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Left out and left behind during the COVID-19 pandemic: a sensemaking study on exclusion, inequality, and resilience among members of equity-deserving groups in Colombia and Venezuela

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Abstract

Background Across Latin America, equity-deserving groups (EDGs) - including women, persons with disabilities, Indigenous peoples, migrants, and LGBTQI+ individuals - experienced disproportionate socioeconomic and health impacts during COVID-19. However, policies rarely address intersecting vulnerabilities, leaving many without adequate protection. This study examined how EDGs in Colombia and Venezuela experienced the health and health-related social impacts of the COVID-19 pandemic, including barriers to care, service disruption, and coping responses.

Methods Using a mixed-methods, cross-sectional, sensemaking design, between August 2024 and January 2025 2,433 participants from Colombia (Bogotá and La Guajira) and Venezuela (Caracas and Falcón) shared 2,591 self-interpreted micronarratives about their COVID-19 experiences. Participants self-identified as belonging to one or more EDGs or served as controls. Sensemaking data combined quantitative interpretation (triads/sliders) and qualitative narratives. Statistical analyses were conducted in R.

Results Three key mixed-methods themes emerged: (1) identity-based barriers to access predominated in rural areas, where women, LGBTQI+ individuals, and persons with disabilities described exclusion from education, health, and employment; (2) policy and system gaps were most pronounced in Venezuela, where participants linked hardship to weak governance and inadequate public support; and (3) financial strain dominated in rural narratives, whereas urban accounts centered on disrupted health care and mental-health challenges. Discrimination generally compounded hardships, although participants also demonstrated resilience through social and community supports.

Conclusions COVID-19 deepened structural inequities, exposing systemic policy failures but also community resilience. Findings underscore the need for intersectional, equity-centered crises responses that integrate gender-

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responsive planning and disability inclusion, as well as LGBTQI+, migrants, and Indigenous rights, using participatory approaches.

Keywords Colombia, COVID-19, Health, Inequities, Sensemaking, Health-related social impacts, Venezuela

Background

In Latin America and the Caribbean (LAC), the marginalization of equity-deserving groups (EDGs) including women [1], persons with disabilities [2], migrants [3], Indigenous peoples [4], and Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and other (LGBTQI+) individuals [5] has been well documented. EDGs are defined as those who face significant collective challenges in participating in society due to attitudinal, historical, social, and environmental barriers based on age, ethnicity, disability, economic status, gender, race, and/or sexual orientation, among others [6].

In LAC, these inequities are rooted in long-standing socioeconomic, structural, political, and historical processes rather than isolated gaps in service delivery. Colonial histories, racialized and class-based hierarchies, land and territorial dispossession, have shaped who is recognized and protected, whose labour is valued, and whose needs are addressed by public infrastructure [4, 7–10]. Gendered divisions of labour, as well ableist and heteronormative norms further structure access to work, care, protection, and participation [1, 5, 11]. As a result, even prior to the pandemic, labor informality, poverty, and lack of social protection left members of EDGs in precarious positions, a reality especially acute for those in rural areas or informal settlements [7, 10, 12, 13]. For instance, female and migrant domestic workers often lacked social protection, earning little and being the first to lose jobs with economic downturns [14].

LAC bore a disproportionate health burden from COVID-19, accounting for roughly 28% of reported global deaths despite only ~ 8.4% of the world's population [15]. The region experienced sharp drops in life expectancy, which were attributed to fragmented, underfunded health systems. Economically, the region suffered a record contraction in 2020, while poverty rose to about 32% and extreme poverty to 13.8% [15]. The pandemic compounded pre-existing inequalities, intensifying the exclusion of groups already at the social and economic margins. Women, particularly those heading single-parent households or working in informal and service sectors, faced heightened COVID-19 risks due to job losses, increased unpaid care responsibilities, and rising rates of gender-based violence (GBV) [16]. Indigenous peoples make up roughly 8% of LAC's population yet comprise about 14% of those living in poverty and more than 17% of individuals surviving on less than US $2.50 per day. They were also disproportionately affected by precarious livelihoods, overcrowded housing, and limited access to health care, sanitation, and economic safety nets [17]. State responses were generally insufficient and poorly tailored to Indigenous realities.

Across the region, COVID-19 hit lower-income, informal, and less-educated workers the hardest, driving a clear rise in inequality as these groups lost jobs and income while better-off households were more insulated [18]. Although emergency cash transfers softened the blow in some places, women and low-income urban families still bore the brunt of economic and social hardships. United Nations (UN) Women and the United Nations Development Programme (UNDP) documented that women entered the crisis with lower labor-force participation (~ 50% vs. ~ 75% for men), were concentrated in hard-hit informal and low-wage sectors (e.g., domestic work), and faced disproportionate unpaid care burdens due to lack of social protection [19]. Despite 2,517 government measures implemented across the region, only 39% were gender-sensitive, with most focused on gender-based violence (GBV), rather than women's economic security and unpaid care responsibilities [19].

The pandemic also deepened inequalities in education and human capital: more than 165 million students were affected by school closures, which widened digital divides and compounded long-term disadvantage among marginalized groups [15]. While the broader population also faced income loss and service disruption, the effects of COVID-19 were amplified for EDGs facing intersecting gender, disability, and migration barriers [16, 20]. For example, persons with disabilities faced compounded exclusion from employment, education, and healthcare [2, 21], while LGBTQI+ participants reported increased social isolation, stigma, and lost access to essential psychosocial and health services [22, 23].

Despite the severe impact of COVID-19 and aspirational recovery plans, emergency responses often did not reach the most affected and were inadequate in addressing the compounded nature of EDG vulnerability [16]. Cash transfer and social protection programs were not frequently tailored to the realities of informal workers or non-citizens, meaning many members of EDGs remained outside the net of government aid [24]. These gaps underscore how policy design, when inattentive to vulnerability and intersectionality, can reinforce pre-existing inequalities. At the same time, the pandemic revealed resilience and adaptive strategies within EDGs. Community-based organizations and informal support networks often filled critical gaps, particularly where formal systems failed to reach those most at risk. For example, LGBTQI+ groups

[25] and organizations of persons with disabilities [26] supported their communities and mitigated isolation in the absence of state intervention. While crucial, these informal, community-based efforts cannot replace the need for equity-centered and participatory reforms to public health and emergency response systems. Despite growing literature on COVID-19 inequities in LAC, there remains limited mixed-methods evidence from both urban and rural settings on how EDGs experienced the health and health-related social consequences of the pandemic, including barriers to care, continuity of essential services, and the social determinants of health shaping experiences in Colombia and Venezuela.

Research question and objective

From a public health and disaster-response perspective, the inequities described above are structural rather than incidental. Disasters and epidemics function as stress tests for social systems, revealing and amplifying existing hierarchies of privilege and marginalization. Equitable crisis response therefore requires an explicit intersectional lens that recognizes how gender, disability, Indigeneity, migration, and sexuality interact to shape differential exposure, vulnerability, and access to support. Understanding how members of EDGs experienced, navigated, and responded to the pandemic is important not only for interpreting the unequal effects of COVID-19, but also for informing future preparedness, strengthening social protection, and advancing rights-based, participatory policy frameworks. Although the acute phase of the COVID-19 pandemic has passed, these findings remain relevant for shaping more equitable policies, programs, and public health measures in future pandemics and other large-scale emergencies.

Colombia and Venezuela were not selected as representative countries for LAC, but as relevant and contextually connected settings. Venezuela offers an important context for examining pandemic experiences amid ongoing political, economic, and health-system crisis, while Colombia provides a neighbouring setting shaped by internal inequalities, rural–urban disparities, and large-scale Venezuelan migration. The study also builds on the first author's prior research examining gendered dimensions of the Venezuelan migration crisis [27–31]. Together, these contexts allowed us to examine how EDGs experienced COVID-19 across connected but distinct socio-political and health-system environments.

Research question

How did members of EDGs in Colombia and Venezuela experience the health and health-related social impacts of the COVID-19 pandemic, and what barriers to care, continuity of essential services, and coping responses shaped these experiences?

Objective

To examine how members of EDGs in urban and rural sites in Colombia and Venezuela experienced the health and health-related social impacts of COVID-19 to inform more equitable public health emergency preparedness, service delivery, and social protection responses.

Methods

Study design and sensemaking methodology

This descriptive, cross-sectional, mixed methods study used a sensemaking approach. Sensemaking draws on the idea that storytelling is a fundamental way people communicate complex experiences and understand their world [32–35]. Using tablets equipped with the sensemaking Sprockler application, participants recorded brief narratives (referred to as micronarratives) in response to one of three open-ended prompting questions related to their experiences during the COVID-19 pandemic (Appendix 1). Participants were encouraged to focus on whatever aspect of their experience they felt was most significant. After the narrative was recorded, participants interpreted their own experiences by answering questions that asked them to position their responses between sets of three variables (triads) or two variables (sliders), as illustrated in Appendix 2. These plotted points were then quantified by the Sprockler software [36], linking statistical data to each individual's narrative. Additional multiple-choice questions collected demographic data to provide context. By compiling many self-interpreted narratives, this method draws on collective insight to form a detailed picture, much like assembling pixels to create a clear image [37].

Participant sampling and recruitment

From August 2024 to January 2025, a purposive sample of individuals aged 16 and older who self-identified as a woman, Indigenous, a person with a disability, and/or as a member of the LGBTQI+ community were invited to participate by engaging with local community-based organizations who supported each of these three groups. A comparison group, who did not identify as belonging to one of those EDGs, was also recruited for participation, allowing us to compare COVID-19 experiences between those who identified as equity deserving and those who did not. For the comparison group, a convenience sample was recruited from various public settings, including markets, cafes, and transit hubs. While our pre-specified focus was on women, persons with disabilities, and LGBTQI+ individuals, we also engaged with migrants and Indigenous peoples.

Setting and protocol

Facilitated sensemaking interviews were conducted in four locations across two countries - Bogotá and La

Guajira in Colombia, and Caracas and Falcón in Venezuela. Data collection was overseen by a national civil association (who wished not to be named) with support by Red Latinoamericana de Organizaciones de Personas con Discapacidad y sus Familias (RIADIS). Enumerators, who self-identified as women, persons with a disability, or as being a member of the LGBTQI+ community, underwent a two-day training. The training included research ethics, sensemaking methodology, participant referral protocols, reporting of adverse events, and survey content, as well as psychological first aid and self-care. All data were collected in Spanish using handheld tablets in private areas. Narratives were later transcribed and translated into English.

Survey

The survey (Appendix 1) was co-developed by the research team alongside local partners. Initially written in English, the survey was professionally translated into Spanish and then back-translated to ensure accuracy. Any discrepancies were resolved collaboratively by a bilingual third reviewer. The instrument was pilot tested among the interview team and resultant feedback was used to refine it.

Data analysis

Descriptive statistics and sensemaking analysis were conducted using R (Version v4.4.3; R Foundation for Statistical Computing, Vienna, Austria) [38]. Chi-squared tests were conducted to explore demographic and COVID-19-related differences across the four sites, based on responses to multiple-choice questions. Tableau (Version 2025.1) was used to visually assess collective response patterns. Triad and slider data (Appendix 2) were disaggregated by equity-deserving group and location. For triads, geometric means and 95% confidence intervals were computed and visualized as ellipses [39]. Non-overlapping 95% confidence ellipses were considered statistically different. Slider data were shown as violin plots with Mann Whitney tests [40], and median responses were marked with asterisks. A thematic narrative analysis of the qualitative data was conducted to help interpret the quantitative findings, and selected quotes were chosen to complement statistical results, using a triangulation convergence approach as described by Creswell [41].

Intersectionality-informed Approach.

We used a group-centred analytical approach, informed by Choo and Ferree [42], by intentionally recruiting members of EDGs and comparing patterns between those who did and did not self-identify as equity-deserving. We then extended this through a process-centred analysis, examining how social positions interacted with institutional, material, relational, and geographic conditions to shape pandemic experiences.

We disaggregated quantitative sensemaking data by EDG status and location, then interpreted these patterns alongside micronarratives to examine how social position, place, and institutional context interacted to shape pandemic experiences. This allowed us to move beyond describing differences between identity groups alone and instead consider how inequities were produced through intersecting material, relational, and policy conditions. Because the micronarratives were brief and self-interpreted, we describe our approach as intersectionality-informed rather than a comprehensive life-history or system-centred intersectional analysis.

Ethics

This study was conducted in accordance with the principles of the Declaration of Helsinki. All participants provided informed consent electronically before the survey began by selecting a consent checkbox on the tablet. For participants aged 16–17 years, parental or guardian consent was waived by the ethics board because the study involved a brief (~15-minute), anonymous survey with minimal risk, collected no identifying information and required no travel or follow-up. No compensation was provided given the brief duration and minimal participant burden. Each of the four data collection sites had a customized referral plan developed with local partners to connect participants with services such as healthcare and psychosocial support if needed. The study received ethics approval from the Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board (#6037174). Study implementation was overseen by two local partner organizations and included members of equity-deserving groups; however, no additional institutional ethics review was conducted in Venezuela or Colombia.

Results

Characteristics of study participants

A total of 2433 individuals participated, sharing a total of 2591 self-interpreted micronarratives. Participants could share and interpret more than one COVID-19 experience and therefore the number of micronarratives exceeds the number of unique respondents. Demographic details disaggregated by whether the participant self-identified as belonging to one or more EDGs are provided in Table 1. Overall, men comprised half of the sample (50.4%) and just over a third of participants were aged over 45 (34.5%). There were slightly more participants in Bogotá (28.0%) but a disproportionate number of participants in La Guajira identified as equity-deserving. Almost 30% of respondents indicated that they sometimes struggled to make ends meet. Three quarters of the micronarratives

Table 1 Study population characteristics disaggregated by self-identification as belonging to an EDG

	Total (% of *N* = 2591)		**Identified as Equity-Deserving (% of *N* = 1799)**		**Did not identify as Equity-Deserving (% of *N* = 792)**		***P*-Value[a]**
Gender identity of individual in the micronarrative							
Woman	1212	46.8	1174	65.3	38	4.8	**< 0.001**
Man	1305	50.4	580	32.2	725	91.5	
Non-binary	35	1.4	35	1.9	0	0.0	
Prefer not to say	39	1.5	10	0.6	28	3.7	
Total	2591	100	1799	100	792	100	
Age of Narrator							
≤ 18	161	6.2	141	7.8	20	2.5	**< 0.001**
19–30	779	30.1	598	33.2	181	22.9	
31–45	732	28.3	517	28.7	215	27.1	
> 45	895	34.5	532	29.6	363	45.8	
Not sure/Prefer not to say	24	0.9	11	0.6	13	1.6	
Total	2591	100	1799	100	792	100	
Frequency of struggling to make ends meet							
All the time	208	8.0	133	7.4	75	9.5	**0.012**
Often	473	18.3	303	16.8	170	21.5	
Sometimes	763	29.4	544	30.2	219	27.7	
Rarely	644	24.9	464	25.8	180	22.7	
Never	415	16.0	288	16.0	127	16.0	
Not sure/Prefer not to say	88	3.4	67	3.7	21	2.7	
Total	2591	100	1799	100	792	100	
Location							
Bogotá, Colombia	726	28.0	533	29.6	193	24.4	**< 0.001**
La Guajira, Colombia	635	24.5	541	30.1	94	11.9	
Caracas, Venezuela	621	24.0	407	22.6	214	27.0	
Falcón, Venezuela	609	23.5	318	17.7	291	36.7	
Total	2591	100	1799	100	792	100	
Whose experience was shared							
Mine	1933	74.6	1318	73.3	615	77.7	**< 0.001**
Someone in my family	490	18.9	379	21.1	111	14.0	
Someone else I know	137	5.3	85	4.7	52	6.6	
Something I heard/read	19	0.7	9	0.5	10	1.3	
Not sure/Prefer not to say	12	0.5	8	0.4	4	0.5	
Total	2591	100	1799	100	792	100	
Emotional tone of the experience shared							
Strongly positive	118	4.6	89	4.9	29	3.7	0.052
Positive	354	13.7	227	12.6	127	16.0	
Neutral	676	26.1	480	26.7	196	24.7	
Negative	868	33.5	591	32.9	277	35.0	
Strongly negative	535	20.6	380	21.1	155	19.6	
Not sure/Prefer not to say	40	1.5	32	1.8	8	1.0	
Total	2591	100	1799	100	792	100	
Experience shared was about being disrespected or judged							
Yes	227	8.8	186	10.3	41	5.2	**< 0.001**
No	2254	87.0	1522	84.6	732	92.4	
Not sure/prefer not to say	110	4.2	91	5.1	19	2.4	
Total	2591	100	1799	100	792	100	

[a] Pearson Chi-Square. Analyses excluded the following sub-categories: Prefer not to say / Not sure

were first-person (74.6%) and a majority of the shared experiences were negative (33.5%) or very negative (20.6%). A minority of micronarratives were about experiencing disrespect or judgement (8.8%), although feeling disrespected or judged was more common among participants who identified as belonging to an EDG.

Mixed methods sensemaking findings

Cross-site analysis across the four study contexts helped to distinguish shared patterns from site-specific nuances, facilitating more contextually specific recommendations. Three major themes were identified and are presented below along with representative quotes: (a) rurality, identity, and institutional exclusion shaped access; (b) policy and systems gaps were heightened in Venezuela; and (c) more financial strain in rural areas versus a focus on health in urban centres.

Rurality, Identity, and Institutional Exclusion Shaped Access

While access to care and services was often universally challenging during COVID-19, this appeared to be particularly true for members of EDGs in rural areas. As shown in Fig. 1, members of EDGs (gender minorities, LGBTQI+ individuals, persons with disability, and Indigenous peoples) in La Guajira and Falcón were statistically more likely to report identity-based barriers to access than EDGs in Bogota or Caracas.

In some cases, the barriers experienced during the pandemic arose not from impairment itself, but from inaccessible educational responses and inadequate accommodation, consistent with a social model of disability. For example, one father, living in La Guajira, reported, "*My son is visually impaired… teachers who simply sent activities did not take into account his disability… I had to cancel the semester. Immediately the university contacted me and they spoke with the teachers, who admitted… that they had not taken my son's disability into account.*" (ID# 62119) This narrative illustrates how disability-related exclusion was produced through the interaction of inaccessible remote education, limited accommodation, rural service constraints, and the transfer of institutional responsibility onto families.

Gendered stereotypes used to control women's autonomy and economic participation also presented a barrier. In the following account, the participant's work was challenged by her male partner, suggesting that restrictive gender norms intersected with economic and psychological forms of violence. This underscores how 'access' can be constrained within families and intimate relationships, especially during lockdowns, which can amplify dependency, restrict movement, and heighten vulnerability.

> *I created my business of strawberries with cream… the business really worked… he [my boyfriend] told me that he did not want me to work… he told me that I was a woman, and I should be thinking and*

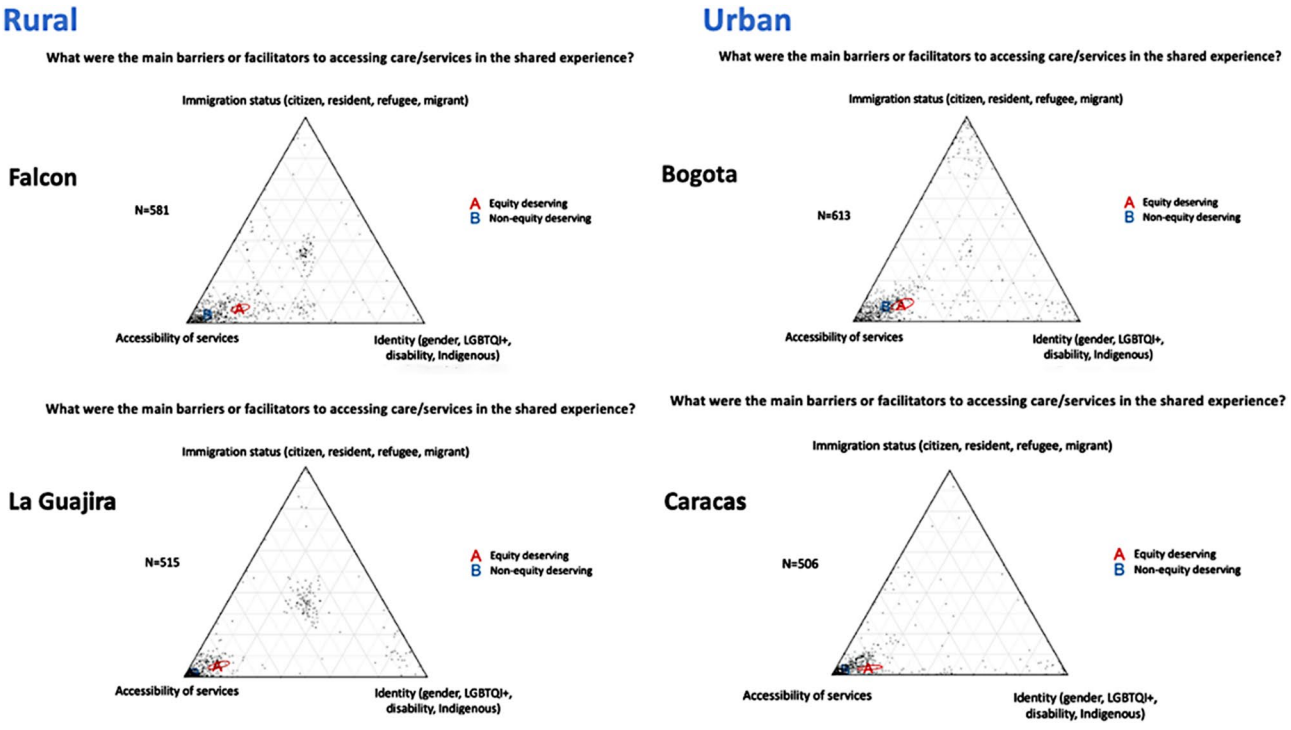


Fig. 1 As illustrated by the non-overlapping 95% confidence ellipses, members of EDGs in the 2 rural locations – Falcón and La Guajira - were statistically more likely to indicate that they faced barriers based on their identity

learning how to cook… and he went mad, he almost hit me. Woman, aged 19–30 living in La Guajira (ID# 61681).

This account also illustrates how pandemic-related harm was produced through interacting structures rather than gender alone. Gendered expectations about women's roles, household power relations, economic insecurity, and disrupted livelihoods together constrained the participant's autonomy and ability to sustain income-generating work.

In Falcón, a participant described how his cousin who identified as LGBTQI+ faced dismissive and discriminatory treatment while hospitalized during COVID, highlighting again that barriers were not limited to structural gaps but also manifested in interpersonal interactions.

I had a cousin…. it was difficult for him because, due to his sexual orientation, being LGBT, gay, however you want to say it, they didn't pay much attention to him. Every time he asked for help, they would ignore him, and it was always a no. I mean, they simply didn't give him importance just because of that. Non-binary individual, aged 19–30 living in Falcón (ID#61377).

Another participant in Falcón also described disability-related barriers that restricted access to care and opportunities during the pandemic. "*This is the case of an athlete who was left in a wheelchair because of the pandemic, which closed her possibilities of moving forward, since her condition did not allow her to move on; this ended all her plans and life projects in terms of sport.*" (ID#60584) The narrative illustrates how abrupt system closures and disruptions translated into long-term loss of function and compromised future plans.

Policy and System Gaps Heightened in Venezuela

Across sites, EDG groups diverged on whether experiences were framed as being about governments and policies versus individuals and families. The clearest statistical difference appeared in Falcón (Fig. 2), with similar significant results in Caracas, likely reflecting Venezuela's complex humanitarian emergency. While EDG participants in La Guajira showed a parallel pattern, in Bogotá, EDG respondents were statistically more likely to emphasize personal or family experiences.

In Falcón, more so than in other locations, participants explicitly attributed their experiences to official policies, illustrating the connection between individual hardships and institutional gaps. One man from Falcón shared his concerns, *"I don't want another type of situation like this for my family, because it would starve us to death, since we don't have any type of governmental help."* (ID#60622).

Similarly, the following account links policy blind spots to job immobility and mental health decline for an LGBTQI+ participant in Falcón, reinforcing that recovery requires both economic and psychosocial supports.

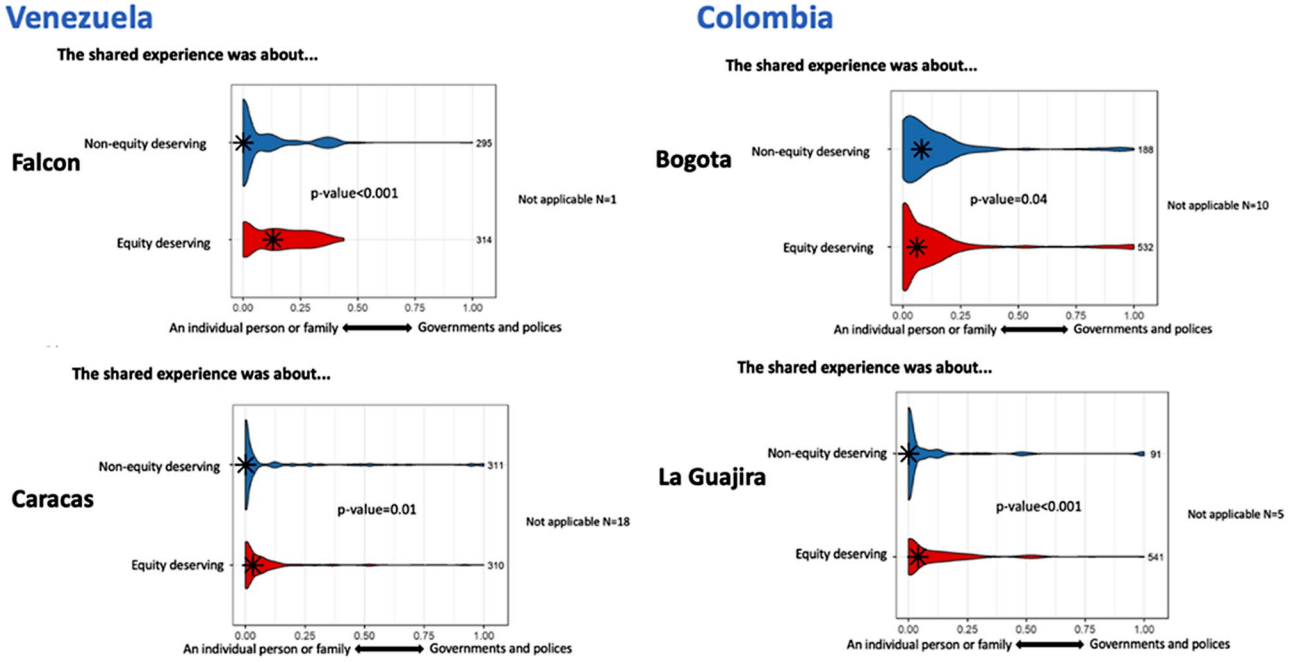


Fig. 2 Members of EDGs in Falcón, Caracas, and La Guajira were statistically more likely to indicate that their narrative was about governments/policies in comparison to those who did not identify as a member of an EDG

I had absolutely no job mobility. This also affected me economically and led to circumstances that caused mental deterioration. Man, aged 31–45, identified as LGBTQI+, living in Falcón (ID#61368).

In Caracas, inequity was produced at the intersection of disability-related service failures, Indigenous marginalization, LGBTQI+ stigma, and Venezuela's weakened health/social-service context.

The challenges have increased since I am a person with disabilities… after the pandemic, the attention to people with disabilities has not improved, and this is not only in the area of health… making the challenges greater every day for me. Man, aged 19–30, identified as Indigenous, LGBTQI+, and a person with a disability, living in Caracas.

In Caracas, a participant identifying as LGBTQI+ highlighted how state responses to COVID-19 intensified the pre-existing complex humanitarian emergency. Rather than feeling protected by public health measures, he described the psychological burden of restrictive control strategies and coercive enforcement practices.

I think that the most complicated things during the pandemic were the mechanisms or public policies implemented by the government for control… there was even a time when they started to arrest people… for not wearing masks… Man, aged 31–45, identified as LGBTQI+ (ID# 62547).

Another LGBTQI+ participant in Caracas explicitly framed the government's pandemic response within broader patterns of authoritarianism and an opportunity for political repression and control, *"… many countries with authoritarian government systems could see COVID-19 as a double-edged sword, i.e. to control the population using the excuse that there was a health emergency."* (ID# 62653) Such accounts highlight how some experienced the pandemic as an extension of state power, with a lack of transparency.

In rural La Guajira, one Indigenous participant drew attention to systemic inequities and the absence of worker protections, describing them as coercive, and showing disregard for personal autonomy, possibly contributing to institutional mistrust.

Well, at that time, when we were all employees, they made us get injected because if we didn't, we would be fired. And if we didn't get the three injections, they would throw us out, and everyone tells me that this is against the law, because they couldn't force us to get it… Man, aged 31–45, identified as Indigenous, living in La Guajira (ID# 60926).

More financial strain in rural areas versus focus on a health in urban centres

In rural sites, EDG respondents often linked COVID-19 impacts to income loss, food insecurity, and housing instability, consistent with higher reliance on informal work, and more limited social protections. In urban centres, on the other hand, EDG narratives emphasized health-related constraints such as disrupted care and medication shortages. As shown in Fig. 3, while the Falcón pattern did not reach statistical significance, the direction of effect parallels that seen in La Guajira, suggesting a rural signal.

These quantitative trends suggest context-specific mechanisms (informal labour vs. health-system congestion) that appear to have differentially shaped experiences. For example, one migrant woman in La Guajira captured the intersecting risks she faced: job loss, eviction, vulnerable housing, and xenophobic abuse.

I had to migrate… when the pandemic arrived… my bosses fired me… I was left on the street… It was very hard, I did not sleep and did not eat, and there were men who wanted to take advantage of me. I suffered contempt for being Venezuelan and also a lot of abuse… Woman migrant, aged > 45, Living in La Guajira (ID#61210).

Other narratives highlighted the structural exclusion faced by persons with disabilities and the impact it had on them. For instance, a woman in La Guajira reported, *"… I have a visual disability… very difficult for me to get a job because they always hired … people who did not have that disability… It helped me a lot to implement strategies… so that they would not take into account the disability…* (ID#62426). Having to compensate for her disability, highlights the 'invisible labor' faced by members of some EDGs, and reinforces how finances can be fragile even outside of pandemic times.

Similarly in rural Falcón, many narratives focused on financial strain and in some cases migration as a result, as was the case in this narrative shared by a man in Falcón who identified as LGBTQI+, *"Well, it all started in 2020, when we immigrated to Colombia… we didn't have any resources… I also declared myself as homosexual… we had to emigrate again to Venezuela"*(ID#60638).

In contrast, in the capital city of Bogota, the focus of shared experiences by members of EDGs was more often health. For example, remote work/study options sometimes reduced exposure and travel but also complicated prosthetic care.

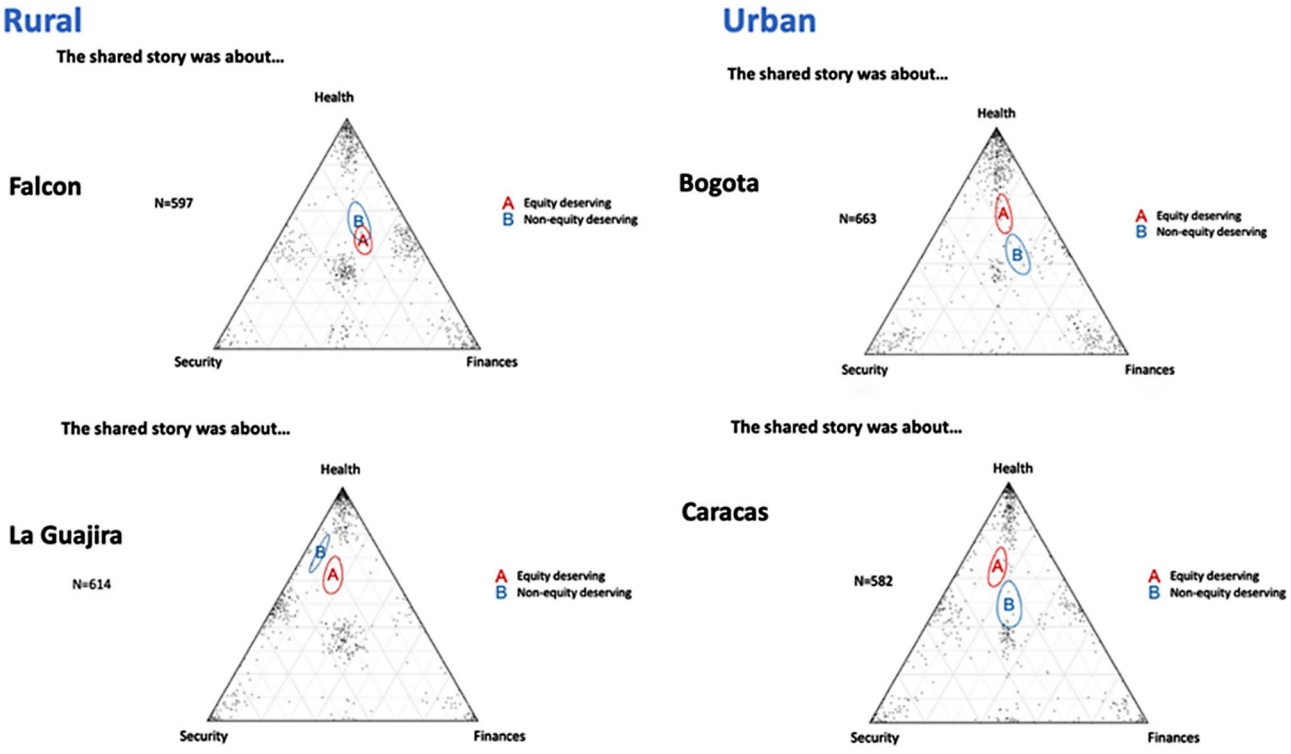


Fig. 3 Members of EDGs in rural locations were statistically more likely to indicate that their experiences were about finances – this was statistically significant in La Guajira as evidenced by the non-overlapping 95% confidence ellipses. In contrast, members of EDGs in the urban centres were statistically more likely to indicate that their shared experiences were about health

> *I didn't have to walk as much at home. But at the same time… I started to gain weight… and I started to suffer pain with the prosthesis… it was very complicated… and [I] suffered a lot of pain in those days. Woman, aged 19–30, living in Bogota (ID# 60558).*

Mental health concerns were also prominent. For example, one woman in Bogota who identified as LGBTQI+ linked her own crisis to system limitations, "*I realized that I was not mentally stable and I had to seek psychological support because I had depressive and almost suicidal symptoms. There I realized the great challenge presented by the health entities, due to inefficiency and different socio-political factors that limited adequate care.*" (ID# 63623).

For another participant in Bogota, who identified as a sex worker, there were health/safety concerns when the prohibition of street-based work meant moving indoors to riskier encounters.

> *My economic activity is prostitution… many of us did not have subsidies, support or anything that could sustain us while we were not allowed to go out on the street to work… very dangerous because I had to go to the houses of some clients… they do not take us into account… Woman, aged 19–30, identified as LGBTQI+, living in Bogota (ID#62268).*

The risks described here are not reducible to gender or LGBTQI+ identity alone. They emerged through the interaction of informal and stigmatized work, exclusion from social assistance, public-health restrictions on street-based economic activity, and gendered exposure to violence in private spaces.

In Caracas, access to health services was often severely restricted, pushing families toward private pharmacies and informal care. In the narrative below, medication shortages and fear of infection impacted a woman caring for daughter who had a disability, also highlighting the balance between COVID exposure risk and essential care.

> *… my daughter who has a disability… she needed me to give her medicine. I went to buy it at the pharmacy and there was none… I returned home without the medicine and found my daughter in crisis. I wanted to take her to the hospital, but I was afraid she would get contaminated…it was very difficult… Woman, under age 18, living in Caracas (ID#63849).*

Participants in Caracas also described how pandemic restrictions exposed critical weaknesses in continuity of care for chronic conditions. For instance, there were

interruptions in access to essential medications such as antiretrovirals for HIV.

> *I lived with my parents and my grandfather, the latter was an HIV-positive patient, and as part of the restrictions we could not go out to look for the [anti] retrovirals… my grandfather's situation worsened… due to his advanced age he passed away, and this devastated us. Woman, aged 19–30, identified as LGBTQI+, living in Caracas (ID#63227).*

Across all four locations, our analysis also highlighted the many ways members of EDGs demonstrated resilience by adapting to the challenges of the pandemic. For instance, one participant who identified as LGBTQI+ shared, "*I found support in my community and discovered new ways to connect with others*." (ID#62440) Another individual living with a disability reported how a community for deaf persons was formed and became an asset, "*a community of deaf-mute people was created, which became a resource and support center during the pandemic*". (ID# 62427). Thus, despite significant structural disadvantages, participants mobilized personal, social, and community-level resources to cope with and counter the adverse effects of COVID-19. Such expressions of resilience illuminate important strengths within EDGs that can inform more responsive, equity-oriented public health and social support strategies.

Discussion

Using a large mixed-methods sensemaking dataset, we examined how members of EDGs experienced the health and health-related social impacts of the COVID-19 pandemic in Venezuela and Colombia. The overall emotional tone of the shared experiences was largely negative, with identity-based barriers to services and economic security more common among members of EDGs living in rural areas. Financial strain as well as disrupted health and social services were particularly noted among EDGs in Venezuela. A rural–urban divide also emerged - rural narratives emphasized economic insecurity, while urban narratives focused on health-system constraints and service interruptions. Regardless of location, discrimination/stigma were widespread, and many accounts described intensified disrespect toward people with intersecting marginalized identities. Across themes, vulnerability was often compounded where equity-deserving identities overlapped, particularly at the intersections of gender, disability, migration status, Indigenous identity, sexuality, and rurality.

Women

The gendered impacts of COVID-19 observed in our study mirror trends across LAC, where the pandemic has been described as reversing earlier feminist policy [43]. UNDP analysed data showing that women, especially heads of households, migrant women, and women with disabilities, faced deepened poverty, rising unemployment, and greater exposure to GBV, as well as an unprecedented burden of unpaid care during lockdowns [19]. Aligning with this trend, in our dataset, women - particularly those in La Guajira and Falcón - described job loss, food insecurity, and increased dependency on informal work.

The themes identified in our data also align with findings from Zambrano-Barragán et al., who documented how Venezuelan women living informally in Colombia faced eviction, exploitation, and restricted healthcare access, which was exacerbated by job loss [44]. Migrant women in our dataset shared similar experiences. For example, one participant in La Guarija described xenophobic abuse, job loss, harassment, and loss of housing, echoing Zambrano-Barragán's findings. Consistent with Acciari's observations of migrant domestic workers collective resilience [45], some women in our study adapted by creating small businesses or informal income-generating activities, often under conditions that restricted them socially and economically. Government measures aimed at mitigating women's economic and care burdens during COVID-19 were fragmented and limited in reach, often reinforcing traditional gender roles rather than challenging them [19]. Participants in our study highlighted the *absence* of protections for sex workers, and there were no references to financial assistance programs specifically targeting women.

With respect to migrants, Jeronimo Kersh showed that Venezuelan migrant women in Colombia experienced downward mobility, precarious informal labor, and restricted access to childcare, education, and health services [46]. Our findings were similar with rural women relying on unstable community networks, while urban participants emphasized health system breakdowns and medication shortages. Agarwal-Harding et al. found that Venezuelan women, especially those without legal status, faced heightened difficulty obtaining medicines and care, with uninsured migrants citing cost and documentation issues, and paying out-of-pocket [47]. Similarly, our participants sometimes turned to private pharmacies or informal networks when public supplies ran out, underscoring how gender, disability, legal status, and poverty constrained access.

Persons with disabilities

The experiences of persons with disabilities described here strongly echo findings from the existent literature. For example, research from Colombia found that persons with disabilities experienced higher poverty, lower human capital, and - because of their health conditions

- required more frequent and costly medical care [48]. Our findings similarly revealed economic vulnerability among persons with disabilities, particularly in rural sites such as La Guajira and Falcon, where participants described being excluded from employment or losing livelihoods due to disability. A 2024 systematic review highlighted that persons with disabilities were more likely to struggle with the cost of services and to experience severe, sometimes catastrophic, health-related expenses [20]. The review further identified inequities such as women with disabilities being less likely to receive cancer screening – consistent with our finding that women with disabilities faced intersecting barriers to health and economic participation, including being passed over for jobs.

These patterns are not unique to LAC. In South Africa, a survey of 2,000 respondents with disabilities revealed adverse economic and emotional effects, limited access to inclusive information, reduced availability of services, and the worsening of pre-existing disadvantage [49]. Participants in our study echoed these experiences, with emotional distress and economic precarity emerging as dominant themes in both Venezuela and Colombia. Wickenden et al., published qualitative research from Bangladesh, Kenya, Nigeria, Nepal and Uganda, showing that the pandemic disrupted livelihoods and care routines for people with disabilities, highlighting the roles of dependent care, inaccessible health information, and significant barriers to healthcare and education during the pandemic [50]. Similarly, our respondents described how inaccessible services and school closures disproportionately affected persons with sensory and physical impairments.

Kubenz and Kiwan further demonstrated that globally, persons with disabilities encountered layered exclusion across health, education, economic life, community participation, and pandemic response [21]. Our data likewise reflected multidimensional exclusion, particularly where disability intersected with gender and migration status. Read through a social model lens, these accounts suggest that exclusion was produced by attitudinal, environmental, and institutional barriers rather than by impairment alone. This raises concerns about the extent to which commitments under the Convention on the Rights of Persons with Disabilities (CRPD) to accessibility, participation, and protection in situations of risk were realized during the pandemic. Kubenz and Kiwan also emphasized the "routine sidelining" of persons with disabilities in emergency planning and policymakers' limited, often superficial, engagement with persons with disabilities at the local, national, and global levels [21]. Likewise, Sakellariou et al. found that the absence of enforceable disability-related legislation in Argentina, Brazil, Chile, and Peru significantly deepened vulnerability among persons with disabilities [51]. Our study participants from Venezuela explicitly linked their hardships to weak policy implementation and inadequate governmental support, illustrating how systemic neglect translated into disadvantage. The lack of enforcement of legal frameworks meant disability was often framed as an individual responsibility, rather than a collective responsibility, amplifying the risks of poverty, discrimination, unmet health needs, and social isolation [51]. Similarly, Wickenden's findings from South Africa underscored uncertainty surrounding both governmental and non-governmental support for persons with disabilities [49].

LGBTQI+ community

In Colombia and Venezuela, we found that LGBTQI+ participants frequently described discrimination, disruptions in care and services, as well as elevated psychosocial stress during the COVID-19 pandemic. Yet despite these challenges, many also demonstrated adaptive coping and community solidarity. This was consistent with a study in the US which highlighted that resilience and resistance were deeply rooted in the historical experiences of systemic trauma faced by LGBTQI+ communities, and that these capacities were creatively re-imagined and adapted in response to the challenges of the COVID-19 pandemic [52]. Our country-specific findings in Colombia and Venezuela align with other evidence from LAC, which demonstrated that pre-existing inequities amplified the pandemic's effects on sexual and gender minorities by deepening social exclusion, constraining access to support systems, limiting employment opportunities, and increasing exposure to violence and discrimination [22]. Furthermore, evidence suggests that mandatory confinement further strained social relationships and heightened feelings of insecurity, fear, and anxiety among LGBTQI+ individuals [23], which is also consistent with our results.

Across LAC, national COVID-19 responses often excluded LGBTQI+ needs, especially those of LGBTQI+ migrants and transgender sex workers [53]. In Brazil, for instance, conservative politics and anti-LGBTQI+ rhetoric left community-based organizations to fill critical service gaps [25]. Dual discrimination based on both sexual or gender identity and migrant status, has been well documented, including expulsion from shelters after being outed, exposure to street violence, and scapegoating as "virus spreaders" [53]. These findings align with our results, where LGBTQI+ participants reported identity-based barriers to health care, stigma from service providers, and loss of employment or housing stability. In the literature, risks were especially high for transgender women, who faced heightened police violence and barriers to healthcare, compounding vulnerability and, in some cases, fatal outcomes [54]. Lockdowns and income loss pushed many into homelessness and limited

aid proved insufficient to meet basic needs, experiences which were also reported in our data.

Mobility restrictions across the LAC region further disrupted access to mental-health services, gender-affirming care, HIV care, and weakened community networks that had previously buffered against stigma [55]. The resulting isolation, financial precarity, and loss of affirming spaces were articulated in our results, and other research has linked these experiences to increased depression, anxiety, and loneliness, even as community organizations adapted through telemedicine, online peer networks, and emergency assistance [56]. Comparable findings were reported in other regions of the world. For example, UK data showed particularly severe mental-health effects for trans and younger participants linked to prolonged isolation and delayed gender-affirming or HIV-related care [57]. Consistent with these regional and global patterns, participants in Colombia and Venezuela described interruptions to HIV medication, counseling, and psychosocial support, underscoring local health-system limitations in both countries.

Intersectional pandemic inequities

Our findings contribute to intersectional health-equity research by showing how pandemic harms were produced through interactions of social position, institutions, and location-based inequities. Rather than operating as separate or additive vulnerabilities, gender, disability, sexuality, migration status, Indigenous identity, class, and rurality influenced one another. These interactions were mediated through systems such as labour markets, household relations, social protection programs, migration regimes, health services, education systems, and public-health enforcement. For example, the experiences of migrant women in La Guajira were shaped not only by gender or migration status, but by the interaction of informal employment, housing insecurity, xenophobia, limited social protection, and gendered exposure to violence. Similarly, narratives from LGBTQI+ participants and persons with disabilities showed how health-system disruption and public-health restrictions intensified pre-existing exclusion when emergency responses failed to account for diverse needs. In this sense, the pandemic functioned less as an external shock than as an amplifier of already-structured inequalities.

Recommendations

The study's findings highlight the need for targeted, equity-oriented policy and programmatic interventions across gender and disability, as well as sexual and gender diversity. These recommendations are directed to governments, humanitarian agencies, and civil-society organizations operating in Colombia, Venezuela, and the wider LAC region.

- Gender-responsive economic recovery and protection for women

Women, particularly migrant women, heads of households, and women with disabilities, experienced disproportionate economic insecurity and exposure to GBV during the pandemic. Governments should expand gender-sensitive strategies that prioritize these groups in employment, livelihoods, and social-protection programs. This includes sustained income-support mechanisms, formal recognition of care work, and targeted investment in safe housing and skills development for informal and migrant workers. Social protection policies must also integrate GBV prevention and response measures, ensuring that emergency cash and food-security programs reach women who are undocumented or working informally.

- Mainstreaming disability inclusion across all emergency and health planning

Persons with disabilities in both countries faced compounded exclusion from education, employment, and healthcare, reflecting weak policy enforcement and inaccessible service delivery. Pandemic and disaster preparedness frameworks should therefore embed disability-inclusive design, consistent with the social model of disability and CRPD principles, ensuring accessible information, continuity of essential services, removal of attitudinal, environmental, and institutional barriers, and routine consultation with organizations of persons with disabilities. Intersectional planning is crucial - women and LGBTQI+ individuals with disabilities require specific attention in violence prevention, social-protection schemes, and rehabilitation support. National health systems should adopt enforceable standards for accessibility, disability-disaggregated data collection, and inclusive workforce training to sustain equitable recovery.

- Advancing protection and inclusion for LGBTQI+ communities

LGBTQI+ participants reported discrimination in healthcare, disruptions to mental-health and gender-affirming services, and loss of income or housing. Governments should enforce comprehensive anti-discrimination frameworks across health, education, and welfare systems, and ensure that LGBTQI+ organizations are formally represented in pandemic and disaster governance structures. Mental-health and gender-affirming care must be recognized as essential services and integrated into public-health coverage. Civil-society and humanitarian actors should strengthen partnerships with grassroots LGBTQI+ groups to support and scale peer-support

networks that proved valuable during COVID-19 and may be essential in future crises.

- Reducing rural–urban inequities in access to care and livelihoods

Identity-based barriers and financial strain were most acute in rural La Guajira and Falcón, while urban participants in Bogotá and Caracas emphasized health-system breakdowns. Public-health agencies should invest in decentralized service delivery, mobile health teams, and culturally responsive outreach. Addressing structural inequities requires data systems that capture differences by gender, sexual orientation, Indigenous identity, disability, and migration status. Investments in rural livelihoods and primary-health infrastructure are essential to prevent future disproportionate harms to equity-deserving groups.

- Participatory responses and accountability

Governments and donors should establish sustained mechanisms for regular consultation, adequate financing, and shared decision-making with affected groups across all phases of disaster preparedness and response. Dedicated resources for participatory approaches, including peer-led data collection and leadership development, are essential to operationalize the principle of "nothing about us without us."

Strengths and Limitations

These findings should be interpreted in light of several limitations. First, we used a purposive sample, so results are not representative and may not adequately capture the experiences of highly excluded groups (e.g., undocumented migrants, transgender sex workers, very remote communities). Second, because analysis was based on brief micronarratives rather than in-depth interviews or life histories, we could not fully describe the historical formation of participants' intersectional position. Our analysis is therefore intersectionality-informed rather than a comprehensive system-centred intersectional analysis. Third, some research team members' positionality as academics largely based in the Global North shaped the design, implementation, and interpretation of the study. More specifically, the use of EDG framing, development of the initial English-language instrument, reliance on Canadian institutional ethics review, and interpretation of translated micronarratives were influenced by the team's institutional and geographic positioning. To mitigate these influences, the survey was co-developed with local partners, professionally translated and back-translated, pilot tested, and implemented by trained data collectors who themselves identified with EDGs. Results interpretation was also discussed with local partners, and focus groups were held to member-check emerging interpretations. Fourth, self-reported micronarratives are subject to recall bias. While reporting and social desirability bias are also concerns, sensemaking methodology helped to mitigate these. Finally, translation from Spanish to English may have reduced nuance despite a detailed bilingual review.

Several strengths are also noteworthy. First, the mixed-methods design, integrating quantitative and qualitative sensemaking approaches, allows for a more nuanced understanding of complex experiences while preserving participants' voices through self-interpretation of lived narratives. Another strength lies in the study's large, diverse, and comparative dataset spanning both urban and rural sites in Colombia and Venezuela. The inclusion of Venezuelan data adds particular value given the scarcity of empirical research amid the country's complex humanitarian emergency. This study also makes a significant contribution to the growing body of scholarship on intersectionality and health equity by demonstrating how overlapping identities shape vulnerability and resilience during public health crises. It provides clear evidence that where these identities intersect, risks are amplified and usual policy responses often fail to address compounded forms of exclusion. Its findings underscore the importance of equity-centered, inclusive research methods that can inform more responsive and participatory public health policies.

Conclusions

This study shows how the pandemic intensified pre-existing inequities in Colombia and Venezuela, particularly for women, persons with disabilities, LGBTQI+ people, Indigenous peoples, and Venezuelan migrants. Across settings, participants reported job and income loss, disrupted health and social services, housing instability, and widespread stigma, pressures that were most acute where identities intersected. A rural/urban divide also emerged, with rural narratives emphasizing economic insecurity and urban narratives highlighting health-system breakdowns. Yet alongside these challenges, we also observed notable resilience with community organizations mobilizing mutual aid, informal safety nets, and problem-solving that helped in the absence of formal supports. These findings underscore the need for an intersectional, equity-based crisis response because harms were intensified not simply within single EDGs, but where multiple forms of marginalization overlapped, for example among migrant women, women with disabilities, Indigenous participants, and LGBTQI+ individuals facing concurrent economic, social, and health-system barriers. For example, strengthening gender-responsive livelihoods and social protection (including those in informal work

and with precarious status), embedding disability inclusion across emergency planning and routine care, safeguarding LGBTQI+ rights and continuity of essential services, expanding safe housing, and reducing rural/urban access gaps. Partnering with members of the community and community-led groups should be a core feature of policy design and accountability going forward.

Appendix 1. Survey questions with possible responses

Question	Possible Responses
Micro-narrative prompts	
Share an example of the biggest advantage or disadvantage of COVID-19 policies and restrictions.	Micro-narrative recorded by participant
Provide a story that illustrates the best and worst action taken by you or someone you know during the COVID-19 pandemic.	Micro-narrative recorded by participant
Provide a story that illustrates how COVID-19 increased or decreased the challenges faced by you or someone you know.	Micro-narrative recorded by participant
Triads	
The shared story was about…	1) Security 2) Finances 3) Health 4) Not applicable
What caused the events in the shared story?	1) Finance strain 2) COVID restrictions 3) Stigma/discrimination 4) Not applicable
What type of support or services were most needed in the shared story?	1) Medical care 2) Necessities like food, water, shelter 3) Ensuring rights related to identity (disability, LGBTQI+, women) 4) Not applicable
What were the main barriers or facilitators to accessing care and services in the shared experience?	1) Accessibility of services 2) Identity (gender, LGBTQI+, disability, Indigenous) 3) Immigration status (citizen, resident, refugee, migrant, etc.) 4) Not applicable
If relevant, what was the primary impact of the experiences shared?	1) Separation from family 2) Financial challenges 3) Poor health / injury / illness 4) Not applicable
Sliders	
In the story you shared, did COVID-19….?	1) Provide too many opportunities 2) Severely limit opportunities 3) Not applicable
The events in the story…	1) Occurred because of COVID-19 2) Would have occurred anyway regardless of COVID-19 3) Not applicable
The shared story was about…	1) An individual person or family 2) Governments and policy makers 3) Not applicable
As a result of experiences in the shared story, is the person's future…	1) Extremely compromised; 2) Secured more than necessary 3) Not applicable
Multiple Choice Questions About the Shared Experience	
What is the emotional tone of this story (choose only 1)?	1) Strongly negative 2) Negative 3) Neutral 4) Positive 5) Strongly positive 6) Prefer not to say/not sure

Table (continued)

Question	Possible Responses
How does this story make *you* feel (choose up to 2)?	1) Afraid 2) Angry 3) Ashamed 4) Disappointed 5) Embarrassed 6) Empowered 7) Frustrated 8) Grateful 9) Happy 10) Helpless 11) Hopeful 12) Inspired 13) Lonely 14) Loved 15) Proud 16) Relieved 17) Sad 18) Strong 19) Supported 20) Worried 21) Prefer not to say/not sure
How often does the situation in your story occur in your community (choose only 1)?	1) It is very rare 2) It happens from time to time 3) It is somewhat typical 4) It happens all the time 5) Prefer not to say/not sure
How did COVID-19 impact the individual's experience in the shared story (choose only 1)?	1) COVID-19 made the situation much worse 2) COVID-19 made the situation a little worse 3) COVID-19 had no impact 4) COVID-19 made the situation a little better 5) COVID-19 made the situation much better 6) Prefer not to say/not sure
Who is the story about (choose only 1)?	1) About me 2) About someone in my family 3) Someone else I know 4) Something I heard or read about 5) Prefer not to say/not sure
What was the age of the individual in the story (choose only 1)?	1) Under age 18 2) 19–30 years 3) 31–45 years 4) > 45 years 5) Prefer not to say/not sure
Does the individual in your story identify as… (choose only 1)?	1) Woman 2) Man 3) Non-Binary 4) Prefer not to say/not sure
Does the individual in your shared story identify as… (choose all that apply)?	1) Women / girl 2) LGBTQI+ 3) Having a physical, sensory, intellectual, or mental health disability 4) Indigenous, being of Afro descent, or other visible minority 5) None of the above 6) Prefer not to say / Not sure 7) Other

Table (continued)

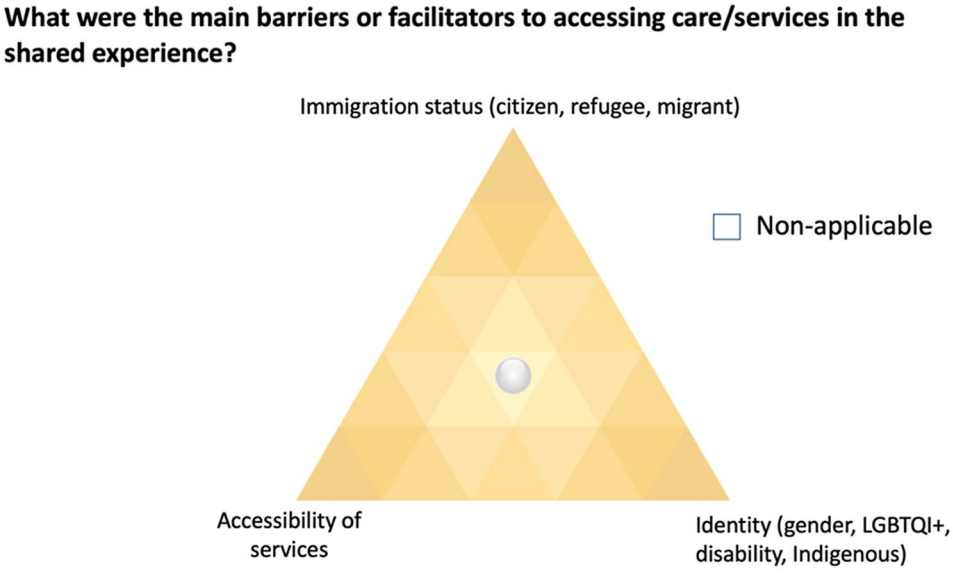
Question	Possible Responses
If the individual in the story identifies as LGBTQ+, do they identify as… (choose only 1)?	1) Gay / Lesbian 2) Bisexual 3) Pansexual 4) Asexual 5)Transgender 6) Gender fluid 7) Non-Binary 8) Agender 9) Prefer not to say/not sure 10) Other
If the individual in the story has a disability, what type of disability is it (choose up to 3)?	1) Psychosocial, psychiatric disability and/or mental health disorder 2) Physical, functional and/or mobility disability 3) Blind or low vision 4) Deaf, deafened or hard of hearing 5) Speech disability 6) Chronic medical condition 7) Neurodiversity 8) Developmental disability 9) Memory 10) Head injury/cognitive 11) Prefer not to say / not sure 12) Other_____
If the individual in the story identifies as indigenous, being of Afro descent or as a visible minority, which of the following do they identify as… (choose only 1)?	1) Indigenous 2) Afro descent 3) Other visible minority 4) Prefer not to say / not sure
Was the story shared about being disrespected or judged (choose only 1)?	1) Yes 2) No 3) Not sure 4) Prefer not to say / not sure
Relative to others in the community, how often does the individual in your story struggle to make ends meet (example, not enough money for food, shelter, clothes…) (choose only 1)?	1) Never 2) Rarely 3) Sometimes 4) Often 5) All the time 6) Prefer not to say / not sure
Where is the individual in the shared story from (choose only 1)?	1) Venezuela 2) Colombia 3) Other
Where was this survey completed (choose only 1)?	1) Caracas, Venezuela 2) Falcon, Venezuela 3) Bogota, Colombia 4) La Guajira, Colombia 5) Prefer not to say / not sure
Did you receive any support or assistance in completing this survey? (choose only 1)	1) Yes 2) No 3) Prefer not to say / not sure
During COVID-19 pandemic did you have access to support person(s), technical supports and other elements necessary for the development of any of your activities (choose only 1)?	1) Always 2) Most of the time 3) Sometimes 4) Rarely 5) Never 6) Prefer not to say / not sure
During the COVID-19 pandemic, did you have access to information appropriate to specific needs about the situation in your location or country (choose only 1)?	1) All of the time 2) Most of the time 3) Sometimes 4) Rarely 5) Never 6) Prefer not to say / not sure

Table (continued)

Question	Possible Responses
What number is this for you (choose only 1)?	1) 1st 2) 2nd 3) 3rd 4) 4th or more
Comments or anything else you would like to share about experiences related to COVID-19?	Free Text
Multiple Questions for the Interviewer	
Did the interviewee receive help answering survey questions on the device?	1) Did it alone without help 2) Did it alone with difficulty 3) Needed help with some questions 4) Needed help during the entire survey
Researcher identification number	Free Text

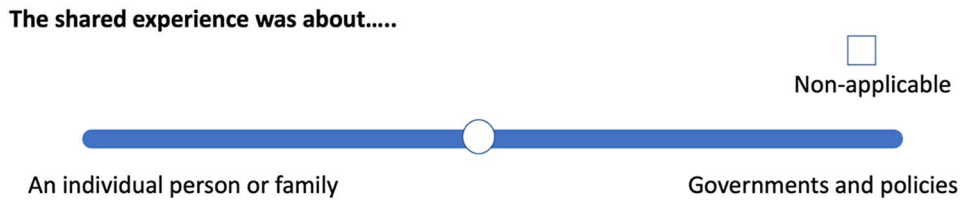
Appendix 2 – Examples of sensemaking questions

Example of a Triad Question



Participants use their finger to drag the indicator to plot their perspectives.

Example of a Slider Question



Participants use their finger to drag the indicator to plot their perspectives.

Abbreviations

COVID	19 Coronavirus Disease 2019
CRPD	Convention on the Rights of Persons with Disabilities
EDG/EDGs	Equity-deserving group(s)
GBV	Gender-based violence
LAC	Latin America and the Caribbean
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and other identities
RIADIS	Red Latinoamericana de Organizaciones de Personas con Discapacidad y sus Familias
UN	United Nations
UNDP	United Nations Development Programme

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12939-026-02995-9.

Supplementary Material 1

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Author contributions

JP, AC, HA, and SAB conceived of the original parent study and secured research funding. EG oversaw the data collection in Venezuela and Colombia. CAD conducted the quantitative analysis. SAB led the qualitative analysis and drafted the manuscript. CR, ZC, JADG, JP, AC, HA, and EG contributed to interpretation of the results. All co-authors reviewed and approved the final manuscript.

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Data availability

The de-identified data are available in Borealis, the Canadian Dataverse Repository, at doi.org/10.5683/SP3/26KULS.

Declarations

Ethics and Consent

This study was conducted in accordance with the principles of the Declaration of Helsinki. The Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board approved this study protocol (#6037174). Informed consent was obtained from all participants by having participants tap a consent box on the tablet.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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