CARE INTERNATIONAL – ZAMBIA

REPORT ON THE RAPID GENDER ANALYSIS ON THE IMPACT OF THE CORONA VIRUS ON GENDER-BASED VIOLENCE IN FOUR DISTRICTS OF ZAMBIA

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
DEBS	District Education Board Secretary
FAO	Food and Agriculture Organisation
GBV	Gender Based Violence
HIV	Human Immuno-Deficiency Virus
KAP	Knowledge Attitudes and Practices
IDI	In Depth Interview
MISA	Media Institute of Southern Africa
MOE	Ministry of Education
MOH	Ministry of Health
NGO	Non-Governmental Organization
RGA	Rapid Gender Assessment
SDG	Sustainable Development Goals
UN	United Nations
VSU	Victim Support Unit
WASH	Water and Sanitation Hygiene
WHO	World Health Organization
ZP	Zambia Police
ZAMPHIA	Zambia Population HIV Impact Assessment

Definition of Key Concepts

Concept	Definition
Adolescent	A young person in the process of developing into an adult.
Covid-19	A newly identified coronavirus, SARS-Co V-2, that has caused a worldwide pandemic of respiratory illness. The new coronavirus can be spread from person to person through droplets released into the air when an infected person coughs or sneezes. The droplets generally do not travel more than a few meters, and fall to the ground (or onto surfaces). There is no coronavirus vaccine yet. Prevention involves frequent handwashing with soap, coughing or sneezing into the bend of elbow or handkerchief, staying home when sick and wearing a mask when one cannot practice physical distancing. Symptoms include cough, fever or chills, shortness of breath or difficulty in breathing, muscle or body aches, sore throat, new loss of taste or smell, diarrhea, headache, fatigue, nausea or vomiting and congestion or runny nose. Those infected can be asymptomatic, experience mild to severe symptoms and in some cases, have caused death.
Economic violence	The unreasonable deprivation of any economic or financial resources to which a victim, or a family member or dependent of the victim is entitled under any law, requires out of necessity or has a reasonable expectation of use, including household necessities, medical expenses or school fees and mortgage bond repayments or rent payments in respect of a shared household
Emotional violence	Infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, social exclusion, stalking, verbal harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc. “Sexual harassment” is included in this category of GBV.
Gender roles	Functional responsibilities which are assigned by society and are influenced by cultural, political, religious or economic situation vary from region to region, within cultures and change over time.
Harmful Traditional Practices (HTPs)	Cultural, social and religious customs and traditions that can be harmful to a person’s mental or physical health. It is often used in the context of female genital circumcision/mutilation or early/ forced marriage. Other harmful traditional practices affecting children include binding, scarring, burning, branding, violent initiation rites, fattening, forced marriage, so-called “honour” crimes and dowry-related violence, exorcism, or “witchcraft”.
Menstruation	A natural part of the reproductive process that occurs to prepare a woman’s body for pregnancy. If a woman does not become pregnant, the uterus sheds its lining. This shedding is called menstruation and is evidenced by the flow of blood through the uterine canal.
Menstrual Hygiene Management	The mechanism through which women and adolescent girls use clean menstrual management material to absorb or collect menstrual blood. This material should be changed in privacy, as often as necessary for the duration of the menstruation period. Soap and water should be available for washing the body as required, and facilities to dispose of used menstrual management materials must be accessible
Physical violence	Any act which causes physical harm as a result of unlawful physical force. Physical violence can take the form of, among others, serious and minor assault, deprivation of liberty, manslaughter and mob violence.
Re-usable pads	These are cloth pads made from absorbent fabrics that are worn by females during menstruation. These types of pads are washable, so they can be used repeatedly.
Sex roles	Roles which females and males perform on the basis of their physiological or biological make-up.
Sexual violence	Any sexual act performed on an individual without their consent. Sexual violence can take the form of rape, sexual harassment, forced marriage, child marriage, sexual assault etc.

Executive Summary

The Rapid Gender Analysis (RGA) was conducted in the four districts of Lusaka, Kalomo, Mpika, and Katete. A mixed method approach was employed to gather data from men, women, boys and girls on the impact of Covid-19 on Gender Based Violence (GBV), health, nutrition and water, sanitation and hygiene.

Key Findings

(53%) of the respondents were female and 47%, male. 82% were male heads of households and 18% were female. The highest level of education attained among the respondents was University degree for males. Both males and females are engaged in crop production.

Radio (43%) and television (30%) are the top sources of information with social media (16%) coming in third. The local language spoken in each district was used to disseminate Covid-19 messages with English as the cross-cutting language. The major languages used were Chitonga (23%) in Kalomo; Chinyanja (19%) in Lusaka; Chichewa (18%) in Katete and Bemba (18%) in Mpika. The most common broadcasted messages on Covid-19 were: thoroughly washing hands with clean water and soap (84%); social distancing (82%); wearing facemasks (77%) and prevention measures (68%). The respondents further indicated they had heard about the symptoms of Covid-19: dry cough (86%); fever (84%); difficulty in breathing (62%); tiredness and fatigue (56%).

On reporting cases of Covid-19, 66% of the respondents indicated that they would report to the local clinic; 26% would report to the hospital; 7% to a mobile clinic; 1% to a traditional healer and 1% stated they wouldn't report anywhere but would instead self-medicate.

The respondents generally knew what GBV was. In order of ranking prevalence of GBV, sexual violence (39%); physical (27%) emotional (14%); harmful traditional practices (11%) and economic violence (9%) were identified. GBV during Covid-19 had increased as indicated by 43% of the respondents and the perpetrators were mostly males and boys aged 15-49 because of alcohol abuse, differential and unequal power dynamics between women and men and the socialization process. Women are girls were the majority of the victims aged 15-49 due to culture that depicts the female as weak, man as superior, cultural expectation for a woman to endure in a marriage no matter how violent and fear of embarrassment of a failed marriage.

In all the four districts, the respondents indicated that sources of water included serviced tap water (30%), stream (7%), dug well (9%), dam (0.5%), borehole with hand pump (53%) and water bowser (0.5%). For most of the community members, the water sources were less than 30 minutes away on foot. Under sanitation, the majority (78%) of the respondents use pit latrines; 13% flushable toilets; 8% are using ventilated latrines and open defecation is practiced by 1% of the population sample.

Menstrual hygiene for women and girls included: disposable pads (46%); washing and disposable facilities (20%); reusable pads (18%) and menstrual hygiene education (16%). In the rural areas, pads are not available and the women and girls have to travel long distances to the districts to purchase the sanitary pads.

42% of the respondents stated that it takes less than 30 minutes to get to the nearest health facility; 30 and 60 minutes (39%) while 19% walk for more than one hour. There were still challenges in accessing health care services. Key health issues included: malaria, cough, flu (26%); maternal health services (25%); under 5 services (16%); HIV/AIDS services (16%); male circumcision (10%) mental health services (7%). Health equipment and infrastructure as well as the shortage of health workers were identified as the key challenges in accessing quality health care.

Key Recommendations

Information dissemination about Covid-19, GBV, WASH, Nutrition and Health

1. With the already existing traditional forms of media such as radio, television and print media, social media and other online platforms (Zoom and Hangout) should be included to disseminate information on Covid-19, GBV, WASH, Nutrition and Health to the men, women, boys and girls. The assessment established that social media, particularly Facebook and WhatsApp can serve as an important source of Covid-19 and GBV information.
2. Communication and information messages on Covid-19 and GBV should be tailor made for men, women, boys and girls to educate and inform communities, on how they can protect themselves from Covid-19 and GBV.

Coping with Covid-19

1. Recognize women's resilience, innovation and roles as critical change agents necessary for effective Covid-19 responses.
2. Ensure women's equal representation, participation and decision-making on Covid-19 prevention and response strategies at district and community levels

Women Economic Empowerment

1. Maintain or expand cash transfer and broader subsidy programs to ensure that the vulnerable women, girls, and their households are not driven deeper into poverty as a result of Covid-19.
2. Investing in training, skills development, and job placement programs for women to access jobs in industries responsive to Covid-19 (e.g., health care product manufacturing, information and communications technology, and food and accommodation)

Access to Health

1. Ensure ongoing access to critical health information and sexual and reproductive health services.
2. Anticipate and address supply chain disruptions, and ensure ongoing compliance with medical privacy regulations in all pandemic responses.

Water and Sanitation Hygiene

1. Increase access to clean water to within 15-30 minutes. Where possible, sink boreholes
2. Distribute sanitary material to adolescent girls and vulnerable women to ensure little or no disruption to their daily lives

Nutrition

1. Ensure agricultural financial and technical assistance initiatives such as the Farmer Input Support Programme (FISP) targets women farmers and agricultural workers, including small-scale farms, and promote increased access to labor-saving, women-friendly technology. Provide food assistance to the poorest and most vulnerable populations during this crisis.

Gender-Based Violence

1. Engage men and boys by tailoring messages to challenge gender stereotypes and unequal gender roles
2. Men and boys also experience GBV and gender-biased challenges to accessing services (e.g. stigma, perceptions that 'real men' don't need support, etc.). Ensure that services are also made accessible to men and boys.
3. Support police and justice actors to provide adapted services during periods of confinement or lockdown

Introduction – Background

The first human cases of COVID-19, the disease caused by the novel coronavirus causing COVID-19, subsequently named SARS-CoV-2, were first reported by officials in Wuhan City, China, in December 2019[1]. Retrospective investigations by Chinese authorities identified human cases with onset of symptoms in early December 2019. While some of the earliest known cases had a link to a wholesale food market in Wuhan, some did not. Many of the initial patients were either stall owners, market employees, or regular visitors to this market. Environmental samples taken from this market in December 2019 tested positive for SARS-CoV-2, further suggesting that the market in Wuhan City was the source of this outbreak or played a role in the initial amplification of the outbreak. The market was closed on 1 January 2020.

From the time it was categorized as a pandemic by the World Health Organization (WHO) on March 11, 2020, the impacts of Covid-19 have been felt at global, continental and national levels.

According to the WHO data[2], globally, as of 15 November 2020, there were 53,766,728 confirmed cases of COVID-19, including 1,308,975 deaths, reported to WHO. In Africa, there were 1,398,935 confirmed cases, including a total of 31,450 deaths. At national level, the cumulative total of confirmed Covid-19 cases was 17,097 with 350 deaths.

Gender and COVID-19

Pandemics and outbreaks have differential impacts on women, men, girls and boys. From risk of exposure and biological susceptibility to infection to the social and economic implications, individuals' experiences are likely to vary according to their biological and gender characteristics and their interaction with other social determinants (UNWomen, 2020). Because of this, global and national strategic plans for COVID-19 preparedness and response must be grounded in strong gender analysis and must ensure meaningful participation of affected groups, including women and girls, in decision-making and implementation.

COVID-19 may have varying impacts on women, men, girls and boys. Some of these according to the World Health Organisation include[3]:

- Increase of intimate partner violence during lockdowns
- Increased stigma and discrimination
- Increased health risk due to caretaking roles
- Inequities of access to information, prevention, care and financial and social protection
- Access to sexual and reproductive health and rights for women and girls may be reduced during the pandemic

CARE International Zambia Rapid Gender Analysis (RGA)

CARE International Zambia, in August 2020, commissioned a Rapid Gender Analysis (RGA) in four districts in Zambia to assess the different impacts of Covid-19 on women, men, girls and boys. Particular focus of the RGA was on the impact of Covid-19 on gender roles, gender-based violence (GBV), health, water, sanitation and hygiene and food nutrition and security in the four districts. The results of the assessment would provide CARE Zambia and the regional office useful information to develop Covid-19 prevention and/or response programmes.

[1] https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200423-sitrep-94-Covid-19.pdf. Accessed November 12, 2020

[2] https://Covid19.who.int/?gclid=Cj0KCQiAwMP9BRCzARIsAPWTJ_FetAVtXEDVasYGuIongHtAX8ZBTXoMKHZ_e4NPpqqt78CpGDwskskaAtduEALw_wcB

[3] file:///Users/user/Downloads/WHO-2019-nCoV-Advocacy_brief-Gender-2020.1-eng%20(1).pdf

The specific objectives of the RGA as outlined by the country office were:

1. To analyze and understand the different impacts that Covid-19 potentially has on women, men, girls and boys and other vulnerable groups in Lusaka, Southern, Eastern and Muchinga provinces in Zambia.

2. To inform and make recommendations to humanitarian and development programming in Zambia based on the different needs of women, men, boys and girls with a particular focus on GBV, health, water, sanitation and hygiene (WASH), food and nutrition security and women's economic empowerment and in relation to identified key Covid-19 prevention and response interventions (risk communication, community engagement, infection prevention and control)

3. To examine the extent to which community members are exposed to identified key Covid-19 prevention and response interventions (risk communication, community engagement and, infection prevention and control and how these are impacting on the general wellbeing of women, men, girls and boys.

This RGA is intended to provide information about the different needs, risks, capacities and coping strategies of women, men, boys and girls in the Covid-19 crisis. RGAs are built up progressively throughout the crisis: using a range of primary and secondary information to understand gender roles and relations and how they may change as a result of a crisis. They provide practical programming and operational recommendations to meet the different needs of women, men, boys and girls. RGAs use the tools and approaches of Gender Analysis Frameworks and adapt them to the tight time-frames, rapidly changing contexts, and insecure environments that often characterize humanitarian interventions.

Methodology

The research methods for the RGA included both primary and secondary data review of existing gender and GBV data and the most recent Covid-19 data from the WHO and the Zambian Ministry of Health. This RGA was conducted in line with CARE's Adapted RGA toolkit and its ethical considerations[4] guidance note for conducting RGAs. The RGA used the mixed methods approach for data collection to minimize the weaknesses and maximize the strengths of each method. Quantitative tools involved the use of a Knowledge Attitudes and Practices (KAP) survey administered to 240 household representatives through electronic questionnaires on tablets using KoboCollect[5]. This is summarised in the table below;

Table 1: Sample Distribution in Urban Areas Per District

District	Quantitative Approach		Qualitative Approaches and Categories					
	Adult Men 15-49 yrs	Adult Women 15 - 49 yrs	Adult Women 21-49 yrs	Adult Men 25-49 yrs	Adolescent Girls 15-20 yrs	Adolescent Boys 15-20 yrs	KIIs: NGOs, Govt heads, Community leaders	Total
Lusaka	15	15	2	2	2	2	12	50
Kalomo	15	15	2	2	2	2	12	50
Katete	15	15	2	2	2	2	12	50
Mpika	15	15	2	2	2	2	12	50
Total	**60**	**60**	**8**	**8**	**8**	**8**	**48**	**200**

[4] See Annex 2

[5] KoBo Toolbox is an open-source tool for mobile data collection, specifically designed for humanitarian settings, that allows collection of field data using mobile devices such as mobile phones and tablets. The application not only lends itself for accurate data collection but real time data analysis as well.

The Qualitative approaches involved the use of Key Informant Interview (KII) guides. A list of key informant institutions interviewed is attached in Annex 1. In-depth Interviews (IDIs) and individual storytelling guides were used to collect qualitative data from adult women and men; and adolescent girls and boys. A total of 392 respondents took part in the survey across the four districts in Katete, Kalomo, Mpika and Lusaka. The distribution and profile of the respondents in the four districts (urban and rural) is shown in the table below:

Table 2: Sample Distribution in Rural Areas Per district

District	Quantitative Approach			Qualitative Approaches and Categories				
	Adult Men 15-49 yrs	Adult Women 15 - 49 yrs	Adult Women 21-49 yrs	Adult Men 25-49 yrs	Adolescent Girls 15-20 yrs	Adolescent Boys 15-20 yrs	KIIs: NGOs, Govt. heads, Community leaders	Total
Lusaka	15	15	2	2	2	2	10	48
Kalomo	15	15	2	2	2	2	10	48
Katete	15	15	2	2	2	2	10	48
Mpika	15	15	2	2	2	2	10	48
Total	**60**	**60**	**8**	**8**	**8**	**8**	**40**	**192**

Secondary information was obtained by carrying out a desk review of key strategic documents and reports from CARE International, the United Nations GBV reports, SGBV literature, internet blogs, key national policies and related literature. All COVID-19 safety precautions were adhered to: observing social distancing; thoroughly washing hands with soap; sanitizing with alcohol-based sanitizers and wearing face masks.

RGA Limitations

The analysis was conducted within a relatively short time relative to the scope (compact objectives) and the complexity of the crisis and the sensitivity of the subject. The qualitative nature of the assessment and the sensitivity of the subject required considerable time investment in the field.

Demographic Characteristics of Households

Information on the demographic characteristics of the households in Kalomo, Katete, Mpika and Lusaka provides a context to interpret the age, educational levels, occupation and identify the heads of households and furnish an indication of the representativeness of males and females that participated in the survey.

A total of 241 households participated in the Rapid Gender Assessment (RGA) survey in Southern, Lusaka, Muchinga and Eastern provinces of Zambia. The survey results indicate that 10 (4%) were divorced; 150 (62%) were married; 5% were in a polygamous marriage; 60 (25%) are single and 9 (4%) were widowed. The majority 150 (62%) were in a monogamous marital relationship with 128 (53%) women and 113 (47%) men. The Table 3 shows a summary of the respondents' marital status;

Table 3: Respondent Profile, Gender & Marital Status

Marital Status	Female	Male	Total
Divorced/Separated	9	1	10
Married (Monogamous)	72	78	150
Married (Polygamous)	8	4	12
Single (Never married)	30	30	60
Widowed	9	0	9
Total	**128**	**113**	**241**

In the communities, an equal number of adult men (16) and women (16) in the rural and urbans areas in Kalomo, Katete, Mpika and Lusaka were interviewed on the knowledge, attitudes and practices (KAP) of Covid-19 on Gender-Based Violence. Adolescent boys (16) and girls (16) also participated in the RGA survey with an equal representation of males and females. Below is a summary of adult men and women as well as adolescent boys and girls.

Head of Household Profile

The survey indicates that the heads of households were 197 (82%) male and 44 (18%) females. The significance of this finding resonates with a study conducted by the Food and Agriculture Organization (FAO) in 2007 that linked heads of households to access and control of household resources. According to the study, fewer abused women seemed to make independent decisions on household items such as land and large livestock. The study also reveals that within the sites covered, 31 percent of the women who are not abused make decisions on land, compared to 17 percent that are abused. In addition, fewer abused women make decisions jointly with their partners on major items compared to women who are not abused (FAO, 2007). According to the Department of Social Welfare in Mpika;

> *"There has been no change for the women since the Covid- 19 pandemic started, the women still have to get permission from the husband for any important decisions of how money should be spent"* ***Social Welfare Department, Mpika***

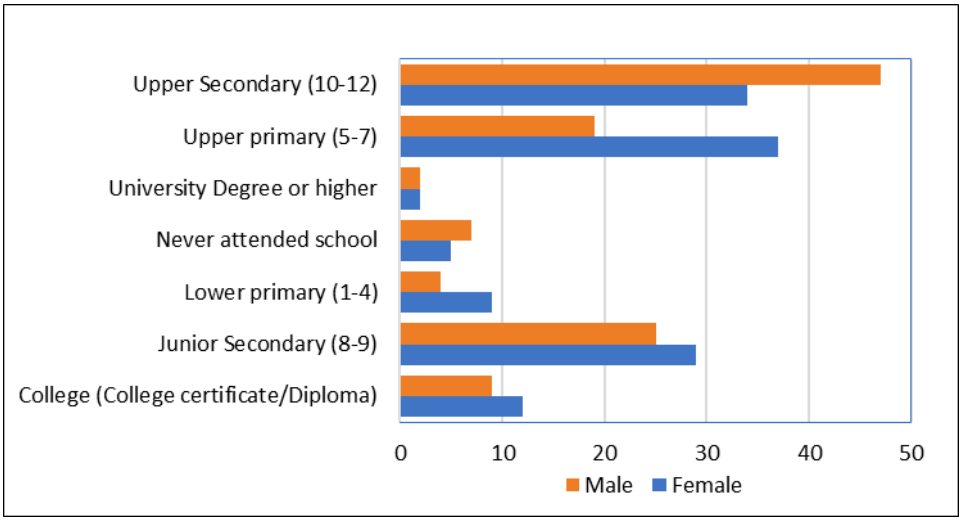
In Katete, however the findings indicate that culture plays a role in the way men and women relate, however with the information on gender among the community members, women have been seen to make decisions at the household level. Among the community members Covid-19 has changed the gender relations among males and females.

> *"I have observed that here in Katete, control is in men going by our culture, but with the coming of gender into play, women are seen to be active in decision making at home."* ***Social Welfare Department, Katete***

Education levels among the respondents

According to the Zambia Demographic Health Survey (ZDHS) the majority of Zambians have either no formal education or only some primary education. Urban residents are better educated than rural residents.[6] The RGA survey indicates that the highest level of education attained among the respondents was University degree. The analysis of the data shows that although the number of females compared to males is higher in the early and middle stages of learning, the trend changes at the upper secondary school stage. At this point, more males than females complete secondary school. See Chart 1 below:

Chart 1: Highest Level of Education Attained

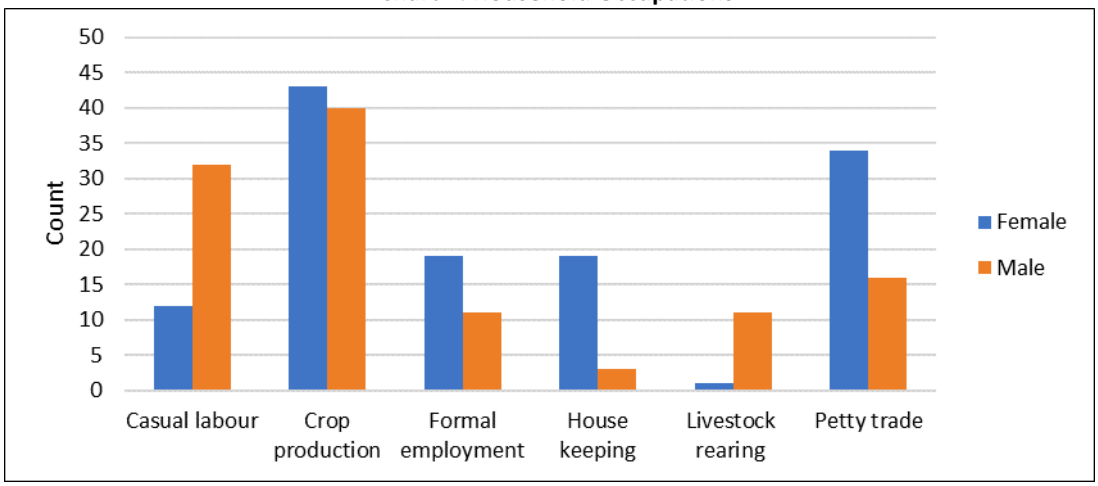


[6] Zambia Demographic Health Survey (2018)

Occupation of the respondents

Among the respondents, the occupation varied. The most common occupation is crop production and then followed by petty trade. However, for both occupations, there are more women than men. The trend is the same for formal employment and house-keeping. Numerically, men take the lead for casual labour and livestock rearing occupations. See Chart 2 below. The occupations contrast the head of household findings where 82% of the men made up the heads of households compared to women (18%). This is despite the fact that more women than men are involved in economic activities.

Chart 2: Household Occupations



The RGA reveals that in some districts such as Katete there have been changes and this has affected the activities men and women were doing before Covid-19.

> *"There is a difference in the way men, women, boys and girls relate before and after COVID 19. Before Covid 19 outbreak, people in this community were able to do different activities regarding their well-being without restrictions such as business and piece works. With the coming of Covid 19, things have changed completely; men have stopped doing their usual activities that benefit their households like business. Women have also stopped doing their activities like village banking where they normally access money."* ***Elderly Female, Katete***

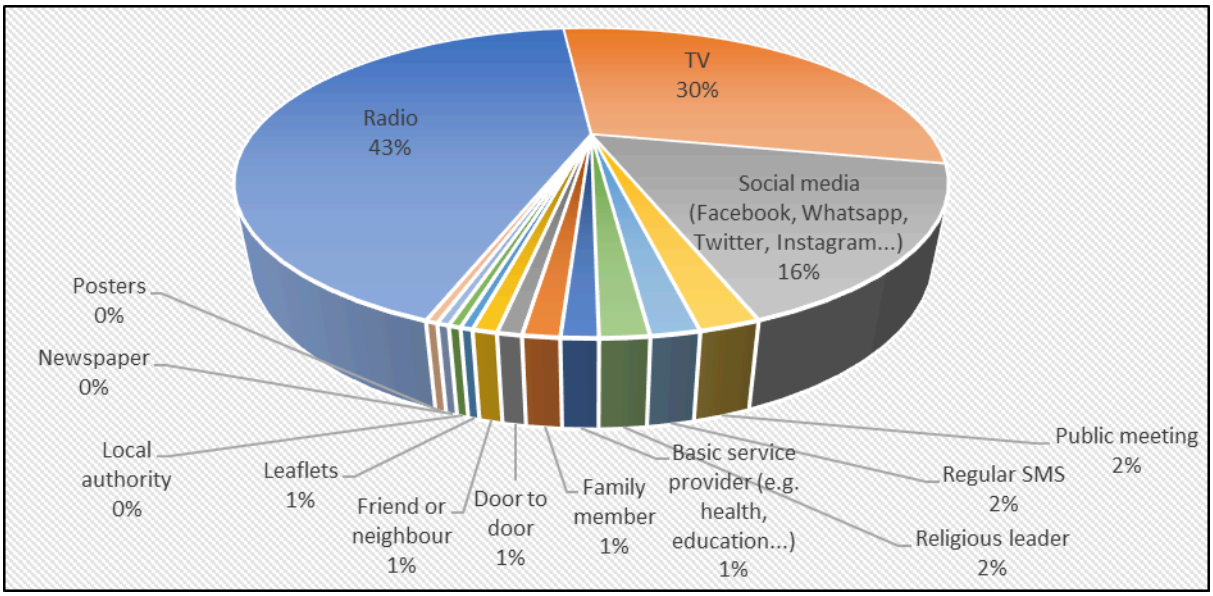
Awareness of and Source of Information on Covid-19

According to the ZDHS[7] access to information is essential in increasing people's knowledge and awareness of important issues. The survey shows that all the respondents 392 (100%) have heard about Covid-19 in Katete, Kalomo, Mpika and Lusaka districts. From the respondents, the top 3 sources of information were radio (43%); television (30%); and social media such as Facebook, WhatsApp, Twitter and Instagram (16%).

The respondents also indicated that there are other sources of information such as public meetings (2%), regular SMS (2%), door to door (1%), religious leaders (2%) and others such as family members and neighbours. Radio (43%) was the leading source of information. According to the Media Institute of Southern Africa (MISA), Zambia Chapter, there are currently 48 community radio stations and 42 commercial radio stations across Zambia. There are 25 television stations across Zambia, out of which six are satellite subscription-based. These results also show that social media (16%) is becoming an important source of disseminating information. Chart 3 shows the sources of information:

[7] ZDHS (2018)

Chart 3: Sources of Information on Covid-19



In Zambia Radio is the dominant medium of information for men, whereas television is the most dominant for women.[8] The internet is also a critical tool through which people access and share information. Internet use includes accessing web pages, email, and social media.[9]

The interviews with the community leaders indicate that they know about Covid-19.

> *"Yes, we have heard about corona, it started in China and spread to other parts of the world and it is deadly."* ***Community Leader, Mpika***

> *"It is the family of diseases like the cough respiratory, chest pains. The moment you see these signs, you need to isolate yourself to avoid further spread."* ***Community Leader Kalomo***

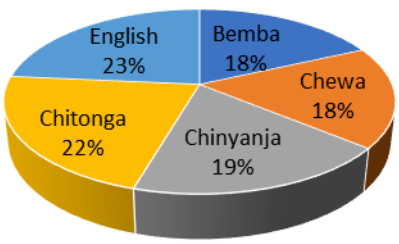
The community members obtain the information on Covid-19 from the radio, television and through sensitizations. According to the community member in Katete:

> *"Yes, people in this community have heard about Covid19 because it has been talked about on radio, news and sensitization have been going on"* ***Adult male, Katete***

Covid-19 Messages Dissemination

The language used to disseminate Covid-19 messages across the four districts was the local languages spoken in that districts. English was also used to disseminate information on Covid-19 in all four districts. The five major languages used were disseminated in English (23%), Chitonga (22%) in Kalomo, Chinyanja (19%) in Lusaka, Chewa (18%) in Katete and Bemba (18%) in Mpika. Chart 4 shows the distribution of the languages used to disseminate Covid-19 messages.

Chart 4: Covid-19 & Message Dissemination



[8] Ibid
[9] ZDHS (2018)

Covid-19 Messages and Understanding of Covid-19 Symptoms

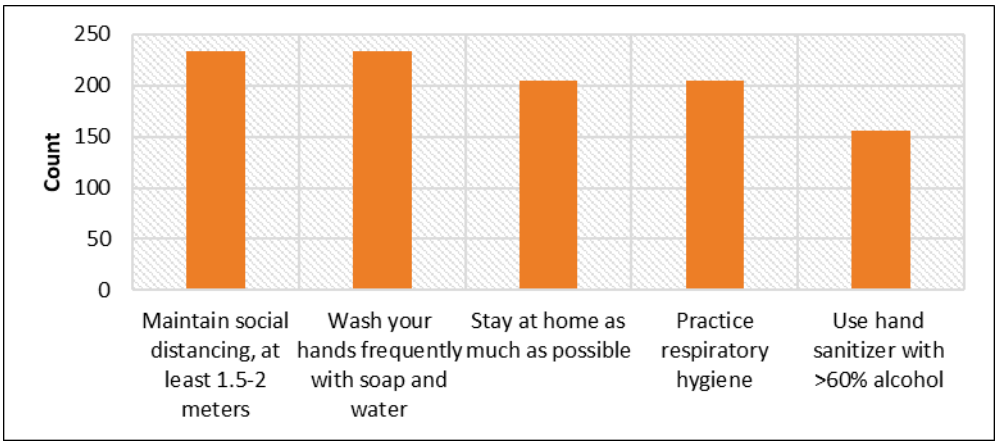
Respondents were asked to list at least four key messages and four symptoms of Covid-19 infection disseminated through the different medial avenues to illustrate their understanding of the disease. The most common types of messages were thoroughly washing hands with clean water and soap (84%); social distancing (82%); wearing facemasks (77%) and prevention measures (68%). Four key symptoms identified by the respondents included: dry cough (86%); fever (84%); difficulty in breathing (62%) and tiredness & fatigue (56%). In all the districts, communities showed that the messages were effective in raising awareness about Covid-19 and its symptoms. According to the adolescents, the messages on Covid-19 has been disseminated and explanations have been given on how it is transmitted and how to prevent it:

> *"I have heard about Covid-19 but I haven't seen a person suffering from the disease. What I know about Covid is that it came from animals and other foods and we can protect ourselves by washings our hands frequently, wearing masks, keeping social distance."* ***Adolescent girl, Kalomo***

Covid-19 Prevention Measures

The respondents were asked to indicate how Covid-19 is prevented and the survey results show that communities were well aware. Maintaining social distancing and washing hands were the most cited examples of preventive measures. Staying home as much as possible and practicing respiratory hygiene were the second most cited examples followed by using hand sanitizers with 60% or more alcohol content. Chart 5 below summarizes the prevention measures identified by the respondents:

Chart 5: Covid-19 Prevention Measures



According to the District Medical Health Office the community have been provided with the guidelines and he explains that:

> *"For the community, it's quite difficult to comply with Covid 19 guidelines such as wearing of masks but for hand washing, they are all complying and they have washing basins in many points of entry."* ***District Health Office, Mpika***

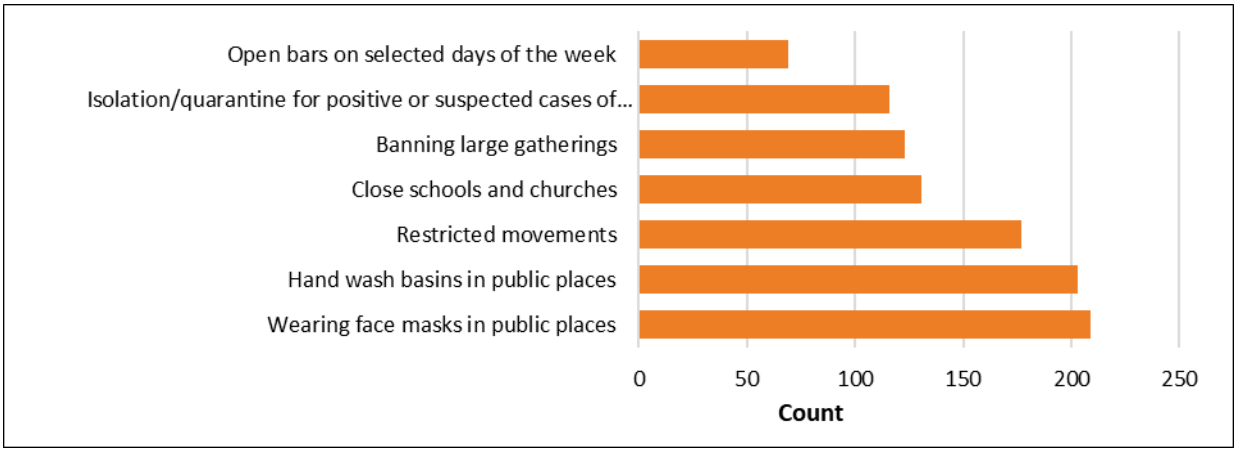
In Lusaka, the Water Vendor reported that there is adherence to the guidelines and has observed that in Chazanga the community members are wearing masks and washing hands.

> *"They are coping very well and following the guidelines. They are adapting very well, for example here at Chazanga water trust people wear face mask and wash their hands before they enter."* ***Water Vendor, Lusaka***

Covid-19 Measures by Zambian Government and Adherence

In the wake of the Covid-19 pandemic, the Government of Zambia put measures in place to prevent and respond to the pandemic. These include restrictions of movements, ensuring that hand wash basins and soap were available in public places and wearing of face masks. Others include temporarily closure of schools and religious places of worship, having bars open on selected days of the week as well as isolation and quarantining of people who tested positive and suspected exposure, respectively. Chart 6 below summarizes the responses.

Chart 6: Government Measures to Curb Covid-19 Responses



As the results show, communities are aware of the Government measures to mitigate the pandemic. However, adherence to the guideline provided by the government varied as community members have different perceptions on Covid-19.

> *"People believe there is no Covid-19 and the government has made it up, people won't protect themselves."* ***Water Vendor, Lusaka***

> *"Families are not adhering to the social distance because it is not they cannot afford masks, soap or sanitizers."* ***Adult male, Kalomo***

> *"Yes, people believe that there is no Covid 19 in the villages unless in towns hence people not adhering to the guidelines. This is affecting the effort in fighting Covid-19 because the response is poor."* ***Community Leader Katete***

The results further show that there is adherence to the guidelines as revealed by key informants:

> *"People have tried their level best to observe guidelines especially in public places, yes people are observing social distancing because if you contract that virus, you risk your entire life."* ***District Health Office, Mpika***

> *"They practice social distance. There are shops where you cannot enter without a face mask."* ***Water Vendor, Lusaka***

Reporting Covid-19 Cases

Communities in the four districts stated that they were reporting cases to the local clinic, the hospital, mobile clinic[10] and traditional healers. Others stated that they self-prescribed medications. The table below shows the responses:

[10] Mobile clinics and medical teams are deployed to reach people cut off from access to health services. For many people, these mobile clinics and teams may be their only source of health care. Mobile clinics offer flexible and viable options for treating isolated and vulnerable groups.

Table 3: Reporting Covid-19 Cases

S/No	Institution	Count
1	Local Clinic	198
2	Hospital	77
3	Mobile Clinic	20
4	Traditional Healer	1
5	Self	3
Total		**299**

Out of a total of 299 responses, 198 (66%) indicated that they would Covid-19 cases to the local clinic; 77 (26%) stated that they would report to the hospital; 20 (7%) to a mobile clinic; 1 (0.33%) to a traditional healer and 3 (1%) stated they wouldn't report anywhere but would instead self-medicate.

Table 4 above further illustrates that the communities are knowledgeable about where to report Covid-19 cases. This is evident as the results indicate that 1% would report to a traditional healer and another 1% would self-medicate.

> *"People are not wearing masks because there are rumors that there is no Covid-19 and others are saying there is a witch doctor who can solve problems, others are also saying there are herbs we can use e.g. ginger and garlic."* ***Department of Social Welfare, Mpika***

Covid-19 and Gender Roles & Responsibilities

The concept of 'gender roles,' refers to the activities ascribed to women and men on the basis of their perceived differences. Gender roles are socially determined, changes over time and space and are influenced by social, cultural and environmental factors characterizing a certain society, community or historical period[11]. The respondents stated that Covid-19 had brought about no change, but others have witnessed the changes in gender roles and responsibilities since the pandemic started.

Table 4: Changes in gender roles and responsibilities

Males	Females
• Men and Boys actively taking part in house chores	• Women becoming bread winners
• Boys can no Longer play their usual activities-swimming in the rivers	• Girls can no longer play their usual activities
• No Football	•
• Cannot Participate in The Traditional Ceremony (Nyau; Mukanda)	• Cannot attend the traditional ceremonies
• Not able to work	• Not able to work
• Not going to school, they have dropped out	• Not going to school due to pregnancies and early marriages

Covid-19 has affected the male and females as well as adolescent boys and girls differently.

> *"The coming of Covid 19 has brought inequality especially to women, they have a lot of work to do because their businesses have gone down but for men it was not that bad."* ***Social Welfare, Kalomo***

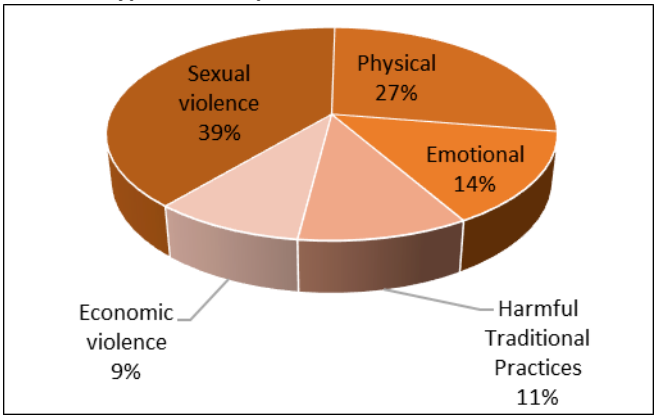
> *"For the boys and girls, they experienced a lot of work since they closed schools."* ***Community leader, Katete***

[11] ILO – Module on Gender, Poverty and Employment, 2015

Gender Based Violence Awareness and Prevalence

Central to the survey was the impact of Covid-19 on Gender Based Violence (GBV)[12] in the four districts. 95% of the respondents stated that they knew what GBV was compared to the 5% who stated they did not.

Chart 7: Types of GBV prevalent in the communities



Respondents were also asked to rank the types of GBV that were prevalent in the communities. To make sure the respondents understood, the responses were read out. The respondents indicated that sexual violence was high (39%); physical (27% (; emotional (14%); harmful traditional practices (11%) and economic violence (9%).

Chart 7 below summarises the responses on the prevalence of GBV cases in the four districts:

According to the Zambia Police-Victim Support Unit men, women, boys and girls have been affected by Covid-19. This has resulted in in physical and economic violence.

> *"Girls have become prostitutes and boys are abusing drugs; whereas the men and women are fighting in their homes they are at home all the time"* ***VSU, Mpika***

> *"Yes, there's a lot of cases of GBV because the tension is high in confined spaces. Yes, we have seen some people have become homeless and others are being abused by their landlords."* ***VSU, Katete***

There has also been loss of income among the among men and women as well as adolescent boys and girls leading to various forms of violence.

> *"Both males and females are not coping very well because a lot of people have lost their jobs. Some businesses where affected such as bars and the crime levels are very high in the community. There has been a lot divorce cases, stealing, prostitution, and poverty levels have gone up."* ***VSU, Katete***

GBV after Covid-19

Results from the survey shows that Covid-19 measures[13] has contributed to the increase in the prevalence of GBV in the four districts. This was also collaborated by officials from the Zambia Police Victim Support Unit (VSU), Ministry of Education (MoE) and the District Education Board Secretary (DEBS). Due to the biological make-up of the females, the adolescent girls have fallen pregnant during the period when schools closed in March, 2019.

[12] According to the Anti GBV Act No. 1 of 2011, GBV means any physical, mental, social or economic abuse against a person because of that person's gender, and includes— (a) violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to the person, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life; and (b) actual or threatened physical, mental, social or economic abuse that occurs in a domestic relationship.

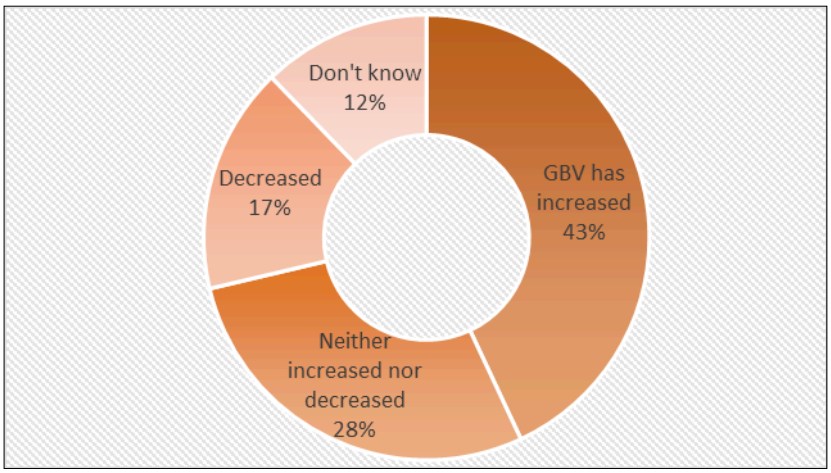
[13] Movement restrictions; Lockdown; Hand wash basins and soap in public places; Wearing face masks in public places; Closing schools and religious places of worship; Having bars open on selected days of the week; Isolating people who test positive; Quarantining suspected to have been exposed

"Some girls are pregnant due to Covid-19 because of that period when schools were closed and the number of school dropout has escalated in the communities." ***Adolescent female, Lusaka***

"Between boys and girls there has been a rise in the number of teen pregnancies and defilement cases in the community. ***VSU, Katete***

The survey reveals that 43% of the respondents stated that Covid-19 had contributed to the increase in the cases of GBV; 28% stated that the cases had neither increased nor decreased; 17% indicated that the cases have reduced and 12% did not know. Chart 8 below summarizes the responses on the impact Covid-19 has had on GBV prevalence.

Chart 8: GBV Prevalence due to Covid-19



Below are some of the reasons from respondents on why the GBV cases have decreased:

"People are now sober most of the times because the bars don't open every day. They would be violent because of being intoxicated by alcohol and other drugs. The Covid-19 measures of partial lock down and restriction in movements meant that the supply was cut off" ***Social welfare Department, Mpika***

"People are uniting for a common cause – fight Covid-19, not each other" ***District Health Office, Katete***

Respondents from Kalomo, Katete, Mpika and Lusaka also indicated the GBV cases have increased and the following reasons were identified;

"Due to the partial lockdown and restriction in movements, husbands and wives are spending too much time together and are now discovering things about each other such as cheating." ***VSU, Mpika***

"Men who lost their jobs are usually stressed and end up venting their frustrations on their spouses and children." ***Elderly female, Kalomo***

"Emotional and economic abuse have risen because a lot of people have been home without doing anything." ***VSU, Katete***

"The men are now always at home and because they have nothing to do, there are a lot of arguments and they beat us." ***Adult female, Lusaka***

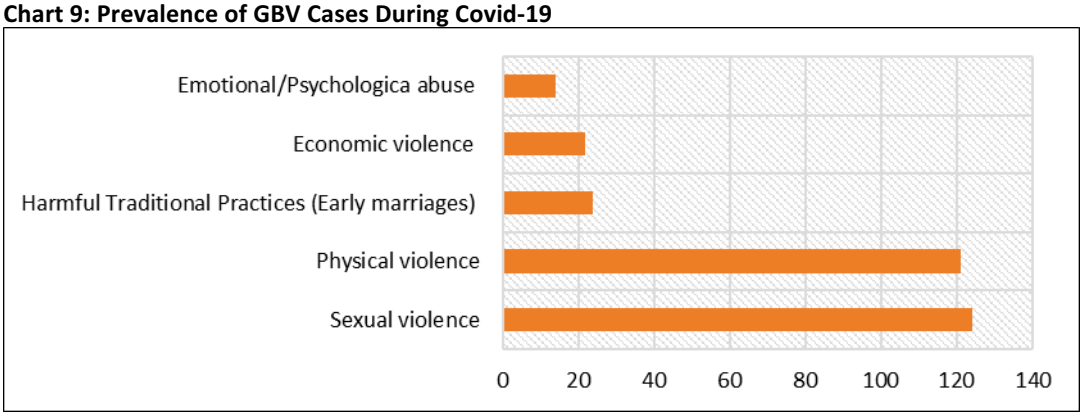
According to the respondents the GBV cases have neither increased nor reduced;

> *"GBV cases have remained the same. I hear the same things before and now. Nothing has changed, men and women used to fight and they still do even now when there is corona."* ***Community Leader, Kalomo***

Types of Cases due to Covid-19 Cases

Due to some of the measures introduced by the government to address Covid-19 such as the partial lock down, restrictions in movements and self-quarantine, the four districts have generally seen an increase in the number of GBV cases. In terms of prevalence, sexual violence tops the other GBV categories with defilement and rape mostly reported. The second most reported GBV category is physical violence and Harmful Traditional Practices (HTPs), particularly early marriages in third. Chart 9 shows the prevalence of GBV cases as a result of the Covid-19 measures:

Chart 9: Prevalence of GBV Cases During Covid-19



Where Communities Reports GBV cases

The community members in the four districts report GBV cases to the services providers available including the Zambia Police Victim Support Unit (ZP-VSU), community leaders such as teachers, religious leaders and traditional leaders. In order of ranking however, respondents stated that they would first report the cases to the VSU (158). Communities are aware that the police need to investigate the cases and that a medical certificate has to be issued by the police for victims of GBV to receive medical attention. Although in reality, a victim may receive a service even in the absence of a medical certificate depending on the severity of GBV. Other institutions where GBV cases are reported in order of preference: GBV-related NGOs (74); headwoman/man (72); teachers and pastors (53); political leaders such as Ward Councilors or Members of Parliament (20); family members or friends (10). Other respondents (20) stated that they didn't report the cases anywhere mainly for two reasons: fear of suffering embarrassment and fear of having the breadwinner arrested.

Rating GBV Response

The response to GBV cases by service providers such as the Zambia Police and GBV NGOs was generally considered efficient with both households and key informants rating the response as efficient (74%). 14% of the respondents rated the response as slow and 12% said they 'didn't know'. However, the police stated that the endemic challenges with logistics: fuel, vehicles and sometimes staff, hampers their effective response to GBV cases.

Profiling GBV Victims and Perpetrators

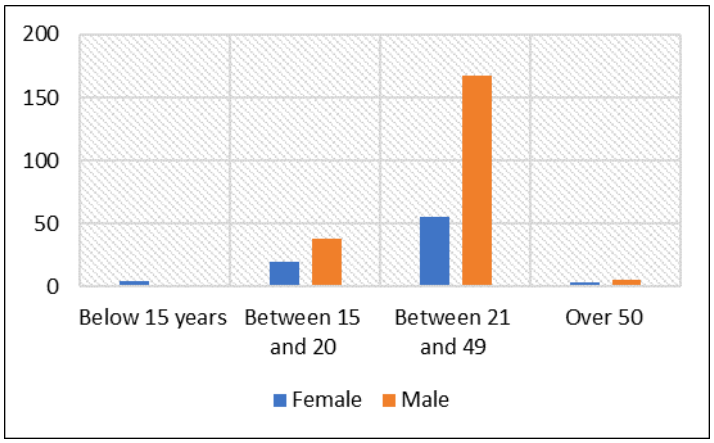
Effective prevention and response mechanisms require insight into the profile of GBV victims and perpetrators. This ensures appropriate programmes are designed with a higher assurance for

success than when designed in abstract. Charts 10 and 11 below compares and contrasts the profile of GBV victims and perpetrators during Covid-19.

Perpetrators of GBV

The RGA results show that in all four provinces, perpetrators of GBV are mostly males between 21-49 years and 15 and 20 years. The finding is consistent with the to the ZDHS which shows that the most commonly reported perpetrators among ever married women in Zambia are husbands/partners (65%).[14] Among never-married women who have experienced physical violence since age 15, the most reported perpetrators are mothers/stepmothers (27%), fathers/stepfathers (19%), sisters/brothers (18%), other relatives and other people (14% each), and teachers (12%)[15]. Chart 10 below summarizes the profile of the perpetrators:

Chart 10: Profile of Perpetrators during Covid-19



The respondents indicated that there are various reasons for GBV. These are summarised in the table below:

Table 5: Reasons for violence

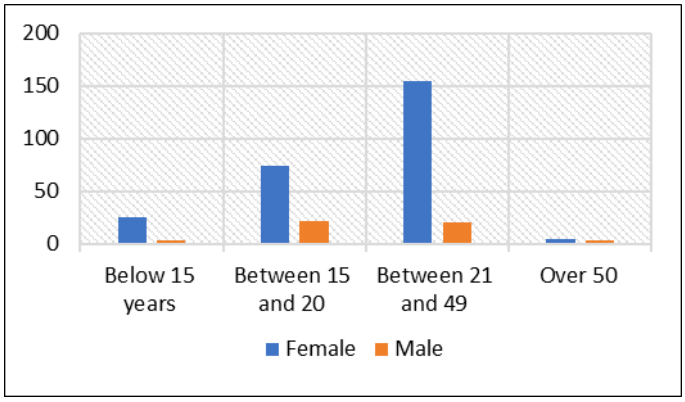
Age Group	Reasons for violence
Boys 15 and 20 years old	• Because of early marriage • Because of alcohol abuse
Men between 21-49	• Sexually active and the drink a lot • Beating each other • Because they have nothing to do • Because we differ the way we understand each other, therefore fights are there in homes
Elder Men over 50 years	• Because men are more superior than women • Because they think coming out of marriages is not right in the sight of traditional

Victims of GBV

Analysis findings on victims of GBV during Covid-19 shows that both males and females are victims. The highest number of victims are women aged 21-49, followed by young women 15 -20 years. See Chart 11 below:

[14] ZDHS (2018)
[15] Ibid

Chart 11: Perpetrators of GBV in Covid-19



From the charts above, a trend is evident that although GBV affects women and men, women and girls constitute the majority of the victims. This is evident in all the four districts. By contrast, the majority of the perpetrators are men and boys.

Victims of GBV

The table provides the reasons why women and girls are victims of GBV during Covid-19 in the four districts of Kalomo, Katete, Mpika and Lusaka.

Table 6: Why women and girls are victims of GBV

Age Group	Reasons for the Age
15 to 21 years for girls	• Because they are orphans and vulnerable • Because most parents who love money give their gals into marriages as early as 12yrs and women have no say • Mostly violated in sex and active in beer drinking • Anger in homes, alcohol abuse n drugs
21 to 49 years for women	• Because they drink a lot • Because most of them have become alcohol abusers, as a result they are become victims • Because of prostitution • Because they think coming out of marriages is not right in the sight of traditional • Disobedience

The above scenario was best explained by one of the officers from the Zambia Police when she explained:

> *"In the context of violence and abuse, most people think of physical power, which includes physical size and strength as well as designated roles, such as soldiers, police or cadres. Compared to women, society has bestowed on men, political, economic, social and gender power. Unless the concept of power is appreciated, women will continue to be the most victims"* ***VSU, Lusaka***

Other reasons for women and girls constituting the most victims were:

> *"This (21-49) is the age most women get into marriage or are already married. At this stage, women would rather endure the violence than risk break up the marriage because they are totally dependent on their husbands economically."*

> *"In our communities, women are considered to be the ones that make the marriage work. A woman would rather suffer in silence than suffer the embarrassment of a failed marriage."*

Water, Sanitation and Hygiene

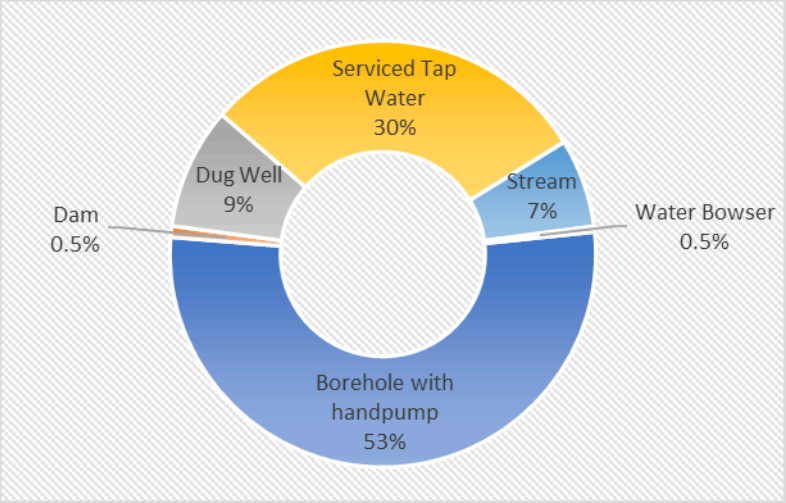
According to the United Nations, 2.2 billion people lack access to safely managed drinking water services and 4.2 billion people lack safely managed sanitation services. Unsafe hygiene practices are widespread, compounding the effects on people's health. The impact on child mortality rates is devastating with more than 297,000 children under five who die annually from diarrhoeal diseases due to poor sanitation, poor hygiene, or unsafe drinking water. Access to clean and safe water is a basic right. However, access to clean and safe water alone is not enough to guarantee good health. Access to adequate sanitary and hygienic conditions are equally important. The fact that there is a Sustainable Development Goal 6 (***Ensure access to water and sanitation for all***) dedicated to promoting access to water and sanitation underscores the importance of the subject.

This part of the report highlights the state of water, sanitation and hygiene (WASH) in the four districts.

Source of water

The communities had six main sources of water: serviced tap water (30%), stream (7%), dug well (9%), dam (0.5%, borehole with hand pump (53%) and water bowser (0.5%). Chart 12 below shows the rest of the sources of water and proportion of access. According to the Zambia Demographic Survey in Zambia, 72% of households have access to an improved water source, although access is more predominant in urban than rural. The most common sources of drinking water in urban households are water piped into the household's dwelling, yard, or plot; water from a public tap or standpipe; and water piped to a neighbour. Rural households obtain their drinking water mainly from tube wells or boreholes, followed by protected dug wells.

Chart 12: Source of Water



Proximity of Water Sources

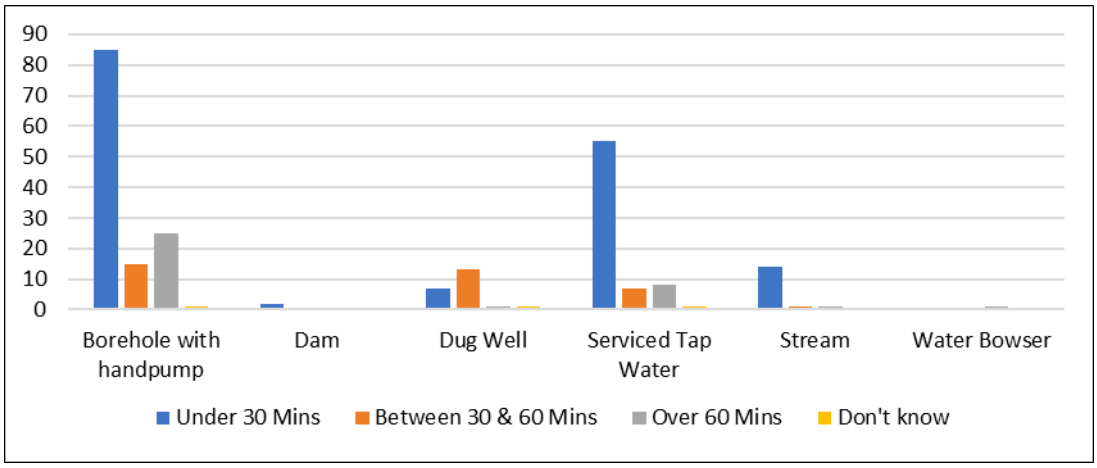
For most of the community members, the water sources were less than 30 minutes away on foot. The SDG's define access to basic drinking water as "using an improved source with a total fetching time of 30 minutes or less for a round-trip including queuing."[16] The fetching of water can represent a substantial physical and economic burden that predominantly affects women and children[17].

[16] Water Supply and Sanitation Collaborative Council. WASH Post-2015: Proposed Targets and Indicators for Drinking-Water, Sanitation and Hygiene. 2014. pp. 1

[17] Blackden CM, Wodon Q. Gender, Time Use, and Poverty in Sub-Saharan Africa. Washington, DC: World Bank;2006. http://siteresources.worldbank.org/INTAFRREGTOPGENDER/Resources/gender_time_use_pov.pdf Available at. [Google Scholar]

However, the study shows that some community members have to walk for more than 60 minutes to access the water as can be seen in Chart 13 below:

Chart 13: Proximity to the Water Sources



Toilet and Latrine Facilities

According to the WHO 2.0 billion people still do not have basic sanitation facilities such as toilets or latrines. Of these, 673 million still defecate in the open, for example in street gutters, behind bushes or into open bodies of water. In the same report, inadequate sanitation is estimated to cause 432 000 diarrhoeal deaths annually and is a major factor in several neglected tropical diseases, including intestinal worms, schistosomiasis, and trachoma. Poor sanitation also contributes to malnutrition. In the four districts, communities rely on four types of toilets: pit latrine, ventilated (improved) pit latrine, flushable toilets and open bush.

Chart 14: Toilet and Latrine Facilities

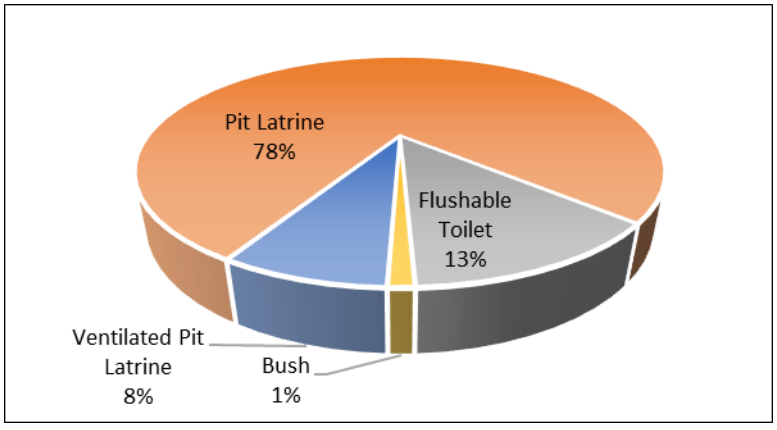


Chart 14 indicates that majority (78%) of the respondents use pit latrines; 13% flushable toilets; 8% are using ventilated latrines and open defecation is practiced with 1% indicating that they use the bush.

The ZDHS also shows that 33% of the Zambian population has basic sanitation service, 41% in urban areas and 28% in rural areas. Fifty-four percent of households have access to an improved sanitation facility, with the most commonly used facility being a pit latrine with a slab (37%)

Women and Girls' Menstrual Hygiene Needs

Menstrual hygiene management requires availability of and access to clean and absorbent menstrual material, privacy, water and soap, and disposal facilities for used menstrual materials[18]. Women and girls were asked to rank their menstrual hygiene needs. Evidence has shown that the provision of adequate Water, Sanitation and Hygiene (WASH) facilities and services in schools has a bearing on health and educational outcomes, especially for girls. According to a sustainability study

[18] JMP. Meeting report of JMP post-2015 global monitoring working group on hygiene. Washington, DC; 2012.

undertaken by UNICEF in 2012, 35% of WASH facilities in schools were not functional. In Zambia water and sanitation facilities in rural primary and basic schools are generally poor.[19]
The female respondents 46% stated that their number one menstrual hygiene need was 'disposable pads'. Chart 15 below summarizes the responses of the women and girls in order of priority:

Chart 15: Women and Girls' Menstrual Hygiene Needs

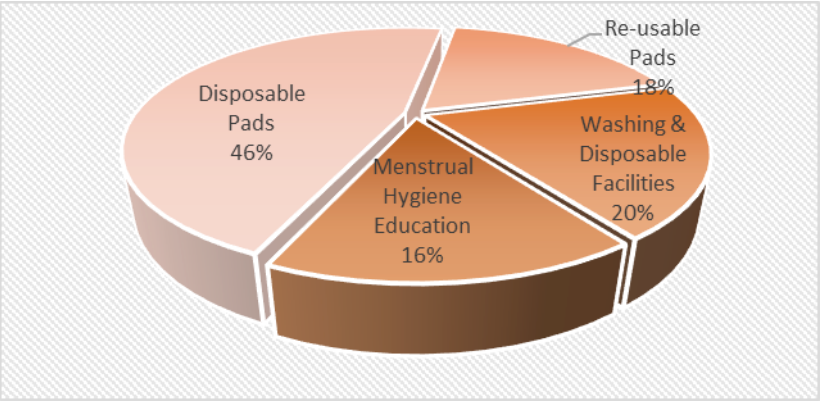


Chart 15 indicates that women and girls' menstrual hygiene needs include disposable pads (46%); washing and disposable facilities (20%); re0usable pads (18%) and menstrual hygiene education (16%).

The key informants revealed that from there are barriers for both women and adolescent girls.

> *"Barriers for WASH are there in schools and in the communities and they are so such as inadequate toilets, few hand washings points. These are also menstrual challenges for a girl child."* ***DEBS-Katete***

The girls have also observed that menstrual hygiene is a challenge de to lack of menstrual materials in the rural areas.

> *"Pads are needed by the girls in this community, it is so unfortunate that there is no shop which sells pads, in this village. The only person who used to sell stopped hence, if we want pads, we usually buy them from Katete town. Schools are not equipped with menstrual hygiene materials, for those pupils who would want to attend class while menstruating but don't have pads, they use small chitenge materials."* ***Adolescent girl, Katete***

Nutrition During Covid-19

143 (65%) of the respondents indicated that they have 3 meals per day before and after Covid-19; 78 (35%) indicated that they are not having 3 meals per day.

Table 7: Meals taken by the respondents during and after Covid-19

Able to have 3 meals per day	Not able to have 3 meals per day
- Adapting to the new normal	- Because business is not going well these days.
- Source of income has not changed	- Because finding money for food has been a challenge due to the restrictions in movement
- Parents have alternative source of income	- Because food is becoming expensive
- 3 meals but smaller portions	- No income
-	- The economy is too high affecting the cost of living
-	- Restricted movements

The table above indicates that the respondents are able to have 3 days' meals per day because they are adapting to the new normal and the source of income has not changed before and after Covid-

[19] Ministry of General Education (2013)

19. However, having 3 meals per day has become a challenge and according to the respondents' businesses have been affected leading to low- or no-income generation, restrictions has affected the income generating activities; the high cost of living and food is expensive. According to the respondents' families are having 1 or 2 meals per day.

> *"It depends if I find money, they will eat breakfast if not they only eat lunch and supper."* ***Adult Male, Kalomo***

> *"Kids are not home during the day, they go to school, so I don't cook, during the day. We only have supper as a family when everyone is home."* ***Adult female, Katete***

However, respondents also indicated that Covid-19 has not affected the number of meals because this is how they have been living even before the pandemic started.

> *"We have been eating like this as long as I can remember. My parents make sure that we have all the meals per day."* ***Adolescent female, Mpika***

Health

Understanding health as a human right creates a legal obligation on states to ensure access to timely, acceptable, and affordable health care of appropriate quality as well as to providing for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, and gender equality. A States' obligation to support the right to health – including through the allocation of "maximum available resources" to progressively realize this goal - is reviewed through various international human rights mechanisms, such as the Universal Periodic Review, or the Committee on Economic, Social and Cultural Rights. In many cases, the right to health has been adopted into domestic law or Constitutional law.[20]

A rights-based approach to health requires that health policy and programmes must prioritize the needs of those furthest behind first towards greater equity, a principle that has been echoed in the 2030 Agenda for Sustainable Development and Universal Health Coverage.

Against this background, the RGA assessed the health needs in the four districts including type and disease prevalence, proximity to health facilities and available of essential drugs.

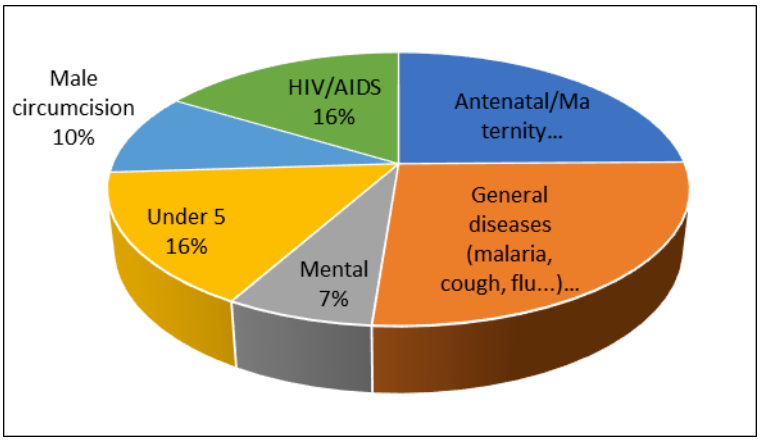
Health needs

Zambia is divided into 10 administrative provinces and 105 districts. Health management is done through provincial health offices. The country has eight third-level hospitals, 34 second-level hospitals, 99 first-level hospitals, 1,839 health centres, and 953 health posts. All third-level hospitals are Government owned. Of the second level hospitals, 26 are Government-owned, and eight are owned by the Churches Health Associations of Zambia (CHAZ) Respondents were asked to describe the health needs in their respective communities. The information obtained from households was collaborated with data from health key informants.

The respondents indicated that the health needs include treatment for malaria, cough, flu (26%); maternal health services (25%); under 5 services (16%); HIV/AIDS services (16%); male circumcision (10%) mental health services (7%). See Chart 16 below:

[20] Transforming our World: The 2030 Agenda for Sustainable Development. UN General Assembly. 2015. 21 October. UN Doc. A/RES/70/1.

Chart 16: Health Needs in the Four Districts



The Analysis findings are consistent with the 2017-2021 Health Strategic Plan which shows that from 2011 to 2015 malaria has been on top; and respiratory infections has been on the increase since 2011.

Human Immunodeficiency Virus (HIV) prevalence in Zambia continued to decline. The recent Zambia Population HIV Impact Assessment (ZAMPHIA) survey shows a reduction of about 1.7% from 13.3% in 2014 to 11.6% in 2016. The health sector has also recorded remarkable progress on antiretroviral treatment (ART) coverage, which stands at 72% of the eligible people against the United Nations AIDS (UNAIDS) global target of 90%.

Distance to Healthcare Facilities

Patients' time and costs during illness and health care treatment are relevant aspects to include in a complete analysis of the social costs of health interventions[21]. Time and costs related to patients' travels from home to their health care providers are also relevant when the social implications of treatment options are assessed in, for example, cost-effectiveness analyses. Travel time and costs vary for the individual patient depending on the type of treatment provided, the frequency of contacts with health care providers, the traveled distance, and the mode of travel.

In the case of the RGA, 42% of the respondents stated that it takes them under 30 minutes to get to the nearest health facility. 39% of the respondents said it takes them between 30 and 60 minutes while 19% said they spend at least one hour to get to the health facility.

Key Challenges to Attainment of Highest State of Health Care

The key health challenges in the four districts are listed in three categories: services, equipment & infrastructure and Personnel. Table 9 below summarizes the challenges per category:

Table 8: Health challenges identified

Health Services	Equipment & infrastructure	Personnel
No eye or ear clinic services	Inadequate bed space	Shortage of staff
No mental health services	Lack of X-ray	
No dental health services	Lack of scanning equipment	
No cervical cancer screening	No ambulance	
No blood Bank	No proper operating theatre rooms	
No laboratory services	No Covid-19 Test Kits	
	No mosquito nets	
	Shortage of drugs	
	No waiting rooms for expectant mothers	
	No proper counselling rooms	

[21] M. R. Gold, J. E. Siegel, L. B. Russel, and M. C. Weinstein, Eds., Cost-Effectiveness in Health and Medicine, Oxford University Press, New York, NY, USA, 1996.

Conclusion

Covid-19 has had catastrophic implications at virtually all levels: global, continental, national and community levels. Millions of lives have been lost, economies have been disrupted causing major socio-economic challenges. Zambian communities have not been spared as evidenced from the results of the RGA in Lusaka, Kalomo, Katete and Mpika. Covid-19 and Covid-19 prevention measures, coupled with historic unequal power relations between women and men is pre-disposing women and girls to GBV. Covid-19 and corresponding prevention measures are further altering gender roles, access to health, nutrition, water, sanitation and hygiene. Any meaningful interventions to respond to Covid-19 must take cognizance of the unequal power relations between women and men, contextual cultural interpretations of gender roles and expectations and the resulting changes in relations between women and men, boys and girls. Innovative information dissemination strategies on Covid-19, GBV, health, nutrition, water, sanitation and hygiene are still some of the key success factors to preventing Covid-19 and stopping the negative implications associated with the Covid-19 measures. Key stakeholders including women, men, girls and boys, community leaders, policy makers and the non-profit sector must be fully involved and engaged in the development of programmes, initiatives, policies and plans that directly or indirectly affect them.

Recommendations

The recommendations are arranged to respond to the three specific objectives for CARE, CARE's Partners and the Zambian Government.

Information dissemination about Covid-19, GBV, WASH, Nutrition and Health

3. With the already existing traditional forms of media such as radio, television and print media, social media and other online platforms (Zoom and Hangout) should be included to disseminate information on Covid-19, GBV, WASH, Nutrition and Health to the men, women, boys and girls. The assessment established that social media, particularly Facebook and WhatsApp can serve as an important source of Covid-19 and GBV information.
4. Communication and information messages on Covid-19 and GBV should be tailor made for men, women, boys and girls to educate and inform communities, on how they can protect themselves from Covid-19 and GBV.
5. General education on physical activities and coping with stress should also be incorporated in the communication strategy. This is because mental health was identified by the respondents as a health need.
6. Community leaders and members should be involved in the development of culturally appropriate messages on Covid-19 and GBV
7. In rural areas, there is still a wide belief that Covid-19 is only in urban areas, there is need to correct this myth through community meetings and sensitizations
8. Develop posters using cartoon characters to be placed in public places on Covid-19 and GBV prevention measures.

Coping with Covid-19

3. Recognize women's resilience, innovation and roles as critical change agents necessary for effective Covid-19 responses.
4. Ensure women's equal representation, participation and decision-making on Covid-19 prevention and response strategies at district and community levels
5. Identify, with communities, representing a wide and diverse experience of women and girls, the needs of the most marginalized, and ensure they are prioritized in COVID-19 response plans and strategies.
6. Incorporate a gender perspective in all policy responses to Covid-19, as social norms and cultural patterns can lead to a differentiated impact for men and women. Take targeted action to avoid exacerbating existing inequalities. Specifically, account for the circumstances of women and girls, including sex, sexual orientation, gender, gender identity, HIV status, race, age, class, religion and disability in all Covid-19 responses.
7. Collect age, gender-and disability-sensitive evidence to create more equitable solutions to the disproportionate impacts of Covid-19 and responses on women, men, boys and girls in all their diversity, and promptly share good practices and lessons learned. Longer term, ensure disaggregation of data is mainstreamed into emergency response planning and preventive measures.
8. Allocate funding to ensure that social services such as health, education, and other care-related functions can continue at levels prior to Covid-19.
9. Distribute Covid-19 prevention material in the short run and supply sewing machines to women and men to sew masks, re-usable sanitary pads, etc. for sale. The sewing machines should be distributed on a revolving scheme

Women Economic Empowerment

3. Maintain or expand cash transfer and broader subsidy programs to ensure that the vulnerable women, girls, and their households are not driven deeper into poverty as a result of Covid-19.

4. Investing in training, skills development, and job placement programs for women to access jobs in industries responsive to Covid-19 (e.g., health care product manufacturing, information and communications technology, and food and accommodation)
5. Addressing and minimizing disruptions to girls' education and taking special measures to ensure that girls return to school so that their future economic opportunities are not diminished.
6. Investing in technological solutions to promote women's employment and entrepreneurship during the Covid-19 crisis, including funding and skills building to narrow the gender digital divide and increase women's access to digital tools and platforms
7. Ensure equal access to education – which is foundational to girls' and adolescents' livelihoods and well-being. School closures can exacerbate gender inequalities, especially for the poorest girls and adolescents who face a greater risk of early and forced marriage and unintended pregnancy during emergencies. Closed schools likely means girls and adolescents are taking on additional responsibilities at home like looking after siblings or caring for sick relatives, which can lead to them falling behind in school work or dropping out.
8. Continue and increase support for longer-term initiatives that advance gender-equitable social norms and infrastructure, such as childcare services and programs to support involvement of men and boys in household duties, particularly given their additional time at home under stay-at-home measures, to alleviate women and girls' disproportionate unpaid care burdens. These measures should also support prevention of gender-based discrimination and violence and promote women's voice and leadership at all levels.

Access to Health

3. Ensure ongoing access to critical health information and sexual and reproductive health services.
4. Anticipate and address supply chain disruptions, and ensure ongoing compliance with medical privacy regulations in all pandemic responses.
5. Look for innovative ways to provide health services during COVID-19
6. Take stock of missing and/or inadequate health services and develop action plans to progressively put these in place.

Water and Sanitation Hygiene

3. Increase access to clean water to within 15-30 minutes. Where possible, sink boreholes
4. Distribute sanitary material to adolescent girls and vulnerable women to ensure little or no disruption to their daily lives
5. Disseminate communication and preparedness information related to handwashing behavior change and promotion, food hygiene and safe water practices. Materials for handwashing and hygiene may include the provision of fixed and portable handwashing facilities, purchasing of soap and alcohol-based hand rubs, provision of water supplies for handwashing and point of use water treatment. Schools, workplaces, markets, transport stations and other areas where people gather all require easy access to water and soap for handwashing.

Nutrition

2. Ensure agricultural financial and technical assistance initiatives such as the Farmer Input Support Programme (FISP) targets women farmers and agricultural workers, including small-scale farms, and promote increased access to labor-saving, women-friendly technology. Provide food assistance to the poorest and most vulnerable populations during this crisis.

3. Align and scale up mitigation plans across food, health, and social protection systems to protect and promote nutritious, safe, affordable and sustainable diets that support adequate nutrition in families and communities affected by the COVID-19 pandemic.
4. In food insecure contexts where communities have limited access to adequate diets, scale-up prevention interventions (e.g. fortified flours, lipid based nutrient supplements or cash) for vulnerable households – the elderly, disabled and chronically ill.

Gender-Based Violence

4. Engage men and boys by tailoring messages to challenge gender stereotypes and unequal gender roles
5. Men and boys also experience GBV and gender-biased challenges to accessing services (e.g. stigma, perceptions that 'real men' don't need support, etc.). Ensure that services are also made accessible to men and boys.
6. Support police and justice actors to provide adapted services during periods of confinement or lockdown
7. Adapt and expand services such as shelters, safe spaces and essential housing along with psycho-social support and advice for individuals experiencing or at risk of GBV
8. Engage men as agents of change through men's network groups, involvement of community leaders and other high ranking male figures as role models

Annex 1: Individual Stories from the Field

My name is Benson Banda, a resident of Katete District and I have lived here for more than 15 years now. I have carefully noted the impact of the ***Covid-19*** *pandemic on the development of the District and its residents. Although I have not heard much on the mortalities caused by the pandemic, I can confirm the fact that development has been slowed down especially with the restrictions that were put in place as health guidelines.*

Story of Change

I have observed so many changes which are both good and bad on the community. Here are some of the changes:

- *Hygiene levels improved*
- *Criminal cases were reduced*
- *Peoples unnecessary movements were controlled*
- *The closure of bars made a lot of youths stop wasting time on reckless beer drinking.*
- *Noise pollution caused by bars was controlled.*
- *Businesses were shut down*
- *People live in absolute fear*
- *Schools and Churches were closed*
- *People lost jobs because some companies were not allowed to operate*

In terms of business, before the pandemic things were better, now, prices of commodities have been hiked causing a huge challenge especially to the disadvantaged – the disabled and the elderly.

I have observed that most of us men are living in absolute stress and frustration mainly as a result of losing jobs which were the major sources of income due to closure of some business entities. I feel the challenge of losing jobs due to the pandemic is more significant in the sense that people's standards of living have been lowered. Some people can no longer afford even just the minor basic needs..

Most affected people will have to reposition and restructure their lives in order for them to pick up again and that's a long process. The pandemic has been a setback to the growth of the economy at large.

As a family, we lost our breadwinner due to Covid-19. The budgets have been restructured, and this has made us to forgo certain privileges. Mentally, we've also been affected by this unforeseen circumstance.
We are currently relying on meagre salaries of members of the family who are working and a backyard garden. I personally make shoes for ladies and this is one of my survival skills which is helping me to earn a living. Through this skill, the family is able to earn income and plan for basic needs.

As a family, we are coping with Covid-19 by following health guidelines and individual consciousness to adhere. I personally feel everyone is vulnerable because the disease does not choose. At our home, decision making is done jointly to the benefit of all family members. This is a way that we have seen as a family to maintain family ties. Basic needs such as food, groceries and money are very critical for survival.

I have a few recommendations to make:

- *Government should consider developing more health research institutes in order for us as nation not to entirely depend on other countries to help us.*
- *Both medical students and individuals interested in carrying researches on eliminating the crisis must be highly supported and empowered*
- *Production of local herbs that can be used to cure the Covid-19 infection must be encouraged*
- *Awareness on the impacts of the pandemic must be spread to all parts of the nation so that people can easily adhere to the health guidelines.*

Indeed, we have access to supermarkets but the challenge comes in if one is not wearing a mask. The missing support is financial empowerment through adoption of business proposals by either government or other well-wishers. I suggest that Leaders be quick to identify potential and support progressive business ideas. I feel there's no security at all since every person is at risk of suffering from the negative effects of the crisis.

Finally, I believe our concerns can be achieved through radio programs community sensitizations

General information

Annex 2: List of Key Informant Institutions

1. Ministry of Health (MoH)
2. Ministry of Gender (MoG)
3. Ministry of Community Development and Social Services (MCDSS)
4. Ministry of Information (MoI)
5. Ministry of Home Affairs – (MHA) Zambia Police – Victim Support Unit (ZP-VSU)
6. Ministry of Labour (MoL)
7. Ministry of General Education (MGE)
8. National Legal Aid Clinic for Women (NLACW)
9. Young Women Christian Association (YWCA)
10. Young Men Christian Association (YMCA)
11. District Education Board Secretaries (DEBS)
12. Community leaders (headmen/women, teachers and the clergy)

Annex 3: Ethical considerations

The ethical principles of confidentiality and respect are especially relevant in the research field of SGBV due to the traumatic and sensitive nature of the subject matter. Ill-conceived or implemented research may have dangerous consequences for the respondents and/or interviewers. Research designs should consider issues of confidentiality, problems of disclosure, and the need to ensure adequate and informed consent (Ellsberg & Heise, 2005)[22]. Minimizing harm to respondents and researchers (non-maleficence) and maximizing benefits to participants and communities (beneficence). In this vein, the research process ensured that the following ethical considerations were adhered to:

- **Individual consent:** This was obtained at the start of all interviews. Respondents were informed of the purpose and nature of the study and were asked to give consent that they were free to withdraw at any point of the interview.
- **Voluntary Participation**: Participation in the study was on a voluntary basis and no inducements were made. It was made clear to the respondents that refusal to participate would not result in any negative consequences.
- **Physical safety of informants and researchers**: This was paramount. Interviews were conducted in a private setting. Where necessary, locations outside the household where the interview could be conducted in private were identified and the participant were free to reschedule (or relocate) the interview to a time (or place) that was more convenient for them.
- **Do no harm**: Particular care was taken to ensure that all questions were asked sensitively, in a supportive and non-judgmental manner. Interviewers were trained to be aware of the effects that the questions could have on the informant and, if necessary, terminate the interview if the effect seemed negative. The training not only discussed survey techniques but also how to respond and, if necessary, provide support to the respondents reporting their experience of violence.
- **Confidentiality:** Respondents were isolated, separate from the household members and the data collected did not include their names during field work. In the report, no names of participants will be included in order to insure confidentiality.
- **Training of Researchers:** All research team members were carefully selected and received specialized training on conducting interviews and how to refer respondents requesting assistance to available sources for support. Those selected to participate as research assistants had a background in working in environments dealing in GBV issues.
- The researchers ensured that the findings were properly interpreted and used to advance policy and GBV intervention development.

[22] Mary Ellsberg & Lori Heise (200), Researching on Violence against Women: A practical Guide for researchers and activists