CARE Rapid Gender Analysis for COVID-19

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CARE INTERNATIONAL IN ZIMBABWE
33 Harvey Brown Road, Milton Park, HARARE, ZIMBABWE

Authors

Augustine Masomera and Ellen Chigwanda

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The views in this RGA are those of the authors alone and do not necessarily represent those of the CARE or its programs, or the Zimbabwe Government /any other partners.

Cover page photo: The cover was taken in April 2020 at of the food distribution point for a lean season food assistance project implemented by CARE Zimbabwe in Zaka district of Masvingo province through funding from the World Food Program (WFP). Image photographer: CARE staff

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Abbreviations

CIZ	CARE International in Zimbabwe
COVID-19	Corona virus disease 2019
GBV	Gender Based Violence
PPE	Personal Protective Equipment
WASH	Water Sanitation and Hygiene
WFP	World Food Program
ZimStat	Zimbabwe National Statistical Agency
ZimVAC	Zimbabwe Vulnerability Assessment Committee

Executive Summary

Zimbabwe has not been spared by the spread of the novel coronavirus (COVID 19). The coronavirus was first detected in Wuhan, the capital city in the Hubei province of China in December 2019. The disease has since spread to every corner of the world causing serious health and socio-economic challenges. As of 31st May, Zimbabwe had recorded 174 confirmed cases and 4 deaths.

CARE carried out a Rapid Gender Analysis (RGA) to assess the immediate and anticipated adverse impacts of COVID-19 on men, women, boys and girls. The assessment was conducted in geographical areas where CARE is implementing its portfolio of development including food security and nutrition, WASH, education, resilience and humanitarian programs. A qualitative methodology was applied and primary data was collected through key informant interviews, and supplemented by a desk review. Primary data was collected remotely using phones and emails. The team could not go on the ground due to the introduction of a COVID -19 national lockdown that initiated on the 30th of March 2020, and also in compliance with WHO and organisational guidelines on the prevention of the spread of coronavirus.

Key findings

Food and Nutrition Security: 5.5 million people in the rural areas and a further 2.2million in urban areas are facing severe food insecurity that is likely to be exacerbated by the national lockdown

Markets and Livelihoods: women constitute the majority of those in informal sectors, both as small-holder farmers and as cross border traders. The travel restrictions and border closures are likely to impact FHH negatively

Water, Sanitation and Hygiene: chronic water shortages increasing women and girls time burden and increasing their risk of exposure as they queue for water;

Education: the prolonged closure of schools will negatively affect the girl child leading to increased dropout rates and reduced grade/level transitions.

Gender Based Violence & Protection: An increase in GBV has been recorded due to increased tensions at household level, food insecurity and loss of incomes

Sexual and Reproductive Health and Rights: access to maternal and reproductive health services e.g. contraceptives, vaccines for children, pregnancy check-ups, family planning and outreach programmes by nurses to some remote rural areas services have been disrupted by the COVID-19 compromising the health of pregnant women and children.

The measures taken by the Government to contain and reduce the spread of coronavirus, have had several negative impacts, especially on marginalised groups including women. The national lockdown has resulted in the disruption of livelihoods and lost time for economic engagement, especially for women and men in the informal economy. Less than a fifth of Zimbabwe's economically active are in formal employment channels. The temporary closure of borders has also affected cross border trader's, a majority of whom are women, as well as resulted in price hikes of basic commodities especially food items. Access to the full scope of health services has been disrupted, as community health facilities concentrate on emergence cases, with most of the cases being referred to provincial hospitals due to limited or no capacity to handle COVID-19 related cases. Reports of women giving birth at home have increased putting them at risk of maternal mortality. Schools and tertiary institutions were closed in line with Government's prevention and containment measures. The school closures have negative impacts on adolescent girls learning outcomes. An increase in GBV has also been reported, as men and women in abusive relationships are locked together with their perpetrators in a tense environment.

Key recommendations

Food Nutrition and security

- Humanitarian assistance provision for the most vulnerable communities, inclusive of female headed households, through cash transfers or combination or in-kind food commodities distributions only depending on availability.

Livelihoods disruptions

- Government and Council should create space for informal traders, (women) to continue to engage in livelihood in a safe and secure environment on community identified income generating activities to help vulnerable women and men re-engage in livelihoods options.

WASH

- Supporting water supply systems including water trucking in vulnerable urban settlements to minimise exposure of potential abuse for women, girls and children as they queue for the precious liquid and meet the increased demand for handwashing.

Education

- Support schools with PPE (masks), disinfectants, hygiene kits (soap, sanitary material, water buckets) and hygiene education for both teachers and students once schools are open.

GBV Protection

- Update GBV referrals pathway and facilitate women and adolescent girls access to GBV services.
- Establish urgent GBV protection services and facilitate access to these services

Health

- Provision of broad based psychosocial services to address the COVID-19 related mental health issues and to help families cope with this new found reality. Ensure that there is continued access to health services at primary health facilities for non-COVID related illness, maternal, neonatal and sexual reproductive health services and chronic illness.

Background information to COVID-19 crisis

The novel coronavirus (COVID-19) was first detected in Wuhan, the capital city of the Hubei province of China in December 2019. The virus has a high contagion rate via community spread, which means people have been infected with the virus through unprotected exposure with an infected person. COVID-19 was declared a Public Health Emergency of International Concern (PHEIC) by the World Health Organisation on the 30th of January 2020[1]. By 31st of May 2020 the disease had spread to 213 countries and territories with 5 934 936 confirmed cases and 367 166 reported deaths and figures rising on a daily base.[2] African countries and other less developed regions are still reporting low numbers; however cases are anticipated to rise exponentially. Initial research showed that older persons, and people with pre-existing health conditions are most likely to suffer serious complications from COVID-19.

The Government of Zimbabwe declared COVID-19 a national disaster on the 19th of March 2020. The first case was reported on the 21st of March 2020. As of the 31st May, Zimbabwe had 174 COVID-19 confirmed cases with 4 deaths[3]. Through the Statutory Instrument 83 of 2020, Public Health COVID-19, Prevention, Containment and Treatment, National Lockdown Order, the Government put in place a number of measures to slow the rates of local transmission, including a 21-day national lock down, which started on Monday 30th March[4]. The lock down was then extended for two weeks until the 3rd of May 2020. The country is now on indefinite lockdown at level 2, which will be reviewed after every two weeks. The potential impact of the spread of COVID-19 in Zimbabwe could be devastating. Zimbabwe has a mix of vulnerable populations for COVID-19, including HIV infection rate of 12.7%, or around one in eight people (UNAIDS, 2018[5]) ,and an estimated 5% of the population have diabetes (WHO). Women and adolescent girls have a higher prevalence of HIV, with 60.83% of the adults living with HIV being women. These conditions are indicated as risk factors and makes people susceptible to severe COVID attack.[6]. Only about 6% of the population is over 65, however, these elderly are primary caregivers for orphaned children and their prolonged illness or death would adversely impact young children who are dependent on them[7].

The Rapid Gender Analysis objectives

CARE carried out the rapid gender analysis in April 2020 in order to better understand the effects of COVID-19 on women, girls, men, boys and other special groups such as those with chronic conditions, people living with disabilities and the elderly. The information generated is intended to help CARE and its partners in developing and adapting programing to mitigate effects of COVID-19.

[1] Ministers of Health Media Statement, Dar es. Salaam, United Republic of Tanzania (9 March 2020) http://www.mohcc.gov.zw/index.php?option=com_phocadownload&view=category&id=14:press-statements&Itemid=740
[2] WHO Dashboard
[3] US Information
[4] Statutory Instrument 83 of 2020: Public Health Covid-19 Prevention, containment and Treatment, National Lockdown Order 2020
[5] https://www.unaids.org/en/regionscountries/countries/zimbabwe
[6] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html
[7] Inter Censal Demographic Survey 2017

Rapid Gender Analysis (RGA) for COVID-19 provides information about the different needs, risks, capacities and coping strategies of women, men, boys and girls in the COVID-19 crisis. Rapid Gender Analysis is 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. It provides practical programming and operational recommendations to meet the different needs of women, men, boys and girls and to ensure we 'do no harm'. Rapid Gender Analysis uses the tools and approaches of Gender Analysis Frameworks and adapts them to the tight time-frames, rapidly changing contexts, and insecure environments that often characterise humanitarian interventions.

The research has been undertaken from 02 to 30th April 2020, and data has been updated as the situation evolves. Primary data collection took place between the 7th and 9th of April. This RGA will be treated as a live document and will be updated when new findings and recommendations become available. Research methods included a secondary data review, remote key informant interviews and remote individual story telling. The data was collected from 5 of Zimbabwe's 10 provinces: Harare, Midlands, Masvingo, Mashonaland West and Manicaland. For expedience and to maximize program relevance, the RGA was conducted in CARE's operational areas, where working relationships with the stakeholders already exist and there was approved access to communities. A total of 13 geographical areas comprising nine rural districts and three urban areas were covered. Urban areas included Epworth suburb in Harare, Masvingo town in Masvingo province and Norton in Mashonaland West while rural areas were represented by Bikita, Chivi, Chiredzi, Mwenezi, Zaka (Masvingo province), Chipinge, Chimanimani, Mutare Rural (Manicaland), Mberengwa and Zvishavane (Midlands province) districts. Key informant interviews were conducted with representatives of district development coordinators offices, urban and rural council, district and ward level staff members from government ministries including health, agriculture, social services, women affairs and gender. Community volunteers working with CARE projects, such as the gender and accountability focal points and food distribution committee members, were also targeted as key informants. A total of 100 key informants and community representatives responded the questions and data was mainly collected using email, WhatsApp and phone (See Table 1).

Table 1: Respondents composition

Geographical location	Key informants /			Community Volunteers		
	# Females	# Males	Total	# Females	# Males	Total
Bikita	1	3	4	0	2	2
Chiredzi	1	5	6	0	1	1
Chivi	2	3	5	1	1	2
Mutare Rural	1	3	4	1	1	2
Chimanimani	1	2	3	0	0	0
Chipinge	2	1	3	0	0	0
Masvingo urban	4	2	6	3	1	4
Norton	3	2	5	2	3	5
Mwenezi	5	7	12	0	3	3
Epworth	2	1	3	0	0	0
Zaka	1	2	3	0	0	0
Mberengwa	1	6	7	2	0	2
Zvishavane	7	3	10	3	5	8

Total	31	40	71	12	17	29

Ethical considerations

When conducting this RGA for COVID-19 a number of practical, logistical and ethical considerations were identified. **A Do No Harm approach was taken and prioritised throughout the process**. This involved mitigating risks- both direct safety risks for staff and the community as well as ensuring essential human, financial and logistical capacity were not diverted away from the immediate needs and direct response to COVID-19. Considerations included:

- The analysis made use of both secondary and primary data with primary data collection being conducted remotely, with no in-person contact with informants
- Data protection, confidentiality and the safety of respondents were considered at all stages and personal details of the respondents were not used in the analysis.

Limitations

The research had several limitations: Primary data collection had to be conducted remotely; the questionnaires were self-administered; and given the format there was little or no follow up on the responses given. Community engagement was limited due to the restrictions in mobility and community gatherings. Input from the key informants and community representatives is based on observations on how communities were coping with the effects of the pandemic. There was also limited secondary data and sex and age disaggregated data on COVID-19 in Zimbabwe, which compromised the data quality, and the ability of authors to triangulate the data. The report is a living document that will be updated as the pandemic unfolds and new data becomes available.

Sex and age disaggregated data

Zimbabwe has a population of approximately 13,6 million: 48 % being male and 52 % female[8]. The country has a youthful population with 40 % being below 15 years and 6 % above 65 years. More than two thirds (68 %) of the population are found in the rural areas (communal and resettlement areas) whilst 32% are in the urban areas. Women constitute the majority of those in rural areas. The average household size is 4.2 persons. The Zimbabwe Vulnerability Assessment Committee Report (2019)[9] found that across all provinces there were more male headed households (64%)than female headed households, with Matabeleland South having the highest proportion (41.2%) of female headed households. More females than males are widowed or divorced/separated. The disability prevalence rate is 9% with the majority of people living with disabilities being female. Nationally, the proportion of chronically ill people is 3%.[10]Unhealthy habits such as drinking and smoking, predisposes men to other diseases. In Zimbabwe, the total per capita consumption of pure alcohol for adults aged 15 and above is 9 litres for men against 1 litre for women. In addition, 28% of men and 1% of women above the age of 15 are tobacco smokers (WHO, 2016)[11]More women are likely to wash their hands after using a public toilet and that more women are likely to use soap than men. Differences in health seeking behaviours between men and women (as health concerns are viewed as being more "feminine" and risk-taking behaviours as more "masculine").As of 31 May, Zimbabwe had 174 confirmed cases and 4 deaths. An increase in the number of cases is attributed to returnees from both South Africa and Botswana. As of 11 April when the Ministry of health last availed sex disaggregated data, men constituted the majority of those confirmed cases and of the four recorded deaths one of them was an 82-year-old woman from Mhondoro. The first three confirmed deaths were men who had travelled to more risk countries, with the fourth and latest case not having travelled outside. The limited number of COVID-19 reported cases could be linked to the country's limited capacity to conduct tests.

Findings and analysis

COVID-19 disease has had adverse effects on health, education, protection/safety and the economy, leading to compromised food and nutritional security. This section provides an insight into some of the primary and secondary impacts of COVID-19 on the different groups.

In Zimbabwe, the pandemic has come against the backdrop of a dire humanitarian crisis in the country; drought, floods, crop failures, macroeconomic challenges combined with austerity measures have taken their toll on vulnerable households in both the rural and urban areas of Zimbabwe[12]. Access to basic services such as water and sanitation, health and water are severely constrained. COVID-19 puts pressure on an already weak public health system, collapsing macro-economic environment, which intensifies the food insecurity situation across

[8] ZIM Statistics - Inter-Censal Data, 2017
[9] https://reliefweb.int/sites/reliefweb.int/files/resources/ZimVAC-2019-Rural-Livelihoods-Assessment-Report.PDF
[10] ZIMVAC Report 2019
[11] https://www.who.int/nmh/countries/zwe_en.pdf
[12] http://www.zw.one.un.org/sites/default/files/Zimbabwe_HumanitarianResponsePlan_2020.pdf

the country[13]. Approximately 5.5 million people and 2.2.million people in rural and urban areas respectively are food insecure.[14]

Gender Roles and Responsibilities

Around the world, women perform as much as three times more unpaid care work than men[15]. The situation in Zimbabwe is the same as there are socially ascribed roles for men, women, girls and boys. Women are primarily responsible for caregiving roles, including water collection and other household chores such as cooking, cleaning, fetching firewood or other alternative energy sources. Over and above their caregiving role, women are also responsible for caring for the sick and the elderly. COVID-19 is likely to increase women and girls' unpaid care roles significantly as clinics and hospitals mainly allow only emergency cases. Women will also be expected to care for their children as well as meet their home schooling needs as most schools have closed due to the pandemic. Women reported being overwhelmed and working long hours taking care of the needs of the family members who were all bound to the home throughout the day. However, there were also reports of men assisting with some household chores, due to limited mobility as well as closure of beer holes.[16]

Informal Employment

COVID-19 is anticipated to disrupt both rural and urban livelihoods and incur huge suffering on vulnerable households, especially if the national lockdown is further extended. More than ninety percent (94 %) of currently employed persons, 15 years and above, are employed in the informal sector[17]. In addition, women make up the vast majority (65 %) of informal sector workers such as vendors and cross boarder traders[18]. Zimbabwe is now under an indefinite lockdown on Level 2 following the 35-day lockdown under level 4 from the 30th of March 2020 to 3 May, and then lockdown under level 3 from 3 May to 17 May.The informal sector is the worst affected by the restrictions[19], which affects most of the employed population of Zimbabwe . Most informal businesses (including public transport (kombis) and large informal markets including second-hand clothing and other wares and vegetables and agricultural produce) were closed down as part of measures to prevent the spread of the virus. Only a few sectors that were categorised as essential (such as electricity distribution, water supply, sewage, communication technology, health and pharmacies) were exempt from the lock down.

Those employed in the informal sector, who are mostly women, often depend on daily payments in order to provide for their families. The lockdown instituted by government has exacerbated the situation of most vulnerable families. Additionally, not all informal sector workers have the capacity to stock up on food and other essentials to sustain them through the lockdown period. This forces informal sector workers to make a difficult decision between staying at home in order to avoid increased risk of viral infection or to venture out of their homes to meet the daily needs of their families.

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[13] http://www.fao.org/3/ca8464en/CA8464EN.pdf
[14] ibid
[15] CARE Global Rapid Gender Analysis
[16] Primary Data
[17] http://www.zimstat.co.zw/sites/default/files/img/publications/Employment/Labour_Force_Report_2014.pdf
[18] Vendors Initiative for Social and Economic Transformation http://kubatana.net/2019/03/08/statement-on-international-womens-day-8-march-2019/
[19] https://www.newzimbabwe.com/informal-sector-to-be-most-affected-by-lockdown/

The government authorised the re-opening of farm produce markets including Mbare Musika, the largest farm produce market in Zimbabwe[20] following an outcry. However, access to market remains an issue to small-holder farmers due to public transport requirements, and the required letter of authorisation. The closure of borders has affected mainly women, mostly female headed household. According to the KII, women travel to countries such as South Africa, Mozambique, Dubai and China where they buy commodities for resale. The border to South Africa was closed on the 26th of March.[21] Thus the lockdown measures hopefully contribute to flattening the curve of the coronavirus infection but unfortunately compromise the ability of women in the informal sector to earn an income during this COVID-19 crisis.

For those employed in the formal sector, the pandemic poses a different set of challenges. In some cases, organisations have asked their staff to "work from home" if their position and responsibilities allows for this – a privilege which is not possible for those in the informal sector. In both cases, COVID-19 poses great risks to both part time and permanent workers as employers will find it difficult to guarantee contracts into an uncertain future, which will affect both women and men's ability to earn an income. At the household level, this uncertainty can contribute to increased anxiety and mental health issues especially for those considered "bread winners". For women, working from home can be increasingly challenging in an environment where there are still expectations to fulfil socially ascribed roles such as household chores and caring for children, the sick and the elderly. According to the men and women who responded to the questionnaire, the pandemic is also eroding savings whilst all other income generating activities are at halt.

Decision Making, Participation and Leadership

Women and men in Zimbabwe do not participate equally in both economic and political decision making. In the health sector, although women constitute the majority of the frontline personnel, they are absent from relevant COVID-19 decision-making structures. Provincial and district level COVID-19 response task forces are constituted by representatives of various government departments and local authorities. Below is a snapshot of women's inclusion in the various structures set up at district and provincial level to respond to COVID-19.

Table 3: Composition of COVID-19 response taskforces

Location	# Females	# males	% Female
Masvingo provincial level	3	14	18
Chiredzi	2	15	12
Gutu	4	14	22
Bikita	1	9	10
Zaka	2	10	17
Mwenezi	4	15	21

[20] https://knowyourcity.info/wp-content/uploads/2015/04/Harare_Slum_Upgrading_Profiles.pdf
[21] The Global Press Journal; 5 May 2020

Masvingo district	2	11	15
Chivi	3	11	21
Mberengwa	0	12	0
Zvishavane	3	13	19

CARE's approach to gender equality is hinged on increasing women's agency and equitable decision making in the home. The invasion of COVID 19 negatively impacted on women's decision making over household resources since they have few resources at their disposal, leaving men with more decision making powers. For instance, because of reduced income, decisions on purchase of basic food items are being made without necessarily looking at the nutritional needs for women and children.

Access to Services

Health including Sexual Reproductive Health

Zimbabwe's health sector has been facing a number of chronic challenges. Women constitute the majority of those in primary health care, they dominate as nurses, midwives, and also as community health workers (village health workers). In the absence of PPE, women are at high risk of exposure to infection and the situation is dire in Zimbabwe, where salaries have been affected by high levels of inflation. Zimbabwe's health budget is chronically underfunded, and stocks of essential medicines, diagnostics and supplies have been depleted.[22] In addition, medical staff have been demanding a review of their remuneration packages in line with changes in the economy, which has lead to frequent strikes throughout 2019[23]. More recently, nurses and doctors refused to work in protest against the shortages in Personal Protective Equipment (PPE), as well as insurance in case of infection and death an essential requirement as they manage suspected and/or confirmed COVID-19 cases.

Sexual and Reproductive Health and Rights are an important consideration, especially during a crisis of this magnitude. The unmet need for contraceptives in Zimbabwe is currently 10.4 %[24] and as travel/movement restrictions increase during the lockdown it will likely become more difficult to access contraceptives. Pharmacies and medical facilities have remained open during the lockdown in order ensure access to medicines and other essential needs. However, according to some key informants, rural health facilities are only attending to emergence cases and most of those cases are being referred to provincial hospitals. If women are unable to access the contraceptives they require, this may contribute to unwanted pregnancies, which further burden vulnerable households who are already struggling.

Mental health and psychosocial support

Mental health in Zimbabwe is not treated in primary health facilities. Stakeholders from both rural and urban areas expressed indications of rising cases of stress especially among women due to the disruption in livelihoods, increased burden of care, and disrupted social networks. It

[22] ROSEA, Zimbabwe Flash Appeal
[23] https://dailynews.co.zw/articles-2019-01-04-labour-unrest-as-teachers-nurses-senior-doctors-join-strike/
[24] https://tradingeconomics.com/zimbabwe/nurses-and-midwives-per-1-000-people-wb-data.html

was noted that socialisation at gatherings such as churches, women clubs including savings clubs, clinics and interactions at water collection points provided an environment for relieving stress for women and girls. However, these networks have been adversely affected by the imposed national lockdown that discourages gatherings of more than two people, with only a few exceptions.

Men interviewed also expressed frustration over their limited mobility and inability to provide for their families. There is a need to include mental and psychosocial support outlets as part of COVID-19 response measures for both men and women to mitigate potentially harmful repercussions.

Access to Health Services

It was noted that the national lockdown, disruption to public transport was adversely affecting access to health services especially for pregnant women, the elderly and those with chronic illness. Expecting mothers waiting areas/shelters, a common feature in some of the rural and provincial hospitals, have been closed down as part of the preventive and containment measures.

For both rural and urban areas, access to maternal and reproductive health services (e.g. vaccines for children, pregnancy check-ups, family planning and outreach programmes by nurses to remote rural areas) have been disrupted by the COVID-19 pandemic. Some health facilities have reduced operating times of health services provision. In rural areas, weight and height measurement, age immunization and vitamin A supplement commonly done to children under five at health centres is now being provided by Village Health Workers who have no access to PPEs, thereby exposing this group, which is mainly made up of women, to risk of exposure to COVID-19. There have been reports of health personnel during the first few days, walking out, or failing to attend to suspected cases of COVID-19 for fear on infection. In Zimbabwe, just like most countries, women constitute the majority of those in community health and primary care work.

There are also fears of increased home deliveries due to movement restrictions from the lockdown, expecting mothers not visiting health institutions fearing COVID-19 infections and over stretched financial resources because of lost income opportunities. This puts the lives of mothers and infants at great risk, especially those who live far from referral district and provincial health centres. Zimbabwe has a maternal mortality rate of 443 per 100 000 per live births.[25] It has also been reported that in some areas health staff was not attending to anyone with flu like symptoms fearing that they could be carriers for COVID-19. In some parts of the country such as Matebeleland there are reports of women delivering at home due to lack of transport to the provincial health centres where they are being referred to by the rural clinics[26]. Women also report not being able to prepare adequately for delivery as nearby shops are closed and thus making purchasing of baby clothes and other preparatory materials that much more challenging.

Access to Markets

According to primary data collected, the price of basic commodities has significantly increased (in some cases by more than 50 %) following the imposition of the 35-day national lockdown. This has forced the government to put a price freeze on basic commodities, though this is not

[25] SADC Gender Protocol, 2016, Barometer
[26] https://www.thestandard.co.zw/2020/04/26/coronavirus-lockdown-puts-pregnant-zim-women-risk/

effected in most of the shops and supermarkets. There are also reports of shortages of basic food commodities (like maize meal and cooking oil) with some basic commodities disappearing from shelves especially during the first days of the lockdown amidst fears that availability of commodities could be affected by the closure of the Zimbabwe-South Africa border. The bulk of goods for some districts, especially Mwenezi, are imported from neighbouring country which would in turn further fuel price increases. Increases in prices are likely to affect vulnerable households, especially women who have the primary responsibility for food provision and preparation at the household level.

Longer queues for food commodities especially maize meal and cooking oil are also being observed in Masvingo town and Epworth of Harare. Access to this scarce commodity is limited especially for the elderly, those living with disability and women as they do not have the stamina to jostle for basic commodities putting women at risk of sexual exploitation and abuse. The national lockdown related food supply chain disruptions coupled with the limited livelihoods options are causing untold suffering especially for poverty stricken peri-urban Epworth households who are used to buying essential items enough for the day depending on a daily earnings from piece jobs and informal trading. The high prices, limited availability and compromised purchasing power has been reported to be resulting in deterioration of balanced diet putting pressure on women as household food providers.

People regardless of age and sex in both rural and urban areas have not been observing social distancing when queuing and jostling for subsidised mealie meal, thereby exposing them to risk of infection. There were no handwashing facilities at most of the informal markets while big supermarkets had sanitizers for use by customers.

Smallholder horticulture farmers who are predominantly women have been experiencing huge marketing related losses due to limited mobility. It has been observed that smallholder women farmers in areas like Masvingo and Manicaland have been experiencing post-harvest loses and low prices for income generating activities (gardening and livestock production) because of restricted movement to access markets. The national lockdown that was instituted, also included restrictions on passenger vehicles. Loses related to limited transport were also reported in Zvishavane with fresh tomatoes and leaf vegetables rotting. This to a larger extent is having a negative impact on the livelihoods, income and resilience capacities of women to cope with stresses and shocks.

Pensioners are not able to access their monthly pensions from their banks because of the lockdown resulting in their money losing value. Failure to access the money has also resulted in this elderly group failing to access their medication and failing to buy other basic requirements.

Food and Nutrition Security

ZIMVAC estimates that 5.5 million people in the rural areas and a further 2.2million in urban areas are facing severe food insecurity following consecutive years of drought and a deteriorating economy. Women constitute the majority of those living in rural areas and female headed households have higher instance of food insecurity compared to men. This situation is likely to be further worsened under the national lockdown and price increases, that has seen a reduction in the purchasing power of the cash voucher assistance or safety nets provided by Government and responding agencies. Key informants reported increased levels of food insecurity especially among the very poor with households adjusting number of meals per day from three to as low as one meal. Given the limited access to vitamin supplements coupled with the increase of unbalanced diets, malnutrition with those under-5, pregnant and lactating

women and people with chronic illness such as HIV are likely to face the greatest hardship. The Country has a high HIV prevalence of 13%, with women constituting 58% of people living with HIV. This puts them at higher risk of being infected by COVID-19, as well as suffering from long term effects linked to malnutrition.

The lockdown has had gross impacts and has disrupted community activities that usually contribute to enhanced food security and nutrition at both household and community levels. It affected group activities like Village Savings and Lending associations and producer and marketing groups which marginalised communities especially women usually depend on for livelihoods and food. The role of women and men to put food on the table and to ensure household food security respectively was interrupted, rendering both parties to more vulnerabilities and increased tension that in some instances erupted to GBV.

Water Sanitation and Hygiene (WASH)

Access to WASH services in both urban and rural areas is low. The WASH sector faces a number of challenges including lack of (or inadequate) fiscal investment in the sector and collapse of service delivery due to the decade long economic crisis.[27] Only 49.4% of water points across the country (mainly hand pumps) are fully functional, according to the 2018 Rural Wash Information Management Systems (RWIMS). Urban areas continue to suffer from ageing and antiquated water pumps and receive an average of 12 hours of water supply per day.[28] Some residential areas in Harare, do not have access to running water. The Bulawayo City Council has been facing 25-year long chronic water shortages for reasons such as ongoing rehabilitation works[29]. City of Harare also faces similar water challenges. Access to water and sanitation is also lagging behind in rural areas. The shortage of water has previously exposed Zimbabwe's capital city, Harare, as well as other parts of the country to other public health disasters such as the 2008 – 2009 and 2018 cholera epidemic.

The limited access to water, is likely to create challenges for the successful prevention containment and management of COVID 19. One of the key messages with regards the prevention of the spread of the coronavirus is washing hands with soap and clean water for at least 20 seconds. For many households which were already facing water supply and sanitation challenges, this will pose a great challenge. Many poor and vulnerable households and communities have no running water, share boreholes and poverty limits what people can afford to buy[30]. Very long queues have been observed at communal boreholes in towns resulting in water collectors who are mainly women being exposed to COVID-19. The pressure at these communal water points could also be exposing women and girls to potential abuse by touts who have positioned themselves at some of the water points for financial gains. Women and girls are likely to experience greater time poverty and possibly increased exposure to infection as they spend more time fetching water in response to increased demand for water at household level.

Girls and women of reproductive age were also having challenges accessing sanitary material as shops had closed, shortages and skyrocketing of prices.

[27] https://www.unicef.org/zimbabwe/water-sanitation-and-hygiene-wash
[28] ROSEA, Zimbabwe Flash Appeal 2019
[29] https://www.thestandard.co.zw/2020/04/05/tackling-coronavirus-zim/
[30] https://africanarguments.org/2020/03/27/surviving-covid-19-fragility-resilience-and-inequality-in-zimbabwe/

COVID-19 has also resulted in disruptions in the education sector. As part of the measures to curb the spread of the virus, the Ministry of Primary and Secondary Education closed schools on the 24th of March 2020 – just over a week before the scheduled end of the term. On the 30th of March, the Government through the National Lockdown, endorsed the position, putting primary, secondary education, tertiary technical and vocational institution on lockdown. The prolonged closure of schools will result in the loss of learning time, increased dropout rates due to long periods without classes and reduced grade/level transitions. School closures have the biggest impact on girls' lives with girls less likely to go back to school, as they face increased risk of child marriage, teen age pregnancy, GBV and sexual exploitation.[31]

The gendered impact of the virus on children, especially girls, will include the following[32]:

- increased household responsibilities/chores which will limit their ability to take advantage of any opportunities for home-based learning (such as online classes or work provided by teachers virtually of before schools closed);
- increased burden of care combined with increased risk of exposure as they support their mothers in looking after sick family members and/or relatives;

Although the proportion of children not in school is somewhat skewed against boys – 55 males; 45 females (ZIMVAC, 2019), the number of drop outs of vulnerable children including those living with disabilities, orphans and girls will likely increase.[33] The COVID-19 induced national lockdown has seriously disputed the learning patterns for boys, girls, and students at all the different levels in Zimbabwe. Socialisation patterns and play time have been cut and this is having psychological impact, especially on girls. Girls are losing a lot of information they used to get from peers. There has been a reduction in time allocated for studies as girls spend much of their time doing household chores – under normal circumstances, girls could go to school even during holidays or weekends for their studies. Socialization among peers is a prime source of information gathering for women and girls, and these interactions have been affected due to the school closures and restrictions in movement.

In rural areas including Chipinge, Chimanimani, Mutare, Mberengwa and Zaka, most of the girls have fewer educational opportunities beyond schools. Feedback from key informants including community and church leaders revealed that some girls were engaging in sexual activities as a way of entertainment exposing them to risks of sexually transmitted diseases and unwanted pregnancies.

Just like their girl counterparts, boys' access to education during school holidays has been disrupted with no peer to peer learning taking place. It has been noted that inactivity was contributing to high cases of drug and substance abuse among boys especially in urban areas like Masvingo and Epworth and growth points.

The adverse effects of the COVID-19 lockdown on education was also being felt by the young men and women in tertiary colleges and universities. Online studies were being hampered by prohibitive costs of data bundles, poor to none connectivity and limited access to the electronic gadgets with those in rural areas being the worst affected.

[31] ROSEA, Zimbabwe Flash Appeal 2019
[32] Integrating COVID19 into Education Programming (CARE USA, March 2020)
[33] Zim VAc 2019 report

Situations of crisis also increases the risk to gender based violence, especially for women and girls. Disruption of livelihoods and worsened food insecurity are fertile breeding grounds for domestic violence and GBV. In Zimbabwe 1 in 3 women aged between 15-49 experience physical violence, whilst 1 in 5 women experience sexual violence. There is a serious under reporting of cases due to the acceptance and normalisation of violence. According to the Southern Africa Gender Attitude Survey 2016 37% men and 25% women believe that a husband is justified in beating his wife if she does something wrong[34]. Intimate Partner Violence (IPV) is the most predominant form of GBV experienced by women, with 69% of women having experienced IPV in their lifetime in Zimbabwe[35] The measures implemented by the government to curb the spread of the coronavirus will find women and girls (and men) locked together with their abusers. Musasa Project, a local non governmental organisation, 13 days into the lockdown had recorded 782 cases, which is 282 cases higher than the average number recorded per month.[36]

Accesses to GBV Services has become even more challenging in COVID-19 conditions. The Gender and Protection clusters, under the leadership of UNFPA and Ministry of Women's Affairs, have been advocating for GBV service providers to be categorised as essential lifesaving services; however, not all GBV services have been given permission to continue operations under lockdown. For those who have continued to operate, they have done so under reduced capacity. Whilst, safe shelters, have continued to provide services, no new cases are being accepted, as part of the measures to reduce the spread of coronavirus.

Access to GBV services have also been affected due to the lack of availability of public transport. Zimbabwe introduced total lockdown, that resulted in the withdrawal of public transport from key routes and leaving only the Government run ZUPCO. This puts women at risk of racing significant dangers in the home with insufficient outlets for medical care and support.

[34] SADC Gender Protocol 2016 Barometer
[35] Ibid.
[36] The Newsday, 14 April 2020

According to UNICEF, as countries take drastic measures to contain the spread of COVID-19, children will face increasing threats to their safety and wellbeing – such as mistreatment, gender based violence, exploitation, social exclusion and separation from caregivers[37]. The potential loss of parents or caregivers can also increase the risk of abuse of children as protection mechanisms are compromised by the spread of the virus. Increased rates of abuse and exploitation of children have occurred during previous public health emergencies – for example, school closures during the outbreak of Ebola virus in West Africa from 2014 to 2016 contributed to increases in child labor, neglect, sexual abuse and teenage pregnancies and in Sierra Leone, cases of teenage pregnancy more than doubled to 14,000 from before the outbreak.[38] According to ZIMVAC, 2019, 8% of girls in Zimbabwe were out of school due to pregnancy. According to the demographics, Zimbabwe also has a large population of widows, orphans and vulnerable children, pensioners and retrenches. Although the government has introduced safety nets for the most vulnerable – such as cash transfers – more will need to be done in terms of setting up social security systems which support these groups within the populace[39].

Needs and vulnerabilities

Households in Masvingo, Norton and Epworth live in crowded houses with sharing of a house by at least 2 households being common. It was noted that this was making social distancing in these areas challenging. Cultural practices, rendering assistance to the elderly and those living with disabilities was also resulting in some people failing to maintain social distancing.

Concluding remarks and recommendations

Disease outbreaks affect girls and boys, women and men differently. While children's health appears less impacted by COVID-19 than the elderly, children's education will be interrupted, protective structures disrupted and their families and communities placed under stress by health and economic burdens. Children are also at risk of psychological distress at times of crisis as well as increased risk of violence, abuse exploitation and neglect. Quarantine measures imposed as a response to the COVID-19 pandemic are putting girls and women at heightened risk of violence in the home and cutting them off from essential protection services and social networks. Economic stress on families due to the outbreak can put children, and in particular girls, at greater risk of exploitation, child labour and gender-based violence. Disease outbreaks affect women and men differently, and pandemics make existing inequalities for women and girls and discrimination of other marginalized groups such as persons with disabilities and those in extreme poverty, worse. Generally, the persistent economic meltdown in face of the COVID 19 is decimating the livelihoods and savings of most households in these domains as there are no longer partake in their livelihood activities

[37] https://www.unicef.org/zimbabwe/stories/covid-19-children-heightened-risk-abuse

[38] ibid

[39] https://www.thestandard.co.zw/2020/04/05/tackling-coronavirus-zim/

Overarching recommendation

This Rapid Gender Analysis report should be updated and revised as the crisis unfolds and relief efforts continue. Up-to-date gender analysis of the shifting gender dynamics within affected communities allows for more effective and appropriate programming and will ensure both humanitarian assistance and the preparedness, prevention and response to COVID-19, is tailored to the specific and different needs of women, men, boys and girls. It is recommended that organisations continue to invest in gender analysis, that new reports are shared widely and that programming will be adapted to the changing needs.

- invest in the national COVID-19 response and work with stakeholders to provide sex and age disaggregated data and come up with a response that takes into consideration the differential needs for men and women
- Response actors meaningfully involve women in all decision-making processes at all levels, as prevention and mitigation programs are rolled out

Targeted recommendations

Food and nutrition insecurity

1. Humanitarian assistance provision for the most vulnerable communities through cash transfers or combination with in-kind food commodities distributions with option to switching to 100% in-kind transfers when maize meal and other basic food commodities become unavailable on local markets. The food basket to cater for the nutritional requirements of under 5s, pregnant, lactating mothers, the sick and elderly
2. Monitor and ensure the availability of affordable basic commodities and those linked to the women reproductive needs e.g. contraceptives and sanitary ware;

Livelihoods disruptions

1. Multi-purpose Gender-responsive social protection programs such as cash transfers, targeted vouchers and trainings on community identified income generating activities to help vulnerable women and men re-engage in livelihoods options.
2. Building women's and girls' economic resilience to copy with the crisis and future shocks e.g. VSL related activities

WASH

1. Government and response agencies to provide sustainable and equitable water solutions which take into account the heightened demand for water given increased handwashing, meal preparation, general and menstrual hygiene;
2. Provision of hygiene kits (soap, sanitisers, sanitary material, water buckets) factoring specific needs of women and girls and hygiene education.
3. Supporting water supply systems including water trucking in vulnerable urban settlements to minimise exposure of potential abuse for women, girls and children as they queue for the precious liquid.
4. Stakeholders also wanted to see increased supply of sanitary material at affordable prices in most of the shops including those located in rural areas and growth points.

Education

1. Support schools with PPE (masks), disinfectants, hygiene kits (soap, sanitary material, water buckets) and hygiene education for both teachers and learners for use once schools are open.
2. Facilitate cross sectoral coordination to mitigate the possible negative coping mechanism arising out of school closures e.g. child/early/forced marriage; child labour and crime
3. Provide alternative methods for education delivery which ensure that the most marginalised girls and boys are not further left behind
4. Review teachers' working conditions and welfare to ensure that they adequately supported to deliver any alternative education programs
5. Support parental and champions' involvement in education of their children for both in school and home based learnings to include community learning circles
6. Facilitate social support structures, safe spaces and networks - peers and mentors - for adolescent girls and in-person and digital platforms for meaningful participation of girls and women in decision-making processes and sharing of key communications, including GBV hotlines and other services and support mechanisms.

Improved access to information

1. Continue real time COVID-19 messaging including enabling communities and families to understand how the pandemic affects different groups, without causing fear or fuelling discriminatory practices
2. Strengthen messaging and investment in protection, child protection and protection of vulnerable groups
3. Update GBV referral pathways and ensure that women and adolescent girls are able to access timely service
4. Design and deliver relevant age- and context specific education models which benefit all leaners including the most marginalised girls and boys

Health & Psychosocial Supports

1. Provision of Psychological First Aid Counselling and psychosocial support to address the COVID-19 related mental health issues and to help families cope with everyday hardships and stress from disrupted income avenues, depleted food stocks and the uncertainty of when the COVID-19 epidemic will be contained.

2. Provision of PPE for frontline workers, nurses and village health workers who daily interact and provide support services to the affected.