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DEVELOPMENT**



MALAWI COVID-19 RAPID GENDER ANALYSIS

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Authors

Christobel Chakwana¹; Grace Malera²; Pamela Mkwamba³; Anthony Malunga,PHD⁴ and Billy Molosoni⁵

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¹ Gender Specialist, UNICEF Malawi Country Office

² Team Leader, DFID Funded Tithetse Nkhanza Programme

³ National Programs Officer, UN Women Malawi

⁴ Gender, Youth and Social Dynamics Lead, USAID Funded Titukulane Program

⁵ Gender Specialist, CARE Malawi Country Office

Abbreviations

COVID-19	Novel coronavirus 2019
GBV	Gender Based Violence
MHM	Menstrual Hygiene Management
NCDs	Non-Communicable Diseases
PSEA	Prevention of Sexual Exploitation and Abuse
PSHEA	Prevention of Sexual Harassment Exploitation and Abuse
RGA	Rapid Gender Analysis
SADC	Southern Africa Development Community
SRHR	Sexual and Reproductive Health Rights
UNDP	United Nations Development Program
UNFPA	United Nations Populations Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation

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Executive Summary

Coronavirus disease (COVID-19), an infectious disease caused by a newly discovered coronavirus has had a devastating impact globally. While WHO declared COVID-19 as a world pandemic on 30th January 2020, Malawi declared a state of disaster on 20th March 2020⁶ and this was followed with some restrictions including closure of schools. While countries in Southern Africa have imposed lockdowns and other restrictions, as of 7th May Malawi was yet to go on lockdown, which was stopped through a court decision. Malawi is in an election period for fresh presidential elections and with the campaign period officially opened, observance of COVID-19 safety and preventive measures will be a challenge.

Global research findings have shown that COVID-19 has significant social and economic impact on people, especially those living in poverty-stricken countries. Malawi is at more risk due to other significant health challenges that would exacerbate the severity of COVID-19, such as high levels of malnutrition, malaria, anemia, HIV/AIDS, and tuberculosis.

For women and girls, the impacts can be much higher due to their social responsibilities as primary caregivers, coupled with childcare and nutrition and farm work. Further a majority of health care workers are female (especially nurses). In Malawi, the nursing profession is dominated by female nurses of which 91.5% are professional and 84.7% are associates⁷. With the Covid 19 response, there is also an increased risk of exposure to the infection for health care workers, particularly if health care services are not provided with adequate Personal Protection Equipment (PPE).

Access to sexual and reproductive health and rights (SRHR) services is limited for women and girls. Malawi has one of the highest maternal mortality rates at 439/100,000 live births⁸. Utilisation of family planning is relatively low at only 59% of married women. Adolescent birth rate is at 143/1000 live births (29% girls aged 15-19 have given birth or are pregnant with their first child) and 30% of babies are born to mothers under 19 years⁹. With the health systems stretched and resources likely to shift to COVID-19 response, women and girls' access to SRHR will be compromised and Malawi is likely to experience an increase in birth rates for most young women and adolescent girls and potentially associated birth complication, and maternal and child morbidity and mortality.

Since 20th March 2020, Malawi schools have closed as a prevention measure of the spread of Covid-19. Since adolescent girls and boys are sexually active, the school closure gives them more free time and hence are at increased risk of sexual activity, which may result in early pregnancies and early marriages. At the end of the school closure, some adolescent girls are less likely to return to schools as they may be found pregnant or married off early than expected. Malawi is therefore likely to reverse the gains on education in general, particularly for girls, due to prolonged closure of schools.

⁶ <https://mw.one.un.org/declaration-of-state-of-disaster-by-malawi-president-20-march-2020/>

⁷ Malawi HRH Census, 2008.

⁸ NSO, 2016, Malawi Demographic Health Survey

⁹ Ibid

Women and girls' voices are excluded in decision-making processes and bodies at different levels. The patriarchal nature of normative Malawian culture has significant consequences for women and girls whose power of self-determination is controlled by males. A majority of the power holders and gate-keepers at different levels are males and that has an impact on women's access and their participation in decision making processes, including emergency response and public health. This is likely to be exacerbated in the COVID-19 response as evidenced by gender biased decision makers on Covid-19 responses committees of both the dissolved Cabinet Committee and Presidential Taskforce. The appointments are far below the 40:60 Gender Equality Act stipulations. Further, women's primary care roles and its intensification during the pandemic will be a further constraint on women's participation and leadership in the response, and in other areas of decision-making.

Women have limited access to key COVID-19 related services and resources. 10.5% of the population living in households have soap and water and 27.1% living in households with water access points of 30 minutes or longer away, round trip, need to fetch water¹⁰. This, coupled with their other triple role, demands makes women and girls to be at risk as water points can be obvious places for transmission. Further, women's access to information is relatively poor. They have limited access to and control over the communication channels hence limiting their access to information.

With the prevalence rates of gender-based violence and violence against children in Malawi being relatively high compared to the global average; women and girls are at risk of increased violence as a result of COVID-19 due to livelihoods losses coupled with restrictive gender norms and harmful cultural practices. For the survivors of violence, they are unlikely to access services as the gender based violence (GBV) services are geographically inaccessible; access to legal services is limited and most GBV service providers are non-responsive.

Key Recommendations

- Update the RGA as the crisis continues including the collection, analysis and use of SADDD, to ensure an informed response based on evolving needs of women, men, boys and girls and at-risk groups.
- Awareness raising and localized messages on risks and prevention measures and available service providers should be scaled up and accessible to all people particularly marginalized groups, the persons with various forms of disabilities, women in refugee camps and IDP settlements, both in urban, peri urban and rural areas. The information should be delivered through low-tech multiple channels and understood by diverse populations.
- Use social media and community radio messaging and other digital tools that increase women's access to and use of information e.g. agriculture extension messages which

¹⁰ NSO, 2016, Malawi Demographic Health Survey

also includes market information. These channels should take into consideration women's specific needs and access to phones and other devices.

- Promote male involvement in child caring roles and other labour and time demanding household tasks performed by women. Engage men, boys, and traditional leaders on women's access to productive resources including nutritional, workload, income, gender-based violence, agency, and decision-making.
- Promote women's meaningful participation in decision making at national, district, community and household levels by ensuring Gender Equality Quota is utilised in all decision-making bodies and processes on COVID 19 at all levels and that efforts are made to ensure women's active and meaningful participation in these processes.
- Develop the capacity of women led and women's rights organisations including women with disability organisations on leading community-based responses to COVID-19 prevention and response.
- Provide gender responsive conditional social cash transfer programmes for poor households (that would promote education, routine immunization among other things). These need to be digitized through mobile money platforms to reduce interactions between people.
- Capacitate all humanitarian clusters in integration of gender, GBV, protection and prevention of sexual exploitation and abuse. Build on existing initiatives that provide prevention, protection and response services to survivors of GBV through existing legal and psychological referral systems.
- Strengthen capacity of protection service providers to provide comprehensive response and protection services to survivors.

A. Introduction

A.1. Background Information to COVID-19

CoronaVirus disease (COVID-19) is an infectious disease caused by a newly discovered virus called coronaVirus. On March 11, 2020, the World Health Organization (WHO) declared the COVID-19 outbreak a pandemic, as it poses a serious public health risk worldwide¹¹. Although Malawi had not had its confirmed case, the President declared a state of disaster on 20th March 2020¹² and this was followed with some restrictions including closure of schools. Malawi had its first confirmed case of COVID-19 on 2nd April in Lilongwe¹³. And the numbers have been rising steadily since then. As of 8th May 2020, Malawi had registered 43 cases-24 males and 19 female. Of these, there have been 3 deaths-2 males and 1 female¹⁴.

In response to the COVID-19 outbreak, Malawi has developed a National Preparedness and Response Plan aimed at preventing, detecting and responding to any COVID-19 outbreak. The plan has four main pillars namely: Emergency Preparedness and Capacity-Building; Spread Prevention and Control ; Response ; and Early Recovery. It is built around nine clusters comprising members from government, United Nations (UN) agencies, NGOs and other humanitarian actors. The UN entities, Development Partners, NGOs and other stakeholders are providing technical and financial support¹⁵.

Unlike other countries in Southern Africa, Malawi is yet to effect a lockdown due to a legal challenge. On 14th April 2020, Malawi Government declared a 21-day lockdown that was to be effected from 18 April to 9 May 2020. However, the Malawi Human Rights Defenders Coalition (HRDC) obtained a seven-day court injunction stopping the lockdown. On 28th April 2020 the court sustained the injunction and referred some of the constitutional issues to the constitutional court.¹⁶

A.2. RGA Objectives

This preliminary Rapid Gender Analysis has the following objectives

- To analyze and understand the different impacts that the COVID-19 in Malawi potentially has on women, men, girls and boys and other vulnerable groups in line with the SDGs '*leave no one behind*' principles
- To gather sex and age disaggregated data as an integral part of a strong COVID-19 response.
- To inform humanitarian and development programming in Malawi based on the different needs of women, men, boys and girls.

¹¹Malawi Government- National Response Plan on COVID-19, March-June 2020, Lilongwe

¹² <https://mw.one.un.org/declaration-of-state-of-disaster-by-malawi-president-20-march-2020/>

¹³ <https://www.unicef.org/malawi/documents/unicef-malawi-covid-19-situation-report-7-april>

¹⁴United Nations Malawi COVID 19 Update- Situation Update No.8 May 8, 2020. Lilongwe

¹⁵ Ibid

¹⁶ <https://www.mwnation.com/lockdown-injunction-stands-kaphale-faulted/>

A.3. Methodology

This Rapid Gender Analysis (RGA) provides information about the potential different impacts, needs, capacities and coping strategies of women, men, girls and boys and other vulnerable groups in Malawi. It seeks to influence among others the National Preparedness and Response Plan for Malawi on Covid-19 to be gender and protection sensitive in its implementation. The research methods for this preliminary RGA is secondary data review of existing gender information and the most recent COVID-19 data. This is in line with CARE's Adapted RGA toolkit and its ethical considerations guidance note for conducting RGA's during COVID-19¹⁷.

The research was undertaken from 27th April to 8th May 2020. This initial analysis will be updated as the COVID-19 pandemic evolves and new issues arise in Malawi, the region and the world over. The analysis provides recommendations for the humanitarian system and humanitarian actors, as well as development workers, to ensure consideration of the gendered dimensions of risk, vulnerability, and capabilities in response and preparedness to this crisis, with a lens toward enabling support for existing humanitarian needs. This report is not intended to raise or answer questions about the epidemiology and pathology of COVID-19.

The research had some limitations, which included lack of access to gender disaggregated data, as well as access to primary data due to COVID-19 safety measures instituted by a number of agencies.

A.4. Malawi's Demographic Profile

Sex and Age

Malawi, just like the rest of Africa, has a young population with about 43.95% of its population in the 0-14 age bracket-with 50.61% of them being female; and nearly 21% in the 15-24 age bracket. 47% of Malawi's population are in the reproductive age group of 15-49 years-with about 52% of them being female. Those aged 65 and above form the smallest proportion of the total population, 5%¹⁸.

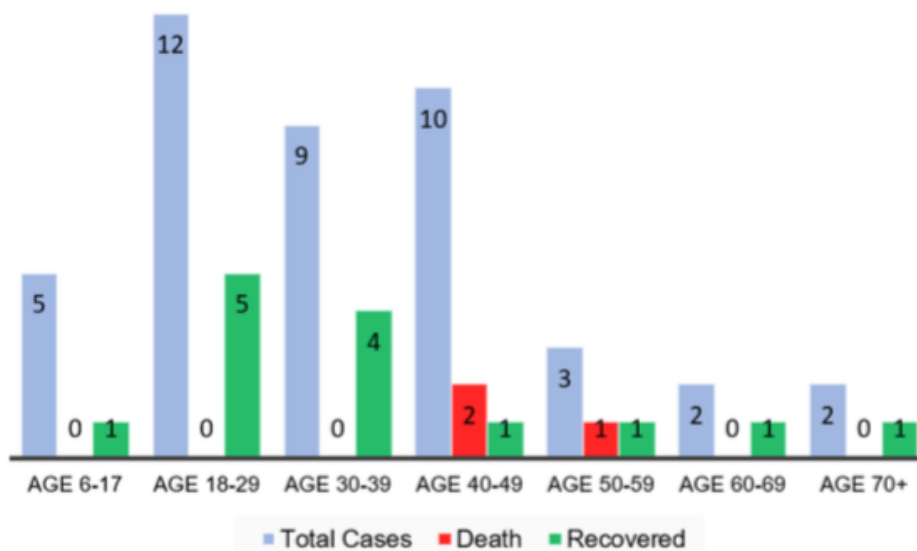
COVID-19 is not affecting all segments of the population equally; it is mainly affecting the elderly and specifically for Malawi almost 60% of the cases as of 8th May 2020 fell within those aged 30 years and above¹⁹ as shown in the graph below;

¹⁷ <https://careinternational.sharepoint.com/sites/Global-Humanitarian-Hub/SitePages/Gender-in-Emergencies.aspx-the-link-is-internal-to-CARE-only>.

¹⁸ NSO, 2018, Malawi Population and Housing Census

¹⁹ UN Malawi COVID-19 Sitrep # 8, May 8, 2020

Malawi's COVID-19 cases by age



Source: UN Malawi COVID-19 Sitrep #8

Malawi has a low life expectancy at birth, 57 years for males and 60 years for females²⁰. With a majority of the population being young, Malawi could theoretically avoid worst impact; however, factors such as high HIV prevalence rate (8.8% of Malawians age 15-49 are HIV positive with 10.8% women and 6.4% men nationally²¹); high levels of malnutrition (23% of all child death cases in Malawi are related to under-nutrition²², anemia and malaria), might make the impact of COVID-19 severe.²³

Urban demographics

16% of Malawi's population live in the urban areas²⁴ with Lilongwe having the highest population. In terms of population density, Blantyre has the highest density at 3334 followed by Zomba at 2500 and Lilongwe at 2455 per square kilometer²⁵. One of the major problems in urban areas in Malawi is informal settlements and slums. 75% of the urban

²⁰ Malawi Government (2017) Malawi Growth and Development Strategy III, Lilongwe

²¹ NSO, 2016, Malawi Demographic Health Survey

²² UNICEF Nutrition Factsheet. Accessed on. https://www.unicef.org/malawi/sites/unicef.org.malawi/files/2018-09/UNICEF_Nutrition_Factsheet_2018.pdf

²³ Kaseje, Neema (30 March 2020). Why Sub-Saharan Africa Needs a Unique Response to COVID-19. World Economic Forum. <https://www.weforum.org/agenda/2020/03/why-sub-saharan-africa-needs-a-unique-response-to-covid-19/>

²⁴ NSO, 2018, Population and Housing Census

²⁵ Ibid

dwellers in Malawi live in slums or informal settlements²⁶. A majority of the slum dwellers live under poor housing conditions, poor sanitation and poor or non-existent infrastructure services. With influenza transmission rates found to increase above a population density of 282 people per square kilometer and in crowded spaces²⁷, Malawi's cities are likely to be worst hit by COVID-19 and women and girls that make up the urban poor may particularly be affected.

People with disabilities

Disability is a factor for social exclusion. In the 2018 Population and Housing Census, persons with disabilities are those having difficulties or problems in one or all of the following areas; seeing, hearing, walking/climbing, speaking, intellectual, self-care and other difficulties. About 10.4% of the population aged 5 years and older had at least one type of disability, 90% of them are found in rural areas. Of these, 10% were males and 11% females. Out of the 1,556,670 persons with at least one type of difficulty, 49% had difficulty seeing, 24% had difficulty hearing, 27% had difficulty walking/climbing and 9 % had difficulty in speaking. 16% of persons with disabilities had intellectual difficulties while 8.5% had problems with safe care. Of the total population about 0.8 % (134,636) were persons with albinism²⁸.

The social isolation measures, and economic challenges could mean the loss of social support for people with disabilities who require more care and support. If Covid-19 awareness messages and campaigns are designed by stakeholders in a way that do not properly consider the needs and situations of those with disability, it will increase their risk of exposure to the pandemic. Further, persons with disabilities encounter environmental barriers to accessing public health information, and barriers that make it difficult to make use of public health measures to prevent infection, such as hand-washing and physical distancing. Since COVID-19 exacerbates existing health conditions, persons with disabilities are at greater risk of developing severe cases of COVID-19 if they become infected due to challenges of access to health facilities timely. Furthermore, in the event of government directives for a lock down as well as other restrictions, persons with disabilities will be heavily impacted socially and economically.

Refugees

According to UNHCR, by 31 December 2019, 44,385 refugees and asylum-seekers were resident in Dzaleka Refugee Camp. 324 new arrivals and new-born babies were registered in December²⁹. Refugees and asylum seekers mainly come from the Democratic Republic of Congo (DRC), Burundi, Rwanda, Somalia and other smaller nationalities as they flee from wars and conflicts in their countries of origin. Approximately 54% of the refugees and asylum seekers in Malawi are children. UNHCR Malawi documents that refugee and asylum-seeking children suffer from separation from their families, psychological trauma, problems associated with child headed households, child labour and exploitation, early marriages and school dropouts. At Dzaleka, people of concern receive on average, seven

²⁶ Malawi Government, 2015, Malawi Habitat III Report

²⁷ CARE, COVID-19 Rapid Gender Analysis for Eastern, Southern and Central Africa Region

²⁸ NSO, 2018, Population and Housing Census

²⁹UNCHR Factsheet Malawi (2019)

litres of water per person per day while the standard is ≥ 20 litres per person per day³⁰. With the COVID-19 outbreak combined with social distancing and limited mobility, women and girls' access to health and hygiene services and food in the event of lockdown would be further challenged.

B. Findings and Analysis

B.1. Gender roles and responsibilities

Social norms in Malawi dictate that women and girls are responsible for doing domestic chores and nursing sick family members. In most communities, women and girls are the last to receive medical attention when they become ill because of the various gendered barriers and bottlenecks, which hinder their ability to receive timely care. These patriarchal expectations could have serious implications for older women or those with chronic conditions or weakened immune systems including women and girls experiencing malnutrition.

Over and above the domestic and reproductive role, women are also expected to provide for their families, creating the “double burden” of work for women.³¹ Women and adolescent girls aged 15+ spend 8.7% of their time on unpaid care and domestic work compared to 1.2% spent by men.³² Women constitute 70% of full time farmers, carry out 70% of the agricultural work, and produce 80% of food for home consumption.³³ Generally in Malawi women and adolescent girls are more involved in collecting water compared to men and adolescent boys. 51% of females collected water and/or firewood compared to 39% of men. In terms of the time, the overall average daily hours spent on collecting is 0.4³⁴. Men are currently believed to be at greater risk of illness from COVID-19 and additional labor may shift onto women and girls as a result of this.

Women are also responsible for caring for the sick, the elderly and the orphaned. High HIV prevalence has resulted in orphaned children- 11% of children aged 0-17 years are orphans with a majority of them-61% having lost father only³⁵. Although state and non-state actors in Malawi focused on re-orienting men to increasingly taking on responsibility for housework and care work; there remains a big gap in the amount of domestic work that women and men take up in many Malawian households³⁶.

³⁰ Ibid

³¹ Ferrant, Gaelle; Luca Maria Pesando & Keiko Nowacka (December 2014). Unpaid CARE Work: The missing link in the analysis of gender gap in labour outcomes. OECD Development Center.

https://www.oecd.org/dev/development-gender/Unpaid_care_work.pdf

³² UN Women Malawi sheet <https://data.unwomen.org/country/malawi>

³³ National Gender Policy

³⁴ NSO, 2016, Integrated Household Survey 4

³⁵ NSO, 2018, Population and Housing Survey

³⁶ Mkandawire Elizabeth, Hendriks Sherly L, 2019 “The role of the man is to look for food”: Lessons from men’s involvement in maternal and child health programmes in rural Central Malawi.

<https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0221623&type=printable>

With temporary closure of schools due to COVID-19³⁷ coupled with 42% marriage rate³⁸ in Malawi, increased childcare is expected to further stretch women's existing household and community burdens. Further it entails more household labour burden for the school going girls who have to stay home and take on domestic responsibilities disproportionately to their male counterparts. Despite this, a lot of people are not aware that women and adolescent girls are disproportionately affected by the COVID-19 epidemic than men. The April 2020 U report³⁹ shows that 85% of respondents incorrectly believed that the COVID-19 situation is affecting male and female the same way.

Women as health workers: Large proportion of women are also engaged in the health sector; estimates shows 45.2% of the total health workforce is female. In terms of cadres, most medical doctors are males (73.2%), most professional nurses are female (91.5%) and most associate nurses are female (84.7%)⁴⁰. These women, in spite of the fact that they are first responders, have limited access to personal protective equipment (PPE). There are reports of medical personnel moving out of patients due to limited access to PPE⁴¹. With COVID-19, women are likely to be on the front lines of the fight against COVID-19 and as a result of the pandemic facing an increase in the double-burden: longer shifts at work and additional care work at home. Beside the increased burden, they may also face stigma and discrimination leading to psychosocial effects as communities and family members may regard them as potential Covid-19 carriers due to their care role to Covid-19 cases. Thus, female health care workers will be at an increased pressure of balancing work and home responsibilities more than their male counterparts.

B.2. Decision-Making, Participation and Leadership

Equal access to power and decision-making for men and women is key to representative and responsive governance and women's substantive representation in political positions is crucial to closing the gender gap in decision-making structures.⁴² For Covid-19, this will be vital to ensuring women's needs are addressed in the response. Women's access to power and decision-making bodies in Malawi is a complex mix of representation; however meaningful inclusion of women's voices, needs and realities remains a challenge. Malawian women face marginalization from lack of constructively participating in various levels of governance.⁴³ At the cabinet level, female representation stands at 22%.⁴⁴ The

³⁷ <https://zodiakmalawi.com/nw/national-news/65-news-in-central-region/1503-malawi-orders-schools-closed-limits-gatherings-in-wake-of-covid19>

³⁸ UNICEF Malawi, 2019, Traditional Practices Survey

³⁹ UNICEF Malawi U Report, April 2020

⁴⁰ Malawi HRH Census, 2008.

⁴¹ <https://www.aljazeera.com/news/2020/04/malawi-health-workers-protest-lack-protective-gear-200414165616071.html>

⁴² Wilson Center (September 2014). Women's Access to Power and Decision-Making IN Africa: Addressing Obstacles and Offering Solutions. https://www.wilsoncenter.org/sites/default/files/media/documents/publication/rhoda_osei_afful_africa_policy_brief_11.pdf

⁴³ HIVOs 'Women Empowered for Leadership' available at <https://womeninleadership.hivos.org/country/malawi/> (2017)

⁴⁴ Analysis of the cabinet list

initial cabinet committee on COVID-19 had no female representation and the Minister for Gender was added later on⁴⁵. The newly constituted Presidential Taskforce is male-dominated with 19% female representation⁴⁶, a slight improvement from the previous committee.

Female representation in public senior management (principal secretaries) is at 29%⁴⁷, which implies low female representation in the humanitarian sector clusters as they are headed by principal secretaries. This also results in low female representation at the most crucial technical leadership and policy guidance level in the COVID-19 response governance structure, i.e. the National Disaster Preparedness and Relief Committee (NDPRC) which is chaired by the Chief Secretary to Government and comprises of Permanent Secretaries from all government ministries, which is the body mandated to provide policy guidance and leadership in implementation of the plan. While the average percentage of female representation in national parliaments (single/lower house) in the sub-Saharan Africa currently stands at 23.99%⁴⁸, Malawi stands at 23%⁴⁹. Beyond the quantitative representation in national parliaments, Malawi has had its first female speaker of the house. However, women in formal positions of authority typically do not have the same power and influence as male counterparts, because of discriminatory attitudes towards women leaders and undue scrutiny of women in public life.⁵⁰ Overall, therefore, women still have limited decision-making power – and are often excluded or marginalized from governance institutions and policy-making processes⁵¹.

The decentralized levels provide entry points for women's advancement in politics, especially within local governance bodies and community levels. In Malawi, representation of women in local governance structures like village development committees and area development committees are well beyond 30%.⁵²

At household levels, gender inequalities in decision-making are especially significant around women's own health care, agricultural assets and incomes and other major household purchases. Decisions on women's health care are vital to the health and well-being of both women and children. About 33% of women reported not having the final say on their own health care⁵³. The different levels of exclusion compromise the health and well-being of all family members, particularly children. Money spent on large purchases may be regarded as a wise long-term investment, but they can consume a large share of household income that might otherwise be used for more immediate household needs,

⁴⁵ Analysis of the Press Statement on Cabinet Committee on COVID-19 and <https://www.manoonline.gov.mw/index.php/sports/item/13723-statement-on-coronavirus-outbreakcovid-19>

⁴⁷ Analysis of statement on April 2020 Circular on Government of Malawi Heads of MDAs and Heads of Independent and Constitutional Bodies

⁴⁸ The World Bank (Data accessed on 09 April 2020). <https://data.worldbank.org/indicator/SG.GEN.PARL.ZS>

⁴⁹ Ibid

⁵⁰ O'Neil, T., Kanyangolo, N. and Wales, J. (2016) [Women and Power: Representation and Influence in Malawi's Parliament](#). London: ODI.

⁵¹ CARE et al. 2019. Gender-Transformative Adaptation – From Good Practice to Better Policy

⁵² UN Women-Malawi (2015). Entry Points for Gender and Local Governance

⁵³ Malawi Demographic and Health Survey, 2016

such as medicine, school supplies and food needed to equip the family given the Covid-19 pandemic. The inability to access the needed supplies and medicines compromises the health and nutrition needs of women and old people who may be at risk of the pandemic. Men generally decide how much of the household income will be allocated towards major expenditures. 44.1% of women in Malawi indicated that their husbands have exclusive control over large purchases⁵⁴.

Women Networks

Generally, poor women have social networks that are closer to home and at village or community level. In Malawi, the most common social networks for poor women is the village savings and loan associations commonly known as **Banki Nkhonde** and women faith groups. As women are often restricted in cultivating market or business-oriented relations or networks, these social networks provide entry points for women to have more say and choice in taking decisions about priority issues that affect them. Further these social groups are also used for sharing and accessing information on agriculture, marketing and others. With COVID-19 prevention measures like mobility restrictions and social distancing, women social network groups like VSLs and producer groups may not share and access information; disrupting sources of income as a majority of them facilitate informal businesses; and have no access to face to face training and extension services.

Participation in Humanitarian Action

Despite the fact that women and girls are almost always the most affected when it comes to crisis; both as a cause and consequence of gender inequality and injustice, women rarely participate in decision making processes.⁵⁵ Current emergency response taskforces at different levels (national, district and local) are overwhelmingly male-dominated. Thus, there is systemic failure to recognise women's capabilities during humanitarian crises.⁵⁶ In Malawi, women-led organisations have historically not been involved in humanitarian response⁵⁷ even though they are first responders. This is mainly due to their perceived 'weak capacity', which continues to be cited by development aid organizations and due to the nature of humanitarian response which is associated with direct provision of shelter, water, sanitation and hygiene (WASH), and food aid, rather than the type of work women-led organizations carry out⁵⁸.

⁵⁴ Ibid

⁵⁵ ActionAid 'Shifting the Power: Empowering women in humanitarian crises' available at <https://actionaid.org.au/shifting-the-power-empowering-women-in-humanitarian-crises/> (accessed 18 April 2020)

⁵⁶ ActionAid 'Shifting the Power: Empowering women in humanitarian crises' available at <https://actionaid.org.au/shifting-the-power-empowering-women-in-humanitarian-crises/> (accessed 18 April 2020)

⁵⁷ CARE (November 2018). Women responders: placing local action at the centre of humanitarian protection programming. <https://insights.careinternational.org.uk/publications/women-responders-placing-local-action-at-the-centre-of-humanitarian-protection-programming>

⁵⁸ Ibid

The limitations in women's participation in humanitarian settings misses an opportunity to contextualize and effectively execute humanitarian responses⁵⁹. Furthermore, the visible absence of women in decision making spaces, creates a dire gap in representation that would lead to the interests and realities of women being systematically overlooked limiting the overall recovery and sustainability of societal progress more broadly.

B.3. Access to and control over resources and services

Food and Nutrition Security

FESWNET⁶⁰ observes that most households across Malawi are now consuming their own-produced food within the households. Households are likely to experience food shortage due to dry spells in localized southern part of Malawi and crop losses due to flooding and waterlogging in localized areas of the northern Karonga and Rumphi districts. In the event of a cessation of movement to and from urban areas and /or a lockdown due to COVID-19, the rural poor have more access to food as compared to the poor and very poor in urban areas. Those in urban areas are more vulnerable to supply chain break downs. However, in households where women are responsible for preparing and managing food and related supplies, food shortages and increased food insecurity places them under heightened pressure. This increased stress in the household could expose them to intimate partner violence or reliance on negative coping mechanisms, such as resorting to transactional sex, violence against women, sexual exploitation and abuse (SEA) or even exposing girls into child marriage⁶¹.

Access to Income

In Malawi, over 80% of the total Malawian workforce is employed in the informal economy- and of the total workforce among men, 84% were informally employed, while Malawian women who were informally employed represented 76%⁶². Furthermore, nearly two out of three (67%) of the total workforce in urban areas is informally employed. Micro, Small and Medium Enterprises (MSME) play a significant role in the Malawian informal economy as approximately 81% of all MSME's are micro (i.e. employing 1 to 4 people), 17% are small (i.e. employing 5 to 20) and only 2% are as medium (i.e. employing 21 to 100)⁶³. With COVID-19 restrictions, some of the informal economy players are scaling down and cutting jobs, particularly affecting women who dominate in the informal sector and are lowest paid. Further, due to limitations in mobility and safety, most small scale businesses of women (such as selling mandasi, bananas, etc on the road side) will be more economically challenged compared to organised businesses run mostly by men (such as grocery shops,

⁵⁹ CARE (November 2018). Women responders: placing local action at the centre of humanitarian protection programming. <https://insights.careinternational.org.uk/publications/women-responders-placing-local-action-at-the-centre-of-humanitarian-protection-programming>

⁶⁰ FEWSNET, Malawi Food Security Update, April 2020

⁶¹ Gender Alert for COVID-19 Outbreak - Interim Guidance, March 2020, IASC Reference Group for Gender in Humanitarian Action

⁶² Danish Trade Union Development Agency, 2019, Malawi Labour Market Profile.

⁶³ Ibid

supermarkets etc). The restrictions on movements may also mean that more women will have even less visibility in the public space and delegate critical productive work to men, which has both short-term and long term negative consequences for the women.

Access to Markets

Market closures, trade disruptions, rising transportation costs, and a reduction in demand for certain commodities, particularly cash crops, could cause farmers, particularly subsistence farmers who mostly are women, to face market challenges that drive a decline in their income levels. Traders, often women, migrate daily to city centers and marketplaces on minibuses and via other forms of public transportation. National lockdown could be problematic as such traders would not be able to move safely around Malawi nor be able to provide and distribute the majority of food to Malawi.

Health Systems and services:

Impacts of multiple health crisis: The health system in Malawi is burdened with high levels of life-threatening communicable diseases coupled with increasing rates of non-communicable diseases such as hypertension, including injury, diabetes, and cancer. Further, the health system faces unique logistical and financial challenges in delivering health care to large populations. A few of the key challenges of Malawi's weak health system include the following: low human resource, insufficient medical supplies and equipment, weak referral systems, inadequate outreach health facilities with little to no support. COVID-19 will likely overwhelm and burden health systems that are stretched thin to begin with and have little capacity to respond to other gender health needs. Women in Malawi are more likely to die from communicable diseases (e.g. HIV, tuberculosis and malaria), maternal and perinatal conditions, and nutritional deficiencies. Redirection of medical resources to COVID-19 patients will mean that women step into caregiving roles for non-COVID-19 patients, further increasing their vulnerability to the virus and workload.

In Malawi HIV infection rates show gender, age, social status and geographical variations, with infections more prevalent in women than men, and more common in urban populations than rural populations. HIV prevalence in the 15-49 age group is higher among women (13%) than men (9%)⁶⁴ reflecting a widening gender gap between men and women.

In view of Covid-19 pandemic, teenage pregnancies which currently are at 29%⁶⁵, may most likely increase in the wake of limited access to family planning resources for adolescent girls combined with harmful cultural practices emanating from girls initiation ceremonies, particularly in rural areas. Just as other health cases that occur in Malawi, in the wake of the Covid-19, the burden of care for the sick will also increase for women and girls and this leaves little room to engage in productive activities, while it also put the women more at risk of contracting the virus. This, along with pre-COVID-19 conditions, is anticipated to

⁶⁴ NSO, 2016, Malawi Demographic Health Survey

⁶⁵ Ibid

increase the need for psychosocial support services, and yet as resources become diverted to manage the COVID-19 outbreak, disruptions to mental health and psychosocial support services (MHPSS) are anticipated. Psychosocial wellbeing is a major issue for adolescents exposed to conflict, displacement, or violence, which is not uncommon in humanitarian settings.⁶⁶ Moreover, MHPSS caseloads will likely increase during COVID-19 outbreaks, as frontline health workers, women and girls with caregiving burdens, and community members fearful of becoming infected or infecting. Many may be in need of increased support amidst the experience of stress and trauma relating to the outbreak.⁶⁷

Sexual and reproductive health and rights:

Health facilities in the 28 districts of Malawi remain generally under-supplied to properly care for pregnant women during antenatal, labour and delivery and postnatal periods. High maternal mortality of 439/100,000 live births⁶⁸ and limited access to family planning and sexual reproductive health service are some of the key challenges for Malawian women in the health sector. Although there are improvements to access of health services in districts, these centers are prone to stock outs of essential medicine and supplies for managing obstetric complications as well as shortage of trained personnel to provide the required comprehensive and basic signal functions in designated emergency obstetric care settings. This is due to the major shift of priority in health financing towards addressing the impending COVID-19 crisis. Sexual and reproductive health services are more likely to be impacted with diverted funding and human resources.

Pregnant women are extremely vulnerable as there is a real possibility that their access to crucial health services will be severely restricted. Currently, while the government has prepared a total of 11 treatment centers across the country, there is no space designated to isolate pregnant women in antenatal, labour and delivery rooms; including provision of comprehensive obstetric care services like caesarean section nor postnatal care with new-born babies.

In view of this and coupled with the fact that in rural areas women must travel long distances to access health facilities, alternative means to deliver their babies will most likely increase such as traditional birth attendants, which may be risky if they are not well trained or equipped. At both policy and service delivery level, Malawi has insufficient resources of space as well as equipment and supplies to handle the COVID-19 crisis. At service delivery level however, the risks are potentially fatal for pregnant women and significant for the wider community. Further, the current national COVID-19 response budget allocation did not take into consideration the specific needs of the maternal and new-born clients⁶⁹.

Education

The coronavirus (Covid-19) poses a big threat to the education sector. The impact of education is likely to be most devastating in countries which already have low learning

⁶⁶ CARE, COVID-19 RGA for ECSA Region

⁶⁷ IASC, "Briefing Note," IASC.

⁶⁸ NSO, 2016, Malawi Demographic Health Survey

⁶⁹ Analysis of the National COVID-19 Preparedness and Response Plan

outcomes, high dropout rates and low resilience to shock, further widening the gender gap.⁷⁰ Dropout rates are higher among girls than boys due to pregnancy⁷¹ and child marriages, a situation likely to worsen due to school closures and high levels of food insecurity.

Malawi government ordered closure of schools in the wake of COVID-19. The schools were closed towards the end of the second term and some learners in higher primary and secondary school levels were preparing for their end of year exams. While school closures seemed to present a logical solution to social distancing, this has affected the most vulnerable students who have fewer opportunities for learning at home, especially the rural girls and boys. The internet is now being used for educational purposes but typically reaches only 16.4% of the population, mostly in urban areas. With the closure of schools there are more vulnerabilities for children, especially the girl child. The rate of pregnancy among teenage girls in Malawi is at 29% and overall one-quarter of all pregnancies in Malawi are teen pregnancies⁷². As being out of school increases the risk of teenage pregnancy⁷³ coupled with the high early sexual debut-59% girls and 53% boys have had sex before age 18 and 14% of girls compared to 19% boys have had sex before age 15⁷⁴ vis-à-vis the weak youth friendly health services (access to contraceptives) especially in rural areas; Malawi is likely to witness a boom of teenage pregnancies, increased girls drop out of school and child marriages.

Adolescent girls in Malawi mirror motherhood roles, and with the closure of schools, these girls are finding it increasingly difficult to balance their caregiving burdens with education using learning from home methodologies.

The closure of school can also increase children's vulnerability and mental health related issues due to lack of peer support and other alternatives for mitigation of risks that could easily be found in schools.

Access to WASH services:

Access to safely managed water and sanitation is poor for females. Although 86.7% of the population live in households with an improved water source; 11% live in households with improved, non-shared toilet facilities and 10.5% in households with soap and water⁷⁵. With 27.1% of the population living in households with water 30 minutes or longer away round trip⁷⁶, women and girls face significant challenge in regard to WASH, as the responsibility for household water, sanitation and hygiene management are largely borne by women.

⁷⁰ Kaliopé Azzhuck and Tigran SHMIS

Managing the impact of Covid-19 on education system around the world how countries are preparing, coping and planning for recovery

⁷¹ SADC Gender Barometer

⁷² NSO, 2016, Malawi Demographic and Health Survey

⁷³ <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0196041>

⁷⁴ ⁷⁴ NSO, 2016, Malawi Demographic and Health Survey

⁷⁵ Malawi DHS, 2016

⁷⁶ Ibid

Lack of water and sanitation also increases women and girl's vulnerability to infection around menstruation and reproduction. Public health officials recommend washing hands with soap. This will be difficult to follow as access to water and soap is a challenge. Furthermore, the demand for more water in communities would entail increased burden for women and adolescent girls as well as increased vulnerability to the virus through water points– especially if many different people from different villages are coming to use the same water point. On the way to longer distance water points, women, adolescent girls and children may also suffer violence and harassment.

Access to information, communication and technology:

Women are information-poor due to a variety of reasons. Women's access to information is strongly affected by gendered norms and systematic gender inequality. Men as 'household heads' and community leaders have control and better access to information. It is further compounded by lack of access to ICT. On household access to ICT, 51.7% have a mobile phone, 33.6% own a radio, 11.8% have a television and 16.4 % have an access to the Internet⁷⁷. Due to intra household power dynamics, women's access to these household communication sources is limited. A higher proportion of male-headed households own a radio compared to female-headed households⁷⁸. While a majority of the information on COVID-19 is relayed through the print and electronic media, it has great bearing on women's access to information. Further considering that 65.9% of women are literate as compared to 71.6% of men⁷⁹, COVID-19 related information dissemination will need to pay particular attention to this literacy gender gap if the messages have to be comprehensible by women.

B.4. Safeguarding and Protection

Gender Based Violence

The prevalence of violence against women in Malawi is very high with 45 % girls (aged 15-19) experiencing physical or sexual violence and seeking help to stop the violence; 20 % of girls reporting an incident of sexual abuse prior to age 18; 68% of those who experience sexual violence also experiencing multiple incidents of sexual abuse. Most adolescent girls experience their first sexual abuse between 12-14 years in Malawi; 13% of women agree that a husband/partner is justified in beating his wife/partner under certain circumstances.^{80,81} It is also noted that sexual violence is mostly perpetrated by close relations. With lock down measures in almost all the countries with COVID-19, economic stress and cramped and confined living conditions of lockdown, the UN has warned of an increase in violence against women and girls⁸². For survivors of violence, the lockdowns have trapped them in their homes with their abusers, isolated from the people and the resources that

⁷⁷ NSO, 2018, PHC.

⁷⁸ IHS4

⁷⁹ NSO, 2018, PHC

⁸⁰ NSO, 2016, Malawi Demographic Health Survey

⁸¹ Malawi Government, 2013, Violence Against Children

⁸² UN (05 April 2020). Secretary-General's message on Gender Based Violence and COVID-19.

(<https://www.un.org/sg/en/content/sg/statement/2020-04-05/secretary-generals-video-message-gender-based-violence-and-covid-19-scroll-down-for-french>)

could help them. South Africa reported 87,000 cases of gender-based violence in seven days of lockdown⁸³ while Kenya has seen a significant spike in sexual offences.⁸⁴ A women's rights organization in Zimbabwe, Musasa, reported a spike in GBV, before COVID used to receive an average of 40 cases per day and they are now receiving an average of 150 cases.⁸⁵

Access to justice and support services for victims/survivors of violence still remains a challenge. In 2013, Malawi established Victim Support Units in police stations and support units in traditional authority institutions; while Zambia has two user-friendly *fast track* courts to specifically expedite GVAW cases, Malawi is yet to have one.

Malawi established One Stop Centers in almost all 28 districts in Malawi by bringing together health, police, social welfare and judicial services under one roof⁸⁶ to, besides other services, facilitate access to protection, redress and justice in the criminal justice system, and make police and courts to be available, accessible, of good quality, and accountable to victims/survivors of sexual violence. The services from the OCS have had both feedbacks on satisfaction and some levels of lack of satisfaction by the users. For instance, in a UNICEF study⁸⁷ a sample of 107 respondents/ survivors at a Blantyre OSC were satisfied with the service they received from Blantyre, but a quarter of the families were not satisfied with the law enforcement response because of perception of corruption or negligence by police while 2% were not happy with the medical assessment.⁸⁸ At a time of a pandemic, when many women and girls need GBV services more than ever, evidence suggests that those services are likely to decrease as resources are diverted to dealing with the COVID-19 health crisis.⁸⁹ There is also knowledge gap among the communities on the continuity of GBV services due to COVID 19. The U report (April 2020) shows that 65 % say that in the current situation where civil society and government are operating from home there is not much that can be done if women experience gender based violence and 31% percent are not aware of the availability and functionality of toll-free Child Helpline 116 and a Gender Based Violence Crisis Line 5600 and that police are also working throughout the country. This implies that most survivors of gender based violence might not seek assistance and their perpetrators may take advantage of low levels of awareness on the availability and functionality of GBV services to cause more harm.

Sexual Harassment, Exploitation and Abuse

⁸³ Power Digital (03 April 2020). COVID-19 Lockdown: Police Receive 87,000 Gender-Based Violence Calls. <https://www.power987.co.za/news/covid-19-lockdown-police-receive-87-000-gender-based-violence-calls/>

⁸⁴ Odhiambo, Agnes (08 April 2020). Tackling Kenya's Domestic Violence Amid COVID-19 Crisis. Human Rights Watch. <https://www.hrw.org/news/2020/04/08/tackling-kenyas-domestic-violence-amid-covid-19-crisis>

⁸⁵ UN Women, COVID-19 and ending violence against women

⁸⁶ National Guideline for Provision of Services for Physical and Sexual violence, 2015

⁸⁷ UNICEF (2019) Access to Criminal Justice Services: The Case of Survivors of Sexual Violence in Malawi, Lilongwe

⁸⁸ Miller et al (2018), Are one-stop centres an appropriate model to deliver services to sexually abused children in urban Malawi? <https://doi.org/10.1186/s12887-018-1121-z>

⁸⁹ CARE International, Gender Implications Of Covid-19 Outbreaks In Development And Humanitarian Settings, March 2020

Economic shocks as a result of Covid-19 will put vulnerable women and girls at increased risk of abuse and exploitation as public health emergencies can have a tremendous, sustained impact on livelihoods, especially for women and girls who are most marginalized due to disabilities, women or child-headed households, and sex workers. Increased deprivation can leave vulnerable women and girls exposed to exploitation and abuse, including by duty bearers, especially where security and justice services have an increased role in society during an emergency. Child marriage and transactional sex may also rise as a coping mechanism. Some front line staff and others in decision making positions within the response even at community and institutional level may abuse their power to harass and sexually victimize women and girls and other vulnerable people. Critical in the response of this nature is the need to increase awareness on the need for safety, protection and safeguarding the rights of survivors and other vulnerable members due to the pandemic.

Child Marriages

Malawi has one of the highest rates of child marriage in the world, with 1 in 2 girls married by the age of 18 years and 12% of girls married before the age of 15 years⁹⁰. Teenage pregnancies are also increasing with the current adolescent birth rate at 136/100,000 live births; the second highest in the SADC region. 59% girls and 53% boys have had sex before age 18; 14% of girls compared to 19% boys have had sex before age 15⁹¹. Harmful traditional practices such as early forced marriage and early pregnancy from unwanted sexual contact may likely increase due to the Covid-19 pandemic⁹². There are many factors contributing to child marriages in Malawi, among the top is poverty- where poverty is acute, a common belief is that marrying off a daughter reduces family expenses, temporarily increases family income; the socialized restrictions which identifies girls and young women as wives and mothers assigned to them by culture and tradition among others⁹³. Due to the losses in economy, and higher food insecurity, there is likely to be a spike in child marriages.

Trafficking in Persons

Malawi as a source country for men, women and children subjected to forced labour and sex trafficking with 132 trafficking victims in 2019⁹⁴. Traffickers exploit most Malawian victims within the country, generally transported from the southern part of the country to the central and northern regions for forced labour in agriculture (predominantly the tobacco industry), goat and cattle herding, and brickmaking. Owners of brothels or other facilitators lure girls, including primary school girls, from rural areas with promises of clothing and lodging for which they are later charged high fees, resulting in debt-bonded prostitution. Malawian victims of sex and labor trafficking especially young women have been identified in Mozambique, South Africa, Zambia, Kenya, and Tanzania, as well as Iraq, Kuwait, and Saudi

⁹⁰ UNICEF, 2015, State of the World's Children. New York. NY UNICEF

⁹¹ Oxfam and CARE documented experiences of girls and women in the Cyclone Idai in Nsanje, 2019.

⁹² National Plan of Action to Combat Gender-Based Violence in Malawi 2014 –2020

⁹³ Girls Not Brides (no date). Ending child marriage in Africa. A brief. <https://www.girlsnotbrides.org/wp-content/uploads/2015/02/Child-marriage-in-Africa-A-brief-by-Girls-Not-Brides.pdf>

⁹⁴ The trafficking in Persons Reports, US Department of State, 2019

Arabia⁹⁵. A majority of the women and girls have undocumented immigration status, which is used by traffickers as a weapon to keep people under their control. With COVID-19 creating a climate of fear, economic and survival challenges, women and girls may be exposed to trafficking risk and those who have been trafficked are less likely to come forward and seek medical or any other help⁹⁶.

C. Conclusion and Recommendations

C.1. Conclusion

Increasing confirmed COVID-19 cases in Malawi clearly indicate that the country is facing a public health crisis with complex social-economic challenges coupled with a fresh election. Malawi's socio-economic challenges range from limited resources, limited health services, large population size, and low economic capacity meaning that the COVID-19 will impact many populations, especially the most vulnerable. Women and girls are more likely to be impacted in various ways including adverse impacts to their health, education, food security and nutrition, livelihoods, and safety and protection. Women are the primary care givers in the family and are also the key frontline responders in the health care system, placing them at increased risk and exposure to infection. The outbreak will also burden women by adding to their existing gendered household and community role. Additionally, there is a potential for an increase in domestic violence-as the outbreak is expected to spike GBV and harmful traditional practices against women and girls. Additionally, the resources to respond to COVID-19, need to include essential maternal, and sexual reproductive health services throughout the emergency (including GBV support resources), and strengthen protection. While males are dominating the decision-making processes; the engagement of men and boys through the COVID-19 response is crucial to mitigate unhealthy masculine behaviors among men and boys.

C.2. Recommendations

- Update the RGA as the crisis continues including the collection, analysis and use of SADDD, to ensure an informed response based on evolving needs of women, men, boys and girls and at-risk groups.
- Awareness raising and localized messages on risks and prevention measures and available service providers should be scaled up and made accessible to all people particularly marginalized groups, the persons with various forms of disabilities, women in refugee camps and IDP settlements, both in urban, peri urban and rural areas. The information should be delivered through low-tech multiple channels and understood by diverse populations.
- Use social media and community radio messaging and other digital tools that increase women's access to and use of information e.g. agriculture extension messages which

⁹⁵ Ibid

⁹⁶ <https://polarisproject.org/blog/2020/03/the-effect-of-covid-19-on-human-trafficking/>

also includes market information. These channels should take into consideration women's specific needs and access to phones and other devices.

- Promote male involvement in child caring roles and other labour and time demanding household tasks performed by women. Engage men, boys, and traditional leaders on women's access to productive resources including nutritional, workload, income, gender-based violence, agency, and decision-making.
- Promote women's meaningful participation in decision making at national, district, community and household levels by ensuring Gender Equality Quota is utilised in all decision-making bodies and processes on COVID 19 at all levels and that efforts are made to ensure women's active and meaningful participation in these processes.
- Develop the capacity of women led and women's rights organisations including women with disability organisations on leading community-based responses to COVID-19 prevention and response.
- Provide gender responsive conditional social cash transfer programmes for poor households (that would promote education, routine immunization among other things). These need to be digitized through mobile money platforms to reduce interactions between people.
- Capacitate all humanitarian clusters in integration of gender, GBV, protection and prevention of sexual exploitation and abuse. Build on existing initiatives that provide prevention, protection and response services to survivors of GBV through existing legal and psychological referral systems.
- Strengthen capacity of protection service providers to provide comprehensive response and protection services to survivors