



**AN ASSESSMENT AND MONITORING THE IMPACTS OF CYCLONE FREDDY ON
PREGNANT AND LACTATING MOTHERS, ADOLESCENT GIRLS AND YOUTH AND
ADOLESCENT BOYS AND YOUTH IN THE SOUTHERN REGION OF MALAWI: A
HUMAN RIGHTS PERSPECTIVE**



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Executive summary

In October 2023, the Malawi Human Rights Commission under strategic outcome 2 of “Improved rights-based culture at all levels of the society” and strategic outcome 3 of “Enhanced availability and accessibility of up-to-date and relevant human rights information and knowledge”, conducted an assessment and monitoring the impacts of Cyclone Freddy on pregnant and lactating mothers, adolescent girls and youth and adolescent boys and youth in the southern region of Malawi with a human rights perspective. The main objective was to assess the impact of cyclone Freddy on SRHR services of pregnant and lactating mothers, adolescent girls and youths, adolescent boys and youths. The monitoring was conducted in 6 districts that were mostly affected by the Cyclone Freddy namely: Thyolo, Mulanje, Phalombe, Blantyre, Chikwawa and Nsanje and Zomba. Each team visited 5 T/As or areas by the end of the activity. The Commission employed a multi-prolonged approach which includes observations, focus group discussions, informant interviews and individual interviews. During key informant interviews, the Commission interviewed a number of stakeholders including district health officials, youth Friendly Services Coordinators, gender officers, child protection officers, disaster and risk management officers, VSU officers and, social welfare Traditional Leaders which were key in the provision of SRHR services before, during and after the Cyclone Freddy.

The findings showed that before Cyclone Freddy (CF) pregnant and lactating mothers as well as adolescent boys and girls were able to access Sexual and Reproductive Health (SRH) information through information easily through the government and mission health centres and other non governmental organisation’s interventions such as outreach clinics. During the CF few people accessed the information as most of the focus was response and recovery interventions. After the CF, people have now started accessing the information, however, there are still some gaps as some communities haven’t recovered fully. The communities before and after CF are also able to access the SRHR services despite some challenges in some communities due to unavailability of some services such as family planning, antenatal, Fistula and bad attitude of some service providers towards the patients/clients. Some cultural traditions such as “*Mwini Mbumba*” matrilineal systems have also seen a number of families without control in terms of the number of children as the decision is left in the hands of the matrilineal uncle or brother.

There are still some myths and taboos surrounding the SRHR that the communities still hold especially, the older generation. It was also note that despite the youth being progressive and having youth friendly services in their communities, 90% of the population are shy or fear their parents to access SRHR services. Menstrual hygiene also posed as a challenge especially during the floods, as most women and girls lost their property to floods including dignity kits as opposed to before and after. As a result, they were forced to improvise thereby facing also a number of challenges on the same.

The Commission also noted the issues of controlling women’s sexuality and cultural values are fueling gender-based-violence (GBV) in the communities visited, as women and girls do not fully have their bodily autonomy; women still endure in the name of submission and saving their marriages. Secondly, the vulnerability that CF rendered also heightened GBV cases in the camps on intimate partner violence and sex in exchange of relief including nutritional supplements during the floods despite having most cases go unreported for fear public reprisal and saving the

marriages. It was also noted that challenges to access WASH facilities especially for girls and women is posing GBV risks and finally, lack of proper housing poses rape and sexual abuse risks to women, girls and young boys.

The Commission, following the findings of the exercise, recommends that:

- i. Ministry of Health and development partners should provide chlorine in communities having limited access to safe water sources such as Likwezembe and Masambanjati.
- ii. Government and other development partners should provide enough food and nutritional supplements for children, pregnant and lactating women, the elderly and those on ART and suffering from TB.
- iii. Stakeholders and well-wishers to provide pants and dignity kits to women and girls in the areas.
- iv. Government, stakeholders and well-wishers to train women and girls in the areas on how to make long lasting menstrual pads.
- v. Government and other stakeholder to provide SRHR related resources at the hospitals.
- vi. Ministry of Health to implement its service charter and other policies and engage health workers on improved attitudes towards patients.
- vii. Government and other well-wishers to help in maintenance of the places where they used to live before the cyclone so that they can go back to their old lives especially the elderly and orphaned adolescents.
- viii. Ministries of Gender, Finance and other financial institutions to support with loans for women and the youth to start businesses so that can manage to access some services.
- ix. Government should provide enough resources and drugs to enable health workers provide SRHR services to people.
- x. Ministry of Gender and other stakeholders should enhance awareness raising and enforce the laws on prohibition of child marriages.
- xi. Ministry of Health and the Office of the District Commissioner in Thyolo should open Malosa Clinic situated in T.A Changata's area which was constructed 25 years ago. The Government and development partners should ensure frequent visits of health officers to the affected communities in order to provide family planning methods in time.
- xii. Ministry of Local Government and the offices of the DC should increase access to water by providing enough boreholes in communities to avoid issues of cholera outbreak and other sanitary problems which come along with no access to clean water.
- xiii. Ministry of Health and development partners should increase awareness on family planning methods, how they are used, how they should be acquired and who to consult to dispel myths and taboos related to SRHR.
- xiv. The Offices of the DC to work hand in hand with chiefs in ensuring that relief items meant for the survivors are not diverted and reach the intended beneficiaries which has been a challenge in almost all camps in Thyolo.
- xv. The Government and development partners should construct health centers close to the communities and adequately resource them.
- xvi. DODMA should be fully prepared in terms of disaster emergencies, coordinate with other clusters in in order to handle emergencies properly.

- xvii. Ministry of agriculture to put in initiatives to have food readily available and have to provide food when disasters happen to pregnant women and lactating mothers.
- xviii. Ministry of labor should continue fostering vocational training for boys and girls who have skills to be promoted.
- xix. The Commission should build the capacity of chiefs about human rights especially for women and children.
- xx. The Government, development partners and the Commission should engage traditional leaders and enhance awareness on child marriages, trafficking and GBV.
- xxi. The Malawi Police Service should investigate all cases of GBV including child marriages, rape and defilement.
- xxii. Stakeholders and development partners should assist government with financial and technical support to implement these and other related recommendations.

List of acronyms

ART	Antiretroviral Treatment
BLM	Banja La Mtsogolo
CAMFED	Campaign for Female Education
CBCC	Community Based Childcare Centre
CBO	Community Based Organization
CDSS	Community Day Secondary School
CCPW	Community Child Protection Worker
CF	Cyclone Freddy
CSO	Civil Society Organization
CVSU	Community Victim Support Unit
GEA	Gender Equality Act
FGD	Focus Group Discussion
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
HRCA	Human Rights Commission Act
HRC	Human Rights Commission
HSA	Health Surveillance Assistant
IUD	Intrauterine Device
KII	Key Informant Interview
NGO	Non-Governmental Organization
PSI/FHS	Population Services International/Family Health Services
PTA	Parent-Teacher Association
SRHR	Sexual and Reproductive Health and Rights
SWO	Social Worker Officer
PSI	Population Service International
T/A	Traditional Authority
TB	Tuberculosis
YFS	Youth Friendly Services

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Chapter 1: Introduction

1.1 General overview of the people affected by Cyclone Freddy

Climate change is a cross-cutting issue and the greatest challenge in achieving sustainable development and has become a global challenge since communities all over the world have experienced its impact in their daily lives.¹ The changing climate has a number of effects that can be described as extreme such as heavy raining that results in flooding among others. This creates a lot of socio-economic challenges for the society, such as loss of life and property.

Apart from the Covid-19 pandemic that the country is slowly recovering from, Malawi has also been hit by a Cholera outbreak that has claimed over 1,700 lives including men, women and children and has affected over 56,000 people. Tropical Cyclone Freddy has added to the turmoil hitting the southern region of the country causing flooding and mud slides. The same southern region was also hit by Cyclone Ana in 2022 where 203,874 people including women, youth and children were affected.

Cyclone Freddy has caused not only death, destruction and displacement but also socio-economic damage posing more vulnerability to men, women, adolescent boys and youth, adolescent girls and youth and children where the country has also been declared as a state of emergency.² The Cyclone Freddy saw at least 1.3 million³ people in need of urgent humanitarian support.⁴ There were 15 districts in Southern region that were affected. As of 27th March 2023, approximately 2,267,458 people (1,110,639 males, 1,156,819 females and 234,729 people living with disability) were affected. This is 11% of Malawi population estimated at 20,428,275. The number of displaced people was at 659,278 with 747 camps commissioned to accommodate the displaced. It was estimated that 65% of the displaced people are women. The death toll was at 679 and the number of injured people was at 2178 with 537 people reported missing 537.⁵

1.2 Marginalized people in crisis

Apart from the sectors affected such as education and agriculture, health sector was also greatly damaged with at least 65 health centers affected, where 10 health centers were not functioning and 41 partially functional despite being affected, and 14 completely not accessible due to damaged roads or bridges.⁶ This created a lot of challenges to many people seeking health services including people at risk and the marginalized such as pregnant and lactating mothers, women and youth with disabilities, adolescent boys and girls and the youth as well as people with chronicle sicknesses including the ones living with HIV and AIDS and other STIs.

1 (United Nations Framework Convention on Climate Change [UNFCCC], 1992).

2 <https://www.youtube.com/watch?v=0IZeq7fdcBo>

3 <https://reliefweb.int/report/malawi/malawi-cholera-floods-flash-appeal-2023-revised-march-following-cyclone-freddy-february-june-2023>, accessed on 12-10-23

4 <https://www.ohchr.org/en/statements-and-speeches/2023/04/un-experts-express-solidarity-people-malawi-wake-cyclone-freddy>

5 [https://africa.unwomen.org/en/stories/news/2023/04/cyclone-freddy-timely-relief-brings-smiles-to-hospital-patients-in-malawi#:~:text=Early%20March%202023%2C%20Malawi%20was,with%20disability\)%20have%20been%20affected.](https://africa.unwomen.org/en/stories/news/2023/04/cyclone-freddy-timely-relief-brings-smiles-to-hospital-patients-in-malawi#:~:text=Early%20March%202023%2C%20Malawi%20was,with%20disability)%20have%20been%20affected.)

6 Malawi Cholera & Floods Flash Appeal 2023 (Revised in March following Cyclone Freddy) (February - June 2023). <https://reliefweb.int/report/malawi/malawi-cholera-floods-flash-appeal-2023-revised-march-following-cyclone-freddy-february-june-2023>

Cyclone Fredy left great wounds among the vulnerable and the marginalized. For example, the most affected population was the rural masses where levels of poverty are also high, receiving a triple burden from Fredy. An analysis by region in the “2021 Malawi’s multidimensional poverty index report” shows that the occurrence of multidimensional poverty is highest in the Southern region at 63% and highest in rural areas at 70.0% compared to 25.7% in urban areas⁷. Malawi’s rural population for 2022 was **16,736,441**, which was a **2.24% increase** from 2021.⁸ It is estimated that there are about 51.7% population for women against 48.3% population for men in the rural areas⁹. In addition, about 2 in every 3 people in Malawi are below the age of 25¹⁰. With this, Malawi has youthful population with more than half the population under the age of 18 (51.3%), and 26% comprising adolescents aged 10-19 years¹¹. Most of the youthful population also stays in the rural areas.

On the youthful population, more than 1 in 4 adolescent boys have had sex before age 15, which is twice as much as adolescent girls¹². On the other hand, more than 1 in 5 adolescent girls begun bearing children by the age 17¹³. Given such circumstances providing sexual and reproductive health services to the people reduces risk of STIs, unintended pregnancies and promotes healthy transition to adulthood as well as reduces risks of death and disability to both the mother and child during pregnancy and childbirth. Cyclone Freddy therefore, saw almost 92,500 pregnant and Pregnant and Lactating Women (PLW) in need of humanitarian support including SRHR services in 15 affected districts¹⁴ as well as almost half to the total population affected in need of SRHR services.

1.3 Role of the Human Rights Commission (the Commission)

With the devastating conditions, the government in partnership with different stakeholders helped the victims of Cyclone Freddy in most of the affected areas. A number of the victims sought shelter in pop up camps, churches and education institutions among other areas where in other cases, men and women, boys and girls were lodging in the same places especially in the first days of Cyclone and issues of privacy and protection, were compromised. With the displacements there were a number of unconfirmed reports on the violations of human rights, where the right to dignity, food and privacy as well as sexual and reproductive health and; gender-based violence among others were deemed to be violated.

The Human Rights Commission of Malawi (the Commission) is a constitutional body established under section 129 of the Constitution with the primary function of protecting and promotion of

7 Malawi MPI report 2021

8 <https://www.macrotrends.net/countries/MWI/malawi/rural-population#:~:text=Malawi%20rural%20population%20for%202022,a%202.43%25%20increase%20from%202018>. Accessed on

12-10-23

9 Malawi Country profile: Gender inequalities in rural employment in Malawi- An overview (2011). FAO

10 Malawi Youth Data sheet. (2014)

11 United Nations Population Fund, Country Programmed document for Malawi. (2023).

https://www.unfpa.org/sites/default/files/board-documents/DP.FPA_CPD_MWI_9%20-%20Malawi%20CPD%20-%20DRAFT%20final%20-%2031May23.pdf

12 Malawi Youth Data sheet.

13 Ibid

14 Malawi Cholera & Floods Flash Appeal 2023

human rights through investigating human rights violations, providing human rights education among other functions and monitoring human rights situation in all spheres including humanitarian sector. Sections 13 and 14 of the HRCA assign various duties and responsibilities on the Commission which includes the provision of human rights information and awareness; provision of opinions on legislation or judicial decisions affecting human rights; and recommending necessary actions on any issues affecting human rights. In addition, the Commission is an enforcer of the Gender Equality Act of 2013 and section 19 states that “every person has the right to adequate sexual and reproductive health. With this, s the Commission, also ensures that it is enforcing all the provisions of the Act that includes the enjoyment of sexual and reproductive health rights by all including the pregnant and lactating mothers, adolescent boys, girls and youth and women and youth living with disabilities.

Further to this, the Commission is cognizant of the Sustainable Development Goals and Malawi’s aspiration to achieve them, including SDG 3, in particular SDG Target 3.7 to ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

With this background, the Commission conducted a comprehensive and systematic monitoring mission on the impact of Cyclone Freddy on pregnant and lactating mothers, youth and women living with disabilities and as adolescent girls, boys and youth on their sexual and reproductive health rights to provide strategic recommendations to various players, including the international development/humanitarian community to inform the future human rights based humanitarian interventions.

1.4 Objectives

1.4.1 Overall objective

To assess the impact of Cyclone Freddy on SRHR services of pregnant and lactating mothers, adolescent girls and youths, adolescent boys and youths.

1.4.2 Specific objectives

- i. To monitor the access and control of SRH services to the communities before, during and after Cyclone Freddy.
- ii. To assess social cultural norms that hinders enjoyment of SRHR in the communities before, during and after Cyclone
- iii. To conduct on spot investigations on the documented or reported violations of human rights in the communities affected by Cyclone Freddy.
- iv. To provide redress on violations as per the Commission’s mandate.

1.5 scope

In light of the different stakeholders and various reports that a number of organizations have produced including the government through department of disaster management affairs (DODMA) and the assessment that the Commission, specifically on children’s welfare, sex exploitations in the camps, as well as the decommissioning of the camps, the exercise undertook selective mapping on communities, in particular the 7 districts in the southern region namely, Zomba, Blantyre, Mulanje, Thyolo, Nsanje, Chikwawa and Phalombe.

1.5 Limitations

In some areas, the teams met with rains during the time they were conducting the assessment. This affected them as they did not manage to visit other areas planned due to the road conditions.

Secondly, the displacement of some people affected the teams as they failed to meet with some of the potential victims of GBV in relation to the SRHR issues. Some of the potential victims that some communities indicated moved to other villages while other to Blantyre and Lilongwe to seek for greener pasture after the Cyclone Freddy, the team therefore failed to appreciate their experiences.

Thirdly, meeting with people living with disabilities was a challenge as they expected the Commission to go to their homes and ferry them to one place to attend the meetings. The Commission, however did not manage to ferry the people to the meeting places due to long distances and time constraints. As such, the Commission only interviewed the ones who were within in the vicinity of the meeting places.

In addition, one of the teams met with a person who was deaf and dumb, it was a challenge to interview him though the team still did as they relied on other respondents who posed as interpreters as the Commission nor the community did not have sign language experts.

Furthermore, respondents were expecting to receive items either in kind or cash which the Commission did not have. This affected the schedule of events and number of respondents in some areas as some of the respondents left after learning that they would not receive any material help. Nevertheless, the Commission explained to them the mandate of the Commission and that the findings will help the Commission to advocate for their SRHR interventions with different stakeholders in the disaster-prone areas.

Lastly, due to the absence of allowances, some district stakeholders, who were supposed to mobilize communities refused to do so. Further, some respondents had no prior knowledge of the activity as the Commission did not have the contacts for local leaders in the community to facilitate communication on the activity.

Chapter 2: Literature review

2.1 Tropical cyclones and their effects

The origins of cyclones can be dated back as early as 1871, where the great storms in the Bay of Bengal were identified¹⁵. Cyclones are caused by climate change Cyclones are the system of winds that are rotating inwards to an area of low barometric pressure, such that in the Northern Hemisphere it is anticlockwise and in the Southern Hemisphere it is clockwise circulation¹⁶. There are two types of cyclones namely Tropical cyclones and Extra Tropical cyclones or Temperate cyclones. ¹⁷ Tropical cyclones develop in the region between the Tropics of Capricorn and Cancer and they are large-scale weather systems developing over tropical or subtropical waters, where they get organized into surface wind circulation¹⁸

Even in their formative stages, tropical cyclones are one of the biggest threats to life and property¹⁹. They comprise of a number of different dangers that causes significant impacts on life and property, such as storm surge, flooding, extreme winds, tornadoes and lighting²⁰. When combined, these threats increase the potential for loss of life and material damage. For example, Over the past 50 years, 1,942 disasters have been attributed to tropical cyclones worldwide and killed 779 324 people and caused US\$ 1 407.6 billion in economic losses – an average of 43 deaths and US\$ 78 million in damages every day.²¹

Malawi has also experienced a number of tropical cyclones over the years. However, they do occur occasionally in Malawi and happen about three times a year²². Since 2019, the country has experienced at least 12 types of cyclones with the worst being Freddy in March 2023, seconded by Anna and Idai²³. From 2nd to 14th March 2023, Malawi experienced the longest lasting tropical cyclone on record known as cyclone Freddy. It left a trail of destruction and caused wide spread damage to property and loss of lives from heavy rains and strong winds. The President declared a State of Disaster in the Southern Region, particularly in Blantyre City and District, Chikwawa District, Chiradzulu District, Mulanje District, Mwanza District, Neno District, Nsanje District, Phalombe District, Thyolo District, and Zomba City and District where there were massive destructions.

15 MURPHY, J. Origin of Cyclones. *Nature* 4, 305–306 (1871). <https://doi.org/10.1038/004305f0>

16 <https://byjus.com/physics/types-of-cyclones/> accessed on 13-10-23

17 <https://www.drishtiiias.com/printpdf/cyclone-19>. Accessed on 13-10-23

18 Ibid

19 <https://public.wmo.int/en/our-mandate/focus-areas/natural-hazards-and-disaster-risk-reduction/tropical-cyclones>

20 Ibid

21 Op cit

22 <https://www.worlddata.info/africa/malawi/cyclones.php> accessed on 13-10-23

23 ibid

No.	Tropical cyclone	Period
1	Freddy	March 2-14, 2023
2	Jasmine	April 24-28, 2022
3	Gombe	March 8-14, 2022
4	Ana	January 23-25, 2022
5	Iman	March 2-11, 2021
6	Guambe	February 11-22, 2021
7	Eloise	January 11-27, 2021
8	Chalane	December 25-30, 2020
9	Chalane	December 20, 2020 to January 4, 2021
11	Kenneth	April 21-28, 2019
12	Idai	March 4-16, 2019
13	Desmond	January 17-22, 2019

Table 1: Types of tropical cyclones and occurrence in Malawi

2.2 Humanitarian responses

With the great devastation that cyclone Freddy caused in the country, the government and other stakeholders continue to provide a number of interventions for response, resilience and recovery. For example, the government of Malawi through the Department of Disaster Management Affairs (DODMA) coordinates and direct the implementation of disaster risk management programmes in the country to improve and safeguard the quality of life of Malawians, especially those vulnerable to and affected by disasters²⁴. After the Department of Climate Change and Meteorological Services (DCCMS) reported that Cyclone Freddy had its center (eye) over Nsanje last night and morning today on 14th March 2023, there were some of the notable 24-hour rainfall figures reported and the country received high rains with the highest beings 458mm in Phalombe²⁵.

With the high rainfalls, a lot of lives were affected and the cyclone triggered torrential rains that led to flooding, mudslides and massive devastation in the southern region as well as worsening the Cholera situation in the country²⁶. More women especially pregnant, lactating, elderly and living with disabilities faced tripled burdens on the same as well as children and adolescent boys and girls who were an accompanied due to the family detachment that was caused by the cyclone.

The challenges faced also included issues of accommodation, food and SRHR services, general health services, education, as well as protection among others. As of 14th March, 2023 Government through DODMA dispatched 45 tons of maize to Phalombe, Mulanje and Blantyre (15 ton each district), 10 bags of maize flour, and 2 bags of 50kg beans to camps. The department also re-fueled 6 vehicles to MDF, Police and Marine to support search and rescue operations²⁷. Other

²⁴ <https://drmims.sadc.int/en/organizations/department-disaster-management-affairs-dodma#:~:text=Established%20through%20the%20Disaster%20Preparedness,and%20safeguard%20the%20quality%20of.> Accessed on 24-10-23

²⁵ DODMA-2023- https://www.undp.org/sites/g/files/zskgke326/files/2023-03/DoDMA%20Sit%20Rep%203%20Cyclone%20Freddy%20_140323%20%281%29.pdf accessed on 24-10-23

²⁶ <https://reliefweb.int/report/malawi/malawi-devastation-caused-cyclone-freddy-wake-call-climate-crisis> accessed on 24-10-23

²⁷ DODMA- 2023- https://www.undp.org/sites/g/files/zskgke326/files/2023-03/DoDMA%20Sit%20Rep%203%20Cyclone%20Freddy%20_140323%20%281%29.pdf Accessed on 24-10-23

stakeholders that distributed the humanitarian support within the same time including FGRC, KUHES, UNICEF, MRCS, and CARE among others.²⁸

Despite having a number of stakeholders coming, there were some gaps in addressing specific issues for pregnant and lactating mothers and adolescent boys and girls due to the shock where a number of rights including SRHR were affected.

2.3 Human rights theories

Apart from having significant environmental impacts, tropical cyclones also affect the social, economic and political life of people. For example, the social, economic and political life of men and women, boys and girls. ²⁹ Despite the groups being affected, women and girls become more vulnerable than men (GoM 2015a; b). Women and girls are more likely to shoulder the burden of unpaid care work and household responsibilities³⁰, as well as facing a number of abuses including sexual in exchange of relief aid among others³¹. To intensify the challenges women and youth with disabilities, pregnant and lactating mothers, elderly women as well as adolescent girls bears a triple burden from the cyclones as they are also prone to gender-based violence. With tropical cyclones, right to security, food and life as well as health among others are violated. Other rights such as sexual and reproductive health rights are also undermined due to the pressure of the needs during disasters such as cyclone Freddy. Cyclones or disasters, then, becomes inseparable from human rights just as the issue of justice. In a study carried by Levy and Patz (2015), on “Climate Change, Human Rights, and Social Justice”, it was noted that consequences of climate change threaten the rights presented in the Universal Declaration of Human Rights. These include the right to life, food, security, housing and social services.

Traditionally, various theories of human rights have revolved around the concept of universalism. Habermas, argues that “human rights have a Janus face, where one side is related to law and the other to morality” (1999:216). This argument has been advanced by other theorists who claim the third dimension is politics (Menke and Pollmann, 2007; Sen, 2004; Tönnies, 2001). This implies that human rights as moral rights are free from legal implementation. As political rights they are norms in which a political practice is constructed. Finally, by codifying legal rights, they are able to be commanded on the ground (Walter, 2014). In terms of disasters such as cyclone Freddy, this approach promotes human rights in both policies and interventions for the victims where justice is also emphasized.

Some scholars have adopted a human rights adaptation approach in dealing with disasters in Malawi for example, where proactive and reactive adaptation approaches are emphasized (Zackary, 2014). In the adaptation approach, disaster relief plans, early-warning systems and emergency responses as well as post-disaster recovery are key in helping the victims.

Other theorists have also argued for a human rights-based approach in dealing with these shocks. A human rights-based approach, strives for obligation, inequalities and vulnerabilities analysis in tackling discriminatory practices and unjust distributions of power that violate human rights

²⁸ Ibid

²⁹ Bland, S. H., E. S. O'Leary, E. Farinaro, F. Jossa, and M. Trevisan, 1996: Long-term psychological effects of natural disasters. *Psychosom. Med.*, 58, 18–24.

³⁰ Tara Carey, 2023. <https://reliefweb.int/report/malawi/cyclone-freddy-has-put-women-girls-malawi-greater-risk-sexual-abuse-exploitation>

³¹ Ibid

(Robinson, 2015; 2013). Though this approach is embraced by the proponents, others highlight that the margin between disasters and human rights is uncertain and divisive (Walker, 2014).

Recognizing the groups that are most vulnerable during these shocks, some scholars have also argued that a humanitarian crisis requires a humanitarian response which must be based on a human rights approach³². This includes the interventions given during and after the crisis, changing of social cultural norms as well as the laws and policies to ensure a human right centered and a victim centered approaches.

2.4 Intersectionality

Human rights-based approaches have also revolved around the social markers of gender, class, and race among others, as significant references in addressing inequalities and oppression (Couto, Oliveira, Separavich and Luiz, 1994). These social markers or identities highlight factors that propel discrimination or make other people to be differentiated and seen as others.

Cho *et al*, (2013), describe intersectionality as a theory of displaying how gender inequality and patriarchy intersect with other systems of oppression as well as how the intersections promote oppression and discrimination. Women and girls and youth are the victims of oppression systems that build multiple identities in the power hierarchies (Carastathis, 2014). Oppression and human rights violation are inevitable in the created inequalities.

Other scholars have also observed that, apart from gender, class and race, women and girls are being oppressed based on other identities depending on the condition they are in (Crenshaw, u d; Cho *et al*, 2013). Identities such as religion, education background, and culture as well as age and stature also lead to violation of human rights and oppression among women.

Other scholars have also argued that intersectionality issues should also being recognized in humanitarian action as it exposes power struggles and relation³³. For instance, in crisis, there are a lot of people in need where marginalized and vulnerable groups face triple burdens. the plan for a more inclusive picture for the victims in humanitarian response is becoming more relevant³⁴. The concept of intersectionality, in the sense of Crenshaw, creates hope in response, resilience and recovery for the victims.

³² Human Rights Council, Twenty-seventh session. 2014

³³ Julia Regina Mühlhauser, (2023) Intersectionality in Humanitarian Response: Just added empty words or the way for an impactful action?

³⁴ *ibid*

2.5 The concept of Sexual and Reproductive health

The concept of sexual health can be dated in 1974 for its full utilization by the World Health Organization (WHO)³⁵. Sexual health is an essential aspect of the general well-being and health as it ensures that everyone have enjoyable and safe sexual experiences, free of coercion, discrimination or health risks. The term ‘sexual and reproductive health’ can be defined as a “person’s right to a healthy body and the autonomy, education and healthcare to freely decide who to have sex with and how to avoid sexually transmitted infections or unintended pregnancy”³⁶. Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system.³⁷ For sustainable sexual and reproductive health, access to accurate information and the safe, effective, affordable and acceptable contraception method of their choice is very crucial.

2.6 Sexual and reproduction health and human rights

Ensuring access for all people to their preferred contraceptive methods, choosing number of children, being treated from STIs and when and with who to have sex with advances several human rights. For example, the right to life and liberty, freedom of opinion and expression and the right to work and education are advanced, as well as bringing significant health and other benefits³⁸. In addition, access to sexual and reproductive health services enable people to exercise their rights. It can also take the form of medical care related to the reproductive system, for example, to treat a sexually transmitted infection, or the facilitation of reproductive autonomy with the provision of contraception and abortion care.

In terms of family planning, the use of modern contraceptives has the potential to protect the health of people with childbearing capacity from the risks associated with unintended pregnancy, especially in adolescents or people with chronic diseases. When the interval between births is less than two years, the infant mortality rate is 45% higher than when this interval is 2 to 3 years, and 60% higher than when it is four years or more³⁹. Finally, family planning also provides a number of potential non-health benefits, including decrease in gender-based violence, prevention from STIs, increased educational opportunities and greater autonomy for women, as well as balanced population growth and sustainable economic development for countries⁴⁰. With this, the physical, emotional and social well-being of women and girls is being promoted and their rights respected.

35 Thomas, Liji. (2023, January 17). History of Sexual Health. News-Medical. Retrieved on October 25, 2023 from <https://www.news-medical.net/health/History-of-Sexual-Health.aspx>.

36 <https://www.msichoice.org/what-we-do/learn/what-is-sexual-and-reproductive-health/> accessed on 25-10-23

37 [https://esaro.unfpa.org/en/topics/sexual-reproductive-](https://esaro.unfpa.org/en/topics/sexual-reproductive-health#:~:text=Good%20sexual%20and%20reproductive%20health,how%20often%20to%20do%20so)

[health#:~:text=Good%20sexual%20and%20reproductive%20health,how%20often%20to%20do%20so](https://esaro.unfpa.org/en/topics/sexual-reproductive-health#:~:text=Good%20sexual%20and%20reproductive%20health,how%20often%20to%20do%20so). Accessed on 25-10-23

38 PAHO- 2023 - <https://www.paho.org/en/topics/sexual-and-reproductive-health>

39 Ibid

40 Optic

2.7 Gender based violence and Sexual and reproductive health

Gender based violence (GBV) is a global challenge. About 1 in 3 women and girls have experienced violence in their life time either intimate partner violence or non-partner sexual violence during their lifetime⁴¹. GBV is an umbrella term for “harmful acts of abuse perpetrated against a person’s will and rooted in a system of unequal power between women and men”⁴². GBV is developmental issues as well as a human rights issue as it knows no social, economic or national boundaries.⁴³ It includes sexual, physical, mental and economic harm inflicted in public or in private⁴⁴. In addition, it manifests through threats of violence, coercion and manipulation; this can be in a form of intimate child marriage, partner violence, harmful cultural practices, female genital mutilation and sexual violence.⁴⁵

Gender based violence affects sexual and reproductive health (SRH). GBV is increasingly recognized as a major public health concern in the most countries⁴⁶. GBV restricts choices and decision-making of those who experience it, curtailing their rights across their life cycle to access critical SRH information and services. It is also a risk factor for sexually transmitted infections (STI), including HIV, and unwanted pregnancy, in addition to causing direct physical and mental health consequences⁴⁷. Studies has also shown that experiencing physical violence, lower likelihood of adopting contraception and increased likelihood of unwanted pregnancies.⁴⁸ Other studies have also shown that physical abuse has been associated with higher rates of miscarriages, bleeding in late pregnancy, premature labor or delivery, still births, abortion and late entry to prenatal care. In addition, Sometimes SRH issues, such as STI and HIV and infertility may be used by perpetrators to propagate violence. Furthermore, societal and cultural attitudes towards these conditions and to women’s non-compliance to gender roles, which are mainly rooted in inequitable and unequal gender norms, exacerbates the problem.⁴⁹

⁴¹ WHO

⁴² [https://www.rescue.org/article/what-gender-based-violence-and-how-do-we-prevent-it#:~:text=Gender%2Dbased%20violence%20\(GBV\)%20is%20an%20umbrella%20term%20for,affected%20and%20on%2Dconflict%20settings..](https://www.rescue.org/article/what-gender-based-violence-and-how-do-we-prevent-it#:~:text=Gender%2Dbased%20violence%20(GBV)%20is%20an%20umbrella%20term%20for,affected%20and%20on%2Dconflict%20settings..) Accessed on 31-10-23

⁴³ <https://www.unfpa.org/gender-based-violence> accessed on 31-10-23

⁴⁴ <https://www.unhcr.org/what-we-do/protect-human-rights/protection/gender-based-violence>

⁴⁵ Ibid

⁴⁶ https://arrow.org.my/wp-content/uploads/2015/04/AFC-Vol.17-No.2-2011_Gender-based-Violence-and-Health-Sector.pdf

⁴⁷ Ibid

⁴⁸ Stephenson, R.; Koenig, M.A., & Ahmed, S. (2006). Domestic violence and contraceptive adoption in Uttar Pradesh, India. *Studies in Family Planning*, 37(2), 75–86

⁴⁹ https://arrow.org.my/wp-content/uploads/2015/04/AFC-Vol.17-No.2-2011_Gender-based-Violence-and-Health-Sector.pdf

Chapter 3: Methodology

There were 6 teams in Thyolo, Mulanje, Phalombe, Blantyre, Chikwawa and Nsanje and Zomba. Each team visited 5 T/As or areas by the end of the activity. The teams employed a multi-prolonged approach which includes observations, focus group discussions, key informant interviews and individual interviews. During key informant interviews, the teams interviewed a number of stakeholders including district health officials, Youth Friendly Services Coordinators, gender officers, child protection officers, disaster and risk management officers, VSU officers and, social welfare Traditional Leaders which were key in the provision of SRHR services before, during and after Cyclone Freddy.

The teams also visited rural communities which were affected by the Cyclone, and conducted individual interviews and focus group discussions with women which included pregnant women, lactating mothers, adolescent girls and boys.

Due to the assessment the Commission also had recently which was funded by UNICEF, this exercise shifted its approach and only focused on a human right perspective on the sexual and reproductive health of pregnant and lactating mothers, youth, adolescent boys and girls in the areas affected by cyclone Freddy.

3.1 Areas visited

No.	District	T/A	GHV	VH	Place
1	Blantyre	Kapeni	Ndirande	Somanje-Makata	Makata
			Ndirande	Malabada	Malabada
		Somba	BT CBD	BT CBD	DHO
		Machinjiri	Chimsewu	Chimsewu	Mpapa Primary school
2	Chikwawa	Makhuwira	Likomba	Likomba	Chaweta primary school
			Mphimbi	Mphimbi	Mavuwu
3	Mulanje	Ngabu	Ngabu	Chikokoto	Chikokoto
		Chikumbu	Chilomo	Chilomo	Chisitu health centre
		Mabuka	Mabuka	Mabuka	Mabuka
		Juma	Nkando	Nkando	Thuchira health centre
		Mkanda	Mkanda	Msamira	Msamira
		Njema	Maveya	Maveya	Maveya CDSS
		Mthiramanja	Mthiramanja	Khobidi	Khobidi
4	Phalombe		Mchenga	Nsukasanje	Chitokolo Primary school
		Phweremwe			
		Jenala	Ndungunya	Ndungunya	Chilusa CBCC
		Kaduya	Mankhanamba	Mankhanamba	Mankhanamba CBCC
		Namasoko	Namasoko	Namasoko	T/A Namasoko HQs

5	Nsanje	Nazombe Chimombo	Lomoliwa Chimombo	Misomali Kanjedza	Malema CBCC Kanjedza
6.	Thyolo	Tengani Bvumbwe	Tengani Dzungu	Nyamithuthu Ligowe	Nyamithuthu Ligowe camp
		Changata	Phalula Chikumba	Phalula Mwalo	Mountain view camp Mwalo
7.	Zomba	January M'biza Mwambo	Changata January M'biza Mwambo	Msambanjati Likwezembe Muhilili Namasalima	Masambanjati Likwezembe camp Muhilili camp Namasali camp
		Kumtumanji Nkagula	Kuntumanji Nkagula	Namisunji Msangu Makumba	Namisunji camp Msangu Primary School camp Makumba camp
		Nkapita	Nkapita	Milepa Chinsewu	Milepa camp Chinsewu youth centre

Table 2: Area visited

Chapter 4: Findings

The Commission undertook a comparative analysis of the SRHR situation to pregnant and lactating mothers, youth, adolescent boys and girls before, during and after cyclone Freddy, to fully understand the impact of cyclone Freddy on SRHR services of pregnant and lactating mothers, adolescent girls and youths, adolescent boys and youths with a human rights perspective.

4.1 Availability and access to SRHR information

When asked on the availability and access to the SRHR information before, during and after Cyclone Freddy, about 70% of the adolescent respondents indicated that the SRHR information before and after the cyclone was available to them through outreach clinics and activities by a number of NGOs including BLM, FOCESE, GAIA, PSI as well as government institutions such as health centres and the Ministry of Gender, Community Development and Social Welfare. On the other hand, about 80% of the adult respondents especially women, indicated that they get information on SRHR through the health centers and campaigns as well under-five clinics. The information is open to any one regardless of sex, age and social status. It was noted that in some areas where there are not outreach clinics such as Likomba Village, T/A Machinjiri- Blantyre and Likwezembe area in Thyolo communities have challenges to access SRHR information.

Nevertheless, during the time they lived in camps, about 70% of the respondents indicated that the information was available to some while 30 % indicated that it was not available due to the damaged road network in the areas caused by cyclone Freddy. For the hard-to-reach areas it was also hard to get the information. However, health personnel were going at least once a month in the hard-to-reach areas while in other areas twice a month. For the areas that were not hard to reach, it was possible to get information relating to SRHR also through different organizations coming for response and relief.

The SRHR information that people were accessing before, during and after the Cyclone comprised messages on family planning, counselling and STIs. In all instances, information users were free to inquire more due to the different needs.

4.2 Availability, access and control of SRHR services

In terms of availability, access and control of the SRHR services there were mixed reactions according to the respondents. For some areas such as Zomba, Namasalima to be specific, they were privileged to access the services easily in the camps as different organizations were coming, while before and after cyclone Freddy, it has proved a challenge for them due to a number of challenges with their health center including shortage of the drugs related to STIs and some family planning methods such as long-term ones, bad attitude of the workers as well as early closure of the facility on working days.

In other areas such as Mulanje, Phalombe, Blantye and Thyolo, about 95% respondents indicate that before the floods they were able to access the services while during the floods it was a challenge as the services were on demand including the ones taking ARTs.

On the other hand, about 70% of the respondent also claimed that SRH services were not needed and was not their priority during the camps, specifically the ones that has to do with sexuality as they were not having chance to have sex in the camps. This was so due to the congestion in the camps as families were not sleeping in one room. Secondly, even in the afternoon it was hard to find time to a place to have sex apart from the bushes which were also not safe for them despite some going to the bushes to have sex.

In terms of family planning methods, in other areas, it was established that there is limited choice of the same before, during and after the cyclone. For example, in Masambanjati, about 60% of the women met complained about limited choice of family planning methods especially when provided by HSAs. At least PSI provides a variety of the services. Whilst at Likwezembe these services were not available both before and during the cyclone. The common type of family planning methods provided in most of the areas visited includes: condoms, injection (Depo Provera), pills, Norplant. On the other hand, at Masambanjati and Likwezembe, injection and pills were the most available while the other ones are hard to find.

After the floods, about 80% of the communities are back to normal despite few hitches while others still find challenges as some facilities were damaged are not properly fixed now. In other areas after the Cyclone Freddy, access to SRHR in communities around the camps have not been reached with the services unless they visit the health centers. Apart from Ligowe in Thyolo, where it was indicated that the health Centre is close, all other camps complained of long distances. For instance, at Mwalo camp, the approximate distance as indicated by the survivors is about 28 kilometers. While in Likwezembe they do cover a distance on foot for 2 hours or they pay transport fare of not less than MK2500. It was noted that most of the communities rely on government and mission health facilities to access the SRHR.

It is worth noting, that about 100% of the adolescent boys and girls interviewed indicated that they also visit the health centres to access the family planning related services while about 90% of the adolescent girls indicated that they do not indulge in sexual activities and see no need of using family planning methods. In terms of emergency services, emergency pills which prevents pregnancy in an emergency, such as when a girl is defiled are also available and accessed in almost all the health facilities.

In terms of control of SRH, about 60% of the respondents claimed that before, during and even after the cyclone, men are the ones who control women's sexuality in terms of which family planning method to use and number of children to have as in the case of respondents in T/A Kapeni, T/A Makata and T/A Somba in Blantyre. On the other hand, about 40% claims that women nowadays are able to choose the family planning methods needed, but for the number of children they discuss as a couple. Nevertheless, more women and girls still have challenges to demand or negotiate sex.

On the other hand, it was also noted that in about 70% of the areas visited, the decision on the number of children to have been placed on the clan heads (Mwini Mbumba) as they are the ones who decide and not the spouses. It was also noted that in as much as men make decisions on family planning, women sometimes do this secretly especially in situations where the other spouse is not willing to agree on any family planning method. In this way, the woman determines the number of children in the family but with potential for marital disputes when the husband discovers the secret.

4.3 Perinatal services (perinatal is the period when one become pregnant and up to a year after giving birth)

About 90% of the respondents indicated that before and after Cyclone they were and are able to access antenatal services by visiting both government and mission health facilities. Women and adolescent girls were and accessing antenatal services at the nearby health centers for example, in Thyolo, at Ligowe and Mountain View centers, respondents were accessing them at Bvumbwe Research Health Center and Mwalo at Mwalo Health Center. Most of the antenatal services were and are still being provided in the communities by HSAs who periodically visit the affected communities.

On the other hand, access to perinatal services was a challenge at the beginning of Freddy in the camps when victims had just moved to camps due to lack of data. However, data collection was conducted on pregnant and lactating mothers, children and youth as well as people with STIs including the ones on ARTs. With this, they were able to get the right services though they were not enough in some instances and there were not readily available as it was before cyclone Freddy.

Secondly, during the Cyclone Freddy, about 3 in 5 pregnant women had a lot of challenges in terms of acquiring birthing materials such as pieces of cloths, basins, plastic papers and clothes, as most of their properties were lost during cyclone Freddy as in the case of Namisunju Camp in Blantyre among others.

Despite the health facilities, especially government facilities being available, before, during and after the flood, for perinatal services, public health facilities are still beyond the World Health Organization's standard availability distance of about 5 to 7 Kilometres as they would be about 10 kilometres up to 45 kilometers away, as is the case with Mpsa Health Centre for members of Ndungunya Village community in T/A Jenala in Phalombe, Likomba Village, T/A Machinjiri-Blantyre and Likwezemba area in Thyolo among others, hence making it a burden for pregnant and lactating women to access perinatal services.

In all the places visited, it was established that there are laws that were put in place by the health facilities that men should be in company of their wives when seeking antenatal services, such that if they do not comply, women do not get the required assistance unless they are granted a letter from the chief explaining the reason for the absence of their spouse. The respondents however, also indicated that those who did not bring letters from their chief were served at the very end, but that they are still assisted.

On the availability of mosquito nets, before and after CF, pregnant women were given the mosquito nets on their first day of seeking antenatal service in the health centers. Hence, during the cyclone,

the mosquito nets were not available in most of the camps in the case with Mulanje, however, about 30% indicated that nets were available and accessible to the pregnant and lactating mothers as in the case with Blantyre and in most of the health centers in Phalombe and some camps in Thyolo. In some areas such as Mpanga and Mpsa health centers in Phalombe, respondent claimed that mosquito nets were a challenge before and even now after the Freddy for pregnant and lactating mothers.



Figure 1: Pregnant and lactating women at Chilusa CBCC

4.4 Myths, beliefs and taboos in relation to GBV and SRHR

Before, during and after the Cyclone, the teams established due to cultural, social and religious values, there are myths and taboos that were related to SRHR. The following were the myths and taboos mentioned:

- i. That SRHR services and methods are satanic and against traditional and religious morals. This was mentioned by about 60% of the respondents (both female and male) however all the respondents, both female and male, stated that they did not believe in it and that these were views held by the older and less educated generation and which are slowly dying out.
- ii. A wife has to always listen to the husband as the husband is never wrong.
- iii. A woman should be slapped once in while to enforce respect.
- iv. Females ought to respect males despite of the age
- v. That contraceptive are drugs for rabies.
- vi. That, expecting women who were about 8 months along, should not have sex with their spouse as it affects the new born baby.
- vii. That, the person who is escorting the pregnant woman to the hospital should not have sex with their spouse as it leads to stillbirth.

- viii. That, pregnant women should not buy cooked food from the market, because it leads to miscarriage.
- ix. That women who uses family planning methods are not sweet in bed.
- x. That women who uses contraceptive methods will develop fibroids which will eventually lead to death.
- xi. That when you use contraceptive methods continuously, you will not be able to give birth.
- xii. That menstruating women and girls should not add salt in relish. If the woman or girl put salt in the relish, she will bring bad luck to the family “awasempha”.
- xiii. Family planning methods causes infertility in women. There is a myth that girls and young women who use family planning will become barren and fail to have children in future.
- xiv. Family planning methods lowers libido in men.
- xv. That, pregnant women should not stand at the door, because it causes difficulties in delivery process.
- xvi. That, unmarried women and girls who access family planning methods are loose. About 100% of the adolescents and youth (both female and male) respondents do not believe despite being popularized, while only about 40% of the adult respondents (female and male) still hold the belief. The youths, however, stated that it was view based on ignorance and misunderstanding of what SRHR actually is held by their parents and the community. In the case of the adult respondents who mentioned this, about 60% of the female respondents believed in it while about 40% of the males’ respondents believed in it. Their view was that an adolescent or youth who accessed SRHR services must therefore already be engaging in sexual activities hence he or she must be “promiscuous”.
- xvii. That some married women will be divorced and marry other women because sex will not be enjoyable if they use family planning methods.
- xviii. That when a woman gives birth, the husband was/or is not supposed to engage in extra-marital sex as the act can result in having the new born baby’s immediate and mysterious death.

4.5 Nutritional values for pregnant, lactating, people on ARTs and TB

Before Cyclone Freddy, *Chiponde* was provided to malnourished babies in health centers. Pregnant women, lactating mothers, adolescents, people on ART and TB were able to get nutritional supplements and drugs at the health centers before CF. However, these supplements were not available during CF in most of the camps and centers. This resulted into most people on ART to skip taking medication. Most camps complained of not receiving sufficient food items resulting into most lactating women stopping their babies from breast feeding. Malnutrition became a significant problem amongst lactating mothers. After the Cyclone, in some areas the *Chiponde* and some food supplements have resumes and food.



Figure 2: Young pregnant and lactating mothers

4.6 SRHR related sickness

The most common SRHR related sicknesses recorded were STIs such as syphilis and gonorrhea, genital warts, Candidiasis and HIV which were treated at the health centers before, during and after CF. Both women with and without spouses were treated equally whenever they visit the health centers. However, during cyclone Freddy, treatment was done at the camps by health officials in a private tent in most of the camps. According to the respondents, there were few cases of Fistula in Chikwawa, Mulanje and Thyolo were treated at the district hospitals during Freddy. In addition, at Chaweta camp at Likomba village, T/A Machinjiri during the cyclone, there was a case of fistula which was left untreated due to lack of knowledge and the camp was never visited by district health officials, the patient sought treatment from traditional healers which did not help as she is still suffering from the disease and it has gotten worse over time. For this case there is also a distance constraint to visit a health centre as it is 8kms away and transport costs K10,000 one way.

4.7 Youth friendly services

Youth friendly services in the form of family planning methods, counselling and information on SRHR were available to the youth during, before and after Freddy in all the districts. This resulted in the reduction of teenage pregnancies and early marriages of those to get them, however, it was reported that about 70% of the youth, adolescent boys and girls are shy to access the services and they also fear their parents. Very few, about 10% of the youth are free to go and access these services, where the other ones are not just sure if they can go and access the services.

Nevertheless, in Likomba village, T/A Machinjiri, Mwalo and Masambanjati, youth friendly services were not available before, during and after CF. However, for Masambanjati the services are no longer available but they had services that were being facilitated by organizations such as

youth alert and the messages included *“how to say no when they do not want to have sex; how to get tested before being sexually active and also how to be confident and comfortable to get condoms and talk to their parents about their sex lives”*. And as for Mwalo community, the program is still there but though not that effective as the youth claim to be hungry and not interested to attend activities on empty stomachs.

4.8 Menstrual Hygiene

Before and after CF, women and adolescent girls were using cotton and the traditional ‘Nyanda’ which are washed and hanged in their homes for drying before the next use. For the ones who can afford they were also using sanitary pads. While about 80% of respondents had challenges in managing their periods as they hardly find nyanda to use. In some instances, they were washing them in the rivers without soap and waiting for them to dry so that they can freshen up by wearing washed and dried nyanda. They also stated that women had challenges during their periods as some of them don’t have pants while others their pants were not in good condition during and after the cyclone to manage their period.

About 60% of the women interviewed during FGDs and one-on-one sessions in TA Chikumbu and T/A Nkanda indicated that when they were in camps, some NGOs could visit the camps and distribute shop made sanitary pads. In addition, some adolescent girls and young women indicated that they received 2 packets of disposable sanitary pads. Adolescent girls interviewed in T/A Njema at Maveya CDSS on the other hand indicated that only selected girls who were beneficiaries in the Campaign for Female Education (CAMFED) received sanitary pads before and during the cyclone. This means that other girls who were not selected for CAMFED interventions still used the traditional cloths to manage their menstrual hygiene.

There was no treatment for menstrual sickness during CF, one would just go and buy painkillers to ease the menstrual crumps, should they have money. If they did not or do not have money, they will just wait until the crumps pass. Soap and washing buckets were not available during CF.



Figure 3: Pregnant and lactating mothers

4.9 Sex trafficking, and Sexual and Gender Based violence (GBV)

There were no recorded cases of sex trafficking in all the districts before, during and after the cyclone. However, in Zomba in Muhilili village, sex trafficking is common in a way that women from the city come to the community and take young girls with them claiming that they are going to be working for them but once they get there, they find that its different from what was being promised. They are used for sex and they don't get paid. An example of sex trafficking that took place in Muhilili community was given where girls were working in a restaurant but when a male customer comes, he could ask the owner for the girls for sex. These cases have not been reported and the girls ususally find their way back home on their own.

Cases of child labour and trafficking into Mozambique were common in Phalombe district both before and after Cyclone Freddy although during the period of Cyclone Freddy they declined as mobility to Mozambique was difficult. However, over time, these cases have been on the decline due to intensified public awareness activities and interventions by both public, for example, Phalombe District Social Welfare Office, District Education Office and the Police, non-public agencies such as NGO's, CSO's, CBO's, traditional leader and PTA's.

On the other hand, incidences of GBV happened as domestic violence was confirmed in a number of communities visited in all the districts, where 80% of the perpetrators were men through intimate partner violence. Respondents provided diverse views on the same in the different districts. some indicated that they report these cases to police VSU while others indicated that most women remain silent as the fear losing the husband through divorce. They indicated that reports sto police would anger their husbands who would opt to divorce them and marry elsewhere. Some respondents, for example, in Nsamira village in Mulanje, mentioned that sometimes they only report to their marriage counselors (ankhoswe) since they find it difficult to report the cases at Nkalo court where they are allegedly pay MK15,000 fee by the court messengers whenever they want to lodge a complaint with the court. In most parts of Nkala district, women indicated that

they get used to violence such that sometimes women are not allowed to eat food in their homes in absence of their husbands at home.

The teams also established that rape and defilement cases are also mostly witnessed, experienced or heard of in the communities visited included. For example, about 75% of the adolescent interviewed confirmed that they have heard or witnessed defilement and rape cases in their communities. Respondents decried that most of the cases go unreported and in the case of reported cases, perpetrators are usually set free. For instance, it was established that about 15 cases of defilement in Mulanje in the areas visited and where only 4 perpetrators were arrested of the 15 and only 1 has been given a sentence where the 3 cases the family members choose to deal with them at family level as family members vehemently denied reporting to police. In another instance in for example as in Masambanjati, in Thyolo, 2 incidences of GBV were reported during the Cyclone in relation to intimate partner violence. At Mwalo camp incidences of physical assault were also common before, during, after cyclone Freddy.

The respondents were however, not clear in terms of the period which these cases occurred. About 70% indicated that the cases mostly occurred before the cyclone while 30% reported that the cases were/are ongoing as they occur before, during and after the cyclone. The Commission noted that cases are largely not reported due to ignorance of the community members on gender related laws as well as alleged corrupt practices among police officers around their areas. For example, some respondents alleged that one of the defilement perpetrators was released because he bribed police officers.

The exercise further established that cases of defilement are not reported due to high levels of poverty existing in the communities. Respondents stated that in some instances, perpetrators of defilement offer money to parents of the victims as a cover-up to prevent them from reporting to relevant authorities. For example, in T/A Njema in Mulanje, stated that one perpetrator in his village was never reported after he had defiled an adolescent girl because he had offered money to the victim's parents. Unfortunately, the victim died some years later.

4.10 Gender based violence in relation to Sexual and reproductive health

It was also noted that the issues of controlling women's sexuality and cultural values are fueling gender-based-violence (GBV) before, during and after the floods, in the communities visited, as women and girls do not fully have their bodily autonomy; women still endure in the name of submission and saving their marriages. About 60% of the women interviewed, indicated that they have experienced or witnessed physical violence in their communities. Physical violence has also resulted to less enjoyment of sexual and reproductive health rights. For example, some cited that their husbands, beat them up when they hear that they went to take family planning methods as this respondent laments:

“Amunanga samagwirizana nazo zakalela wa kuchipatala. Pena ukakatenga mobisa amakwiya ndikukumenya” (Lactating mother)

Secondly, the vulnerability that CF rendered to women and girls also heightened GBV cases in the camps on intimate partner violence and sex in exchange of relief including nutritional supplements

during the floods despite having most cases go unreported for fear public reprisal and saving the marriages. This also affected women and girls as they are prone to contracting the STIs.

4.11 Gender-based violence safety audit

The teams, through observations, also assessed the safety and security concerns for the pregnant and lactating mothers as well as adolescent girls and youth especially those that have direct link to their sexual and reproductive health. In terms of water, sanitation and hygiene (WASH) it was noted that before CF people were accessing these services easily. During the floods, the services were hardly available as well as congestion in the camps worsened the situations. Despite having a number of communities seem to bounce back to normal, issues of WASH after the Cf are still a challenge. For example, a number of boreholes and sanitation facilities were destroyed. This has created situation where a number of communities visited in all districts still use rivers as their source of water and other sanitation issues. Some of these rivers are quite a distance from the settlements where they create risks of rape and molestation for the girls.

Secondly, apart from the risk of water borne diseases as most of the water used are untreated, menstrual hygiene is also affected as women and girls wash their pieces of cloths “nyanda” in the rivers without soap and poses risks of diseases such as Candidiasis among others.

In terms of the shelters, during and after the CF a number of challenges have been noted as most of the houses they are using are not of standards, some houses are still damaged on one side or the other. With the concept of “gowelo” (a small hut that a girl or boy sleep after puberty), risks of rape are also high for the adolescent girls resulting to contracting STIs and unwanted pregnancies.

Lastly, there have been a number of committees that have been constituted in the communities before, during and after the CF. These committees include protection, ADC, VDC, disasters among others. Nevertheless, there are still some gaps in terms of the capacity of the committees, which needs to be built. For example, some of the respondents claimed that sometimes they are not treated properly when they complain especially if it is an issue of sexual abuse. As a result, it was noted that the mental health of the victims is left uncared for. In addition, referral pathways for GBV and SRH need to be strengthened on the same.

4.12 Challenges in accessing SRHR services

This section presents challenges that the communities visited experience before, during and after CF in accessing SRHR services in their communities.

Before CF

- i. Stigma relating to unmarried people accessing family planning methods there were no other challenges for the adolescent and youth.
- ii. Shortage of drugs and other medical resources in the provision of SRHR at the district hospitals and some health officials use personal resources to assist where they can.
- iii. Lack of awareness on family planning methods in most camps made it difficult for women to make a proper decision as to which method to opt for.
- iv. Limited provision of female condoms.
- v. Unwelcome attitude of medical personnel in some health centers whereby those seeking services are sometimes ill-treated, as in cases at Namasalima, Mountain View and Changata health centres.

- vi. Men shunning vasectomy for fear of being mocked by their colleagues or being considered barren or sexually useless by women.
- vii. Most people fail to afford family planning methods from private institutions due to lack of financial capacity in the event that there are no methods at the government facilities and most of the youth were shy to go mobile clinics on the camp to access family planning help or any help related to the sexual health.
- viii. Long distances to access SRHR services.
- ix. Some health extension officers lacked expertise in handling victims of trauma during delivery of services, therefore, there is need for a capacity building for these officers on service.

During CF

- i. Insufficient food supplies during and after CF resulted in most people on ART from skipping medication.
- ii. Limited availability of a variety of family planning methods resulted into women and girls opting for a method they are not comfortable with.
- iii. Insufficient availability of water sources affected sanitation of women and girls. For example, at Mwalo camp, there was only a single borehole for a population of more than 200 survivors who were in the camp.
- iv. Limited provision of female condoms.
- v. Little provision of nutritious food to lactating mothers leading to malnutrition of babies.
- vi. Inadequate provision of mosquito nets to pregnant and lactating mothers which exposes them to the risk of malaria.
- vii. A number of pregnant and lactating mothers faced a number of challenges in accessing SRHR services because of shaky response to the crisis due to being overwhelmed and unpreparedness by authorities including on access to maternal health.
- viii. Most of the youth were shy to go mobile clinics in the camps to access family planning services or any help related to their sexual health.

After CF

- i. Insufficient food supplies during and after CF resulted in most people on ART from skipping medication.
- ii. Limited availability of a variety of family planning methods resulted into women and girls opting for a method they are not comfortable with.
- iii. Limited provision of female condoms.
- iv. Unwelcome attitude of medical personnel in some health centers whereby those seeking services are sometimes ill-treated, as in cases at Namasalima, Mountain View and Changata health centres.
- v. Men shunning vasectomy for fear of being mocked by their colleagues or being considered barren or sexually useless by women.
- vi. Most people fail to afford family planning methods from private institutions due to lack of financial capacity in the event that there are no methods at the government facilities and in cases of long distances to government facilities.
- vii. Most of the youth are shy to go mobile clinics on the camp to access family planning help or any help related to the sexual health.

viii. Long distances to access SRHR services.

4.13 Immediate interventions needed in the areas visited

The following are the interventions needed immediately as identified in the exercise based on the post cyclone Freddy situation:

- i. Training of adolescent women and girls in defensive skills from violence.
- ii. Provision of food supplies and nutritional supplements especially targeting children, the elderly, those on ART, those on TB treatment, pregnant and lactating women.
- iii. Provision of mosquito nets to pregnant and lactating women and children.
- iv. Supply of sufficient condoms, both male and female, sanitary pads, pants to women and girls, soap, buckets and chlorine.
- v. Government and development partners should provide shelter to the survivors such as tents as most of them have not yet been able to reconstruct permanent structures. The situation puts them at a high risk as the rainy season is fast approaching. Secondly, issues of safety from violence are also compromised.
- vi. Construction of a clinic at Likomba village, T/A Machinjiri as there isn't a clinic to provide SRHR services, antenatal services and under five clinic services in the area, people have to travel for 10kms to access such services.
- vii. Supply of sufficient family planning methods to survivors of CF in all areas is crucial.

4.14 Successes for the exercise

The following were the successes from the exercise:

- i. Data was collected from intended groups despite some challenges
- ii. The teams conducted some awareness session on GBV, SRHR in referral pathways when human rights are violated in some communities Awareness on functions and duties of the Commission was successfully done to survivors.
- iii. High turn-out of survivors despite weather and damaged roads challenges in most of the areas visited.
- iv. Good collaboration with stakeholders including local stakeholders.

4.15 Challenges faced during the exercise

The following were the challenges faced during the exercise:

- i. Damaged roads.
- ii. Lack of lunch allowance and refreshments for participants and stakeholders that resulted to some resistance by other participants and stakeholders.
- iii. Survivors sought immediate life -saving interventions such as AIP meetings rather than engage with the Commission.
- iv. Dispersed population, therefore survivors had to travel long distances.
- v. Psychosocial trauma of survivors therefore making it difficult for survivors to open up.
- vi. The assessment coincided with adverse weather conditions in some areas, making it difficult for survivors to travel.

Chapter 5: Conclusions and recommendation

The Commission conducted an assessment and monitoring the impacts of Cyclone Freddy on pregnant and lactating mothers, adolescent girls and youth and adolescent boys and youth in the southern region of Malawi with a human rights perspective. The objective was to assess the impact of cyclone Freddy on SRHR services of pregnant and lactating mothers, adolescent girls and youths, adolescent boys and youths. There were 6 teams in Thyolo, Mulanje, Phalombe, Blantyre, Chikwawa and Nsanje and Zomba. Each team visited 5 T/As or areas by the end of the activity. The Commission employed a multi-prolonged approach which includes observations, focus group discussions, ey informant interviews and individual interviews. During key informant interviews, the Commission interviewed a number of stakeholders including district health officials, youth Friendly Services Coordinators, gender officers, child protection officers, disaster and risk management officers, VSU officers and, social welfare Traditional Leaders which were key in the provision of SRHR services before, during and after the Cyclone Freddy.

Below are the key findings from the assessment conducted.

5.1 Major Findings

- i. About 70% of the adolescent respondents indicated that the SRHR information before and after the Freddy was available to them through outreach clinics and activities by a number of NGOs and government.
- ii. About 80% of the adult respondents especially women, indicated that they get information on SRHR through the health centers and campaigns as well under-five clinics.
- iii. SRHR information is open to any one regardless of sex, age and social status.
- iv. For some areas, they were privileged to access the services easily in the camps as different organizations were coming, while before and after the Freddy, it was a challenge for them. Nevertheless, 80% of the respondents indicated that services were accessible before and after.
- v. On the other hand, about 70% of the respondent also claimed that SRH services were not needed during the camps, as they were not having chance to have sex in the camps due to issues of privacy.
- vi. Bad attitude of the workers as well as early closure of the facility affected accessibility of the services in some communities.
- vii. In terms of family planning methods, in other areas it was established that there is limited choice of the same before, during and after the cyclone.
- viii. Long distances affect accessibility of SRHR services for pregnant and lactating mothers.
- ix. About 80% of the adolescent are shy to get SRHR services especially the family planning for fear of their parents.
- x. In terms of control of SRH, about 60% of the respondents claimed that before, during and after men controls women's sexuality.
- xi. However, about 40% of the respondents claimed that women nowadays are able to choose family planning methods.
- xii. More women and girls still have challenges to demand or negotiate for sex.

- xiii. About 70% of the areas visited, it was noted that the brother or uncle of the wife popularly known as *Mwini Mbumba* is the one that makes the decision on the number of children the family to have.
- xiv. Despite the health facilities being available before, during and after the cyclone, for perinatal services, public health facilities are still beyond the World Health Organization's standard. For instance, on availability, facilities are to be located in a distance of about 5 to 7 kikometres but most are located about 10 kilometres up to 45 kilometers from communities.
- xv. During the Cyclone Freddy, a number of pregnant women had a lot of challenges in terms of acquiring birthing materials such as pieces of cloths, basins, papers and clothes, as most of their properties were lost during cyclone Freddy.
- xvi. On the availability of mosquito nets, before and after CF, pregnant women were given the mosquito nets on their first day of seeking antenatal service in the health centers. Hence, during the cyclone, the mosquito nets were not available in most of the camps.
- xvii. There are bylaws in most of the communities to encourage men to escort their wives to the antenatal services.
- xviii. There are still a number of myths and taboos that communities are still holding regarding to SRHR issues which hinder the realization of SRHR.
- xix. Before Cyclone Freddy, *Chiponde* and other food supplements were provided to malnourished babies in health centres as well as Pregnant women, lactating mothers, adolescents, people on ART and TB were able to get nutritional supplements and drugs at the health centers before CF unlike during CF. lack the supplements during CF resulted to a number of people on ART were skipping taking medication and lactating women stopping breast feeding their children.
- xx. The most common SRHR related sickness were STIs such as syphilis and gonorrhea, genital warts, *mauka* and HIV which were treated at the health centers before, during and after CF.
- xxi. According to the respondents, there were few cases of Fistula in Chikwawa and Mulanje, Blantyre
- xxii. Youth friendly services in the form of family planning methods, counselling and information on SRHR were available to the youth during, before and after Freddy in all the districts and they are helping to reduce pregnancy in some areas.
- xxiii. Before and after CF women and adolescent girls were using cotton and the traditional 'Nyanda' which are washed and hanged in their homes for drying before the next use.
- xxiv. About 80% of respondents had challenges in managing their periods as they hardly find nyanda to use as well as soap to use during and after CF.
- xxv. A number of women and girls did not have pants during Freddy and some still don't have pants now after the Freddy which affects them especially when doing periods.
- xxvi. There were no recorded cases of sex trafficking in all the districts before, during and after the cyclone apart from Zomba where women from the city come to the community and take young girls in promising them work but use them for sex in the city.
- xxvii. Cases of child labor trafficking into Mozambique were common in Phalombe district both before and after Cyclone Freddy although during the period of Cyclone, the figures reduced due to damaged roads.

- xxviii. On the other hand, incidences of GBV are still an occurrence as domestic violence seems to be on rise where rape and defilement are also mostly witnessed, experienced or heard of in the communities visited.
- xxix. Challenges to access WASH facilities especially for girls and women is posing GBV risks
- xxx. Lack of proper housing poses rape and sexual abuse risks to women, girls and young boys.

5.2 Recommendations to improve and promote SRHR services in Malawi

Due to the above findings, there are some glaring gaps noted on the issues of SRHR. To improve and promote SRHR services in the country, the following recommendations have been therefore made:

- i. Ministry of Gender and MHRC to strengthen the GBV referral pathways.
- ii. Ministry of Health and development partners should provide chlorine in communities having limited access to safe water sources such as Likwezembe and Masambanjati.
- iii. Government and other development partners should provide enough food and nutritional supplements for children, pregnant and lactating women, the elderly and those on ART and suffering from TB.
- iv. Stakeholders and well-wishers to provide pants and dignity kits to women and girls in the areas.
- v. Government, stakeholders and well-wishers to train women and girls in the areas on how to make long lasting menstrual pads.
- vi. Government and other stakeholder to provide SRHR related resources at the hospitals.
- vii. Ministry of Health to implement its service charter and other policies and engage health workers on improved attitudes towards patients.
- viii. Government and other well-wishers to help in maintenance of the places where they used to live before the cyclone so that they can go back to their old lives especially the elderly and orphaned adolescents.
- ix. Ministries of Gender, Finance and other financial institutions to support with loans for women and the youth to start businesses so that can manage to access some services.
- x. Government should provide enough resources and drugs to enable health workers provide SRHR services to people.
- xi. Ministry of Gender and other stakeholders should enhance awareness raising and enforce the laws on prohibition of child marriages.
- xii. Ministry of Health and the Office of the District Commissioner in Thyolo should open Malosa Clinic situated in T.A Changata's area which was constructed 25 years ago. The Government and development partners should ensure frequent visits of health officers to the affected communities in order to provide family planning methods in time.
- xiii. Ministry of Local Government and the offices of the DC should increase access to water by providing enough boreholes in communities to avoid issues of cholera outbreak and other sanitary problems which come along with no access to clean water.
- xiv. Ministry of Health and development partners should increase awareness on family planning methods, how they are used, how they should be acquired and who to consult to dispel myths and taboos related to SRHR.
- xv. The Offices of the DC to work hand in hand with chiefs in ensuring that relief items meant for the survivors are not diverted and reach the intended beneficiaries which has been a challenge in almost all camps in Thyolo.

- xvi. The Government and development partners should construct health centers close to the communities and adequately resource them.
- xvii. DODMA should be fully prepared in terms of disaster emergencies, coordinate with other clusters in in order to handle emergencies properly.
- xviii. Ministry of agriculture to put in initiatives to have food readily available and have to provide food when disasters happen to pregnant women and lactating mothers.
- xix. Ministry of labor should continue fostering vocational training for boys and girls who have skills to be promoted.
- xx. The Commission should build the capacity of chiefs about human rights especially for women and children.
- xxi. The Government, development partners and the Commission should engage traditional leaders and enhance awareness on child marriages, trafficking and GBV.
- xxii. The Malawi Police Service should investigate all cases of GBV including child marriages, rape and defilement.
- xxiii. Stakeholders and development partners should assist government with financial and technical support to implement these and other related recommendations.

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Annex
Annex 1: KII

MALAWI HUMAN RIGHTS COMMISSION



SRHR CYCLONE FRED KII

INTRODUCTION

My name is..... We are interviewing people in order to get information on the human rights situation in areas affected by the recent flooding. The findings of this exercise will ensure a more human rights-based approach to disaster prevention, preparedness and response.

Confidentiality and consent: Emphasize that answers of the respondent are completely confidential. Tell him/her that he/she is free not to answer any question he/she feels uncomfortable with, and that he/she is also free to terminate the interview at any point

Interviewer	
Interviewee:	Any Disability if any:
Age range:	Sex:
Occupation:	
Contact details if any:	
Village of origin and T/A	
Name of Displacement Site/Camp/Location/ area	
Date of monitoring:	Signature of monitor:
Checked by:	Signature:

A: Availability and access to SRHR information

Before CF

- i. Was the information on SRHR available before Cyclone Fred to the victims? If yes ask 2 if no, why was it not available
- ii. How were they accessing the information on SRHR before cyclone Fred?

During CF

- iii. Was the information on SRHR available during Cyclone Fred to the victims? If yes ask 2 if no, why was it not available
- iv. How were they accessing the information on SRHR during cyclone Fred?

After CF

- v. Is the information on SRHR available after Cyclone Fred to the survivors? If yes ask 2 if no, why was it not available
- vi. How are they accessing the information on SRHR after cyclone Fred?

B: Availability, access and control of SRHR services

Before CF

- vii. Were SRHR services available to the victims before CF?
- viii. Were the SRHR services accessible to the victims before CF?
- ix. Were men and women, adolescent boys and girls able to choose the family planning methods to use before CF?
- x. What family planning methods were available before for them CF?
- xi. Were people free to use condoms?

During CF

- xii. Were SRHR services available to the victims during CF?
- xiii. Were the SRHR services accessible to victims during CF?
- xiv. Were men and women, adolescent boys and girls able to choose the family planning methods to use during CF?
- xv. What family planning methods were available during CF?
- xvi. Were people free to use condoms?

After CF

- xvii. Are SRHR services available to you now to the survivors CF?
- xviii. Are SRHR services accessible to survivors now CF?
- xix. Are men and women, adolescent boys and girls able to choose the family planning methods to use now CF?
- xx. What family planning methods are available now CF?
- xxi. Are people free to use condoms?

C: Perinatal services (perinatal is the period when one become pregnant and up to a year after giving birth)

Before CF

- xxii. How were women and adolescent girls accessing antenatal services before CF?
- xxiii. Were women and adolescent girls in company of their spouse when seeking the services?
If no why?
- xxiv. Were mosquito nets available and accessible to pregnant and lactating mothers before CF?

During CF

- xxv. How were women and adolescent girls accessing antenatal services during CF?
- xxvi. Were you in company of your spouse when seeking the services? If no why? If yes how did that helped you?
- xxvii. Were mosquito nets available and accessible to pregnant and lactating mothers during CF?

After CF

- xxviii. How are women and adolescent girls accessing antenatal services after CF?
- xxix. Are they in company of your spouse when seeking the services? If no why? If yes how did that helped you?
- xxx. Are mosquito nets available and accessible to pregnant and lactating mothers now?

C: Myths and taboos in relation to SRHR

- xxxi. What myths were there in relations to SRHR before CF?
- xxxii. Which acts were regarded as taboos for men, women and youth in relation to family planning before CF?
- xxxiii. Which acts were regarded as taboos for men, women and youth in relation to pregnancy before CF?
- xxxiv. Which acts were regarded as taboo for men, women and youth in relation to menstrual health?

During CF

- xxxv. What myths were there in relations to SRHR before CF?
- xxxvi. Which acts were regarded as taboos for men, women and youth in relation to family planning before CF?
- xxxvii. Which acts where they regarded as taboos for men, women and youth in relation to pregnancy before CF?
- xxxviii. Which acts were regarded as taboo for men, women and youth in relation to menstrual health?

After CF

- xxxix. What myths were there in relations to SRHR before CF?
- xl. Which acts were regarded as taboos for men, women and youth in relation to family before CF?

- xli. Which acts were they regarded as taboos for men, women and youth in relation to pregnancy before CF?
- xlii. Which acts were regarded as taboo for men, women and youth in relation to menstrual health?

E Nutritional values for pregnant, lactating, people on ARTs and TB

Before CF?

- xliii. Were pregnant and lactating mothers able to access nutritional supplements before CF? if yes from where?
- xliv. Were adolescent boys and girls, pregnant and lactating mothers on ARTs and TB able to access nutritional supplements and drugs before CF? if yes from where?

During CF?

- xlv. Were pregnant and lactating mothers able to access nutritional supplements during CF? if yes from where?
- xlvi. Were adolescent boys and girls, pregnant and lactating mothers on ARTs and TB able to access nutritional supplements and drugs during CF? if yes from where?

After CF?

- xlvii. Are pregnant and lactating mothers able to access nutritional supplements now CF? if yes from where?
- xlviii. Are adolescent boys and girls, pregnant and lactating mothers on ARTs and TB able to access nutritional supplements and drugs now CF? if yes from where?

F: SRHR related sickness

Before CF

- xlix. What were the common SRHR related sicknesses for men, women, adolescent boys and girls before CF?
 - l. How were they treated? was the medication available for them?
 - li. Were they going for treatment with spouses or sex partners?
 - lii. Have you ever heard a case on Fistula before CF? If yes how was the person treated?
 - liii. Were counselling services available for them?

During CF

- liv. What were the common SRHR related sicknesses for men, women, adolescent boys and girls during CF?
 - lv. How were they treated? was the medication available for them?
 - lvi. Were they going for treatment with spouses or sex partners?
 - lvii. Have you ever heard a case on Fistula during CF? If yes how was the person treated?
 - lviii. Were counselling services available for them?

After CF

- lix. What are the common SRHR related sicknesses for me, women, adolescent boys and girls now CF?
- lx. How were they treated? was the medication available for them?
- lxi. Were they going for treatment with spouses or sex partners?
- lxii. Have you ever heard a case on Fistula now CF? If yes how was the person treated?
- lxiii. We're counselling services available for them?

G: Youth friendly services

Before CF

- lxiv. Were the youth friendly services available to the adolescent boys and girls before CF?
- lxv. If yes what kind of services were available?
- lxvi. What is the impact of the services of the youth in relation to the promotion of SRHR?

During CF

- lxvii. Were the youth friendly services available to the adolescent boys and girls during CF?
- lxviii. If yes what kind of services were available?
- lxix. What is the impact of the services of the youth in relation to the promotion of SRHR?

After CF

- lxx. Are the youth friendly services available to the adolescent boys and girls now CF?
- lxxi. If yes what kind of services are available?
- lxxii. What is the impact of the services of the youth in relation to the promotion of SRHR?

H: Sex trafficking, and Sexual and Gender Based violence (GBV)

Before CF/ during CF and after CF

- lxxiii. Have you ever experienced/ witnessed/ heard of cases of GBV in the following categories? If yes how many?
 - i. Rape/defilement
 - ii. Sexual Harassment
 - iii. Domestic violence
 - iv. Child marriage
 - v. Other
- vi. Were the cases reported? Who reported and to whom?
- vii. If the cases have never been reported, why have they not been reported?
- viii. Is there a system in place to enable victims of violence and abuse and exploitation to access necessary care and services? If yes, do you think that the community is aware of the existence of the system?
- ix. Have you ever heard of any incidence of sex trafficking? If yes, how was it dealt?

I: Challenges in accessing SRHR services

Before CF

- x. What are the challenges pregnant and lactating mothers face in accessing SRHR services (family planning, STIs treatment,
- xi. what are the challenges adolescent boys and girls face in accessing SRHR services
- xii. Have you ever heard of any incident where a pregnant, lactating, or adolescent boy and girl was molested by a medical officer? If yes what was done?

During CF

- xiii. What are the challenges pregnant and lactating mothers face in accessing SRHR services (family planning, STIs treatment,
- xiv. what are the challenges adolescent boys and girls face in accessing SRHR services
- xv. was there any incident where a pregnant, lactating, or adolescent boy and girl was molested by a medical officer? If yes what was done?

After CF

- xvi. What are the challenges pregnant and lactating mothers face in accessing SRHR services (family planning, STIs treatment,
- xvii. what are the challenges adolescent boys and girls face in accessing SRHR services
- xviii. was there any incident where a pregnant, lactating, or adolescent boy and girl was molested by a medical officer? If yes what was done?

J: Recommendations

- xix. what are your recommendations to improve SRHR services in Malawi?
- xx. what are your recommendations to promote SRHR in Malawi?

Annex 2

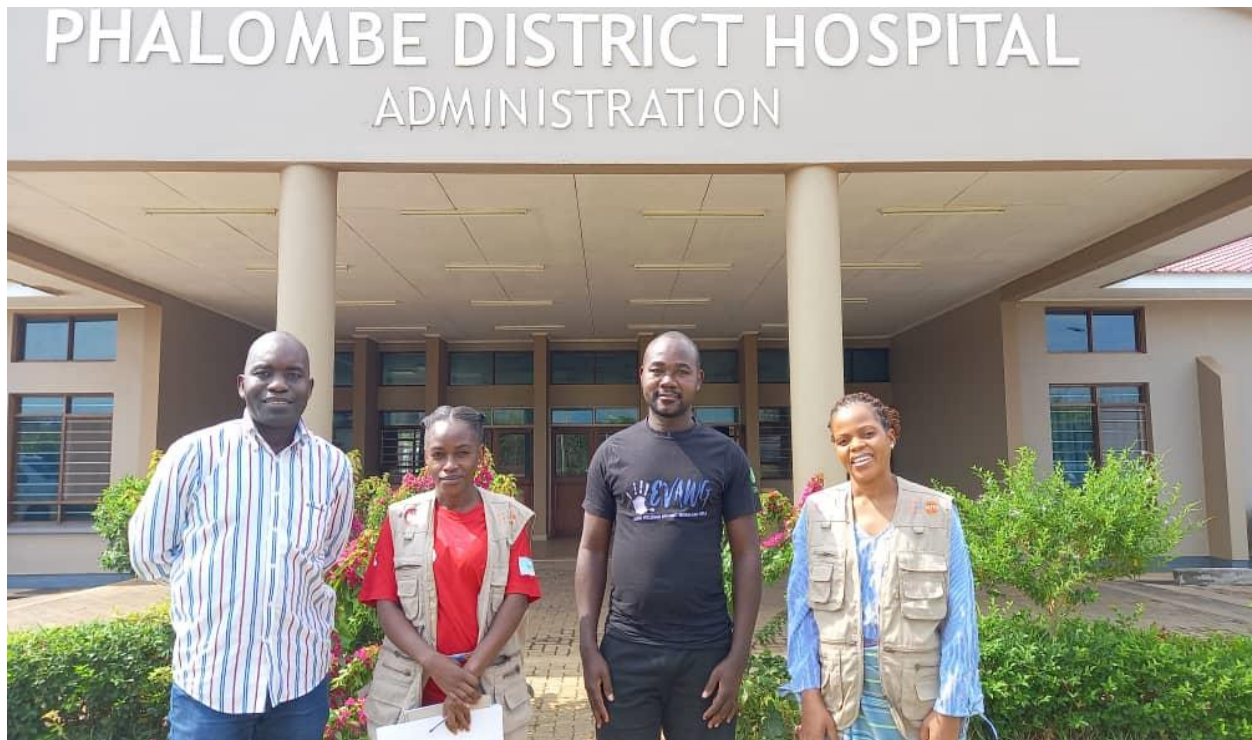


Figure 4: MHRC officers with Hospital personnel



Figure 5: FDG with lactating mothers



Figure 6: KII with one of the service providers



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