



# CARE Rapid Gender Analysis

A Commitment to Addressing Gender and Protection Issues in Cyclone- and Flood-Affected Malawi, Mozambique and Zimbabwe

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## Acknowledgements

Cover page photo: *This is everything I own. My life has been swept away. The child on my back is the only one I know is OK. I have no idea if my other children are alive* – Virginia Gimo, 42, who fled Maucumba, Mozambique

Images: CARE/Josh Estey



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**CARE's Approach to Gender in Emergencies: Activities during a humanitarian response can increase and reinforce, or reduce, existing inequalities** - CARE's humanitarian mandate is to meet immediate needs of women, men, girls and boys affected by natural disasters and humanitarian conflicts in a way that also addresses the underlying causes of people's vulnerability, especially as a result and cause of gender inequality. The impact of crises on people's lives, experiences and material conditions differ based on their gender and sexuality. Our activities during a humanitarian response can increase and reinforce, or reduce, existing inequalities. Integrating gender into every stage of a response is therefore a core part of CARE achieving their humanitarian mandate.

<https://www.care.org/our-impact/gender-in-practice/priority-areas/gender-in-emergencies>

CARE's focus on women and girls is based on overwhelming evidence of gender discrimination as an underlying cause of poverty and marginalisation, leading them to being more vulnerable to the effects of disasters than men and boys. Humanitarian programming that fails to account for the differing roles and power dynamics between men and women tends to exacerbate gender inequalities. At the same time, disasters often disrupt and displace social structures and relations, creating opportunities to promote gender transformational change, such as women taking on leadership roles in their household and community during relief and recovery. While urgent, lifesaving action is critical in crisis response, CARE firmly believes that gender-sensitive action is essential to an effective response. CARE is also convinced that humanitarian action can advance gender equality and transformation.

CARE Insights, 2017, *Gender & Localising Aid: The potential of partnerships to deliver*, pg. 4  
[https://www.care-international.org/files/files/publications/Gender\\_and\\_Localizing\\_Aid\\_high\\_res.pdf](https://www.care-international.org/files/files/publications/Gender_and_Localizing_Aid_high_res.pdf)

## OBJECTIVES AND METHODOLOGY

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CARE International is responding to the impact of Cyclone Idai and the associated floods in Malawi, Mozambique and Zimbabwe. As part of our response, CARE's team in each of the countries is currently developing or is planning to develop a Rapid Gender Analysis (RGA) for the affected regions. An RGA provides information about the different needs, capacities and coping strategies of women, men, boys and girls in a crisis. It is built up progressively using a range of primary and secondary information to understand gender roles and relations and how they may change during a crisis. It provides practical programming and operational recommendations to meet the different needs of women, men, boys and girls of different ages, abilities and other contextually relevant forms of diversity and to ensure we 'do no harm'. RGA uses the tools and approaches of Gender Analysis Frameworks – such as community mapping; focus group discussions, key informant interviews, safety audit tools and secondary data review - and adapts them to the tight time-frames, rapidly changing contexts and insecure environments that often characterise humanitarian interventions.

In the interim, pending the finalisation of the country-specific RGAs, CARE has developed this regional RGA, which is based almost exclusively on secondary data. The objectives of this preliminary regional RGA are to better understand;

- How women, girls, boys and men of all ages and abilities are affected by the crisis.
- How to design sectorial and multi-sectorial programming that addresses the distinct assistance and protection needs of women, girls, boys and men of all ages and abilities without doing harm.
- How to identify and realise emerging opportunities to facilitate and promote the participation and leadership of all segments of affected communities with a particular focus on women and adolescent girls, as well as people from marginalised groups, such as the elderly and people with disabilities.

## NATURE AND SCOPE OF THE DISASTER

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### Malawi

Prior to Cyclone Idai, heavy rains had already caused severe flooding across Malawi and Mozambique. Heavy rainfall between 5 and 8 March affected 15 districts in the Southern Region of the country. On 8 March, on receipt of preliminary damage reports, the Government of Malawi declared a state of disaster. Between 14 and 15 March, Cyclone Idai made landfall near Beira in Mozambique as a Category 2 storm. As of 23 March, Malawi's Department of Disaster Management Affairs (DoDMA) [reported](#) that 868,995 people have been affected and close to 87,000 are displaced in 173 camps. Additionally, 59 deaths had been reported at that time. Nsanje and Phalombe Districts are two of the most affected.

As of 23 March, assessments indicate that approximately 50% of the people initially displaced have returned to their communities to start the recovery process. In Zomba, displacement camps are mainly in schools and churches. While some schools have adequate toilet facilities for pupils and IDPs, there are some schools that urgently need additional toilets. Where there are inadequate numbers of toilets, open defecation is occurring. Almost no displacement sites have bathrooms/wash areas. Also as of 23 March, DoDMA reports the following gendered issues:

- UNFPA estimates 230,000 women of child bearing age and about 12,000 expected deliveries.
- One maternal death has so far been reported due to inaccessibility of the roads from health centre to the district hospital.
- Pregnant women are delivering in the camps with unskilled birth attendants and, to date, four complicated cases have been reported.
- Health facilities are far from each other and the flooded roads are impassable to access health care services. Two facilities have been submerged, destroying drugs, condoms, equipment and health records.
- Health workers have also been displaced and are, therefore, not available to provide services.

- There is no precise information on the list of facilities including their immediate needs to resume the provision of SRH services and, therefore, limited information is available on where the women can get the services in the absence of community outreach.
- Insecure camp settings and shortage of food increase the risk of trafficking, violence, especially GBV for young and adolescent girls and women. Child marriage was another risk noted for teenage girls. According to an inter-agency assessment mission in Nsanje and Phalombe, about 30% of IDPs are not aware of what constitutes sexual violence.
- Women and girls have inadequate access to sanitary amenities and facilities, as many have lost items such as underwear, soap and sanitary pads in the floods.
- The affected population has been affected psychologically. Many children and youth are idle in the camps and, presently, none of the camps assessed clubs or safe spaces where children and adolescents can access psychosocial support or recreational activities.

## Mozambique

As of 25 March, the Government of Mozambique's National Institute of Disaster Management (INGC) provide that the official death toll is 447 people, while a further 1,500 have been injured. At least 128,941 people are sheltering in more than 143 sites – the majority of which are schools and churches - across Manica (26), Sofala (103), Tete (4) and Zambezia (10). In addition, 72,264 houses have been either totally destroyed (36,747), partially destroyed (19,733) or flooded (15,784). The death toll is expected to continue to rise as the flood waters recede and more people are reached by response teams. Thousands of children are thought to have been orphaned or separated from their families, made homeless or otherwise affected by Cyclone Idai, creating significant protection risks for them.

As of 27 March, the following gendered issues are being reported in the March 2019 updated version of the [HRP for Mozambique](#) (unless otherwise stated):

- More than 96,000 people are now living in over-crowded and unsanitary conditions in collective centres – mainly schools and churches. This creates a difficult situation for school-age children who are unable to attend school. In addition to this more than 30,000 classrooms are destroyed.
- Many children have been separated from their families as they fled flood waters. Unknown numbers of children are now orphaned.
- Rolling power outages throughout the affected areas impact people's ability to safely access resources and increases tension in communal living spaces, exposing people to risks of heightened GBV as people live in crowded and unsafe environments.
- Those people with specific needs, including children, persons with disabilities, elderly people and child-headed households face particular risks in accessing safety and resources. Within such a context, the risk of sexual exploitation and abuse is present, as people become desperate for live-saving resources such as food, shelter and water.
- On 27 March, [UNFPA reported](#) that they estimate that over 75,000 cyclone-affected women are pregnant, with over 45,000 live births expected in the next six months and 7,000 of those could experience life threatening complications.
- A [report on ReliefWeb on 27 March](#) warns that thousands of children who survived the cyclone face new risks of being sold into slavery by human traffickers or forced into early marriage by families struggling to survive.

## Zimbabwe

In Zimbabwe, the impact of the cyclone is overlapping with the existing food security crisis. As of 26 March, UN OCHA reported that, according to government reports, the death toll is at 172, with 327 people still missing. Approximately 270,000 people have been affected by flooding and landslides, with the majority (240,000) located in Chimanimani and Chipinge districts. Nearly 4,500 people are displaced and at least 16,000 families are in need of shelter assistance. A temporary camp has been established at Skyline and two additional temporary camps will be established at Wengezi and Ngangu. IDPs in Chimanimani are currently sheltering in schools and the clinic in Ngangu, as well as in Chimanimani

Hotel. A rapid assessment conducted on 18-19 March revealed that the majority of health care facilities in Chimanimani district are inaccessible, including the district hospital Mutambara Mission. In addition, access to the provincial hospital is limited due to the destruction of roads and bridges. Facilities of Chipinge district are all accessible.

- Approximately 50,000 households, including 120,000 women and 85,000 children, are in dire need of protection interventions especially in the two districts assessed by CARE, i.e. Chimanimani and Chipinge.
- In terms of the prevention of GBV and sexual exploitation and abuse (SEA), an estimated female population of 120,000 in the assessed districts are at-risk (Inter-Agency Rapid Assessment/Appraisal Update OCHA 2019).
- CARE Zimbabwe's Assessment Report (27 March) in Chimanimani, Chipinge, Mutare and Zaka Districts (Manicaland) and Bikita, Buhera Districts (Masvingo) finds the following gendered issues:
  - Flooding has disrupted normal family, community and national child protection and safeguarding systems in the assessed districts.
  - Local protection personnel, including CCWCs, SWs/Case Management Officers and Behaviour Change Facilitators, and facilities have themselves been affected with the result that the protection response is inadequate. Women and children are seeking refuge in the two Musasa GBV shelters in Chimanimani.
  - In Chimanimani and Chipinge, inaccessibility of some areas remains a major obstacle with critical service providers and prepositioned supplies still waiting at Skyline Rescue Centre waiting for the access issues to be resolved.
  - The Ministry of Public Service, Labour and Social Welfare is in charge of Government coordination sub-committee on Psychosocial Support.
  - In Buhera district, both male and female IDPs, including children, staying at Gombe Business Centre are sharing the same room, which creates an unsafe environment. The same situation was observed in the assessed sites in Mutare district.

## GENDER IN BROAD STROKE FIGURES

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Based on an estimated 2.6 million people affected by the disaster, we can extrapolate the following estimates:

<b>Gender</b>	1,326,000 (51%) women and girls and 1,274,000 (49%) men and boys
<b>WASH</b>	650,000 women and girls (i.e. 25% of reproductive age) require support with menstruation hygiene management
<b>SRHR</b>	104,000 will be pregnant (4%) and 15,600 will face life-threatening complications in pregnancy
<b>GBV</b>	1,326,000 (51%) women and girls at risk of GBV

## RECOMMENDATIONS

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This regional RGA report has been developed ahead of the country-specific RGAs for Malawi, Mozambique and Zimbabwe. Once developed, it is important that the country-level RGAs are updated and revised as the crisis unfolds and relief efforts continue. Analysis of the shifting gender dynamics within affected communities allows for more effective and appropriate programming and will ensure humanitarian assistance is tailored to the specific and different needs of women, men, boys and girls. It is recommended that CARE continues to invest in gender analysis; that new reports are shared widely; and that programming is adapted continuously to the changing needs.

### Overarching Recommendations

The following initial recommendations are suggested to support gender-sensitive programming that promotes the protection and empowerment of women. Given the overall regional nature of this RGA, the recommendations will most likely change and new recommendations made for each of CARE's operational sectors as the country-specific RGAs become available:

- **Sex- and age-disaggregated data (SADD)** - All humanitarian programming activities, including assessments, implementation and monitoring and evaluations, must collect SADD at a minimum and, additionally, disability-disaggregated data insofar as is possible. Once collected, it is critical to ensure that someone is tasked with analysing the data and making recommendations to the respective teams on how to adjust their programming to be more accurate and inclusive.
- **Gender-balanced teams** - CARE assessment and project teams must include female staff that are better placed to speak with female programme participants.
- **Community-driven response** – It is critical that the response is based on the needs and priorities of local affected communities. This will entail significant investment in community structures/committees, two-way dialogue and relationship building. With a marked increase in the number of female-headed households, it is critical that the CARE teams consult with women and identify and put in place any special measures required to ensure their participation in decision-making around the design, implementation, management and evaluation of humanitarian activities. In addition, ensure that women, adolescent girls, those with limited mobility and other groups at increased risk are meaningfully engaged in all sector and multi-sectoral programming including in decision-making processes and coordination mechanisms.
- **Self-recovery** – Where possible, support the self-recovery of the populations affected, paying attention to existing capacities and the populations own recovery decisions. Consider how CARE can support, accommodate and promote these decisions especially through efforts that will stimulate local market resilience.
- **Programme participant committees** – Where CARE is establishing or facilitating the establishment of committees, e.g. camp committees, WASH committees, include equal – at best - or representational – at a minimum - number of women.
- **GBV services** - Liaise with GBV service providers and actors in affected areas to map available response services. Ensure that all CARE staff and partners are briefed and aware of the protocols for referring survivors who may disclose to them. For this, a contextually adapted version of the Global Shelter Cluster's Constant Companion is useful (<https://www.sheltercluster.org/gbv-shelter-programming-working-group/documents/gbv-constant-companion>). All CARE and partner staff must respect a sexual violence survivor's rights to life, self-determination, high quality health care, non-discrimination, privacy, confidentiality, information and respect.
- **Partner with women's and youth organisations** to understand the needs, priorities and capacities of women and adolescent girls and deliver appropriate and adequate services to them.
- **Code of Conduct and PSEA Policy** - Ensure that all CARE staff and partners have been briefed on, are aware of their responsibilities related to the prevention of sexual exploitation and abuse and have signed the Code of Conduct and the PSEA Policy.

- **Complaints and Feedback Mechanisms** - Ensure that girls, boys, women, and men, including older people and those with disabilities have access to complaint and feedback mechanisms so that corrective actions can address their specific protection and assistance needs.
- **Gender and Protection on the Agenda** – Sector Leads are encouraged to accommodate short briefings by Gender Advisers or other personnel to share the overall and sector-specific recommendations with their teams, including addressing how in practical terms to ensure the recommendations are followed.

### Food Security Recommendations

- Consult women and men separately about how the crisis affects their own and their children's food security and how they are distinctly impacted by crop deficits and livelihood losses.
- Consult women and men separately to assess who makes decisions within the home on what is cultivated or grazed, consumed or sold and what is done with production's benefits in order to inform the design of distribution, committee, cash-for-work and training activities.
- Find out who makes decisions within the home that affect family nutrition (for example who eats first, most and best, spending on food) to determine which groups may be at particular risk of malnutrition. Understand who has access to markets and any changes arising from the crisis. Ensure that food security programmes are designed to meet the nutritional needs of the general population, with special attention on supporting access to complementary foods for young children and to nutritionally adequate diets for pregnant and lactating women, in order to protect these vulnerable groups from immediate and lasting consequences of malnutrition.
- Provide to women the means to reduce their workload, freeing up their time to engage in other economic and social activities (for example provision of tools, techniques, irrigation techniques, improved seeds).

### WASH Recommendations

- Consult women, girls and people with mobility issues on the location of water and sanitation facilities, ensuring that they are assured about the safety of routes to/from the facilities. On this recommendation, it is worth noting that recent research shows that over 40% of women do not use latrines provided. If time, logistics and language allow, show this short video clip to WASH personnel - [https://www.youtube.com/watch?v=IEIW\\_rsh\\_vA0&feature=youtu.be](https://www.youtube.com/watch?v=IEIW_rsh_vA0&feature=youtu.be) to highlight the gender, vulnerability and quality issues around latrine design, location and use.
- Be very aware of any particular marginalised people or groups in each country context. This may include people from a particular ethnic group, people from the LGBTI community, people in particular occupations, etc.
- Install lights near the facilities, especially if they are communal or away from homes. If lighting is not possible, consider alternatives such as providing torches for each household.
- Given women's critical role in water management, consult with them on safe access to water, the timing and location of water distributions, water carriers, water storage, etc. In the second phase of the response, attention should turn to women and men's equal access to training on construction, operation, and maintenance of WASH facilities, and ensuring that specific hygiene needs are available on the local markets.
- Consult with women and adolescent girls about locally-preferred sanitary materials and their disposal and/or washing and drying. Provide adequate materials and facilities.
- Use the **WASH minimum commitments for the safety and dignity of affected people**<sup>1</sup> as a practical guide to plan, implement and monitor the quality of WASH interventions.

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<sup>1</sup> The tool can be accessed at <http://gender.careinternationalwikis.org>

## Shelter & Settlements Recommendations

- In collective shelters located in non-residential buildings without space to separate households, overcrowding and/or integrating unrelated groups have the potential to increase the risk of exposure to different forms of GBV. Overcrowding can lead to lack of privacy and women and girls sleeping in spaces that could be shared by extended family or strangers, putting them at risk. In response, minimise the shelter options requiring displacement and/or use of collective centres as a temporary solution. If this is not possible, consider specific actions to increase dignity and privacy including ensuring adequate provision of blankets/bedding materials so that different groups are not forced to share and prioritise relocation to individual household shelter solutions.
- Discuss with women their specific shelter needs to ensure privacy and to prevent GBV due to poor, inappropriate or cramped shelter conditions (e.g. partitions, locks and lighting).
- Provide tarpaulins and other temporary shelter materials for affected people to build separate or larger shelters to allow for privacy.
- Discuss with women, men, boys and girls which specific NFI meet their needs and are culturally appropriate, including bedding, mattresses, clothing and kitchen sets.
- Ensure that female-headed households, older people and people with disabilities have safe, dignified and equal access to shelter items. Include a separate line for the most vulnerable at distributions. If necessary provide support in transporting heavier items to their homes.
- Ensure that everyone has the ability and knowledge to use or construct the shelter items provided safely and effectively or has access to additional support. Target widows, female-headed households, child-headed households or those at risk of GBV as a priority or provide them with technical assistance in building/rebuilding their shelters.
- Women often have the responsibility of gathering construction materials such as grass for thatch. Consult them to ensure this is done in a safe and secure way.
- Train women as well as men in shelter construction, rehabilitation and maintenance, with an emphasis on safer building principles and healthy homes.
- Organise childcare or alternate sessions so women can participate actively in trainings and/or distributions.

## Sexual & Reproductive Health and Rights Recommendations

- Collaborate with other actors on women's health and protection programming to ensure the full package of life-saving SRH services in line with the Minimum Initial Service Package (MISP), including but not limited to full range of reversible contraceptive options, syndromic management of STIs, 24/7 access to Emergency Obstetric and Newborn care for complications in pregnancy, support for continued anti-retroviral treatment (ART) for those previously on ART, is available to the affected population.
- Assess the safety and accessibility of existing SRH services and immediately integrate and implement SRH and GBV health responses. In close collaboration with GBV actors providing case management and psychosocial response services, support survivor-centred referral systems that increase access to post-rape care and provide information to communities on availability and benefits of utilising these services.
- Ensure adolescent-friendly SRH services, including targeted support and referrals, are available at health facilities and community distribution points.

## Market-Based Approaches and Cash and Voucher Assistance Recommendations

- When designing market-based approaches and using cash and voucher assistance (CVA), in the market assessment understand: who in the household should receive the cash; specific household and community risks that women, men, boys and girls face in receiving and spending the money or using vouchers; household decision-making dynamics; and mobility analysis, including access to markets.

- Consider the potential gendered implications of conditional transfers so as to avoid putting undue burden on, or excluding segments of the population, especially women and marginalised groups.
- Ensure that the distinct needs for women, men, girls and boys are considered in cash transfer values or items for voucher contents.

## HUMANITARIAN CRISES ARE NOT GENDER-NEUTRAL

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**Disasters affect everyone differently** - CARE recognises that women, girls, boys and men have different capacities, strengths, needs and vulnerabilities; each of which can impact how an individual and the wider community are impacted, as well as how they will react, respond and recover to the disaster.

### Why women and girls are most and worst affected by conflict and disasters – the global evidence:

#### Pre-existing social and cultural norms and expectations

- Pre-existing social and cultural norms and expectations placed on women and girls, including their roles and responsibilities in the home and in the community; their decision making power in relation to men and boys; their engagement in paid work; level of education (and many more), can lead to women and girls being disproportionately impacted by disasters.
- Because of social norms, women are often the last to eat, which makes them more vulnerable in times of drought when meals are reduced.<sup>i</sup>
- The share of extreme poor living in conflict-affected situations is expected to rise from 17% of the global total today to almost 50% by 2030.<sup>ii</sup>
- Globally, due to discriminating social norms and considerable differences in access to employment and pay, more women than men live in poverty.<sup>iii</sup>
- One in two women aged 15 and over is in paid employment compared with about three in four men; 1.27 billion women against two billion men of working age were in paid employment in 2016. Women take on about three times more unpaid work than men. Even when women are paid, they tend to work in jobs that reflect gender stereotypes and are characterised by relatively low earnings, poor working conditions and limited career-advancement opportunities; and even when women do the same jobs as men or perform work of equal value, they are paid less on average than men, although the size of the pay gap varies considerably around the world.<sup>iv</sup>
- In 2015, only 1% of all funding to fragile states went to women's groups.<sup>v</sup>
- Disaster-affected people's level of participation in household and community decision-making around the disaster response will depend upon their status in the household and the community, as well as how rewarding they find the experience and whether they gain something from the process. In terms of status in the household and community, because of social norms, women and girls may have no or limited decision-making roles in both their own household – beyond household chores and their caring role – and the community. Participation of disaster-affected women and their capacity and strategies to survive with dignity are central to emergency response.
- "Humanitarian emergencies are accompanied by inherent risks that increase adolescents' vulnerability to violence, poverty, separation from families, sexual abuse, and exploitation. These factors can disrupt protective family and social structures, peer networks, schools, and religious institutions and can greatly affect the ability of adolescents to protect themselves and practice safe SRH behaviors. Their new environment can be violent, stressful, and/or unhealthy. Adolescents (especially adolescent girls) who live in crisis settings are highly vulnerable to sexual coercion, exploitation, and violence, and may engage in high-risk or transactional sex for survival" and result in significant SRHR and protection needs. (IAFM 2018)

## Gender-based Violence (GBV)

- Rape, trafficking, early marriage and other forms of violence against women tend to increase in times of conflict and natural disasters.<sup>vi</sup>
- Approximately 20% refugee or displaced women in complex humanitarian settings is estimated to have experienced sexual violence, a likely underestimation given the barriers associated with disclosure.<sup>vii</sup>
- With the onset of the drought in Mozambique (2016), many families have used child marriage as a coping mechanism to raise income (through dowry) or to reduce the number of dependents per household.<sup>viii</sup>
- The risk of maternal mortality is highest for adolescent girls under 15 years old and complications in pregnancy and childbirth is a leading cause of death among adolescent girls in developing countries<sup>ix</sup>
- Girls are more likely to be pulled out of school in crises and less likely to return, than boys.<sup>x</sup>
- GBV happens in all communities and contexts globally and is one of the most pervasive and yet least-recognised human rights abuse in the world; even in stable contexts, the most common form of violence that women face is domestic violence or violence from intimate partners.<sup>2</sup> Data shows that 36.6% of women in the Africa region will experience physical and or sexual violence by a partner or sexual violence by a non-partner in their lifetime.<sup>3</sup>
- In times of disasters the prevalence of GBV increases and new forms of violence emerge. This can be due to many factors, including but not limited to: a collapse of protective systems such as families, friends and communities – many of whom may be displaced by the disaster; increased individual and collective stress; economic hardship due to loss of livelihoods; as well as crowded and insecure environments.
- Women, men, boys and girls can experience GBV, however women and girls, as well as men and boys who do not conform to societies expectations, are disproportionately affected.

**Therefore, CARE is committed to mitigate this disproportionate impact and ensure that all women, girls, boys and men, irrespective of age, disability, health status, social, religious, migrant or ethnic group are protected during and after the emergency, in a way that meets and respects their specific needs, capacities and vulnerabilities.**

## GENDER AND PROTECTION IN BRIEF<sup>4</sup>

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### MALAWI

Malawi is considered a patriarchal society with men holding most of the authority within the family unit. While women are responsible for household upkeep and childcare, the 2016 Global Gender Gap reports their high levels of activity in the economic sphere, 81% of women working compared to 80% of men.

Marriage in Malawi is common and expected, with arranged marriages still taking place in rural areas. Dowry, often paid in livestock, is also customary. As most people in the country are religious, it is a socially conservative place where gender norms are respected. Decision-making power for women is relatively limited, with 44% of women reporting that their husband alone makes the decisions related to their own healthcare and 69% reporting that their husband alone makes decisions related to major household purchases. Children, especially girls, are raised to be obedient and to help with chores such as fetching water and collecting wood in rural areas and helping with childcare in more urban areas.

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<sup>2</sup> <https://www.careinternational.org.uk/fighting-poverty/empowering-women-and-girls/ending-gender-based-violence>

<sup>3</sup> [http://www.who.int/reproductivehealth/publications/violence/VAW\\_Prevalence.jpeg?ua=1](http://www.who.int/reproductivehealth/publications/violence/VAW_Prevalence.jpeg?ua=1)

<sup>4</sup> Information and data in this section has been taken from the 2017 Gender in Briefs (GiB) for each country unless otherwise indicated. All sources of data are contained in the GiB available at [https://gender.careinternationalwikis.org/gender\\_in\\_briefs](https://gender.careinternationalwikis.org/gender_in_briefs)

Primary school is from ages 6 to 13 years, with an option for secondary school to age 17 years. Most Malawian children do not complete their full schooling as they drop out to help with agriculture or with taking care of younger siblings. Within Malawi, 19% of women and 11% of men have never attended any formal school. Women are also generally less exposed to the outside world than men, with a higher proportion of men listening to the radio, reading newspapers, or watching television at least once a week. Higher education is uncommon in Malawi. Though a few institutions exist, most students from wealthier families choose to go abroad for their higher studies.

True figures capturing women's labour outside of housework are hard to identify, as many women work on family farms or in family businesses but do not consider this to be "work." Sometimes this labour is compensated, sometimes not, but women frequently earn less than men for the same type of labour. Of those women who are married and earning money, 40% report that decisions about how their income is spent are made primarily by their husbands. Most women work in the agricultural sector (58%), followed by the sales and service sector (25%); while most men also work in agriculture (48%), followed by skilled labour (18%) and then sales and services (16%). It is estimated that 20% of children aged 5-14 years are working, often in poor conditions, primarily in the tea and tobacco industries. This labour interferes with their ability to gain an education and can be damaging to their health.

Despite having had a female president between 2012 and 2014, overall women's participation in Malawian politics is limited. Participation peaked in 2009 with 23% of the total members of parliament being female, a figure that fell to 17% in 2014. A number of laws have been passed to help protect women's rights to varying degrees of effectiveness. The 2011 Deceased Estates Bill gives women legal right to inheritance after the death of her husband. However, this has been hard to enforce in practice, and female illiteracy has contributed to a lack of knowledge regarding basic rights. The justice system is also considered inefficient and generally unhelpful towards protecting women's rights. The 2006 Prevention of Domestic Violence Act protects women against physical, emotional, financial and sexual abuse but does not account for marital rape. There are a number of women's groups in Malawi seeking to educate women on their rights, train them in useful skills, and/or offer small microfinance loans to increase their productivity.

Malawi is party to Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and is a signatory to the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, signalling its commitment towards reducing incidences of GBV. However, women are still at risk of GBV with almost 15% of women in Malawi reporting that their first sexual experience happened against their will. Two out of five women reported that they had experienced sexual or physical violence at some point. This violence is usually perpetrated by a current or former partner. Among women experiencing violence, less than 4% went to the local police to seek help, a testament to cultural stigmas, lack of awareness, and police ineffectiveness. Child marriage is an issue of particular concern in Malawi. Different laws state the legal age for marriage to be either 18 or 21, granting the possibility to marry younger with parental consent. More than half of all women aged 25-49 were married by the age of 18. Marriage at a young age can contribute to poorer education and health outcomes, as well as increase the likelihood for abuse. Further, nearly half of all 19 year-old women have had a live birth, which can be dangerous for both young mother and child. Poverty contributes to the likelihood of child marriage, as families might see daughters as an economic burden or perceive marriage as a chance at a better life. HIV/AIDS is a significant concern in Malawi, with less than half of those between ages 15-24 having knowledge of HIV prevention methods.

As women are the primary caretakers of the household, disasters affecting access to resources will disproportionately affect women and girls. For example, as the primary collectors of water, women will face extra burden in times of drought or flood, similar to food insecurity. Women and girls will also have increased stress related to sanitation and hygiene. Women staying in relief camps are at increased risk of sexual violence and/or coercion in return for aid. Finally, increased economic strains on family could lead to a rise in child marriage as families may encourage their daughters to wed in an effort to decrease household costs.

## MOZAMBIQUE

Mozambique has the 13th highest level of women's participation in parliament in the world yet, at the same time, a third of women report experiencing violence, reflecting entrenched gender inequalities.

In terms of gender roles and responsibilities, women and girls in Mozambique are generally responsible for domestic labour while men and boys worked outside the home. At the household level, women and girls care for children, the sick and the elderly, as well as cooking, collecting water and cleaning. Men and boys are responsible for hunting, fishing and cow-herding, collecting firewood and building houses. In the current crisis, it has been noted that men are not involved in water collection, handling, management, storage or treatment, therefore making it imperative that women and girls are consulted and inform decisions around access to and availability of water. In previous years, during periods of drought, it was noted that during the water collection activities, girls faced increased risk of confrontations with wild animals and GBV.<sup>5</sup> Further, it was noted at access to sanitary materials for menstrual hygiene became challenging; with household cash and food reserves strained, this made it harder for women to purchase the materials needed.

Traditionally, men have been responsible for making decisions for the household and the payment of dowry (lobolo) is used to justify this. Things are changing particularly in urban areas and in the south of the country where migration is common especially for men. Polygamy is quite common in Mozambique although the Family Law 2004 prohibits it.

One-third of all women in Mozambique have experienced violence at some point since the age of 15. Moreover, 12% of women reported being forced to have sex at some point in their lifetime. Of those surveyed who were survivors of sexual violence, 59% never sought help or informed anyone. In Mozambique, changing attitudes that accept or excuse violence is critical to reducing the risk of violence against women and girls.

Child protection issues include child marriage and child labour. Almost 50% of young Mozambican women aged 20-24 years were married before the age of 18, while 14% were married before the age of 15. Child marriage is more common in the north of Mozambique and more common in rural areas than in urban ones. There is an association between adolescent pregnancy and child marriage: the majority of adolescent mothers were married during their teens. Child marriage is associated with a significantly higher likelihood of leaving school early.

In previous emergencies, negative coping mechanisms were noted, which caused protection issues for women and girls. Many families used child marriage as a coping mechanism to raise income (through payment of a bride price) or to reduce the number of dependents per household. This increase in child marriage left many girls at risk of sexual and physical abuse, poor nutrition and increased chance of maternal neonatal death.<sup>6</sup> Further, shortage of food and income among families also saw increased risk taking, with many women and girls forced to engage in sex for food or money, marry early or be exposed to increased violence from stressed spouses.<sup>7</sup>

In the current crisis, the most affected are pregnant and lactating mothers, women and children. Large numbers of people have been displaced, living in spontaneous settings and temporary evacuation centres. In many areas, residents are crowded into makeshift shelters, with poor lighting and little or no separation between families. It is, therefore, crucial that actions are taken to mitigate against, prevent and respond to GBV; ensuring lifesaving services are made available.

As noted above, an estimated 900,000 children are thought to have been orphaned or separated from their families, made homeless or otherwise affected by Cyclone Idai. Protection partners continue to receive daily calls from parents who have been separated from their children, emphasising the critical

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<sup>5</sup> CARE International in Mozambique, November 2016, *Hope dries up? Women and Girls coping with Drought and Climate Change in Mozambique*

[https://www.care-international.org/files/files/EI\\_Nino\\_Mozambique\\_Report\\_final.pdf](https://www.care-international.org/files/files/EI_Nino_Mozambique_Report_final.pdf)

<sup>6</sup> *ibid*

<sup>7</sup> *ibid*

need to reunite unaccompanied children with their families. This is further evident in displacement camps and schools - which double as temporary shelters - where children are sleeping rough. As a result of the loss of life and family separation, it is key to ensure that female-headed, lone male-headed and child-headed households are identified and are receiving the right protection and assistance services.

Access to education and healthcare is compromised; initial assessments in Beira indicate that more than 2,600 classrooms have been destroyed and 39 health centres impacted. This is likely to most affect already vulnerable individuals and groups, including those in inaccessible and hard-to-reach areas and those with mobility issues such as persons with physical disabilities, the elderly and pregnant women.

## ZIMBABWE

Traditional gender roles are embraced in Zimbabwe, with women responsible for most household work, including cooking, cleaning, childcare and the collection of water and firewood.

Families in rural areas tend to be large with several generations living together while homes in urban areas are more likely to consist of only the nuclear family. Marriage in Zimbabwe is common, as are negotiations over bride price to be paid by the man's side. The legal age for marriage is 16 years for women and 18 years for men. Men are considered to be the authoritative figures in the family, though women do gain more respect and power within the family as they age. Women in Zimbabwe have relatively high levels of decision-making power, with more than 84% making their own or joint-spousal decisions on their healthcare, household purchases and visits to family and relatives. Although wives are legally entitled to inheritance after divorce or widowhood, in practice, these assets are often not obtained due to a lack of support from the husband's family or from failures in the justice system.

Children are taught from a young age to emulate the activities of their parents, with, for example, girls often joining their mothers in the kitchen and boys helping their father with livestock or other livelihood.

Boys and girls have roughly the same school attendance rate at the primary and secondary levels, with high literacy rates observed in both genders. Educational attainment is higher in urban areas than in rural, regardless of gender. The economic crisis is the biggest threat to Zimbabwe's education system where children in rural areas, especially girls, drop out of school due to being unable to pay school fees.

In terms of labour, women are heavily active in the agricultural sector, working in both family- and commercially-held farms. Female labour in the informal sector (baking, gardening, cleaning, etc.) is also used to supplement household income. Zimbabwean men are more likely than women to work in the formal sector and earn a higher proportion of the household income. Census reports show a higher proportion of males than females work; but these figures likely underestimate or do not capture informal work being done by women. Among married women, the number with employment outside of housework rose from 45 – 55% between 2005 and 2015. Of those women earning a salary, 95% say they either have full or joint-spousal decision-making power over how that money is managed.

The employment sector poses a number of gendered risks:

- A number of children/young adolescents (10-14 years) are working in Zimbabwe, potentially interfering with their education.
- Women and adolescent girls living on the border of the country are particularly at risk of being forced into labour in neighbouring countries, including domestic labour and prostitution.
- Changing economic conditions mean men are more likely to be unemployed than before; general unwillingness to assist with traditional 'women's work' thus leaves women overburdened as the sole providers for their families.

Zimbabwe's Constitution was updated in 2013 to recognise gender equality as one of the constitutional founding principles and outlawing discrimination against women. Through a new quota system for national elections, a historic 35% of seats in Parliament went to female politicians in the 2013 elections. These changes have added some weight to the voice of women in the country at the national level as women rise to positions of leadership. Female activists and women's groups played a key role in lobbying for the approval of the new constitution. However, a lack of trust in the government, as well as a perception of politics as a male-driven field, has led to lower interest in

political engagement from young women. In addition, government positions are overwhelmingly held by men at the local-level. The absence of a legislative framework for affirmative action to ensure attainment of gender quota systems for political parties and in urban and rural councils is a key hindrance to achieving gender parity. The Domestic Violence Act of 2007 takes a broad definition of domestic violence and prohibits forced marriages, the practice of wife inheritance, and early marriage. However, legality often pales in comparison to what is practiced.

Two thirds of Zimbabwean women have experienced some form of GBV in their lifetime. This violence manifests itself as physical, emotional and sexual violence. Services for victims of violence, including women's shelters and the justice system, are often expensive, inefficient, or non-existent. This often causes women to remain silent about their experiences. Patriarchal and traditional values also influence perspectives on violence, with nearly 40% of Zimbabwean women believing men are justified to beat their wives under certain circumstances. Reports of violence against women and rape as political tools have also been documented.

Through a series of legislative and policy reforms and programs, Zimbabwe has stepped up action against GBV, including domestic violence. These include; the enactment of the Criminal law Act (2006); Domestic Violence Act (2007) and the setting up of the Anti-Domestic Violence Council to enforce this law; the putting in place of mechanisms to effectively implement the Sexual Offences Act of 2001; and the annual 16 Days of Activism against GBV and other campaigns. Zimbabwe has some of the highest HIV rates in the world, affecting both men and women. In terms of sexual violence, women in Zimbabwe are at high risk of infection, particularly if they do not have decision-making power regarding condom use. Zimbabwe has consistently rejected issuing recognition or rights related to LGBT communities and conditions for those identifying as LGBT are extremely poor.

Women's equality in decision-making power is critical to disaster-preparedness. As women are usually the primary caretakers of the home, the more control a women has over resources, the better she can prepare for disaster. Work to increase household resilience has been quite successful in Zimbabwe. There has also been some success targeting aid at women during an emergency response. Programmes and meetings with a gender focus can be perceived as exclusive to females by males in society; thus, efforts should be made to engage local community leaders who will be influential in shaping public view of disaster response. Male approval/permission will likely lead to more female participation in emergency response programmes.

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CARE works with poor communities in developing countries to end extreme poverty and injustice.

Our long-term aid programs provide food, clean water, basic healthcare and education and create opportunities for people to build a better future for themselves.

We also deliver emergency aid to survivors of natural disasters and conflict, and help people rebuild their lives.

We have 70 years' experience in successfully fighting poverty, and last year we helped change the lives of 65 million people around the world.

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<sup>i</sup> CARE International. “Empowering women and girls affected by crisis: CARE progress towards achieving gender equality in humanitarian programming” [https://www.care-international.org/files/files/Empowering\\_women\\_and\\_girls\\_affected\\_by\\_crises.pdf](https://www.care-international.org/files/files/Empowering_women_and_girls_affected_by_crises.pdf)

<sup>ii</sup> World Bank: <http://www.worldbank.org/en/topic/fragilityconflictviolence/overview>

<sup>iii</sup> Leave no one Behind: A Call to Action for Gender Equality and Women’s Economic Empowerment. Report of the UN Secretary Gender’s High-level Panel on Women’s Economic Empowerment 2016

<sup>iv</sup> Ibid

<sup>v</sup> UN Women: <http://interactive.unwomen.org/multimedia/infographic/humanitarianaction/en/index.html>

<sup>vi</sup> UN Women <http://interactive.unwomen.org/multimedia/infographic/humanitarianaction/en/index.html>

<sup>vii</sup> UN Women <http://interactive.unwomen.org/multimedia/infographic/humanitarianaction/en/index.html>

<sup>viii</sup> CARE Mozambique. “Hope dries up? Women and girls coping with drought and climate change in Mozambique” [https://www.care-international.org/files/files/El\\_Nino\\_Mozambique\\_Report\\_final.pdf](https://www.care-international.org/files/files/El_Nino_Mozambique_Report_final.pdf)

<sup>ix</sup> Maternal-perinatal morbidity and mortality associated with adolescent pregnancy in Latin America: Cross-sectional study. Conde-Agudelo A, Belizan JM, Lammers C. American Journal of Obstetrics and Gynecology, 2004, 192:342–349; Global patterns of mortality in young people: a systematic analysis of population health data, Patton GC, Coffey C, Sawyer SM, Viner RM, Haller DM, Bose K, Vos T, Ferguson J, Mathers CD. Lancet, 2009, 374:881–892.

<sup>x</sup> UN Security Council (2015). Report of the Secretary-General on women, peace and security; and UN Security Council (2014). Report of the Secretary-General on women, peace and security