-Frequency-Phone-Surveys.pdf
[48] See cweee_covid_and_wee_brief_final.pdf (icrw.org)
[49] See https://www.globalpartnership.org/blog/calling-africa-ensure-girls-go-back-school-post-covid-19-closures
[50] See https://reliefweb.int/sites/reliefweb.int/files/resources/Under%20Siege-Impact%20of%20COVID-19%20on%20Girls%20in%20Africa.pdf
[51] See https://www.unicef.org/ethiopia/stories/case-safely-reopening-schools-ethiopia
[52] See https://riseprogramme.org/blog/reopening-schools-ethiopia-perspectives
[53] See cweee_covid_and_wee_brief_final.pdf (icrw.org)
[54] See https://www.mckinsey.com/featured-insights/future-of-work/covid-19-and-gender-equality-countering-the-regressive-effects

many families. Amina Abdulla, Country Director for Kenya at Concern Worldwide observed "in many places, if you are fired today, it means that you do not eat tonight." This is the situation for many women in Africa. For example, during the 2013–16 Ebola outbreak, women traders saw much higher levels of unemployment than men, and subsequently took considerably longer for them to re-enter the workforce. Reported in the Lancet, the UN has cautioned that a lot of women who have escaped extreme poverty in Africa are at risk of falling back.[55] This is also the case for women in Ethiopia for whom COVID-19 has resulted in reduced employment and household incomes, particularly female-headed households. A World Bank survey found that about 8 percent of respondents lost their jobs at the beginning of the outbreak, with a ratio of over 2:1 for women to men (13% of women compared to 6% of men). The survey showed that self-employed workers or casual laborers in urban areas were hit the hardest in Ethiopia.[56] However, as described in the accompanying text box, women who work in industrial parks in Ethiopia have also suffered.

WOMEN'S ENGAGEMENT IN COVID-19 RESPONSE

Finally, before turning to the results of the primary research in Ethiopia, understanding women's engagement in the COVID-19 response globally, in Africa and in Ethiopia specifically is an important element of gender-responsiveness of COVID-19 initiatives.

In short, women have been largely excluded from decision-making processes related to COVID-19 response. For example, in the health sector globally, women make up 20 percent or fewer of key committees while accounting for 70 percent of the healthcare workers as illustrated below.

CARE conducted a review of women's engagement across 30 countries, resulting in a report entitled *The Absence of Women in COVID-19 Response*.[57] The report found that women average 24 percent of COVID-19 committee membership; 76 percent of the countries surveyed had made at least one commitment that supports women, woefully insufficient given the impact of COVID-19 on women; and more than half of the countries surveyed had not taken any action on GBV while about one third do not appear to have addressed SRH in their response.

The CARE report concluded that countries that do not engage women in their response planning risk not only being unable to lessen the disproportionate impact of COVID-19 on women and girls, but also going backwards on gendered gains that had been made prior to the pandemic. The following table, extracted from table with all 30 countries in the report, illustrates the range across developed countries (e.g., Canada

[55] See https://doi.org/10.1016/S1473-3099(20)30568-5
[56] See Ousmane Dione | World Bank Country Director for Eritrea, Ethiopia, South Sudan and Sudan
[57] See https://careclimatechange.org/wp-content/uploads/2020/06/CARE_COVID-19-womens-leadership-report_June-2020.pdf

and New Zealand) and developing countries showing Ethiopia's stronger performance than other low- and middle-income countries.

Country	Name of COVID-19 Response Team (activated or convened)	Percent C-19 response team that is female	Funding for GBV	Policy announce-ment or commitment for GBV	Funding for SRH	Policy announce-ment or commitment for SRH	Childcare support	Support to mitigate economic effect of C-19 on women	Assistance for vulnerable and/or low-income groups
Canada	The COVID-19 Immunity Task Force Leadership Group	52.17	Y	Y	Y	Y	Y	Y	Y
New Zealand	"The Quint," as part of the National Crisis Management Center	20	Y	N	N	Y	N	N	Y
Ethiopia	COVID-19 National Ministerial Committee	28.6	N	Y	N	Y	N	N	Y
India	Corona Task Force 11 Empowered Action Groups	n/a	N	N	N	N	N	Y	Y
Kenya	National Emergency Response Committee on Coronavirus	28.57	N	N	N	N	N	N	Y
Mali	Le Comite de Crise Comité Scientifique et Technique de l'Institut National de Santé Publique	10	N	N	N	N	N	N	Y
Myanmar	National Central Committee for COVID-19 Prevention, Control, and Treatment	18.18	N	N	N	N	N	N	Y

5. PRIMARY RESEARCH FINDINGS

Supported by the stakeholder mapping and desk review, primary research has provided significant insights into gaps, constraints and opportunities for COVID-19 gender-responsiveness of government, CSOs and IOs across health, social and economic sectors in Ethiopia.

IMMEDIATE PREVENTION AND CONTAINMENT

As widely documented in the media and literature, and described above, the Government of Ethiopia acted swiftly, adopting, adapting and innovating policies, strategies and interventions for the prevention and containment of COVID-19. Actions ranged from social distancing and lockdown to a healthcare system response that reached from the national to the village level. In parallel, with years of strong economic growth, the lockdown aimed to be moderate and allow for the economy to keep moving forward. Shigute el al reflect a common expressed viewpoint when they report that "a good balance has been maintained, and economic activities, especially agriculture and industry, have continued with a view to maintaining food security and preventing unrest."[58] A favourable assessment of the government's quick action was also evident in primary research. For example, 43 out of 76 survey respondents indicated a high impact and 24 a medium impact for the government's efforts overall (not gender-specific).

This attention to public safety was also reflected in the workplace. Key informants detailed the many ways that they had been protected by their employers. Almost all government ministries and agencies, as well as CSOs and IOs, put in place various strategies to curb the spread of the virus in their respective institutions. Such measures included maintaining physical distancing, protocols and resources for hygiene and sanitation, use and distribution of personal protective equipment, awareness raising, thermal scanning at the gates of institutions and testing of employees. Physical distancing was implemented through a range of methods such as supporting staff to work from home (including in some cases the distribution of internet modems and tablets), introducing shift work, staggering schedules for cafeteria use and limiting staff transportation services to 50 percent capacity. As a government official reported "Forty percent of our staff got tested for COVID-19. We give priority to testing for cafeteria workers and other high-risk staff (who interact with more people)" There was also some consideration for more vulnerable groups: "In order to keep the safety of pregnant and lactating women, older age employees (both women and men) and employees who have underlying health conditions, and to reduce their exposure to the virus, they were given annual leave to stay at their home. When those employees stayed at home, the rest of the employees covered for them."

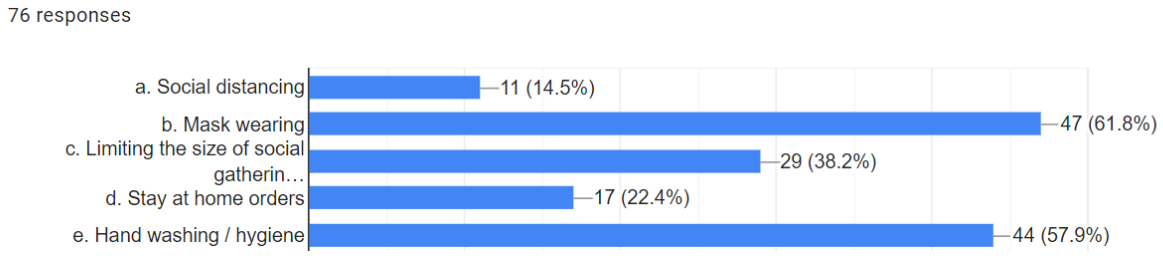
Vulnerable Female Workers

Generally, organizations attempted to be gender sensitive in terms of staff protection through giving priority to pregnant and lactating women, women with different health conditions and other women with different vulnerabilities to stay at home. One government official noted that "Most of our office cleaners are women and they are highly susceptible to the virus. To protect them from the virus we decided that the 10 percent of employees who come to the office during the lockdown should clean their own offices and the janitors should come and clean only once a week."

Primary research also demonstrated there is strong public support for mask wearing and hand sanitizing, as well as to a lesser extent limiting the size of gatherings. However, there is lower adherence to social distancing and stay at home orders as illustrated from the survey question on compliance below.

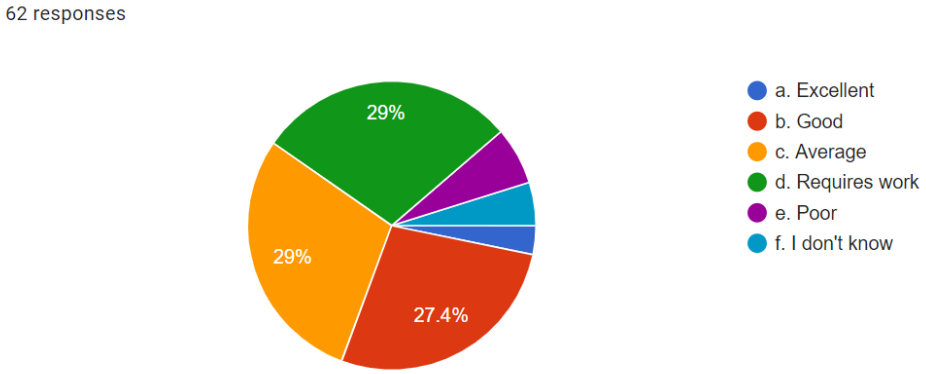
[58] See https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7296219/

In response to the survey question “For which COVID-19 regulations or restrictions is there strong public compliance? Select all that apply,” 76 respondents replied as follows, showing a greater emphasis on mask wearing and hand washing.

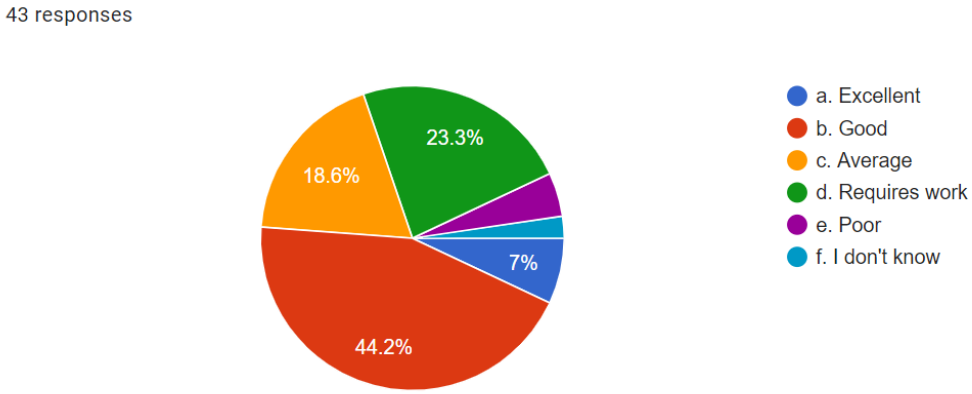


However, as concerns moved from the immediate issue of prevention, gaps in general and in gender-responsiveness in particular became more evident across stakeholders and sectors. The following pie charts illustrate the level of survey respondents’ perception of the success of response by organisation type: government, CSO and IOs. While CSOs received the highest percentage of ‘Excellent’ or ‘Good’ ratings for their gender-responsiveness, government was ranked lowest. IOs’ gender-responsiveness was rated more ‘Average’ and therefore did not have as many ‘Needs Work’ responses.

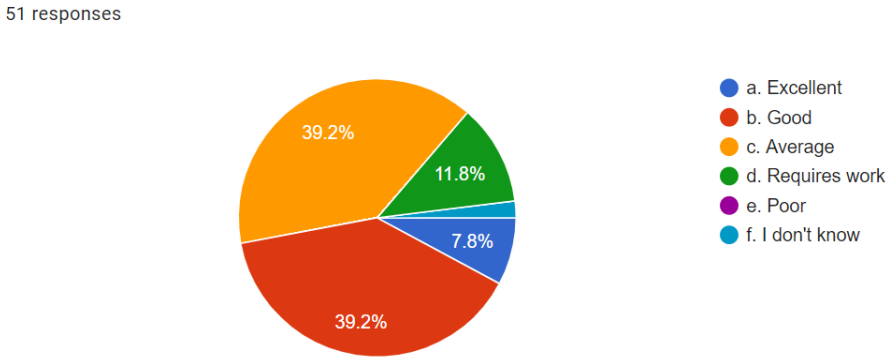
Question: “What is your general perception of the **government's achievements** in gender-responsive COVID-19 initiatives?” Of the 62 respondents, we see the majority responded Good (27.4%) or Average (29%), with one third opting for Requires Work. Otherwise, two individuals indicated the government response was Excellent, three Didn’t Know and four considered it to be Poor.



Question: “What is your general perception of **CSO achievements** in gender-responsive COVID-19 initiatives?” In the case of CSOs, the 43 responsens were more favourable with mainly Good (44.2%) and Average (18.6%), about a quarter Requires Work, three indicated Excellent, one Didn’t Know and two rated CSOs as Poor in their response.



Question: "What is your general perception of **IOs' achievements** in gender-responsive COVID-19 initiatives?" There were 51 total responses of which the majority were Good (39.2%) or Average (38.2%), only a few indicated Requires Work (11.8%) and four responded Excellent, one Didn't Know and none responded that IOs had performed poorly.



The following sections describe specific concerns around COVID-19 gender-responsiveness among government, civil society and international organisation key informants and survey respondents in Ethiopia as they pertain to response and recovery.

Gender-Responsiveness in COVID-19 Response and Recovery Efforts

The ability to respond to gendered needs and build recovery efforts during COVID-19 (or other crises) depends on recognizing that men's and women's needs, and the required approaches and processes for meeting these needs, are different. To be 'gender neutral' is to be gender blind,[59] often resulting in catering to needs through established systems and methods that are typically skewed in favour of a dominant group (typically men) (e.g., household relations, paid and unpaid work, access to finance and jobs, decision-making, etc.).

The consensus among primary research respondents was a pressing cross-sectoral need for:

- Coordination of a gendered response
- Better gendered information and data
- Access to the knowledge and skills of gender experts
- Sustainable funding allocations
- Improved targeting of vulnerable populations
- Greater attention to non-COVID health issues as well as social and economic sectors

Each of these areas is addressed in this section, introduced by a summary Finding and backed up with information from primary and secondary sources.

Coordination of a Gendered Response

Finding: Ethiopia's COVID-19 gender response has been fragmented and at times even conflicting. Despite concerns about the government's performance, organisations agree that the government must take the lead on coordinating a more effective gender response.

The lack of a coordinated gender response among and between government, civil society and IOs was widely noted by key informants and survey respondents. In the survey only 9 of 76 respondents strongly agreed that there was a coordinated response to COVID-19 in general (while 44 somewhat agreed) and 59 percent indicated that women's needs had not been met in any sector (health, social and economic). However, we repeatedly heard from KII informants how important government coordination is to a successful response

[59] See https://beamexchange.org/uploads/filer_public/ce/72/ce725978-3302-45a6-8e75-781eac287f7e/the_weams_framework_lj_compressed.pdf

and recovery and the opportunity for mechanisms available within the government – the National Task Force, the Ministry of Women, Children and Youth Affairs (MoWCY) and the Women's Machinery – to ensure an informed and coordinated response.

Government Committees and Gender-Responsiveness: A Snapshot

Despite this recognized need for the role of government in gender-responsiveness, primary research indicated a general lack of leadership on the part of the government. Respondents to the KIIs indicated that they had not seen specific activity from the government concerning gender and COVID-19, that the government had not done well on gender, there is no specific budget allocation for gender, insufficient attention was paid to the vulnerable. There was a strong sense that the emphasis on a medical response meant that the gender impacts were not fully understood or responded to. This is further discussed in the sections on social and economic sectors below.

Government representatives reported that a significant COVID-19 initiative of the national government was the establishment of Ethiopia's multi-sectoral National Task Force in the early days of the pandemic. The Task Force was chaired by the Prime Minister (PM) and the PM designated the Deputy Prime Minister (DPM) to lead this national task force that consists of seven sub-committees: Quarantine Centers Preparation Committee, Information Technology Committee, Health Committee, The Resource Mobilization Committee, Macro Economy Committee, Safety and Law-enforcement Committee, Media and Communication (note that there was no committee on gender or inclusion).

Many activities or declarations of the National Task Force were reported as press releases only, with little guidance beyond the media announcements. A series of press releases from March 16 to 27 stated decisions and guidance on topics such as size: closures of religious institutions, night clubs and bars, schools and institutes of higher learning; allocation of budget for masks, soaps and alcohol solutions in critical locations; monitoring of businesses to regulate unnecessary increase on prices of consumer goods; quarantine protocols and facilities; medical staffing; etc.

However, the National Task Force was soon replaced. In April, a nation-wide State of Emergency was declared (Proclamation 3/2020) and the National Task Force was re-established as a Ministerial Committee (article 5, SOE Regulation 466/2020). The Ministerial Committee was chaired by the DPM, accountable to the PM, with five sub-committees for communication, legal affairs, diplomacy, peace and security and technology. (Article 7, Directive 2/2020). At the same time, as reported by key informants, many government offices also established COVID-19 prevention and response committees within their organization.

The National Ministerial Committee communicated action plans through various press releases such as those on March 16, 20, and 27 which can generally be summarized as below:

- Prohibition of large gatherings;
- Temporary closure of religious institutions;
- Temporary closure of night clubs and bars;
- Allocation of budget by government for masks, soaps and alcohol solutions in critical locations;
- Monitoring of businesses to regulate unnecessary increase on prices of consumer goods;
- Quarantining of arriving passengers for 14 days in designated hotels;
- Expansion or alternative location for correction facilities;
- Interim ceasing of flight operations by Ethiopian Airlines to 30 countries;
- Preventive measures to be taken in elderly care centers;
- Closure of schools with the exception of higher education institutions;
- Government quarantine centers for arriving passengers who cannot afford to quarantine into hotels;
- Two week's extension of school closures including higher learning institutions;
- Calling upon retired and and in-training medical professionals for national duty; and

- Identification and setting up of more than 134 quarantine facilities.

The National Ministerial Committee has been mostly engaged in the response work through the establishment of the MOH's Emergency Operation Center (EOC) and Ministry of Peace's (MOP) Emergency Coordination Center (ECC). While the former focused on health issues, the latter took up the cause of vulnerable populations – much of which focused on emergency food packets, those confined to prison or care centers, and quarantine protocols and facilities.

Despite these reported efforts of the government, only 60 percent of survey respondents were aware of the task force, and 40 percent felt that it needed to strengthen its role in the coordination effort. This communication challenge has been observed by researchers in general (not just re gender-responsiveness). For example, in May, implementation and communication success was questioned by the International Food Policy Research Institute (IFPRI)[60] with analysis showing that the high rural population of Ethiopia did not have access to information, water and soap, and other services needed to slow the spread of the virus. In addition, IFPRI reported that stay at home orders were increasing gender-based violence. The conclusion was that government communication platforms and messaging are needed to adapt to different local realities.

More recently, in November, Zikargae conducted an assessment of how the Ethiopian Government has executed administrative actions and managed risk communications and community engagement.[61] This study reinforced findings from our key informant interviews, that despite some government policies and mandates, there is little coordination on the ground and policies are not taken forward. A key conclusion of the study was that different communication forms are needed to reinforce existing efforts and alleviate socio-cultural, political, economic factors while promoting existing strategies and the drawing of new documents by focusing on high-risk parts of the population.

For gender guidance and coordination, government and civil society KII respondents often look to the MoWCY and the women's machinery overseen by MoWCY,[62] noting, for example, "previously we used to have planning, monitoring, and evaluation sessions together. Currently, they [MoWCY] are not taking the lead in coordinating gender-related programs; they should be the ones that lead the national gender programs since they are the ones with the mandate".

However, this emphasis on MoWCY's role demonstrates to some government officials that "gender is not mainstreamed" and other government agencies are "gender neutral", while "partner organizations such as UN agencies and international organizations worked more on the issue of protection, and gender specific targeting." But the challenge of mainstreaming is that it is uneven since, as one UN official explained "not every institution considers gender as a cross cutting issue. For some, it comes secondary. As an organization, as much as we would like to mainstream gender, I think our work is constrained by not having partners who are fully committed to gender."

The challenges of coordination were noted not only at the national level and through the women's machinery but also among regional governments and CSOs, as well as across ministries/agencies responsible for specific target groups. For example, while IOs reported being invited to MoWCY events and learning about priorities, a lack of coordination within the government created confusion and conflicting guidance. One IO respondent explained that the Federal Attorney General Office of Ethiopia (FAGE) and MoWCY have different approaches which impact social areas of COVID-19 gender-responsiveness since FAGE has a role in dealing with gender-based violence and child abuse.

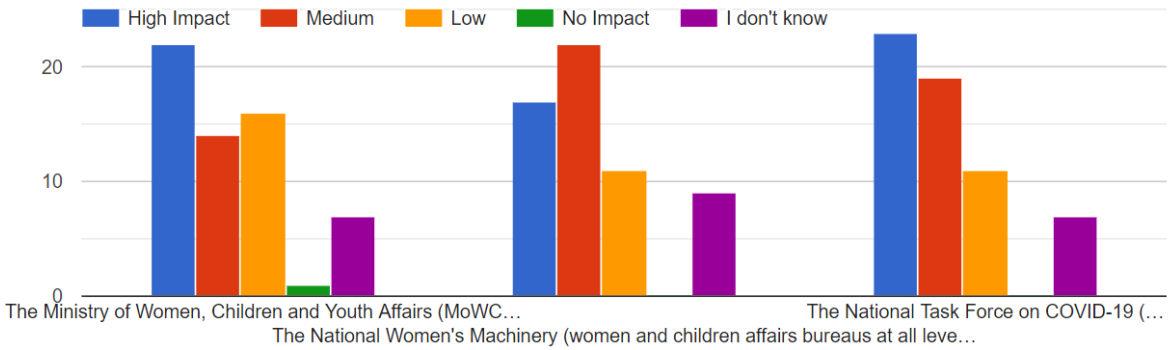
[60] See https://ebrary.ifpri.org/digital/collection/p15738coll2/id/133729
[61] See https://www.dovepress.com/covid-19-in-ethiopia-assessment-of-how-the-ethiopian-government-has-ex-peer-reviewed-fulltext-article-RMHP
[62] The coordination mechanisms of the women's machinery is twofold: horizontal and vertical. While vertical coordination takes place through MoWCYA's working and reporting relationship with regional women's departments and programs, horizontal coordination takes place at the federal level with women's directorates of sector ministries, and other public organizations. See USAID https://www.usaid.gov/sites/default/files/documents/1860/Preliminary%20Gender%20Profile%20of%20Ethiopia%20Nov%2017%20final.pdf

A similar challenge was identified by CSOs seeking support for gendered responses for persons with disabilities (PWD). The Ministry of Labour and Social Affairs (MOLSA) was responsive because, as one respondent explained, “they are already working on PWDs” but “MoWCY wasn’t easily responsive because they think that the issue of disability is the responsibility of MOLSA.” Through various interventions including a formal letter and discussions with the UN Human Rights Commission, some support was received from MoWCY for women with disabilities. CSO representatives would like to see this strengthened and suggested a disability directorate within MoWCY for women with disabilities, giving them the same status and right to support and services as other vulnerable groups.

The situation is further complicated by the fact that some organisations do not work with MoWCY for COVID-19 related work as their focus is on the health sector and they therefore engage with the Ministry of Health (MoH), Ethiopian Public Health Institute (EPHI), and the Ethiopian Drug and Food Administration (EDFA) as these are the main health related public stakeholders. And, there are situations where MoWCY reaches out to other agencies for support such as working closely with the Ministry of Peace, the Police College and Ethiopian Psychologists’ Association to get professional help for GBV survivors.

CSOs also reported a lack of coordination with one another including those that work on women’s issues. “Every organization was working in its own way, in a scattered manner… We have tried our best but I don’t think it was enough. If the organizations worked together, women might not have been affected as much.” This has been more problematic in rural areas where CSOs report that communities do not get proper information about the disease, and CSOs are not coordinated with the government in their response. In fact, the majority of survey respondents (government, CSO and IOs) indicated greater coordination among CSOs as a top priority going forward.

Despite these gaps in coordination, there is still a somewhat favourable attitude of survey respondents to the coordination role of the key government bodies for gender and COVID-19 response. When asked during the survey, “What is the impact of the following government bodies on COVID-19 gender-responsiveness through activities such as coordination, support, outreach to communities?” the following rating was provided from 'High Impact' to 'No Impact'.



More importantly, there is a strong desire and support for gender-responsiveness to be led and coordinated by the government, setting the stage with guidance and funding for gendered initiatives going forward.

Gendered Information and Data – Evidence-Based Decision-Making

Finding: High quality information and data are generally recognized as necessary to improve Ethiopia’s COVID-19 gender-responsiveness and to support evidence-based decision-making. Despite this recognition, the level of commitment and investment in resources is inadequate to the need.

Gendered information and data are needed in different forms for evidence-based decision-making at various stages in COVID-19 prevention, response and recovery. In the absence of assessments and evidence-based approaches, it has been challenging to identify gendered needs and to make informed decisions. In some cases, government KII respondents have been quite open about not using gendered information and not specifically targeting women: for example, comments include statements such as “we didn’t intentionally

target women in our COVID-19 related interventions" and "we didn't take gender factors into consideration in our COVID-19 response activities."

Gendered Assessments: Gendered assessments are typically carried out prior to designing or implementing an intervention, to understand gendered differences particularly around supply side issues such as identification of needed products and services, and availability of and access to those products and services. For example, hand sanitizing stations could be identified as a need in low-income urban communities. A gendered assessment might explore the best location for such stations to be accessible to women, such as near markets, housing complexes, or places of work.

A number of KII respondents indicated that there was not sufficient time to conduct preliminary assessments before responding to COVID-19. However, government officials reported that while they were unable to conduct such assessments, they could use department-level assessments or field observations to support the design of initiatives. It was reported that assessments were carried out on "the readiness of quarantine centers, isolation centers and COVID-19 treatment centers to accommodate the needs of people with specific needs such as migrant returnees, pregnant women, GBV victims, children, and persons with disabilities." Similarly, "rapid and continuous assessments took place to identify the peak of COVID-19, who is very likely to get affected by it, where to give more focus, and so on."

However, these assessments were not typically gender-sensitive with KII informants making comments such as:

- "I don't think gender has been adequately and properly integrated into our COVID-19 responses."
- "I am afraid the interventions implemented by the agency for our COVID-19 related work didn't consider gender."
- "We didn't work on women and men separately. We didn't give any special attention to mainstream gender in our COVID-19 related interventions."

Furthermore, consultation was limited. According to IO KII respondents, while government officials indicated they prepared gender-responsive initiatives in consultation with different government actors and regional bureaus, they did not consult with CSOs or women associations who are active on the ground. Since CSOs work with local constituencies, they have a better understanding about the gendered impacts of COVID-19 and potential solutions, so not including CSOs in such platforms can needlessly result in a gender gap in policy making and implementation.

Gender Analysis: Gender assessments can be strengthened by gender analysis that digs deeper into underlying systemic biases such as gendered social norms—for example, in the case of public hand sanitizer stations, gender analysis might explore systemic issues for women's use of public hand sanitiser stations such as young women's hesitancy due to being harassed by men or women with disability being unwilling to leave their homes. This gap in analysis was exemplified by a statement of a KII respondent from an IO: "When we develop our COVID-19 response guideline, we have done some form of assessment; but it's difficult to call it a gender analysis. It's some form of rapid assessment with which we have briefly looked at the gender impacts of COVID-19 and integrated them in the guideline." Another IO indicated that as an organization, they have a minimum requirement of conducting a gender analysis before starting any project; however, "we didn't have gender experts to do that on the short term; therefore, it really didn't happen." Other IOs supported this statement indicating they didn't have time to conduct gender analysis or needs assessments but rather "what we did was, conduct a kind of descriptive analysis/literature review on the gender impacts of COVID-19."

While survey respondents gave more positive answers about gender assessments and gender analysis, this may be more an expression of an aspiration or a minimum requirement that has not actually played out during COVID-19. The survey responses are summarised in the following table.

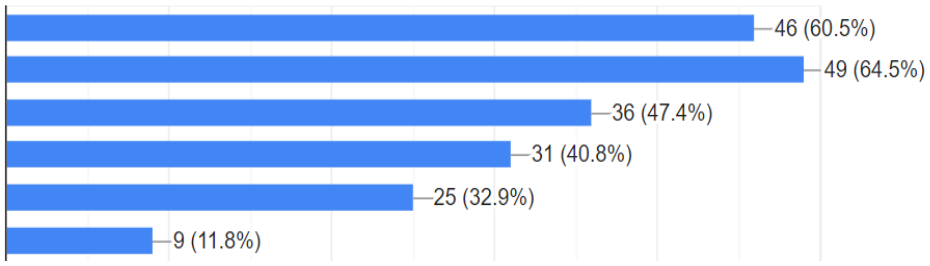
Question: Which approaches does your organisation employ to ensure gender-responsiveness in COVID-19 prevention, response and recovery initiatives? Select all that apply.	
Optional Responses	Percentage Respondents Selecting Each Option
a. Women-focused initiatives that consider supply (transactional) issues such as availability and access	44%
b. Women-focused initiatives that consider underlying issues such as gender norms and biases [gender analysis]	42.7%
c. Gender is mainstreamed across initiatives taking supply (transactional) issues into account such as availability and access	54.7%
d. Gender is mainstreamed across initiatives taking underlying issues into account such as gender norms and biases [gender analysis]	62.7%
e. None of the above	9.3%

Gendered Evaluations: Evaluations of COVID-19 activities had either not yet been completed or shared at the time of the primary research. For example, during KIIs, government officials stated that evaluations had not taken place as "works are still undergoing" or that information is "not yet ready for circulation as it hasn't been published." While some of the organizations stated that they have a plan to evaluate their COVID-19 initiatives, others said they have simply gone back to business as usual.

Several ministries reported holding bi-weekly or monthly monitoring sessions where they discuss their achievements and challenges, while others conduct regular monitoring of initiatives and compliance with protocols (for example, the Ministry of Finance, Ministry of Science and Higher Education, EPHI, MoH).

Survey respondents view evaluation as a critical need with 67 out of 70 respondents indicating that evidence-based decision-making is a top priority (45 a high priority and 22 a medium priority) for their organization going forward. The following graph illustrates **the gender-inclusive approaches or tools used by respondents i**n their COVID-19 evaluations (although this may be planning only):

a. Sex disaggregated data
b. Gendered questions
c. Qualitative tools
d. Gender analysis
e. Women researchers
f. None of the above



Sex-Disaggregated Data: As described above, the majority of countries do not provide sex-disaggregated data, even in the area of health statistics when reporting to the WHO, and gender outcomes have often been projected or extrapolated from subsets of data. During KIIs, respondents reported that early in the pandemic "Disaggregated data (by sex and age even sometimes by occupation) used to be released by MoH and EPHI using various media. But when the number of cases rose, MoH and EPHI started to provide general data."

KII respondents explained that in May, a system (DHIS2) was set up to collect and submit data to the MoH. This system was customized for COVID-19 reporting purposes, and disaggregates data by sex, age, pregnancy, and other socio-demographic characteristics. (This customized data collection does not yet allow disability disaggregation). As explained in the Data Challenges section of this report, all treatment centers

enter data online and that MoH and EPHI have well established and disaggregated data. However, this disaggregated data is not disseminated and is currently not available on their Website or Facebook page respectively. As shared by a key informant from the MOH, "Initially, there were efforts to provide sex-disaggregated data in daily COVID-19 updates; however, as the number of cases arise, it becomes difficult for us to provide disaggregated data in our daily updates. This being the case, we still tried to provide sex-disaggregated data in our DHIS-2 system but due to technical challenges this is not functional at all times."

Gender Experts and Expertise

Finding: Gender experts are not utilized consistently, and gender expertise in government does not always carry through to middle management and regional offices. This is recognized as a gap that needs to be addressed for the best gender-responsive outcomes.

Fewer than half (46 percent) of survey respondents indicated that a gender expert is on their team or consulted regularly about decisions and approaches (that is 35 out of 76 respondents), with a slightly higher percentage for government respondents (12 out of 23 government respondents or just over 50 percent) asserting this fact. According to KII respondents, some gender experts are within Gender Directorates while others are within Operational Directorates. Operational Directorates without their own gender expert reported that the Gender Directorate was involved in gender mainstreaming. However, a significant number of KII respondents from Gender Directorates state that they have not been included in their respective organizations' COVID-19 interventions. Moreover, there is a sense among some government respondents that gender issues are not taken as seriously at all levels with comments such as "even though higher-level managers have the commitment to gender, the middle-level managers don't give enough attention to it. Especially when you go to the regions, let alone supporting the gender office, they even use the budget of the gender office for other activities."

Of the 15 CSOs responding to the survey question, none had a gender-expert on the team, although most promoted women's leadership and/or gender-inclusion criteria for their initiatives. However, CSOs noted that they often work jointly with IOs and look to them for support in gendered planning and assessments as they often have gender experts on staff. CSOs also observed that government is not engaged on gender issues and in fact, one CSO stated that "They don't have the consciousness. Even though there are women directorates, their voice is very weak. I can confidently say that there is gender awareness in almost all CSOs, but I don't think there is as much awareness on the government side." The reliance of CSOs on IOs was also reflected in the statements of IO KII respondents who noted that main criteria for selecting CSOs are the alignment of values and goals. IOs and CSOs then work together to achieve gender equality and inclusion and to bring justice to women and girls.

Sustainable Funding Allocations

Finding: There is insufficient funding for gender-responsive initiatives from assessments through design, implementation and evaluation. The need for increased and coordinated funding is recognized as a critical component of the response for greater gender inclusion.

While the government's prevention activities received a favourable response from survey participants, a key element of concern was the level of government funding for gender-responsive initiatives. Out of the 58 survey respondents to the pertinent survey question, 12 somewhat disagreed and 24 strongly disagreed that government funding was adequate for gender-responsive initiatives (while the majority of the remaining responses were neutral or did not know). However, with regard to IOs, the majority (7 strongly and 26 somewhat out of 48 respondents) agreed that they had been successful in raising sufficient funds for gender-responsiveness. Even with regard to CSOs, the 40 responses still skewed in favour of sufficient funding for gender-responsiveness (22 in the agree range, 11 in the disagree range and 7 neutral/don't know).

Government officials were very aware of this challenge in lack of sufficient funding. One informant very eloquently described the massive need as compared to available resources. "We had limitations of resources; the demand was so high. People needed our support everywhere. There were displaced persons

in Somali region, Benishangul, Amhara, Oromia, SNNPR,[63] Dire Dawa, you can say all over the country. On the other hand, there are the migrant returnees from the Middle East. Our support was needed everywhere."

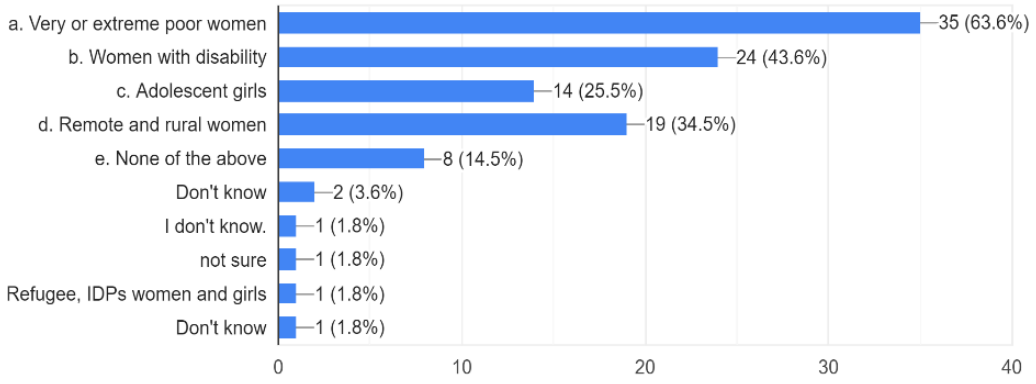
In general, a key deficit contributing to unequal impacts on gender by governments is the lack of gender budgeting. Gender gaps persist across sectors, and gender budgeting is a way that governments can improve gender outcomes.[64] Gender-budgeting challenges were raised in discussion with CSO representatives where one highlighted the prevention-recovery-response funding gap: **"**They have just seen the medical impact of COVID-19; they haven't seen the gender impact." Moreover, CSOs noted discrimination in resource distribution with male-headed households favoured over female-headed households, with lack of transparency and no disaggregated data to support or refute this observation.

Targeting of Vulnerable Populations

Finding: Vulnerable populations have been hardest hit by the health, social and economic impacts of COVID-19. Targeting of vulnerable populations, particularly those with intersectional identities (PWD, IDPs, female-headed households), needs significant and immediate attention to reduce hardship and suffering.

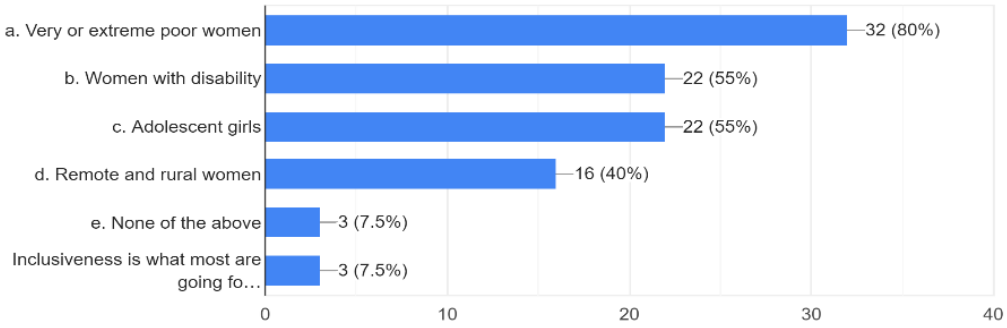
In terms of vulnerable populations, there is a relatively favourable perception among survey respondents of outreach to very or extreme poor women across stakeholder type (see charts below). However, there is a decline in positive perceptions for other types of exclusion such as disability, age, location and status as a refugee or IDP, indicating that targeting of vulnerable populations across all organisation types needs improvement. As the background research indicated, these are critical issues globally, across Africa and also specifically in Ethiopia

Government (55 respondents) to the question "Which of the following intersectional identities are considered by government in COVID-19 initiatives? Select all that apply."

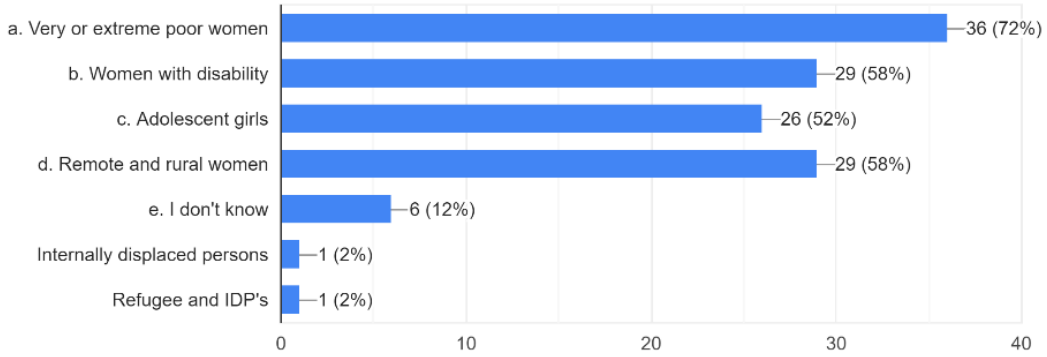


Civil Society Organisations (40 respondents) to the question "Which of the following intersectional identities are considered by CSOs in COVID-19 initiatives? Select all that apply."

[63] Southern Nations, Nationalities, and Peoples' Region
[64] See https://www.oecd.org/gov/budgeting/gender-budgeting.htm



IOs (50 respondents) to the question "Which of the following intersectional identities are considered by IOs in COVID-19 initiatives? Select all that apply."



This perception of outreach to the most vulnerable not being inclusive was backed up in the KIIs. For example, the following statement represents a common viewpoint: "The response at the lower level of government was coordinated by local committees. Our members (who are women with disabilities) are not represented in those groups because they are not considered as active members of the community."

Women participating in the FGDs viewed CSOs more favourably than government as the CSOs are "doing much better in terms of reaching vulnerable groups through their members."

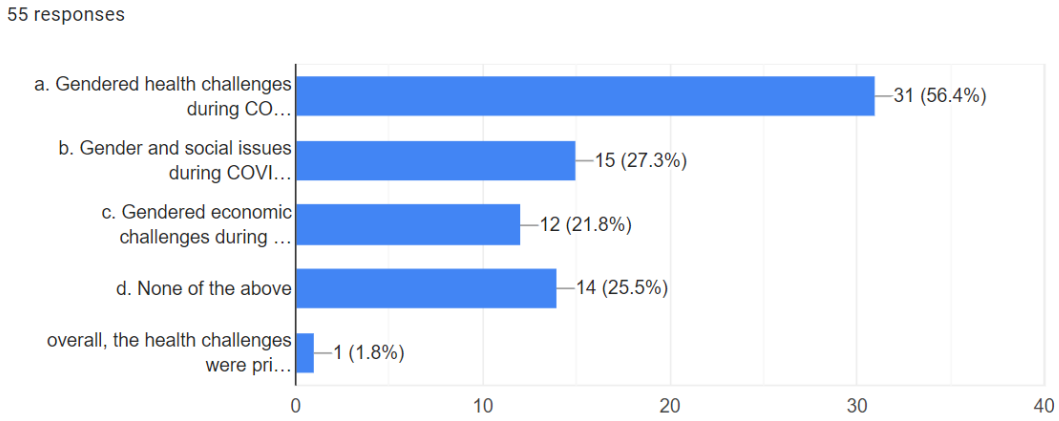
However, it is when we turn to the social and economic sectors in particular that the situation of vulnerable populations becomes even more stark.

Non-COVID Health, Social and Economic Sector Recovery

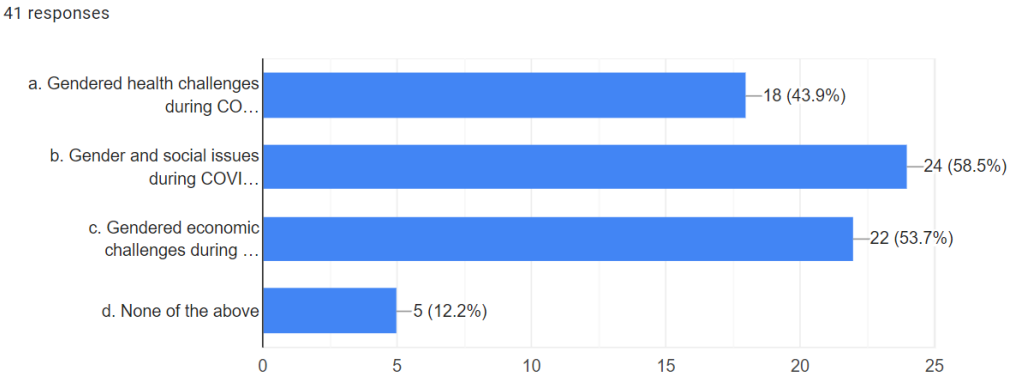
Finding: A sectoral examination of COVID-19 impacts – non-COVID health, social and economic sectors – highlight a significant need for recovery strategies and programs to be funded and implemented. Sector-specific gender-responsiveness can only be improved if challenges are also met (e.g., coordination, budgeting, outreach to vulnerable people, etc.).

The following charts illustrate the assessment of survey respondents around the effectiveness of sector-specific gender-responsiveness by government, CSOs and international organizations.

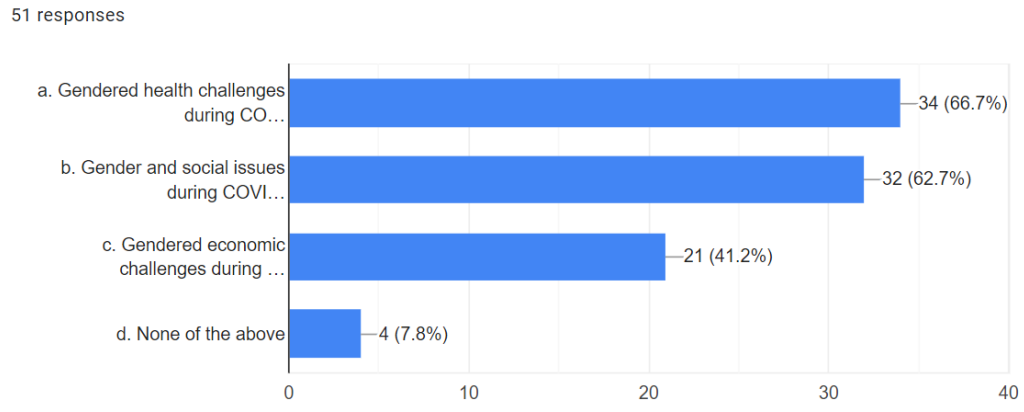
Question: "In which key sector or sectors has the government's gender-responsiveness been the most effective? Select all that apply." Respondents identified that government's gender-responsiveness had been effective in areas of health, but lagged in terms of social and economic areas. A full 25.5 percent of respondents indicated that the government had not been effective in gender-responsiveness in any sector.



Question: "In which key sector or sectors has CSO gender-responsiveness been the most effective? Select all that apply." CSOs were assessed as being most effective in their gender-responsiveness in social areas, followed closely by economic areas. Even in areas of health, almost 44 percent of respondents felt that CSOs had been effective in gender-responsiveness.



Question: "In which key sector or sectors has IO gender-responsiveness been the most effective? Select all that apply." IOs (including both INGOs and international bodies such as UN Women) were identified as more effective than government and CSOs in gender-responsiveness in health and social sectors but lagged behind CSOs in economic areas.



There was overwhelming agreement from survey respondents that stakeholders needed the greatest strengthening in gender-responsiveness in economic and social areas as follows:

Stakeholder Needing Strengthening	# of Respondents	Percentage Respondents Identifying Need for Strengthening	
		Economic Sector	Social Sector
Government	56	87.5%	92.9%
CSOs	41	85.5%	85.4%
IOs	51	74.5%	70.6%

In an introductory question, the majority of survey respondents (52 out of 77 respondents) agreed that healthcare systems had adapted well to meet the demands of COVID-19. In terms of social issues, there was much higher levels of concerns with 39 out of 76 disagreeing that social needs (especially GBV) had been met, 17 agreeing and 20 neutral/don't know. In the case of economic issues, 32 out of 77 disagreed that economic activities and income had been safeguarded, while 25 agreed and 20 were neutral/don't know.

Focused on the delivery organisation and gender-responsiveness in general, IOs were viewed most favourably (44 out of 51 respondents reporting excellent, good or average results), CSOs were next at 30 out of 43, and government was behind in gender-responsiveness with only 37 out of 62 responses showing average or above. This reinforces earlier statements about a stronger government focus having been on health/ prevention and less so on women's social and economic needs.

Going forward in the recovery phase, respondents recommended government strengthening especially in social areas (52 out of 56), 49 in economic areas and 38 in health. CSOs on the other hand were viewed as responding more strongly in social areas (24 out of 41 respondents), almost as strong in economic (22) and less so in health (18). Nevertheless, all areas were seen by the majority of respondents as requiring strengthening. IOs were seen as the weakest in economic areas (21 out of 51 respondents) and the one that required the most strengthening (38), followed by social (32 supporting effectiveness; 36 the need for strengthening) and health the least urgent (34 effective, 31 requiring strengthening).

There are existing interventions in social and economic areas that can be built upon to promote recovery.

Social Sector Issues: At the initial stage of the pandemic in Ethiopia, there were reports that the number of GBV cases increased. As a result, a key informant from FAGE shared that "Coordinating the one-stop centers is our responsibility and there is a national coordination body that gives a response on women and children violence and our office acts as a secretariat for that body and supports it to lead its work in a coordinated manner." Courts are another institution that responded to the reports that number of cases of GBV increased; for example, the Chief Justice stated in a press release that courts that entertain cases of GBV and other gender matters, family issues and children's issues would be operational despite the suspension of other services of the courts. However, despite courts being opened, as a key informant interview respondent from the Federal Police Commission (FPC) shared "There wasn't a police hotline or any formal or informal structure where victims or ordinary people could report incidents of GBV [due to other GBV hotlines already operating]; however, there were times when people reported GBV either in person or through our office telephone lines. When we receive such a report we will go to the place and investigate the case. Usually, victims come to us when other people tell them to go to the Federal Police. However, when COVID-19 hit, we suspect there were many cases because many organizations were closed".

Women's burden of care and household work has worsened in Ethiopia despite men being out of work, indicating the need for gender analysis around social norms and the need for efforts to shift harmful social norms and gender biases. This consensus of FGD respondents is exemplified by the statement of one woman who explained, "First of all, the entire house chores are the responsibility of women. Now that children are staying home, looking after them for the whole day is an additional burden. In our country, women are expected to do everything in the house. Men aren't that much involved in house chores and they've proved that during this pandemic season. Previously, they used to claim that it's because they have to go to work; but now, when there is no work, they'd rather spend time at the bar than help us in the house."

Other social issues such as the impact of school closures on girls were not discussed in the primary research, but desk research in the background section above has emphasized this as a critical concern for Ethiopia's

girls and young women. Similarly, the situation for non-COVID health impacts was overshadowed by the pandemic response and was not discussed in primary research. Fortunately, as with girls and school closures, there is adequate evidence from the desk review to prioritize this area in the recommendations in the following section.

Economic Sector Issues: *"For us women, the economic impact of COVID-19 outweighs all the other impacts. We know how to protect ourselves from the virus as we have received different forms of training on the precautionary measures; however, we have no means of averting the economic impacts*" (Representative FGD Respondent).

Almost none of the organisations interviewed – government, CSOs or IOs – focus on women's economic empowerment and very little information was forthcoming on the topic. At the same time, respondents recognized economic challenges as a priority area going forward along with the need for significant strengthening to mount an effective response and recovery from COVID-19 impacts.

During FGDs, low-income women were able to share their challenges and experiences, highlighting the extreme impact of COVID-19 on women's economic well-being:

- Women are often engaged in informal work arrangements and have experience loss of jobs and income without benefits or any other resources.
- For women business owners (from micro-enterprises such as a trader selling bread to larger businesses employing 10 or more other women), there are reduced economic opportunities during COVID-19. Women feel the weight of not only supporting their own families, but also their women employees and their families.
- Access to finance has become constrained, and pre-existing loans have become difficult to pay off. Even when women take loans, they often end up losing the money due to economic challenges and have repay without regular income.
- Being a single parent in a female-headed household puts immense burden on women to provide all the needs of children and the household, with few options to earn and in some cases not being eligible for social protection or charitable handouts.
- In order not to lose a school spot (and remote learning may at least be theoretically in effect), women have to keep paying school fees to ensure their children's future prospects.
- Labour migrants are often returning to their rural homes where without jobs they might contribute to and benefit from the household (often agricultural) economy.
- District-level offices, wards and neighbourhood associations often favour women that they know in terms of social transfers and government handouts. Labour migrant returnees and PwD have reported examples of being left out and not benefiting from government programs. This can be exacerbated by the fact that government officials may require identification cards for financial support which labour migrants from rural areas do not necessarily carry with them.

The above identified gaps, constraints and opportunities provide inputs for the following discussion and recommendations, along with desk review findings in the previous section. In particular, social and economic impacts require critical efforts for recovery to take place.

6. DISCUSSION AND RECOMMENDATIONS

The following recommendations are based on input from primary and secondary sources with deep knowledge of the Ethiopian context, as well as broader African and global experience. This section builds on analysis of constraints, gaps and opportunities to offer high level strategic recommendations as well as pinpointing the needs of vulnerable populations in response to harms that have been suffered.

The National Government Must Lead on a Coordinated Cross-Sectoral Response for COVID-19 Gender-Responsiveness Inclusive of All Stakeholders

The national government has the authority and structure to lead on a much-needed coordinated gender-responsive strategy for COVID-19 prevention, response and recovery. This study revealed that while there is keen interest and support for gender-responsive COVID-19 policy and implementation, and a general awareness of mechanisms such as the National Task Force, respondents wanted clearer national-level guidance and support. The commitment to be gender-responsive needs to be made at the national level and cannot be made by just one ministry for adoption across all ministries and agencies. Moreover, since the epidemic touches upon almost every aspect of women's lives, prevention, response and recovery efforts call for concerted involvement of all stakeholders to mitigate the multifaceted problems and consequences. Government, CSOs, IOs, private sector actors, media, academia, volunteers offer different critical inputs to bring about maximum impact using their comparative advantages. Although certain ministries—MOH and MOWCY, for example—might be key in the implementation of a national strategy, supporting and coordinating with other ministries, agencies and stakeholders, they must have the necessary authority from national government and the resources (personnel and budgets) to support the operationalization of the strategy. Therefore, a national commitment to gender-responsiveness is a foundational recommendation of this report. In addition to needed resources and guidance, for the strategy to be successful, public awareness raising and consultation, stakeholder dialogue and improved communications are critical supporting elements.

A National Gender-Responsive Strategy Needs to Establish the Collection of Sex-Disaggregated Data as a Minimum Requirement for Evidence-Based and Gender-Responsive Decision-Making

Respondents indicated that COVID-19 response decisions were often made without gendered assessments, analysis or evaluations. In order for data to provide evidence for decision making – the differing needs of women and men have to be understood and demonstrated by data and information. Sex-disaggregated data not only supports decision-making, it allows for the tracking of change over time, remediation where gaps are widening or not being closed, and learning where gaps have been reduced. Beyond sex-disaggregated data, **gender-specific indicators** are necessary, especially around gendered areas that are of greater relevance to one sex or the other (e.g., gender-based violence, women's economic empowerment, sexual and reproductive health indicators for women; suicide prevention, rehabilitation and parenting support indicators for men).

A National Gender-Responsive Strategy Requires Gender-Budgeting across Ministries and Agencies at All Levels of Government (and provide the capacity support for this to be carried out)

Lack of funding for gender-responsive planning and implementation was identified as a deficit by government, CSO and IO respondents – particularly with regard to government funding allocations. Gender-budgeting at the national and sub-national levels would address funding gaps and therefore gender inequalities in the system. Gender-responsive budgeting has been introduced at the district level in Ethiopia, but for the most part budgets remain 'gender neutral' (which is equivalent to 'gender blind') and the COVID-19 funding and outcomes reflect this.[65] Gender-budgeting is a long-term solution and, as noted by the World Economic Forum,[66] there are multiple steps required for long-term continuity: legislation, leadership of the ministry of finance, engagement of other stakeholders in government, civil society, and academia, alignment of objectives with SDGs or national gender policies and plans, and engagement of various levels of government including subnational/district levels.

Gender Expertise and Leadership for Gender-Responsiveness Needs to be Integrated Across All Relevant Government Ministries, Agencies and Other Organisations Including CSOs and IOs

[65] See https://gpsaknowledge.org/making-budgets-work-for-gender-equality-in-ethiopia/
[66] See https://www.weforum.org/agenda/2019/03/do-the-math-include-women-in-government-budgets

The need for enhanced capacity for COVID-19 gender responsiveness was repeatedly underscored during the research. Respondents identified a range of options including increased consultation with gender experts, building internal capacity through training, engagement in collaborative learning events across stakeholder groups, assessing one's own initiatives and learning from them, and enhanced women's leadership in general. The meaningful engagement of gender experts and women leaders in pandemic prevention, response and recovery efforts can be achieved through a commitment to gender equality and the advancement of women within organisations. Resources and trainers are readily available with modules and manuals available on topics ranging from health management (WHO),[67] decision-makers leadership (ILO),[68] making trade policies gender-responsive (UNCTAD),[69] conducting a gender-responsiveness organisational audit (UN Women),[70] and more. UN Women will be offering an introductory training early in 2021 on gender-responsiveness of COVID-19 initiatives in Ethiopia.

Strategies, Policies and Initiatives Must Serve the Needs of Vulnerable Women by Recognising, Funding, and Promoting Awareness of Intersectional Identities and the Increased Challenges Faced by Excluded Groups

The voices of vulnerable women and the CSOs that serve them were the most poignant reminders of how vulnerability itself results in increased marginalisation and suffering during times of crisis. Greater emphasis needs to be placed on targeting women with intersectional identities (e.g., women with disability, out-of-school girls, remote/rural women, IDPs/refugees). In order for this to be achieved, there has to be evidence (disability-disaggregated data and qualitative assessments), awareness of the barriers faced by women with disabilities ranging from affordability of healthcare including for special needs, availability of disability-specific services, removal of physical barriers to all kinds of public venues including transportation, knowledge and skill of service providers, and so on. This means that solutions have to be multi-faceted and systemic, with changes in policy, budgeting/financing, public awareness campaign, improved opportunities and skills for employment, greater social protections and improved social services from hotlines to housing.

Development of and Support for Gender-Responsive Sector Strategies including in the Non-COVID Health Sector, Social Sector and Economic

Non-COVID Health Sector Response and Recovery: Non-COVID health issues including sexual and reproductive health (SRH), family nutrition, child well-being, have not received significant attention in Ethiopia during the pandemic, and were not on the radar of our respondents. The exception to this appears to be concern over the well-being of front-line healthcare workers. However, we know from secondary research that issues remain around personal protection equipment (as described in the desk review) and workplace protocols for healthcare workers with a significant impact on women's well-being on the frontlines. We also know from desk research that SRH challenges have been exacerbated for women across the continent, and further exploration for Ethiopia is needed to develop a comprehensive strategy and plan for gender-responsive policies and services.

Social Sector Response and Recovery: Social issues – particularly, gender-based violence, the burden of unpaid care work, girls' leaving school (combined with child marriage and teenage pregnancies)–were global challenges long before the global pandemic. COVID-19 has brought these inequities to the fore and provided the opportunity to reassess and redress gender imbalances. There is significant desire across organisations in Ethiopia to integrate social issues more fully into COVID-19 response and recovery plans. While a national strategy, plan and budget allocations are needed, first steps should include the adoption of 'Do No Harm' principles into all COVID-19 emergency response funding and action plans with targeted funding for gender-based violence programming, unpaid care support and girls' return to school. Over time, gender budgeting /

[67] See https://www.euro.who.int/en/health-topics/health-determinants/gender/activities/capacity-building/gender-mainstreaming-for-health-managers-a-practical-approach2
[68] See https://www.ilo.org/gender/WCMS_735995/lang--en/index.htm
[69] See https://unctad.org/system/files/official-document/ditc2019d1_en.pdf
[70] See https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/rapid-guide-gender-covid-19-and-audit-en.pdf?la=en&vs=1231

aid funds should support longer-term initiatives that advance more equitable social norms through practical outcomes such as improved childcare services, public awareness-raising (especially targeting men and boys), and 'Stay in School' campaigns.

Economic Sector Response and Recovery: As noted in the findings section, and as learned from global experience, improving gender-responsiveness in the economic sector requires funding and programming that addresses the specific economic impacts on women, especially lower income, migrant, and other marginalized women.[71] Skills upgrading, flexible work hours, paid maternity leave and workplace conditions are areas where government and other organisations can support women's economic advancement in general. In terms of response to COVID-19 specifically, additional interventions would involve improved gender inclusion and equality in business and the labour market; expanded social protection programming for the most vulnerable; remote work wherever possible; innovative financing reaching to the microenterprise level; and support to access a range of services especially digital platforms for business improvements and e-marketing. With Ethiopia's high rural population, it is also important that agricultural financial, technical assistance, market linkages and appropriate equipment reach women farmers and agricultural workers.

7. CONCLUSIONS

Ethiopia has done well in terms of COVID-19 prevention and containment. The pandemic itself has not had the huge impact on loss of life that is witnessed in other countries, including wealthier countries with more developed healthcare systems in Europe and North America.

In recent years, Ethiopia has proven itself to be a resourceful economic powerhouse (even while dealing with the pandemic, droughts, floods and other emergencies) that holds promise for poverty reduction and improved well-being for all. Moreover, there is a sense of community and people make sacrifices to support one another – including, as an example, the army of community-level healthcare workers who earlier rallied for maternal health and now for COVID prevention and messaging.

However, COVID-19 has heightened awareness around gender disparities particularly for women with intersectional identities and multiple vulnerabilities, who are impacted by the social and economic fallout of the pandemic. From girls staying out of school and marrying young (a generational loss in educational outcomes for girls is a genuine fear globally), to women with disability closeted in their homes, or marginalised labour migrants without status, the suffering is immense.

Ethiopia has the opportunity to once again demonstrate to the world the strength of good governance and the energy of its people that will enable it to become a model for gender responsiveness among its institutions, communities and citizens.

8. ANNEXES

ANNEX ONE: STAKEHOLDER MAPPING

[71] See https://www.icrw.org/wp-content/uploads/2020/04/cweee_covid_and_wee_brief_final.pdf

No.	List of Stakeholders	Type of Stakeholder	Purpose of Organization and relevant initiative for the assessment of gender responsiveness of COVID19 Prevention and Response Efforts
1.	Ministry of Women, Children and Youth (MoWCY)	Executive Organ	In accordance with the provisions of article 28 of Proclamation No.1097/2018 – Definition of the Powers and Duties of the Executive Organs (hereinafter Proc. 1097/2018) MoWCY is entrusted with the responsibility to design strategic plans to ensure that opportunities are created for women and youth to actively participate in political, economic, and social affairs of the country, and implement same; design strategies to effectively prevent and take measures against gender-based violence against women; implement same in collaboration with relevant organs and work in collaboration with relevant organs to support women and youth living in poverty to improve their livelihood, …etc.
2.	Ministry of Labour and Social Affairs (MoLSA)	Executive Organ	In accordance with the provisions of article 27 of Proc. No. 1097/2018, MOLSA has the duty to work in collaboration ith the concerned bodies to strengthen the social protection system to improve and ensure the social and economic wellbeing of citizens and, in particular to enable persons with disabilities to benefit from equal opportunities and full participation and enable the elderly to get care and support and enhance their participation and prevent social and economic problems and provide the necessary services to segments of the society under difficult circumstances particularly the elderly and people with disabilities, … etc.
3.	Ministry of Health (MoH)	Executive Organ	In accordance with Article 27 of Proc. No. 1097/2018, MOH is entrusted with the responsibility to devise and follow up the implementation of strategies for the prevention of epidemic and communicable diseases; take preventive measures against events that threaten the public health and in the events of an emergency situation, coordinate measures of other stakeholders to expeditiously and effectively tackle the problem…etc.
4.	Ministry of Education (MoE)	Executive Organ	In accordance with Article 25 of Proc. No.1097/2018, MOE has to ensure that quality and relevant education and trainings are offered at all levels of the education and training centers excluding higher education and technic and vocational institutes.
5.	Ministry of Science and Higher Education (MSHE)	Executive Organ	In accordance with Article 26 of Proc. No.1097/2018, MSHE is entrusted with the duty to undertake and implement strategies that seek to synchronize higher education with the country's overall developmental policies and sectoral specific developments.
6.	Ministry of Agriculture (MoA)	Executive Organ	In accordance with Article 18 of Proc. No. 1097/2018, MoA has, among others, the responsibility to coordinate activities relating to food security.
7.	Ministry of Finance (MoF)	Executive Organ	In accordance with Article 16 (1) (e) of Proc. No. 1097/2018, MoF prepares the Federal Government fiscal budget, make disbursements in accordance with the approved budget, and evaluate the utilization of the budget.
8.	Ministry of Trade and Industry	Executive Organ	In accordance with Article 19 (1) (e) of Proc. No. 1097/2018 MoTI has the responsibility to establish system, in coordination with other agencies, for the provision of support to domestic investors engaged in service, agriculture and industrial sector in exporting their produces to overseas markets; and implement same.

No.	List of Stakeholders	Type of Stakeholder	Purpose of Organization and relevant initiative for the assessment of gender responsiveness of COVID19 Prevention and Response Efforts
9.	Ministry of Revenues	Executive Organ	In accordance with sub-articles 1 and 2 of Article 6 of Proclamation No. 587/2008, MoR has the power to establish and implement modern revenue assessment and collection system; and provide, based on rules of transparency and accountability, efficient, equitable and quality service within the sector; properly enforce incentives of tax exemptions given to investors and ensure that such incentives are used for the intended purposes.
10.	Ministry of Peace	Executive Organ	In accordance with Article 13 (1) (b) and (m) of Proc. No. 1097/2018 in collaboration with relevant Regional Organs, MoP shall facilitate the provision of proper protection to citizens living in any part of the country and make appropriate preparations for natural and man-made disasters as well as lead and follow up national disaster risk management.
11.	Ministry of Water, Irrigation and Energy	Executive Organ	In accordance with Article 23(1) (i) of Proc. No. 1097/2018 MOWIE is entrusted with the responsibility to establish system that facilitates the expansion of potable water supplies and coverage of sanitation infrastructure; follow up implementation of same.
12.	Federal Attorney General (AG)	Executive Organ	In accordance with Article 17 (1) (a) of Proc. No. 1097/2018 AG has the power to lead, supervise, follow up and coordinate the criminal investigation function of the Federal Police.
13.	Addis Ababa City Administration	City Administration	In accordance with Article 11 (2) (j) of Proc. No. 361/2003 the City Government has the power to prepare, approve and administer the budget of the City; to determine and collect, according to law, taxes, duties and service charges out of the sources of income specifically given hereby to the City Government; to revoke taxes and penalties imposed as per the law; to participate in income-generating activities and to receive donations and gifts.
14.	Planning and Development Commission	Executive Organ	In accordance with Regulation No. 281/2013, the Commission has the power to draw out sector plans iteratively in consultation with the relevant federal and regional executive organs, detailing programs and projects to be undertaken as well as reform measures pertaining to policies and legislations; formulate plan implementation matrix by line ministries at the federal level and . regional bureaus showing actions to be undertaken covering the entire sector plan.
15.	National Disaster Risk Management Commission	Public Institution	Established by Regulation No. 363/2015 NDRMC has the duty to implement, lead, and coordinate responses in the event of disasters that either do not fall under the responsibility of any one of designated lead sector institutions or a sudden disaster that is beyond the capacity of the lead sector institution; and hold and administer disaster response fund, relief food and non-food stock.
16.	Ethiopian Public Health Institute	Public Institution	Established by Regulation No. 301/2013, the EPHI has the responsibility to conduct, during epidemics or any other public health emergency or public health risk, on sight investigation when deemed necessary, verify outbreaks, issue alert, provide warning and disseminate information to the concerned organs, mobilize or cause the mobilization of resources, support the response activities carried out at Woredas, zones and regional levels as deemed necessary;
17.	Federal Police Commission	Law Enforcement	Per its establishment Proclamation No. 720/2011, FPC has the responsibility to prevent and investigate any threat and acts of crime against the Constitution and the constitutional order, security of the government and the state and human rights; work in collaboration with the Ministry of Justice and other relevant organs with respect to crime investigation; and execute orders and decisions given by courts.
18.	Ethiopian Customs Commission	Executive Organ	The Ethiopian Customs Commission, which was the Ethiopian Revenues and Customs Authority (ERCA), until recently, has the mandate to regulate imports and exports of goods, goods in transit and any goods that are subject to customs control as per Article 3(2) of Proclamation No. 859/2014. Although the powers and duties of the Customs Commission are set to be determined in a regulation that is yet to come to effect, it is assumed that it has retained much of

			the powers and duties provided for ERCA in the proclamation for the Establishment of the Ethiopian Revenues and Customs Authority Proclamation No. 587/2008.
No.	List of Stakeholders	Type of Stakeholder	Purpose of Organization and relevant initiative for the assessment of gender responsiveness of COVID19 Prevention and Response Efforts
22.	World Health Organization	UN Agency	Works worldwide to promote health, keep the world safe, and serve the vulnerable. With regard to emergencies, WHO helps countries prepare for emergencies by identifying, mitigating and managing risks; prevent emergencies and support development of tools necessary during outbreaks; detect and respond to acute health emergencies and support delivery of essential health services in fragile settings.
23.	UN Women Ethiopia Country Office	UN Agency	UN Women is the UN entity dedicated to gender equality and the empowerment of women. Four strategic priorities for UN Women are women's leadership and participation in governance systems; women's income security, decent work and economic autonomy; ensuring women and girls live a life free from all forms of violence and making sure that women and girls contribute to and have greater influence in building sustainable peace and resilience, and benefit equally from the prevention of natural disasters and conflicts and humanitarian action.
24.	United Nations Population Fund	UN Agency	UNFPA is works with governments, other UN agencies and partners to improve access to sexual and reproductive health care; elimination of harmful practices like child marriage, which keep girls from school, and advocates for young people's access to health care, skills development and jobs.
25.	United Nations Children's Fund	UN Agency	UNICEF works to support national efforts to ensure the realization of the rights of children and women through improved child survival, development and protection.
26.	United Nations Office for the Coordination of Humanitarian Affairs	UN Agency	With its partners, OCHA contributes to principled and effective humanitarian response through coordination, advocacy, policy, information management and humanitarian financing tools and services.
27.	Food and Agriculture Organization	UN Agency	FAO is a specialized agency of the United Nations that leads international efforts to defeat hunger. FAO's goal is to achieve food security for all and make sure that people have regular access to enough high-quality food to lead active, healthy lives.
28.	World Food Program	UN Agency	WFP's efforts focus on emergency assistance, relief and rehabilitation, development aid and special operations. WFP provides unconditional food and cash transfers to the most vulnerable families. Contingency stocks of food are prepositioned in case of conflict or climate-related shocks.
29.	International Labour Organization	UN Agency	ILO is a specialized agency of the UN that brings together governments, employers and workers of 187 member States, to set labour standards, develop policies and devise programmes promoting decent work for all women and men.
30.	IOM		
31.	World Bank	Multilateral Financial Institution	The World Bank is helping to fight poverty and improve living standards in Ethiopia. Goals include promoting rapid economic growth and improving service delivery.
32.	European Union Delegation to Ethiopia	Political and Economic Union	The Delegation has the status of a diplomatic mission and officially represents the European Union in Ethiopia. Among others, the delegation has the mandate to participate in the implementation of the European Union's assistance programmes in Ethiopia.
33.	USAID	International Governmental Organization	USAID's assistance in Ethiopia leverages a partnership with the Government of Ethiopia to increase economic growth, deliver quality basic public health and education services, and promote a governance environment that is conducive to sustainable economic development.
34.	Department for International Development (DFID)	International Governmental Organization	DfID leads the UK's global efforts to end extreme poverty, deliver the Global Goals for Sustainable Development (SDGs) and tackle a wide range of global development challenges. It's top three spending programs in Ethiopia are Productive

Agency refugees and overall coordination of refugee assistance interventions in Ethiopia.

2. UN Agencies, multilaterals and International Organizations

			Safety Net Program (Phase 4); Building Resilience in Ethiopia (BRE); and Sustaining and Accelerating Primary Health Care in Ethiopia.

No.	List of Stakeholders	Type of Stakeholder	Purpose of Organization and relevant initiative for the assessment of gender responsiveness of COVID19 Prevention and Response Efforts
38.	Oxfam Ethiopia	INGO	Agriculture, food security, women's rights and gender justice
39.	African Medical Research Foundation (AMREF- ETH)	INGO	Adolescent and youth reproductive health services, Mother Newborn, child health care, HIV/AIDS, Family Planning, Fistula, RH communication
40.	Marie Stopes International Ethiopia	Foreign CSO	RH, Clinical Services for mothers and pregnant women
41.	Action Aid Ethiopia	Foreign CSO	Food Security, Health, Economic Empowerment, Gender, Youth

No.	List of Stakeholders	Type of Stakeholder	Purpose of Organization and relevant initiative for the assessment of gender responsiveness of COVID19 Prevention and Response Efforts
44.	Ethiopian Women Lawyers' Association	CSO	Legal Protection/Aid, Women Empowerment, VAW, Advocacy
45.	Network of Ethiopian Women's Association	Network of CSOs	Women, Socio-Economic Empowerment, HTPs, Women Rights
46.	Ethiopian Network of Women Shelters	Network of CSOs	ENWS is a network of women's shelters providing a safe space for women escaping abuse who cannot enter existing refuge shelters.
47.	Organization for Women in Self-Employment	CSO	Economic and social empowerment of women and girls
48.	Addis Ababa Women's Association	CSO	Women's Rights
49.	Ethiopian Women with Disabilities National Association	CSO	Disability Inclusion, Socio-Economic Empowerment of Women with Disability
50.	Ethiopian Media Women Association	CSO	EMWA's areas of work include enabling women to own and become beneficiary of alternative and community media, creating gender sensitive media in Ethiopia, improving women's access and participation in the media, improving the image and representation of women in the media as well as the public's perspective
51.	Integrated Family Services Organization	CSO	focuses on mitigating the plight of children at difficult circumstances in Ethiopia
52.	Confederation of Ethiopian Trade Unions	Labour Union	CETU is an alliance of trade unions in Ethiopia representing more than 200,000 workers.
53.	Setaweet/Alegnta – GBV Hotline	CSO	Setwaweet is operating a free telephone service for women experiencing violence. The service includes phone counselling, referrals and provides any related information.
54.	Covid19 and Gender Working Group	Collaborative Space for CSOs	An informal collaborative space for representatives of different CSOs and gender professionals encouraging and challenging CSOs and different stakeholders towards gender and social inclusion.
55.	Young Women Christian Association in Ethiopia (YWCA)	CSO	Gender Equality, Women and Girl's Socio-Economic Empowerment; Empowerment Sexual Reproductive Health, Youth Leadership Development, HTPs.
56.	Catholic Relief Service (CRS)	Foreign CSO	Relief Services, Health, Education, Food Security, Economic Empowerment
57.	Ethiopian Orthodox Church Development and Inter - Church Aid Commission	CSO	Health and capacity building
58.	Ethiopian Muslims Development Agency	CSO	Health, Emergency Relief, Economic Empowerment

ANNEX TWO: KEY INFORMANT INTERVIEW GUIDES

Primary research guides (key informant interviews and focus group discussions) were flexible and adapted to the specific respondent and context.

Government Sector Key Informant Interview Guide

INTRODUCTORY SECTION	
Government Department/Office/Agency:	**Date:**
Stakeholder Mapping Summary (Please insert here – this will be useful reference for preparing for the interview)	
Respondent Name:	**Respondent Official Position:**
Description of the Respondent's Role in Organisation's COVID-19 initiatives:	
Contact Information email/phone:	**Organisation Address/Location:**
Respondent Gender:	**Interviewer Name:**
Key Informant Interview Guidance for Government Sector Government plays multiple roles in prevention, response, recovery and risk mitigation during the pandemic – setting policy and regulations, providing funding, infrastructure support, direct program delivery, gathering of statistics, national and local communications and more. It will be important early in the interview not only to understand the mandate/objectives of the department/office or agency of the interviewee, but also the role of the interviewee as this may skew their perspective.	
MAIN QUESTIONS	1. What policies / regulations/ areas of focus / initiatives have been developed and implemented by the organisation as result of COVID-19? Please categorise by sector: health, social (esp. GBV), economic. Start generally, and then determine it the organisation's programs use gender mainstreaming or targeted at women and other vulnerable groups). Were these initiatives focused more on prevention, response, recovery? Assess to what extent National Women's Machineries and women associations were engaged in identification of beneficiaries and delivery of services/information. Were selection of priorities and approaches evidence-based (and what evidence was available) – how were decisions

	made? Were gender experts used in assessment and planning? Was women's leadership encouraged and promoted? Were beneficiaries involved in consultations.
	2. Are gender issues relevant to COVID-19 response work? To what degree have gender considerations been integrated into assessments? Determine to what extent initiatives were informed by context/gender analysis, the type of gender analysis (key areas of assessment) and if they were designed bases on evidence (and if that evidence was even available). Were gender experts used in assessment and planning? Was women's leadership encouraged and promoted?
	3. What types of gender factors have been considered in planning and design of initiatives: transactional issues related to availability, access, uptake of regulation and services and/or root causes like women's agency, social norms, gender bias and discrimination? Please see questions in the survey guide for how this can be nuanced according to the respondent. Were gender experts involved in assessment and planning?
	4. What were those initiatives that were most successful and why/how? Which policies / regulations/ areas of focus / initiatives were successful according to gender evaluation and reporting? Determine the approach to data collection and sex disaggregation of data as well as gender-relevant data points (e.g., hours spent on unpaid care work, status as female head of household, GBV). Understand how the 'success' was measured and reported. Were gender experts involved in designing evaluations and analysing responses? If so, how?
	5. What were the gaps, constraints, opportunities, negative, positive of the organisation's initiatives as identified by evaluation? How were these identified – what was the process of evaluation? What was the greatest challenge or constraint in reaching women and other vulnerable populations? Was the organisation able to pivot and correct based on feedback loops? Have these areas been analysed and documented to further inform recovery and long-term risk mitigation? Were gender experts involved in assessing gaps, constraints etc? If so how?
	6. What are your organisation's key recommendations going forward? Has your organisation documented these recommendations? Were these based on evidence as per the evaluation questions above. Are there aspirations of your organisation or yourself that would be nice to achieve but seem out of reach? What do you think is the most valuable learning that can be repeated or built upon to ensure a strong COVID record for your organisation or the country going forward? Do you have additional thoughts or observations from your own experience?
Wrap-up	Thank you. Next steps.

	Request any reference documents (e.g. legal documents, strategies, policy papers, initiative reports, etc.)?

Civil Society Organizations/Associations Key Informant Interview Guide

INTRODUCTORY SECTION	
Organization:	**Date of Interview:**
Stakeholder Mapping Summary (Please insert here – this will be useful reference for preparing for the interview)	
Respondent Name:	**Respondent Official Position:**
Description of the Respondent's Role in Organisation's COVID-19 initiatives:	
Contact Information email/phone:	**Organization Address/Location:**
Respondent Gender:	**Interviewer Name:**
Key Informant Interview Guidance for Civil Society / Associations Sector Civil Society Organisations (CSOs) and Associations act as advocates, networkers, implementers of projects etc. They combine both direct engagement in communities with knowledge of national, district and local contexts. CSOs are therefore well suited to advise on and offer direct delivery of prevention, response and recovery initiatives on the ground. CSOs / Associations exhibit a wide range of characteristics (size of the organization, budget, level at which they are operating, specific knowledge and technical skillsets, services often targeted to specific groups or communities, etc.) . This means that understanding the characteristics of each CSO/Association and the role of the respondent will be critical to the success of the key informant interview.	
MAIN QUESTIONS	1. What initiatives have been developed and implemented by the organisation as a result of COVID-19? Please categorise by sector: health, social (esp. GBV), economic. Start generally, and then determine it the organisation's programs are gender mainstreaming or targeted at women and other vulnerable groups). Were these initiatives focused more on

	prevention, response, or recovery? Assess to what extent National Women's Machineries and women associations were engaged in identification of beneficiaries and delivery of services/information? Were selection of priorities and approaches evidence-based (and what evidence was available) – how were decisions made? Were gender experts used in assessment and planning? Was women's leadership encouraged and promoted?
	2. To what degree have gender considerations been integrated into assessments? Assess to what extent initiatives were informed by context/gender analysis, the type of gender analysis (key areas of assessment) and if they were designed bases on evidence (and if that evidence was even available). Were gender experts used in assessment and planning? Was women's leadership encouraged and promoted?
	3. What types of gender factors have been considered in planning and design of initiatives: transactional issues related to availability, access, uptake of regulation and services and/or root causes like women's agency, social norms, gender bias and discrimination? Please see questions in the survey guide for how this can be nuanced according to the respondent. Were gender experts involved in assessment and planning?
	4. Which initiatives were successful according to gender evaluation and reporting? What were those initiatives that were most successful and why/how? Determine the approach to data collection and sex disaggregation of data as well as gender-relevant data points (e.g., hours spent on unpaid care work, status as female head of household, GBV). Understand how the 'success' was measured and reported. Were gender experts involved in designing evaluations and analysing responses? If so, how?
	5. What were the gaps, constraints, opportunities, negative, positive of the organisation's initiatives as identified by evaluation? How were these identified – what was the process of evaluation? What was the greatest challenge or constraint in reaching women and other vulnerable populations? Was the organisation able to pivot and correct based on feedback loops? Have these areas been analysed and documented to further inform recovery and long-term risk mitigation? Were gender experts involved in assessing gaps, constraints etc? If so how?
	6. What are your organisation's key recommendations going forward? Has your organisation documented these recommendations? Were these based on evidence as per the evaluation questions above. Are there aspirations of your organisation or yourself that would be nice to achieve but seem out of reach? What do you think is the most valuable learning that can be repeated or built upon to ensure a strong COVID record for

	your organisation or the country going forward? Do you have additional thoughts or observations from your own experience?
Wrap-up	Thank you. Next steps. Request any reference documents (e.g. legal documents, strategies, policy papers, initiative reports, etc.)?

International Organisations Key Informant Interview Guide

INTRODUCTORY SECTION	
Organization:	**Date:**
Stakeholder Mapping Summary (Please insert here – this will be useful reference for preparing for the interview)	
Respondent Name:	**Respondent Official Position:**
Description of the Respondent's Role in Organisation's COVID-19 initiatives:	
Contact Information email/phone:	**Organization Address/Location:**
Respondent Gender:	**Interviewer Name:**
Key Informant Interview Guidance for International Organisations International Organisations include both i) International Bodies such as UN Women, other UN agencies and multilateral bodies such as the WB, FAO, IFAD, etc.; and ii) International Non-Governmental Organisations. As such their activities cut across advocacy, guidance, training, assessments and research, program design and delivery, and evaluation. These organisations primarily rely on funding from bilateral donors such as EU, DFID, USAID, GAC, DFAT, Norad, DANIDA, and more, and in the case of INGOs are reliant on the priorities of those donors. It will be important to understand the initiatives of the organisation as well as the role of the respondent and their engagement in COVID-19 initiatives whether prevention, response or recovery.	
MAIN QUESTIONS	1. What initiatives have been developed and implemented by the organisation as a result of COVID-19? Please categorise by sector: health, social (esp GBV), economic. Start generally, and then determine it the

	organisation's programs use gender mainstreaming or targeted at women and other vulnerable groups). Were these initiatives focused more on prevention, response, recovery? Assess to what extent National Women's Machineries and women associations were engaged in identification of beneficiaries and delivery of services/information. Were selection of priorities and approaches evidence-based (and what evidence was available) – how were decisions made? Were gender experts used in assessment and planning? Was women's leadership encouraged and promoted?
	2. To what degree have gender considerations been integrated into assessments? Assess to what extent initiatives were informed by context/gender analysis, the type of gender analysis (key areas of assessment) and if they were designed bases on evidence (and if that evidence was even available). Were gender experts used in assessment and planning? Was women's leadership encouraged and promoted?
	3. What types of gender factors have been considered in planning and design of initiatives: transactional issues related to availability, access, uptake of regulation and services and/or root causes like women's agency, social norms, gender bias and discrimination? Please see questions in the survey guide for how this can be nuanced according to the respondent. Were gender experts involved in assessment and planning? How did you take these into account when selecting partners?
	4. Which initiatives were successful according to gender evaluation and reporting? What were those initiatives that were most successful and why/how? Determine the approach to data collection and sex disaggregation of data as well as gender-relevant data points (e.g., hours spent on unpaid care work, status as female head of household, GBV). Understand how the 'success' was measured and reported. Were gender experts involved in designing evaluations and analysing responses? If so, how?
	5. What were the gaps, constraints, opportunities, negative, positive of the organisation's initiatives as identified by evaluation? How were these identified – what was the process of evaluation? What was the greatest challenge or constraint in reaching women and other vulnerable populations? Was the organisation able to pivot and correct based on feedback loops? Have these areas been analysed and documented to further inform recovery and long-term risk mitigation? Were gender experts involved in assessing gaps, constraints etc? If so how?
	6. What are your organisation's key recommendations going forward? Has your organisation documented these recommendations? Were these based on evidence as per the evaluation questions above. Are there aspirations of your organisation or yourself that would be nice to achieve but seem out of reach? What do you think is the most valuable learning that can be repeated or built upon to ensure a strong COVID record for

	your organisation or the country going forward? Do you have additional thoughts or observations from your own experience?
Wrap-up	Thank you. Next steps. Request any reference documents (e.g. legal documents, strategies, policy papers, initiative reports, etc.)?

ANNEX THREE: FOCUS GROUP DISCUSSION GUIDE

Location (city/neighbourhood):	**FGD Organised by** (include contact name, organisation name, and contact information):
Date:	
Number of participants:	
Group name (if any):	**FGD Facilitator**
Objective of FGD: to understand the support and services received by women in response to COVID-19 from government, civil society and international organisations.	
Participants: Women (5-6 people) of similar backgrounds who can discuss responses from a similar perspective (e.g., a FGD could focus on low income women or young women or female-headed households or PwD, etc.). Manage the response so that one or two women do not dominate the discussion. Look at everyone as you ask questions, encourage responses from everyone. *[Note that due to COVID-19, we have reduced the typical number of 8-12 to 5-6 to allow for social distancing.]* **Time Management:** The FGD should take 60-90 minutes – remember that while it is important to hear from across the group of women, it is not necessary for each woman to answer every question. If 90 minutes is not an option, manage time so each section is shortened from the guidance below. Some groups are naturally more talkative, others need to be drawn out more. **FGD Format:** The format is facilitated discussion – to explore and drill down on the key research questions. We are seeking to understand the issues and gain consensus on these and to also recognize 'outliers' that deviate from the norm. We also aim to allow flexibility to explore points that come up that might be outside the questions but still relevant. The questions in each section below are not hard-wired, but represent guides to how the discussion can be prompted and unfold. Be an active listener, smile, don't be intimidating and don't push too hard on a question if it is difficult.	
5 minutes	**Welcome, introduction** to FGD and its purpose/importance. Introduction to researchers and participants. Explain the process – it is a discussion, all comments are valuable, we would like to hear from everyone even if opinions are different, practical experience is good. We very much value their input into this important discussion. THANK YOU for making the time.
5 minutes	**Brief warm up question**: Ask women if their life situation was challenging before COVID-19 and if so how. Try to relate this to the focus of the group

	composition (e.g., low-income women or young women or female-headed households or PwD, etc.).
10 minutes	**Impact of COVID-19 in general:** How has COVID-19 affected them? In what area has it affected them most – health, social (incl. GBV), economic or all three? Has this changed over time? Has it affected them differently than it affected men? Ask them to explain their answers. Probe as needed.
10 minutes	**General support made available in response to COVID-19:** Have they received any support in terms of health, social, economic or other areas (ask separately about each sector)? Who provided this support? Do they know who paid for the support (e.g., community volunteers may have delivered support but it may have been initiated by an organisation from outside the community). Was support even across the community? Ask them to explain their answers. Probe as needed.
5 minutes	**Overall rating of support:** How would they rate the support they received overall? Very good, good, so-so, not great, terrible? Is there consensus in the group? Do they think men got better support? If so, please explain.
15 minutes	**Focus on key area of support:** Drill down on a key area of support to understand more. Ask them to describe the support in detail. Was it provided to both men and women? Did it meet the needs of men and women equally? If not, how did the support fall short? Were they asked if they needed this support, or how they needed it to be delivered beforehand? Ask them to explain their answers. Probe as needed.
15 minutes	**Critical needs that have not been met:** Were there critical gaps in services – gaps or limitations in receiving support in health, social or economic areas? What were those gaps specifically? How did the lack of service impact them? Were they able to resolve the issue in some other way? Ask them to explain their answers. Probe as needed.
10 minutes	**Ideas on what could be done differently:** Looking forward, what do they think could be done differently in the future? What would be the most important support they would like to receive? Are there specific thoughts on how the support should be delivered? Ask them to explain their answers. Probe as needed.
10 minutes	**Other thoughts:** Are there other issues around COVID-19 and the support provided to women that they would like to raise? Other observations that did not come out in the discussion?
5 minutes	**Wrap-Up:** Questions, comments? THANK YOU for your helpful contributions to the discussion.

Annex Four: Survey Questionnaire

The Survey Questionnaire is attached separately as a pdf

Annex Five: Training Manual And Module

The training manual and module responds to the identified needs of research participants. Both the survey and key informant interviews showed a high interest in training. That is, almost 90 percent of survey respondents have not received COVID-19 gender-responsiveness training, about 76 percent would like training (an additional 11% undecided) and 63 percent would like to be a trainer themselves. This is in a respondent pool where 47 percent are mid-level managers / experts and 35

percent are senior managers / experts. Related to this earlier in the survey, there was a lower priority placed on recruiting new skilled staff and a high priority placed on training existing staff. So, all in all a very high demand for training coming from experienced people considering training as a priority for themselves and their staff.

The respondents demonstrated an interest in topics such as background and mapping (to a somewhat lesser extent), with interest in 'how-to' topics such as assessing their own organisation's gender responsiveness, designing gender-responsive interventions and evaluating their interventions. The training module has been prepared in response to this preference and need of the majority of research participants. The training module is represented in a PowerPoint presentation.

The training manual incorporates the PowerPoint deck, notes, questions, exercises and checklists as a reference for facilitators to support training. The manual offers a plug and play format allowing facilitators to select the length and depth of information for a training. The manual will be shared with the participants as a resource on completion of the training module. As such, the training module is suitable for online training (presumably shorter timespan) but also be adaptable to in-person venues.

The training module will adhere to principles of adult education – active, experiential and collaborative using techniques such as Socratic teaching, small-group discussion and sharing, reflection-listening-consolidating-sharing, etc.

The first online training will be facilitated by the international consultant with support of the national consultant, assessments will be collected, and revisions made. Following this, the national consultant will be responsible for an e-learning platform (Zoom-based) and ongoing training, in person as appropriate, including potential training of trainer sessions.