Nepal

Rapid gender Analysis for Gorkha

Introduction

Rapid Gender Analysis provides information about the different needs, capacities and coping strategies of men, women, girls and boys in a crisis. Gender analysis does this by examining the gender relations between men, women, girls and boys. This Rapid Gender Analysis is designed to provide an overview of the gender relations between men, women, boys and girls affected by the crisis in Gorkha District.

Methods

The Rapid Gender Analysis in Gorkha uses a range of methods to collect data and information. It is based on the CARE Emergency Pocketbook's Rapid Gender Analysis tool adapted from the IASC Gender Handbook in Humanitarian Action.

Sources of information used in this initial analysis: secondary data, focus group discussions, key Informant interviews.

Dates: Primary data were collected from 3 to 8 May 2015.

Overview of Gender Relations in Nepal

The overall analysis for Nepal is attached in the hyperlink below.

Click Here

Gender Relations in Gorkha Prior to the Earthquake[1]

- The population of Gorkha was 271,061, according to the 2011 Census, of whom **44.09 percent were male** and **55.91 percent female**. The population consisted of 66,506 households, with an average household size of 4.08 people (almost 20 percent of households had more than six members).
- More than one-third (37.20 percent) of Gorkha households were **female headed**, much higher than the national average of 25.73 percent. There are more female headed households than male headed households from the age group of 10–39. Among female-headed households, 18.84 percent are headed by women over the age of 60, and another two percent by girls below the age of 19. For economic reasons many men leave Gorkha to find employment in Kathmandu or overseas. **Male-headed households in which the head of the household is aged 50-70+ comprises 35.05 percent of all households)**
- There is discrimination against single women in Nepal, especially those who have been widowed. Some 6.3 percent of the female population in Gorkha was comprised of widows, divorced or separated women, compared to the national average of 5 percent.[2]

Age Grouping	*% of all marriages*	*Number of marriages*	*% involving male*	*% involving female*
< 10 years	2.4	3,399	14.4	85.6
10-14 years	10.33	14,919	18.11	81.89
15-19 years	45.9	66,283	29.04	71.96

- **Child marriage is prevalent**. Among marriages recorded in Gorkha in 2011 census, the majority involved at least one spouse aged 19 or under (see table). This is a particular area of concern, because child marriages are likely to increase post-crisis as a form of protection and as a means to ease family economic burdens.
- Only 17.9 percent of households reported that female members owned fixed assets (house, land or both), much lower than the national average of 25.73 percent. Thus 82.1 percent of the female population do not own any fixed asset, compared to national average of 79.5 percent.
- According to anecdotal evidence, adult men usually work away from Gorkha, **leaving their wives and children alone**.
- Gorkha is predominantly Hindu, but with a large Buddhist population, and smaller Islamic and Christian populations. A small number of people practice Kirat, Prakriti, Bon, Jainism, Bahai, Sikhism and other religions.
- The caste and ethnicity breakdown for Gorkha is as follows. Hill Janajaties (indigenous) make up 49.9 percent of the population, and Brahman/Chetri (highest level within the caste system and therefore likely to be wealthy) make up 28.2 percent. Dalits (lowest level and therefore likely to be low on the economic scale) are 18 percent, and Newar (indigenous Nepalese originally from the Khatmandu region, who themselves have a separate caste system) make up 3.9 percent.[3]
- **The 2011 census identified 2.3 percent of the Gorkha population as having a disability** (of whom, 44.4 percent male and 55.6 percent female). However the census uses self-identified disability. Due to a lack of knowledge of what qualifies as a disability and stigma

[1]A lot of the information in this section has been taken from http://cbs.gov.np/wp-content/uploads/2012/11/National%20Report.pdf
[2]Poverty and Vulnerability Tool, Households composition – 2011, International Centre for Integrated Mountain Development www.icimod.org

around certain disabilities, these figures should be assumed to be much higher. On average, 15 percent of any population has a disability, and females have a higher rate than males. (This global 15 percent is an average; disability of course varies from context to context according to a number of variants.)

- In Gorkha, people self-identified as follows:
  - Physical disability: 2,066 (58.2% male, 41.8% female);
  - Sensory disability (sight, hearing, speech): 3,176 (50.4% male, 49.6% female);
  - Mental disability: 379 (49.3% male, 50.7% female);
  - Intellectual disability: 188 (55.3% male, 44.7% female);
  - Multiple disabilities: 460 (49.6% male, 50.4% female).
- In Nepal, 38.16 percent of all households had no toilet, while in Gorkha the figure was lower at 27 percent[4], though this will be significantly higher post-quake.

Sex and Age Disaggregated Data

Sex/Age Disaggregated Data for Gorkha
source: Census 2011

Sex	Male				Female				Total
Age Group	0-4	5-19	19-59	60 +	0-4	5-19	19-59	60+	
No.	11,768	46,913	45,536	16,824	11,436	50,416	70,476	17,692	271,061
% by Sex	9.72%	38.75%	37.62%	13.89%	7.62%	33.60%	46.97%	11.79%	

There are significantly more women in all age groups except the 0-4 age group. This is largely because so many men and boys migrate outside Gorkha for employment opportunities. Some men and boys have returned temporarily to help with rebuilding and recovery, but they will soon leave to gain employment to help their families recover from the economic impact of the quake. Many have lost the savings that were invested in their homes, land and livestock.

Initial Gender Recommendations

From these primary and secondary sources of information on gender relations in Gorkha, the following initial recommendations are suggested to support gender-sensitive programming and gender mainstreaming, and to start developing gender-specific projects. Given the incomplete nature of this rapid gender analysis, the recommendations may change as more information becomes available.

Overall recommendations

- Ensure both women and men are consulted in priority needs, distribution mechanisms and access to most vulnerable groups
- Ensure women are represented in all decision-making and consultation structures. All committees being set up, either by organisations or local government, should have at least 50 percent women. Equal number of women and men should be in leadership positions.
- Consult with and involve women's civil society groups and women of all ages, including those who are hard to reach or at risk such as women with disabilities.
- When moving towards early recovery stages, ensure that women are provided with livelihoods and income generation opportunities *based on direct consultation with them* and that activities are tailored to their needs, circumstances, and capacities.

[4] Nepal Census 2011

For more information: emergencygender@careinternational.org

- Ensuring equal access to services for all religions, caste, class and ethnic groups is vital.

SRMH

According to the Global Development Index (GDI), women's life expectancy at birth is 69.6 years (2013 figures).

As the national maternal mortality rate is very high (170 deaths per 100,000 live births), there are likely to be large numbers of women in need of skilled birth attendants and (where not available) clean delivery kits.

- The national contraception prevalence pre crisis was 49.6 percent for the age group 15-49 years, and unmet needs were 25.2% percent.[5] A number of women have reported that their husbands are reluctant to use contraception and do not allow their wives to do so. They are now worried that they will now be in 'trouble' (their word for potential pregnancy) because they are unable to access contraception or convince their husbands to use condoms—this during a time when they need to focus their energy on rebuilding their homes and planning for their future.
- The number of child marriages, and resulting early pregnancies, is high. As a result, the likelihood of complications during child birth is also high, and is a large contributing factor to maternal mortality. Girls below the age of 20 are at significantly higher risk of complications and maternal/child mortality in normal circumstances. Because two hospitals at the district level, three primary health centres, and 25 health posts have been partially damaged in Gorkha, and 33 health posts completely destroyed, women's access to SRMH services is further limited.
- In urban areas, the proportion of births with a skilled attendant was 72.7 percent (2009–2012); this dropped to 32.3 percent in rural areas. With the damage to health services and impact on the population, some skilled birth attendants might not be in a position to continue their work. This should be taken into account for any SRMH programming.

Suggested gender-sensitive responses:

See Overall recommendations, above. In addition:

- Use community health volunteers to address maternal health issues. Nepal has a functioning system with a Female Community Health Volunteers (FCHV) Program. Agencies in collaboration with the district health authorities should mobilise and strengthen this network to address the immediate health needs, especially SRMH needs.
- Ensure access for all by actively engaging women and men from the community and the health workforce, including those who belong to vulnerable groups, equally and at all levels in the design and management of health service delivery, including the distribution of supplies.
- Ensure ongoing and coordinated health service delivery strategies that address the health needs of women, girls, boys and men. For instance:
    - Provide Minimum Initial Service Packages (MISP) so that women and men and adolescent girls and boys have access to priority SRMH services in the earliest days and weeks post-quake, comprehensive SRMH services, including GBV-related services, as the situation stabilises.
- Ensure prevention of and response to GBV as described in the IASC *Guidelines on Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*, including treatment, referral and support mechanisms for GBV Survivors, ensure linkage with GBV actors.

[5] NMIC 5 2015

Food Security

Lack of food and resources to buy food will impact on families and have a deep impact especially on female-headed households and those who have limited mobility (age and disability).

Women and girls (and to a lesser extent boys and men) may enter into exchanges for food and resources. These may be exploitative. In all crises, we must assume and believe that sexual exploitation and abuse – and all forms of SGBV – are happening at a heightened rate.

Pregnant and lactating women and infants require additional nutrition, which may be difficult to obtain due to mobility and discriminatory gender norms. We are already hearing anecdotal evidence that when food quantity diminishes, it is women and girls who are eating less.

For a large number of women, especially in rural areas, livelihood is linked to home-based activities, agriculture and livestock, most of which have suffered damage. Lack of prompt livelihood options will make girls more vulnerable to trafficking.

Food stocks and storage of food have been severely affected, especially in the mountainous areas of Gorkha. Most households have lost most of their livestock, which will make them more vulnerable to food insecurity and (where it is linked to their livelihoods) decreased cash inflows. Estimates of damage to households vary.

Suggested gender-sensitive responses:

See Overall recommendations, above. In addition:

- Ensure that the physical and safety risks associated with collecting food assistance are minimised and that access is universal.
- Ensure that the weight and size of food packages are manageable for women, girls and other at-risk groups.
- Use community mobilisers/volunteers to engage with community, identify those who are unable to collect food, and organise for household/individual distribution.
- Use community mobilisers/volunteers to address gendered access and control issues surrounding food and nutrition in the household.

Further area of Enquiry: Conduct a livelihood assessment

WASH

Prior to the quake, 26.95 percent of Gorkha households had no toilet. Almost half (47.8 percent) of households had tap/piped water source, while others used tubewell and handpumps (35 percent), spout (5.74 percent), uncovered well (4.7%) and covered well (2.45 percent).

Due to gender norms, women and girls take on the responsibility of water collection and management of resources in the home

There is always a possibility of water borne disease and illness associated with lack of sanitation. This will affect women, men, boys and girls differently and this situation should be monitored closely and through a gender lens.

Suggested gender-sensitive responses:

See Overall recommendations, above. In addition:

- Ensure that menstrual hygiene items are locally and culturally appropriate. In some locations they use cloth and in others pads. Get specific information for your locations to plan for procurement.
- Ensure that hygiene promotions activities encourage hand-washing (which was not prevalent before the crisis) and work with the District health official and FCHV who have had success in this to address the issue.
- Ensure water points, latrines and bathing facilities set up/being used for those without a home are sex-disaggregated and universally accessible. Mitigate risk of sexual violence:

ensure all facilities are centrally located, lockable and lighted.

Shelter

Prior to the quake, one in ten households (10.85 percent) used liquefied petroleum gas for fuel; 84.33 percent used firewood (the national average is 64 percent). Given the extent of destruction to homes, even more people are likely to rely on firewood. Further, given that cooking and firewood collection are considered jobs for women and girls, there is a likelihood that they will need to travel to forests to source firewood and there are protection risks related to the same. Safe cooking options need to be made available to households, and a regular supply of fuel easily accessible. Because wood will be needed for construction, forests should not be depleted for firewood. Safe and clean alternatives need to be provided.

Women's cooking duties are made particularly difficult: food stocks have been lost, and most cook stoves have been destroyed. Outdoor cooking will be difficult due to the rainy season. Inability to provide food may put women at risk of abuse.

Dignified areas for privacy are not in place.

Suggested gender-sensitive responses:

See Overall recommendations, above. In addition:

- Deliver construction materials for women, girls and other at-risk groups to their homes, and provide physical support (labour). This is to avoid protection concerns and physical constraints preventing construction. Protection concerns include theft of goods, exchanging sexual favours for construction labour, and attack if collecting shelter materials.
- Ensure that shelter for female-headed households, child-headed households, people with disabilities, unaccompanied children etc, is sited in safe locations. Conduct community mapping exercises to ensure that they feel safe.
- Provide safe-fuel collection initiatives
- Work with GBV actors to provide and prioritise shelter support for GBV survivors, ensuring that we are able to remove GBV survivors (or those at immediate/heightened risk of GBV) from spaces where they are insecure or at risk of further violence. .
- Ensure that shelter vulnerability criteria include GBV, child protection, age, disability, sexual orientation and gender identity, class, caste, religion and other discriminatory issues present in Nepalese society. Include female-headed households, child-headed households and other issues that contribute to vulnerability and that are likely the result of the crisis itself.
- Ensure that people have access to a combination of blankets, bedding or sleeping mats to keep them warm and to enable separate sleeping arrangements. There should be enough blankets and bedding for each person: in other words, there should be no need to share them within households, which could lead to women and girls (or possibly boys and men) going without.
- Ensure that NFI kit contents are culturally appropriate and include appropriate male and female clothing, for different ages and body sizes, including underwear. Use Volunteers to engage with the community and raise awareness on individual entitlements; the quality and variety of the items they should receive; place, day and time of distribution. Clothes distributions should be conducted as market-style distributions where people can choose the right types and sizes of clothes for them. Consider separate distributions for men and women.
- Female outreach workers should work within communities to identify households where *purdah*, *chaupadi* or other harmful traditions are practiced. Identify widows, female-headed households, child-headed households and people with a disability or impairment: these groups (along with other groups mentioned in this document) have mobility and access issues either because of physical restrictions or gender norms. Address this by ensuring identification in a non-stigmatising way, and house-hold distributions until an alternative, context-appropriate solution can be found. Volunteers may be able to extend distributions

to the household level where distribution teams do not have the bandwidth to do so. This will further ensure that we are delivering a community driven response.
- Where community members are given the responsibility of distributions, they should work in pairs and be given a quick overview of Prevention of Sexual Exploitation and Abuse (PSEA) policies before working (and before a more formal training can be given after the acute phase of the emergency has passed).
- Provide solar lighting as part of shelter kits (ideally two lamps or torches and spare batteries)
- Use Volunteers to organise group collection of fuel for cooking and heating. Women and girls are at increased risk of sexual violence if collecting fuel on their own. Ideally, distribute smokeless fuel to decrease health risks to women and mitigate the risk of sexual violence and the burden of collecting fuel.

GBV

All humanitarian personnel should assume and believe that GBV, and in particular sexual violence, is taking place and is a serious and life-threatening protection issue, regardless of the presence or absence of concrete and reliable evidence.[6] Humanitarian actors often have difficulty believing that this is the case during an environmental emergencies. *Due to the breakdown in normal social protection mechanisms, GBV (and in particular sexual violence) increases, and disproportionately affects women and girls.*

Survivors of GBV may not have access to services, or know where existing services are. This places them at particular risk of dying or complications from physical injury, HIV contraction, STI contraction and pregnancy – all of which may be prevented with access to appropriate care.

Due to gender discrimination, women and girls may more generally be denied access to resources, opportunities and services –this denial is itself a form of GBV.

From the later acute phase of the crisis onwards, other types of GBV are likely to increase. Intimate partner violence may rise as gender roles are challenged and frustrations increase. The already endemic issue of child marriage may escalate as poverty deepens and families seek to reduce the economic burden on the household and the burden to protect the girl. This phenomenon has been seen in crises in South Sudan, India, Syria, Somalia, Nigeria and Pakistan—all countries where child marriage is prevalent.

Suggested mainstreamed gender and protection responses:

See Overall recommendations at the start of the Initial recommendation section, above.

In addition:

- Mainstream GBV guidelines into CARE's sectoral response.
- Share the GBV referral pathways (being finalised the GBV sub cluster) with all staff, partner staff and volunteers, and provide orientation on how to share information on referral and what to do when they interact with a survivor.
- Use community mobilisers and volunteers to deliver information about GBV mitigation and the health impacts (in particular) of certain forms of GBV. Make sure to include child marriage: we should strive to prevent their rise. Inform the community on where to receive appropriate services and why it is important to do so (prevention of HIV contraction, emergency contraception and STI prophylaxis) within 72 hours.
- Be aware that schools are closed at least till the end of May, and this will increase the child-care burdens on women and older girls.
- Boys and girls are at heightened risk of experiencing violence in humanitarian settings due to a lack of rule of law, lack of information, restricted decision-making power and their level of dependence. They are already discussing their frustration to not able to provide for their families.

[6]IASC GBV in Humanitarian Action Guidelines 2005. And where possible the roll out of the new pilot guidelines

- Be aware that children are more easily exploited and coerced than adults, and are often taken advantage of by people in authority. Proximity to armed forces, overcrowded camps, and separation from family members all contribute to an increased risk of exposure to violence.
- Coordinate with GBV and child protection actors, agencies.
- We will be collecting and analysing key gender and protection concerns on a weekly basis to inform our Humanitarian programming . This information will also be made available to the Gender Task Force and the Protection cluster for them to address issues where appropriate.