‘We are women, we are survivors, and we are here to assist each other’

(Community volunteer *‘activista’*, participating in focus group discussion in Montepuez, August 2021)

A rapid assessment of the gender-based violence (GBV) situation and response in Cabo Delgado, Mozambique

The UN Refugee Agency (UNHCR) in Mozambique and the London School of Hygiene & Tropical Medicine (LSHTM)

UNHCR The UN Refugee Agency

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AUTHORS

This rapid assessment was conducted by a research team based at the London School of Hygiene & Tropical Medicine's (LSHTM) Health in Humanitarian Crises Centre, with support from the United Nations Refugee Agency (UNHCR) in Mozambique.

Research team:

LSHTM (UK)
Giulia D'Odorico
Mazeda Hossain
Jennifer Palmer

UNHCR (Mozambique)
Elisa Jamal
Danielle Scarpassa do Prado
Colleen Roberts

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CORRESPONDENCE

Correspondence about this document can be sent to Jennifer Palmer (jennifer.palmer@lshtm.ac.uk) at the London School of Hygiene & Tropical Medicine, 15–17 Tavistock Place, London WC1H 9SH or Colleen Roberts (robertco@unhcr.org) at UNHCR.

PARTNERS

The London School of Hygiene and Tropical Medicine (LSHTM) is renowned for its research, postgraduate studies and continuing education in public and global health. The Health in Humanitarian Crises Centre at LSHTM works in partnership to advance health and health equity in crises-affected countries through research, education, and translation of knowledge into policy and practice.

The United Nations Refugee Agency (UNHCR) is mandated by the United Nations to lead and coordinate international action for the worldwide protection of forcibly displaced persons of concern including refugees. In certain contexts, UNHCR also supports internally displaced people (IDPs). In all of its activities, UNHCR also promotes the equal rights of women and girls. UNHCR is currently providing Protection responses in the IDP context of Cabo Delgado, Mozambique, including community-based protection, GBV prevention and response, and Protection Cluster coordination.

All photographs have been provided courtesy of UNHCR Mozambique to describe the context of service provision for internally displaced people in Cabo Delgado and do not specifically depict gender-based violence (GBV) or GBV-related services.

If you require this leaflet in an alternative format, please email: jennifer.palmer@lshtm.ac.uk

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Executive Summary

Displaced Family in Najua B IDP site, Ancuabe District, Cabo Delgado, Northern Mozambique. ©UNHCR/Martim Gray Pereira.

During humanitarian crises, gender-based violence (GBV) is a life-threatening health and protection issue, often continuing beyond the early phases of emergencies. GBV is a common violation faced by internally displaced people (IDPs), particularly for women and girls, but also for men and lesbian, gay, bisexual, transgender and intersex (LGBTI) populations.

Specific evidence to guide GBV responses in Cabo Delgado is needed. In the province of Cabo Delgado, in northern Mozambique, over 740,000 people have fled the north-eastern and central parts of the province since armed conflict began in 2017. Existing evidence suggests that GBV has been a key feature of the conflict. However, specific information that could guide humanitarian responses on the forms and drivers of GBV and the availability and reach of existing GBV services is missing or unclear.

This rapid assessment, carried out by the London School of Hygiene and Tropical Medicine (LSHTM), in collaboration with the United Nations Refugee Agency (UNHCR) in Mozambique, sought to understand the GBV risks and response for displaced populations in Cabo Delgado. Information was collected through qualitative interviews with GBV service providers and focus group discussions (FGDs) with community-based volunteers involved in the GBV response. Data was collected between August and October 2021 in the districts of Metuge, Montepuez and Pemba. All research activities followed existing guidelines on safe and ethical research on GBV in emergencies.

The conflict in Cabo Delgado has had a devastating impact, especially for women and girls who are experiencing ongoing and new forms of GBV. The crisis has compounded multiple forms of GBV including intimate partner violence (IPV), physical and sexual violence, abduction, sexual trafficking, sexual exploitation and abuse (SEA), early and forced marriage, and economic violence. Existing support structures and prevention measures have been widely compromised by conflict and displacement, leaving the urgent needs of GBV survivors overwhelming unaddressed.

Different vulnerable groups have different GBV-related risks. Adolescent girls are at particular risk of abduction, sexual violence, early and forced marriage, and trafficking in conflict-affected areas. Sexual exploitation and abuse appear to be pervasive in IDP locations and in some host communities, particularly against single women, female-headed households and unaccompanied girls. Disabled women and girls are also considered a high-risk group, although knowledge on the extent and forms of violence against them is still very limited. Men and boys and LGBTI persons were also identified as a high-risk group, particularly of physical and sexual violence by armed combatants, although very few cases are reported.

Displaced populations face heightened GBV risks in IDP sites and host community areas where they seek safety. In IDP sites, both the female and male population are exposed to physical and sexual violence and harassment by armed actors. Many displaced people lack civil identification documentation which exposes them to physical and sexual violence from armed actors, particularly sex workers. Traditional discourses about the insecurity that IDPs face often promote men's roles in protecting women while normalising and amplifying controlling behaviours towards women and girls, which may restrict some women and girls from seeking support.

Socio-economic vulnerability related to the crisis is increasing vulnerability to GBV. IPV and early or forced marriage were reported by families who have lost their livelihoods, and experienced acute food insecurity and housing instability due to the crisis. Other forms of GBV are directly linked to the socioeconomic vulnerability of already at-risk groups. This includes the sexual and economic exploitation and abuse of women and girls within a wider context of transactional sex and unequal gender norms within household, community leadership and humanitarian assistance distribution structures. The socio-economic risk factors of GBV need to be addressed by GBV responses and humanitarian programs.

Existing government GBV services have been extensively disrupted by the conflict and displacement, particularly in the hard-to-reach north-eastern and central zones of the province from where many GBV service providers had to flee or interrupt the provision of services. In the southern districts where most displaced people have found refuge, government actors and humanitarian agencies are collaborating to adapt GBV programmes to the new context and needs. Several women's and girls' safe spaces have been created, while other key structures have been strengthened, such as volunteer-led community awareness programmes, and outreach programmes.

There is a grave lack of access to essential support for GBV survivors especially for the most at-risk groups in remote conflict-affected locations. GBV survivors' safety, care and recuperation are impacted by gaps in access to comprehensive GBV case management. These include access to healthcare, social services, safety support (including safe shelter and women and girl's safe spaces), and access to justice and protection which are especially lacking in the north-east. Across the province, multiple barriers are preventing access to existing government and NGO services, such as limited resourcing and capacity, long travel distances, stigma and limited community awareness.

The capacity of GBV services to provide quality responses in line with national and international guidance is limited due to the scale of needs, lack of adequate resourcing and limited technical capacity building. Some service providers lack protocols and guidance adapted to specific GBV needs found in a conflict and displacement context. The risk that responders may reinforce harmful gender norms, discrimination and harm is a particular concern given that many service providers appear to lack knowledge of frameworks that should guide quality survivor-centred care.

Existing GBV response programs are still adapting to the new crisis context. There is an urgent need to fully engage with the groups at heightened risk of GBV and understand how displacement and conflict have created new vulnerability dynamics. Vulnerable groups include sex workers, women and girl heads of households, unaccompanied and separated children, adolescent girls, LGBTI persons, persons with disabilities, and men and boy survivors. However, existing programs often lack resources, training and guidance to effectively and safely respond to their specific GBV needs.

Coordination between GBV response services is limited and impacts quality and holistic care for survivors. Service providers are often not aware of other programs or options available for survivor support, thereby reducing their capacity to provide integrated support to survivors. Equally, information and data related to GBV risks and needs is not always shared between actors to improve response.

Recommendations to improve GBV prevention and response for vulnerable groups in Cabo Delgado include: providing urgent funding to scale up survivor-centred GBV response service provision across the province; ensuring that essential GBV services are provided by trained service providers and are accessible to all vulnerable communities; fostering strong community-engagement and robust coordination between government, NGOs actors and the community; mainstreaming GBV risk reduction programs, especially to protect against SEA, across all humanitarian sector programs; strengthening linkages with livelihood and other development actors as part of integrated response services; and supporting further research to develop effective programmes for at-risk groups, particularly adolescent girls.

Paquitequete beach, where hundreds of families fleeing violence arrived in Pemba, Cabo Delgado, Northern Mozambique. © UNHCR/Martim Gray Pereira.

Acronyms

APEs:	Agentes Polivalentes Elementares/ Elementary Multipurpose Agents
CCPC:	Comités Comunitarios de Proteção da Criança/Community Committees for the Protection of Children
CMCC:	Camp Management and Camp Coordination
CMR:	Clinical Management of Rape
DGCAS:	Departamento de Género, Criança e Acção Social/Department of Gender, Children and Social Action
FGD:	Focus-Group Discussion
GAMC:	Gabinete de Atendimento a Mulher e Criança vítimas de violência/Office of assistance to women and children victims of violence
GBV:	Gender-Based Violence
GBV AoR:	Gender-Based Violence Area of Responsibility
GBVIMS:	Gender-Based Violence Information Management System
IASC:	Inter-Agency Standing Committee
IMC:	International Medical Corps
ID:	Identification Document
IDP:	Internally Displaced People
IDPs:	Internally Displaced Persons
INE:	Instituto Nacional de Estatística/National Institute of Statistics
IOM:	International Organisation of Migration
IPAJ:	Instituto de Patrocínio e Assistência Jurídica/Sponsorship and Legal Assistance Institute
IPV:	Intimate Partner Violence
KIIs:	Key Informant Interviews
LGBTI:	Lesbian, Gay, Bisexual, Transgender, Intersex
LSHTM:	The London School of Hygiene and Tropical Medicine
MGCAS:	Ministério de Género, Criança e Acção Social/Ministry of Department of Gender, Children and Social Action
MHPSS:	Mental Health and Psycho-Social Support
MoH:	Ministry of Health
NSAGs:	Non-State Armed Groups
NGO:	Non-Governmental Organization
PEP:	Post-Exposure Prophylaxis
PSEA:	Prevention and Sexual Exploitation and Abuse
SAJJ:	Serviço Amigo de Adolescentes e Jovens/ Adolescent and Youth Friendly Service
SEA:	Sexual Exploitation and Abuse
SOP:	Standard Operating Procedure
SRH:	Sexual and Reproductive Health
STIs:	Sexually Transmitted Infections
UCM:	Universidade Católica de Moçambique/ Catholic University of Mozambique
UN:	United Nations
UNFPA:	United Nations Population Fund
UNHCR:	The United Nations Refugee Agency
UNICEF:	United Nations Children's Fund
USAID:	U.S. Agency for International Development
WASH:	Water, Sanitation and Hygiene
WFP:	World Food Programme
WGSSs:	Women and Girls' Safe Spaces
WHO:	World Health Organization

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Thousands displaced by conflict in north urgently need assistance. Northern provinces, Mozambique. © UNHCR/Deiliany de Souza.

Introduction

This rapid assessment aimed to describe the context of gender-based violence (GBV) in the conflict-affected province of Cabo Delgado, Mozambique and identify gaps and opportunities in protection responses to improve access to services and the wellbeing, health and safety of GBV survivors.

Gender-based violence (GBV)[1] in humanitarian crises is a serious violation of human rights and a life-threatening health and protection issue. During complex emergencies GBV disproportionally affects women and particularly girls [2, 3], although men, boys and lesbian, gay, bisexual, transgender and intersex (LGBTI) populations [4, 5] also experience multiple forms of violence, including GBV.

In conflict affected and displacement settings such as Cabo Delgado, GBV risks can be heightened in a context of armed and societal violence, acute socio-economic vulnerability, rapid reconfiguration of living arrangements and social networks, and adoption of new legal, social and gender norms which enables impunity from GBV incidents. The forms of GBV that displaced populations are at higher risk of include intimate partner violence (IPV), sexual violence, sex trafficking and sexual exploitation, early and forced marriage [3]. Alongside these heightened risks of abuse and violence, existing support structures and prevention measures are often compromised by conflict and displacement, making access to support for GBV survivors even more challenging [6, 7]. On the other hand, humanitarian crises can also attract international attention, funding and programmes which introduce new, international forms of expertise and programmatic approaches, such that different displacement situations (such as sites for internally displaced persons (IDPs)) and phases of crisis provide different opportunities for intervention [8, 9].

Since armed conflict erupted in 2017 in the Province of Cabo Delgado in Mozambique, attacks on local communities by non-state armed groups (NSAGs) and subsequent military interventions have caused widespread violence against civilians as well as destruction of homes, schools, health centres, and government offices. Most of the attacks are concentrated in the north-eastern and central parts of the province (e.g., Macomia, Mocimboa da Praia, Muidumbe, Nangade, Palma and Quissanga). Most people escaping violence find refuge in the southern districts of Cabo Delgado, particularly in the districts of Mueda, Montepuez, Metuge and Pemba as well as in other provinces in the country (Figure 1)[10]. Violence has displaced over 744,949 people [10], while other vulnerable individuals remain in areas which are still difficult to access by humanitarian actors. Children and women are key vulnerable groups, representing 52% and 27% respectively of the overall IDP population [10]. Those who have fled face challenging humanitarian conditions in displacement, with the majority (around 80%) staying with relatives and host communities who face socio-economic hardships themselves, and the remaining living in formal or informal IDP sites[2] [11]. Others have fled to Tanzania, but the Tanzanian government has been forcibly returning people they identify to Mozambique since September 2020 [12][3].

Within Cabo Delgado, multiple sources and forms of evidence suggest GBV has been a key feature of the

1. In this report we will adopt the IASC definition of Gender-Based Violence (GBV): 'an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (e.g., gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private' [1].
2. The Cabo Delgado context of displacement includes persons of concern located in internally displaced persons (IDPs) sites which could include but are not limited to relocation sites, temporary accommodation sites, and host community extension sites; host community locations could be urban or rural settings, as well as temporary shelters, community shelter solutions, foster families/alternative care, and any other location in Cabo Delgado where persons of concern may be residing.
3. According to UNHCR, between January and June 2021, over 9,700 Mozambicans fleeing violence in the Cabo Delgado Province to seek asylum in Tanzania were forcibly returned to Mozambique, while exposing them to worse living conditions at the border as well as to GBV and other health risks [12].

conflict [14-26]. However, specific information that could guide humanitarian responses such as the forms and drivers of GBV, the impacts on GBV survivors, and the availability and reach of existing GBV services is missing or unclear. This rapid assessment sought to understand the GBV risks and response in Cabo Delgado from the perspectives of service providers, their views on gaps and challenges, and priority areas where adaptations and new interventions are needed. The findings are intended to provide guidance for appropriate prioritization and coordination of GBV programming, policies and funding.

Largest movements recorded during the reporting period

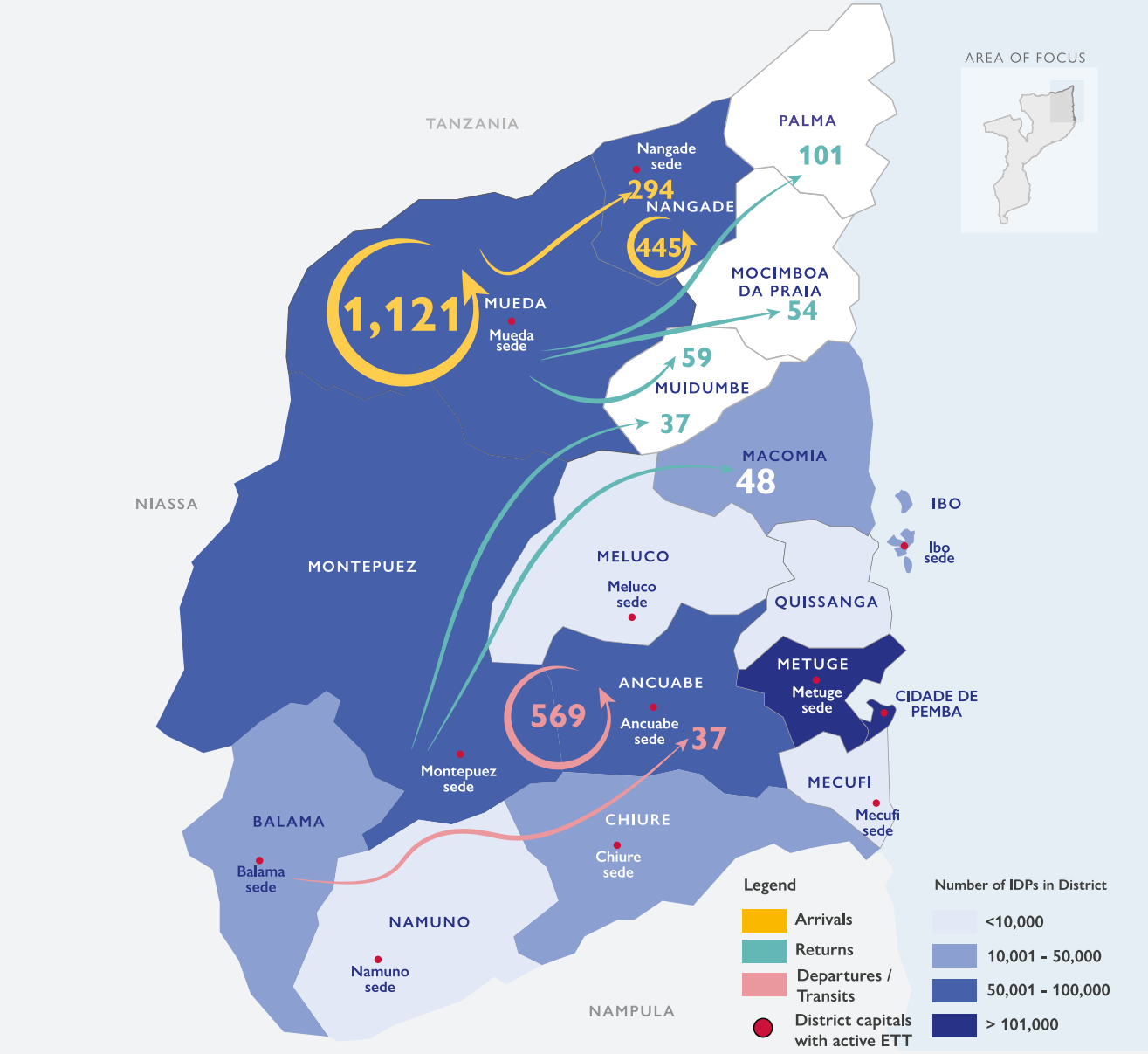

Figure 1. Estimated IDP presence and movements, as of 17-23 November 2021. [13]

Source: The International Organization for Migration November, 2021, Displacement Tracking Matrix. IOM ETT Report: No. 131/ 17-23 November 2021.

The depiction and use of boundaries, geographic names, and related data shown on maps and included in this report are not warranted to be error free nor do they imply judgment on the legal status of any territory, endorsement or acceptance of such boundaries by IOM. Creation date: 17 November 2021.

Study design

A qualitative study design was used, drawing on interviews and group discussions conducted between August and October 2021. Interviews were held with representatives of 39 organisations or government departments providing services potentially targeting populations at risk of GBV including: healthcare, psychosocial, case management for GBV survivors, protection, legal aid services, material support and women's and girls' safe spaces.

The views of community-based providers working as *'activistas'* (outreach volunteers)[4], traditional birth attendants and GBV case workers in these programmes were mainly sought through six in-person focus group discussions (FGDs), which were conducted with 33 people from IDP or host communities.

Research participants came mainly from the provincial capital, Pemba and the districts of M etuge and Montepuez, all of which host large populations of IDPs[5]. These areas are relatively secure which facilitates a high operational presence of humanitarian responders [28] and enables safe and ethical research on GBV [29]. Existing GBV and psycho-social services were mapped before starting interviews and discussions to facilitate safe and consented referrals of any disclosures of GBV that were anticipated to arise during data collection. GBV survivors or the wider IDP community were not directly targeted for participation for both ethical and practical reasons given the scope of the assessment project. Several GBV safety audits and needs assessments conducted by responding organisations which have directly collected information from affected communities using participatory methods were, however, reviewed alongside other research produced between May 2020 and October 2021.

For further details on study methods, including a list of participants' characteristics and documents reviewed, see Appendix.

Data from interviews, FGDs and response documents were analysed to describe and contextualise the types of GBV and risk factors (section 1) and reflect on GBV service provision (sections 2-4) within categories and in relation
to best practices commonly adopted in global guidance for responding to GBV in humanitarian action [1, 30-33] and existing government policies [34]. We particularly enquired about populations identified as vulnerable including girls and young women, disabled people, LGBTI people and sex workers. We collected information on providers' and community outreach volunteers' direct experiences of responding to GBV happening in displacement settings as well as to the needs of forcibly displaced people who have left and are continuing to arrive from the most insecure areas of the province. While many providers conceptualised limited access to GBV information and services as a key risk factor for GBV, especially when this was due to discrimination and isolation, we mainly present our analyses of GBV service coverage and access
in Sections 2-4, focusing on the response in the districts of Pemba, Montepuez, and Metuge.

4. Community outreach volunteers, commonly known as 'activistas' in Mozambique, are community members who perform a pivotal role in supporting prevention and response programs within a variety of sectors (e.g., health, protection, water, sanitation and hygiene (WASH) and nutrition), acting as a liaison between programs or services and other community members. In Cabo Delgado, 'activistas' working in community-based protection programming are particularly key resources for sharing information about GBV prevention and services and responding to incidents of GBV within their communities.
5. The districts hosting the highest number of IDPs in the province of Cabo Delgado are Pemba (152.702), Metuge (127, 646), Mueda (79.223) and Montepuez (58.930). In Montepuez an estimated increase of IDPs (12.111) was recorded between March and September 2021, due to fear of attacks in Nangade and Muidumbe [10]. In Metuge IDP population mainly resides in six IDP sites (Tratara, Unidade, Ngalane, EPC de Manono, Ntocota, Naminawe) and six host community extensions (EPC 25 de Junho, Saul, Cuaia, Centro Agrario de Namuapala, EPC de Nangua, Nquitcha). In Montepuez IDPs reside in four IDP sites: Centro de Piloto Mapapulo, Centro de Ntele Mapapulo, Nicuapa A, Centro de Namputo [27].

Data was collected collaboratively by a team of investigators from the London School of Hygiene & Tropical Medicine (LSHTM) and the United Nations Refugee Agency (UNHCR) based in Pemba. The research was approved by the Department of Gender, Children and Social Action in Cabo Delgado (DGCAS) (the government institute mandated with provision of protection services for GBV survivors), the UN humanitarian system's Protection Cluster GBV Area of Responsibility (GBV AoR) working group in Cabo Delgado (mandated to improve the effectiveness and accountability of humanitarian response for the prevention, risk mitigation and response to all forms of GBV), as well as the LSHTM's research ethics review committee.

REPORT STRUCTURE

This report is divided into four sections:

1. **Experiences of gender-based violence in Cabo Delgado:**

   This section provides an overview of the types and context of GBV experienced in the province and risk factors which increase vulnerability.

2. **The GBV response in Cabo Delgado:**

   This section maps out the main response structures providing GBV services in the province by government and humanitarian actors as well as the community entry points and informal structures that support access to them.

3. **Barriers to care-seeking for GBV survivors among IDPs:**

   This section explores potential barriers to GBV care-seeking identified by providers.

4. **Gaps in the GBV response:**

   This section outlines key gaps in the GBV response from the perspective of service providers working within the response.

Displaced woman joining International Women's Day recreational Activities in Pemba, Cabo Delgado, Northern Mozambique. ©UNHCR/Martim Gray Pereira.

1 Experiences of gender-based violence in Cabo Delgado

GBV is a common experience in Mozambique but among people affected and displaced by conflict in Cabo Delgado it appears to be even more prevalent.

Although GBV affects all genders, violence against women and girls was reported more often by the assessment participants than violence against men and boys. Adolescent girls, women and girl heads of household, unaccompanied children, people with disabilities, LGBTI persons and sex workers are reported to be at greatest levels of risk of GBV, although service providers have reported also helping men and boy survivors of GBV [35]. Intimate partner violence (IPV), sexual exploitation, and sexual violence are particularly common among women and girls, and particularly in IDP sites. They may also experience socio-economic and psychological violence. Early and forced marriage is reported as very common among adolescent girls both in conflict and displaced settings. Violence against men and boys, LGBTI and disabled persons, particularly physical and sexual violence, seems to be underreported and for some of these groups only few GBV survivors have sought support. Table 1 presents an overview of the types of violence that were reported by GBV service providers in Cabo Delgado. Table 2 presents the identified risk factors for GBV by vulnerable groups.

PHYSICAL VIOLENCE

Physical and sexual violence perpetrated by a male intimate partner (IPV) was reported as common in Cabo Delgado before the conflict[6], and has continued amid the conflict and displacement. **Wives being beaten** is described as the most common occurrence of IPV. For example, it was reported that girls in Montepuez who are in early marriages experience male-perpetrated physical violence [38]. One interview respondent mentioned that a woman was beaten by her husband for attending activities organized at women's and girls' safe spaces. Another service provider reported that a husband hit his wife for coming home late after collecting water and not having prepared food on time.

Respondents attributed IPV to various interconnected stressors related to the socio-economic context of conflict and displacement: loss of livelihoods and increased household dependency on humanitarian assistance, and changes in gender norms and roles, such as the increased role of women as breadwinners within the household, which may expose them to domestic violence.

> 'I do not know if it is because in the IDP sites, men when they wake up, they do not have a proper house to stay in, they do not know where to go and therefore feel frustrated, not a week goes by without attending at least two to three cases of women who are physically assaulted at home. When we ask if it is something new to them, if their husbands used to do it before displacement, women always answer that violence started in the IDP sites. When women go to collect water, if they come home late because there are often long queues, men accuse them of betrayal and beat them'.
>
> (GBV case worker, government service)

6. According to the National Institute of Statistics of Mozambique (Instituto Nacional de Estatística or INE), based on data collected from the Offices of Assistance to Family and Children Victims of Violence (Gabinetes de atendimento a família e menores vítimas de violência), in 2020 8,1% every 10,000 inhabitants in the province of Cabo Delgado were female survivors of domestic violence [36]. Between 2014 and 2016, they were the 5,8% [37]. We are, however, aware that these figures may represent only an increase in the number of reported cases in Cabo Delgado and not necessarily an increase in domestic violence.

Table 1. Contexts of GBV during conflict and displacement in Cabo Delgado identified through the assessment[7]

Violence types (definitions)	Types of violence reported to service providers	Common perpetrator profiles reported
Physical violence		
Hurting or trying to hurt someone physically. This may include hitting, kicking, burning, grabbing, pinching, shoving, slapping, hair-pulling, biting, or using other physical force that results in injury.	Intimate partner physical violence (i.e., hitting by a male intimate partner)	Husband/Intimate partners
	Non-partner physical violence (i.e., hitting or any other act that results in injury)	Armed actors Community members Clients of sex workers
Psychological violence		
Causing fear by intimidation or threats. This may include threatening physical harm to self, partner, family members, or children; destruction of property; or forcing social isolation from family, friends, or others.	Controlling behaviours, social exclusion Threats of physical violence, stalking, humiliation	Husband/Intimate partners/Family, in-laws Community members
	Threats of physical violence, intimidation particularly against survivors of sexual exploitation and abuse Verbal harassment, particularly against adolescent girls	Community leadership Community members People involved in humanitarian assistance
	Discrimination and social stigma for being associated with non-state armed actors	Armed actors
Sexual Violence		
Forcing someone to take part in a sex act without consent. This may include sexual harassment, unwanted sexual touching, forced stripping, or non-consensual vaginal, anal, or oral penetration by another person or object.	Sexual violence, particularly against women and girls and sex workers	Community members Armed actors Family, in-laws
	Child sexual abuse	Family, in-laws
	Sexual violence against men and boys (e.g., group sexual violence by armed combatants in conflict-affected areas)	Armed actors
	Marital rape	Intimate partner

Sex trafficking & exploitation		
Forced exploitation of people through force, coercion, abduction, fraud, or deception.	Sex trafficking, particularly of adolescent girls	Community members
	Sexual exploitation, especially of women and girls	Community leadership People involved in humanitarian assistance Armed actors
	Abduction and sexual violence, particularly against adolescent girls	Non-state armed actors
Economic violence		
Controlling someone through financial dependency. This may include controlling all financial resources, denying, or withholding access to money or payment, extortion, or forbidding employment.	Denial of economic resources/assets (e.g., inheritance, child maintenance, humanitarian assistance) Controlling financial resources (e.g., harvest proceeds) Forbidding employment	Husband/Intimate partners
	Denial of payment, extortion of money and belongings of sex workers	Armed actors Community members
	Extortion of money from GBV survivors	Armed actors
Early and forced marriage		
Marriage where at least one spouse is under 18 years old. This may be forced or non-consensual. Girls are most often married at a young age, drop out of school, and can become more vulnerable to violence.	Early and forced marriage	Family members Community members Community leadership
	Forced marriage (through abduction and sexual violence)	Armed actors

7. The descriptions of the types of violence provided here are based on data emerging from interviews, FGDs and document review. They are presented in relation to international standards for categorising GBV [3] and do not necessarily match definitions of violence by the national legal system of Mozambique.

While some households were broken up by conflict and during flight, IPV compounds stressors for women and contributes to the break-up of households in displacement settings. For example, a service provider described attempting to help a displaced woman subjected to continuous physical and psychological violence from her husband until he eventually expelled her from the home, forcing her to stay with her sister.

Other forms of physical assault include **physical violence against female sex workers**[8] by clients and by armed actors. A focal point from the sex workers' rights platform said that they often helped displaced sex workers who were beaten by male clients refusing to pay an extra amount after breaking the condom on purpose. They also mentioned that armed actors often beat sex workers, especially when drunk. While many comments are related to female sex workers, most informants were unable to comment on violence potentially committed against displaced male and transgender sex workers.

Physical violence perpetrated by armed actors against women and men occurs in conflict zones, during flight and in IDP sites. During displacement, stigma and discrimination towards people originating from conflict-affected areas also contributes to increased levels of violence, with IDPs often accused of affiliations with non-state armed groups. For example, a service provider reported that armed men in Pemba accused some single women arriving in the provincial capital after the Palma attacks in March 2021 of having insurgent husbands fighting in the north and subjected them to discrimination and physical violence. During an FGD, one community volunteer reported a case of a boy who was carrying construction materials in an area surrounding an IDP site and who was stopped by armed combatants and beaten. Other service providers reported giving support to displaced men and boys who had lost teeth and received bruises after being subjected to armed violence or robbery, often when they were out at night. One interview respondent mentioned that IDPs prefer to finish work earlier and walk home when it is still day-light in order to avoid being out at night and being stopped by armed actors as they risk being subject to physical violence and robberies, especially if they do not have any formal identification on them. Risk factors for this violence may be a combination of violating COVID-19 restrictions and discriminatory attitudes towards IDPs. Reports of discrimination against displaced people is common in the IDP sites with service providers describing how local people often refer to displaced people with nicknames such as *'Al-shabaab[9]'.*

PSYCHOLOGICAL VIOLENCE

Along with physical violence, women survivors of IPV often suffer **psychological violence** from their husbands or intimate partners. A GBV case worker reported a case of a woman whose husband controlled and monitored all her movements and would hit her in public, which left her feeling afraid and vulnerable. The case worker furthermore worried about the impact of IPV on the psychological wellbeing of the survivor's children.

Displaced woman from Palma hosted at Pemba Temporary Centre, Cabo Delgado, Northern Mozambique. ©UNHCR/Martim Gray Pereira.

8. Sex work is not considered a legal activity in Mozambique, although it is not criminalized by Mozambican law. The law, however, condemns any behaviours seen as assaults on decency and public morals, such as having sex in a public space or dressing 'indecently' (Article 225 of the 35/2014 Law) [39]. Sexual exploitation and trafficking are prohibited. In particular, the law penalises persons who 'professionally or with any lucrative intention encourage, promote or facilitate another person entering prostitution' (Article 227 of the 35/2014 Law). The law on human trafficking (Article 11 of the 6/2008 Law) prohibits recruiting or facilitating the exploitation of a person for purposes of prostitution, forced labour, slavery, or involuntary debt servitude [40]. The 7/2008 Children's Rights Law (Article 63) prohibits the exploitation of children in prostitution [41].

> ‘When she was physically assaulted in public by the husband, she started feeling ashamed to go out of the house, speak to other people, other women. […]
>
> The husband was prowling day and night around the house where she stayed.
>
> She was feeling very vulnerable, she was afraid because she did not know why he was always there, what were his intentions. […] We also noticed that the violence against her had negative repercussions on the children. […] They were very scared of the father’.
>
> (GBV case worker, international organisation)

Alongside this, service providers reported that men and boys often feel that displaced women and girls need their protection in IDP sites because of widely-recognised risks of sexual violence and harassment. This discourse that promotes men’s roles in protecting women and girls also, however, has a tendency to normalise and amplify controlling behaviours towards women and girls. Some IDP sites, for example, have imposed curfews and prohibitions on the sale of alcohol after 4pm specifically to reduce sexual violence [42] however, early curfews are especially enforced for adolescent girls by their parents, rather than for adolescent boys or men [38]. While women in some camps have promoted travelling in groups as a feasible solution [43], in most displaced settings, men have promoted the creation of community police or security groups predominately led by men [38, 43, 44].[10]

Women and girls may also be forbidden to meet in each other’s homes [41]. Wives may even be prohibited by their husbands to visit women’s safe spaces because of the lifestyles and freedoms for women these centres are perceived to promote, using the logic that learning about women’s rights could lead to greater harm for men:

> ‘When we speak about the safe spaces with women, what they say is […] husbands forbid women to visit them because the spaces are prohibited to men; ‘wrong’ things are probably taught to women; women who attend the safe spaces learn about their rights as women and may stop being submissive to their husbands’.
>
> (GBV case worker, government service)

Curfews and limitations to women’s and girls’ ability to move freely, however, may magnify the feelings of fear and insecurity in public spaces that they already have. A GBV case worker described how since the emergence of the non-state armed groups (NSAGs) and their violent attacks on villages, some girls express near constant fear of remaining alone because there are anxious about being sexually assaulted or abducted. Girls have told her that they prefer to sleep during the day to be able to run away at night if they are attacked; some reportedly also prefer not to go to school for the same reason. Case workers believed that the constant fear and anxiousness of threats of violence could, in the longer term, reduce girls’ opportunities to participate in community activities and develop strong social networks needed to avoid social isolation and the associated risks of IPV and other forms of GBV.

Women and girls also often feel unable to report experiences of violence due to **threats against them or their families** by the perpetrators. Threats may include further violence, including death. Service providers reported that displaced women expelled from their homes were threatened with murder by their intimate partners if they returned. Perpetrators may also threaten survivors not to go to hospital if they need medical care, as shared by male community volunteers during an FGD. Perpetrators of sexual exploitation threaten women and girls by saying they will delete their names from humanitarian assistance lists to receive food or other forms of aid if they speak out. One respondent described how a community

9. *Al-shabaab* (the youth in arabic) is one of the several names by which the non-state armed groups (NSAGs) are known in Cabo Delgado. It seems there are no known connections between Al-Shabaab in Somalia – the Al-Qaida-affiliated jihadist organization – and references to Al-Shabaab in Mozambique [20].
10. Community Policing Councils *(Conselhos de policiamento comunitário)* are also officially foreseen by the Ministry of Interior with the aim of involving volunteer citizens in crime prevention. Some major challenges have however been identified, such as their illegal recourse to the use of force [42] and the illegal use and possession of arms [43].

leader who abused a displaced woman put pressure on her landowner to threaten to evict her if she did not withdraw her police complaint.

SEXUAL VIOLENCE

Sexual violence in **conflict-affected areas** has been frequently documented by other investigators [14, 15, 19, 20, 23, 45-48]. Women and girls originating from Mocímboa da Praia, Quissanga, Macomia and Ibo reported being **abducted by armed combatants** [22]. Abductions of women and girls have also been documented by other investigations [14, 15, 20, 23, 46-48]. Sexual violence against women committed by armed actors in conflict-affected areas has also been documented [20, 45]. Men and boys are also targeted for recruitment as new fighters [20, 22]. Sexual violence has also happened **during flight**. Girls fleeing the conflict reported to service providers about being raped by unknown men at night while they were sleeping in the forest. One respondent described an adolescent girl who was raped by four men while trying to move from one IDP site to another.

Only one service provider reported supporting a **boy** who recounted his experience of sexual violence by a group of armed actors while he was running from the conflict zone.

Sexual violence also occurs in IDP sites. Women and girls might be sexually assaulted on their way to the fields or to get firewood or collect water, as well as in their homes, or in bars. Sexual violence might be committed by family members, as well as other men from host and displaced communities and armed combatants. During other assessments, women have mentioned **marital sexual violence** as among the most common GBV forms [49]. Other cases of sexual violence and abuse towards children was also often reported by service providers, with perpetrators including other family members (such as a stepfather or brother-in-law), and neighbours and other displaced men.

> 'A girl of 14 years old was raped twice by an armed combatant. She was on her way to the field. He raped her. Another day she saw him again. She started running away. He started chasing her [...] he raped her

Displaced mother and her three daughters hosted at the temporary centre in Pemba, Cabo Delgado, Northern Mozambique. ©UNHCR/Martim Gray Pereira.

> again. When she came home, the mother realized that something was wrong. The girl denied, because the armed man threatened her that if she spoke out, he would kill her parents. The mother accompanied the girl to the hospital. When she was left alone with the staff, she told us everything that had happened'.
>
> (GBV case worker, government service)

> 'A girl of 11 years old was attending the celebrations for a national festivity in a IDP site. She stayed late and she asked a man she knew to accompany her home. The man forced the girl to follow him into the bush and he raped her. The man then accompanied the girl home. Once at home, the girl spoke to the mother about what happened.'
>
> (Community-based worker, international organisation)

> 'An adult woman went to a place where they sell traditional alcohol in an IDP site. Some young people – she does not remember the exact number, but she knows they were many – raped her in group.'
>
> (GBV case worker, international organisation)

Service providers mentioned that risks are higher for adolescent girls and persons with disabilities due to limited community, school, and peer protective mechanisms and for living in insecure and crowded areas. In interviews and other assessments [38, 42], service providers reported that women and girls feel unsafe with the presence of armed combatants in the camps, mainly due to previous experiences of violence by fighters in the conflict affected areas and during flight. They also mentioned that women and girl IDPs have been critical of certain aspects of the living conditions within IDP sites, which, in their opinion, increases their risks of being targeted by sexual violence and harassment. Limited availability of firewood[11], food and non-food items inside the IDP sites force women and girls to venture out, often at significant distance, to peripheral areas of camps (e.g., small gardens, the bush, markets). The limited lighting at night in IDP sites, particularly in latrines which are often not adequately separated, are situated far from living areas, and often without doors or locks [11, 51] compound feelings of insecurity among women and girls especially[12].

When they are outside their homes in the IDP sites, adolescent girls and young women also experience **verbal, sexual and physical harassment by men and boys from host and IDPs communities.** They feel threatened by men and boys in the streets who call them 'whores' and subject them to unwanted sexual touching when found alone [44]. Adolescent girls may also be sexually harassed by armed combatants in IDP sites, as indicated by community volunteers in Metuge. Service providers mentioned that hostility by the host population towards IDPs – particularly as they are considered materially privileged or affiliated with the armed groups – result in verbal harassment by men from the host communities against displaced women and girls [35]. Most service providers were unable to report evidence of sexual and physical violence, or sexual and verbal harassment against lesbian, gay, bisexual, transgender, intersex (LGBTI) and other gender non-binary persons. This may reflect that this **violence against LGBTI and other gender non-binary people is hidden** and not reported. A service provider who identified as coming from this community, however, described how LGBTI people often shared their feelings of insecurity in IDP settings and fear of homophobic and transphobic attitudes from both host and IDP populations.

> 'I met four boys in Pemba. [...] A boy used to live with his parents [...] they have been abducted by the non-state armed combatants [...]

11. In all the locations, households primarily collect their cooking fuel (wood) individually which can raise protection concerns during fuel collection – GBV – as highlighted by the International Organisation for Migration (IOM) [50].
12. In the majority of the locations (69%) no one has access to at least 2 hours of lighting per night at the household level, while in 77% of locations, no street light is available for at least 4 hours per night and 62% of the locations reported no sources of lighting in/around latrines. Limited access to lighting might lead to protection risks, such as GBV as highlighted by the International Organization for Migration (IOM) [50]. In 50% of the locations, not enough individual lighting solutions (e.g., solar lanterns, torches) for each family member are available [10, 50]. Only 11 sites (33% of the total) reported that latrines are separated for males and females [10].

> They said that in their areas of origin they had the support of their families who could understand who they are, but here it is more difficult.
>
> They are new to the city, people look at them in a different way, as if they were different people'.
>
> (Focal point, LGBTI community)

Representatives from the sex workers' community also reported that **displaced sex workers** are particularly exposed to sexual violence. One said that displaced women are often raped by armed men if they are caught without identification documents[13] or violating the COVID-19 curfew.

> 'Police abuse displaced sex workers. When they say that they are from Mocimboa da Praia, they threaten them because they do not have any ID document. They say that they will release them only if they accept to have sex with them for free. They are worried and prefer to accept it. They inform me that the day after they will not come [to work] because they are worried it will happen again'.
>
> (Focal point, sex workers' community)

Interview respondents described that displaced sex workers usually work in more insecure work environments such as their homes in host communities and IDP sites and on the streets because of fear of police raids and professional competing interests between new/young displaced sex workers and older/longer term local sex workers (e.g., displaced sex workers' rates are lower). Their limited knowledge of Portuguese and/or other local languages, and little work experience, especially for the new and youngest sex workers, limits their ability to assess the risks and increases the chances of exposure to sexual violence and abuse.

SEX TRAFFICKING AND EXPLOITATION

Exchange of sex, or commonly known as *'sexo de troca'* in Mozambique, has been documented as an everyday reality in Cabo Delgado prior to conflict and displacement [53], especially among adolescent girls. This is when people actively engage in transactional sexual relationships to offset extreme poverty and meet basic personal or household needs but also to access consumer goods, such as clothing, a telephone, a hairstyle, more appetizing food (e.g., fish) or money to go to the cinema, as indicated by community volunteers in Metuge and Pemba. For many displaced women and girls, it plays a large role in their survival strategies during flight and in IDP settings where households may be even more economically stressed. Families may directly or indirectly encourage girls to engage in it. In some circumstances, transactional sex may expose displaced women and girls to sexual exploitation, sexual and physical violence.

Displaced women in Montepuez District, Cabo Delgado, Northern Mozambique.
© UNHCR/Martim Gray Pereira

13. Although access to civil identification documents (e.g., 'ID', such as birth certificates, marriage and divorce certificates, identity card among others) is a common problem for both displaced people and host communities, IDPs are particularly affected by it. Many have never had an ID, others may have forgotten or lost documentation during flight; in other cases, their ID has been burned or destroyed in the areas of origin. According to an evaluation done by the Protection Cluster in 2020, 45% of IDPs in 5 districts of Cabo Delgado did not have civil documentation [52]. This may result in serious protection risks for displaced people, especially for women and girls. Girls who cannot prove their minor age, for example, are thought to be easy targets for sexual trafficking as well as early and forced marriage [52]. Interview respondents also reported that some GBV survivors faced challenges accessing legal assistance without IDs and might be turned away from police to report GBV crimes associated with withholding food assistance when they could not provide evidence that they lived in a settlement site.

In conflict-affected areas, women and especially adolescent girls are highly exposed to being **forcibly or deceptively trafficked for sexual activities.** Women and girls who escaped abduction by armed combatants reported having heard that some fellow prisoners were going to be trafficked by these groups to Tanzania [22]. Participants in this rapid assessment and previous reports [54] also reported that families of girls and boys in conflict-affected zones and IDP sites may also be deceived by offers of jobs and education opportunities, as confirmed by community volunteers in Metuge.

> **'Young displaced girls are at high risk of trafficking and sexual exploitation and abuse. They are highly mobile. They tend to cling to someone in order to be able to move from one site to the other. [...] We helped two young girls of 14-15 years old. They were brought by a local transporter from a district where they were already displaced to [location]. Once here, the man put the girls in a house where he abused them over two weeks. When they asked him to pay them as promised, he refused. They then ran away from the house without clothes, money. They were walking around the city looking for a way to go back to where they came from. They were therefore referred to us in order to receive support.'**
>
> (GBV case worker, government service)

Sexual exploitation and abuse (SEA) of women and girls happens during flight and in host communities and IDP settings [17, 24, 55, 56]. It might be actual or threatened by soldiers and security personnel, influential community members in positions of authority with access to resources (such as community leaders or others involved in humanitarian assistance distribution)[14], or host community members and other IDPs.

Service providers, for example, reported women and girls having to submit to requests or demands for sexual favours in exchange for 'safe passage' to displacement areas, including by armed actors.

Most cases of sexual exploitation and abuse reported by respondents in IDP sites related to demands for sexual favours to include individuals (often women or girls, particularly those who are single or unaccompanied) or households on food distribution lists, or in exchange for food, shelter, or construction materials. Community leaders were described as the main perpetrators. The predominantly male camp leadership and complex distribution structures that are not easily challenged by the most vulnerable may contribute to increasing the sexual exploitation risks faced by recipients of assistance.[15] Some girl heads of households reported to a service provider that they have been beaten by community leaders after objecting to their exclusion from assistance distribution lists.

It seems common for girls, including those who have children and household responsibilities, to struggle to get on distribution lists; some have been required to pay bribes to community leaders [38]. Another participant described how a community leader removed from the assistance distribution list the name of a young girl who had refused sex with him and shamed her in the community by saying that she was HIV positive. Another service provider described how one young girl became pregnant as a result of being forced to have sex with a person in charge of food distribution. Unaccompanied and newly arrived women are particularly vulnerable to sexual exploitation.

> **'The chief of the neighbourhood took advantage of a displaced woman who recently arrived to the IDP site. She did not have a place to stay. She had many children. She did not have any food to give to them. The chief told her that if**

14. We ensured that any cases of SEA documented during interviews and focus group discussions were referred to the Protection from Sexual Exploitation and Abuse (PSEA) Network for further follow up. Cases of sexual exploitation have also been reported by other investigators [24].
15. Local women's committees and disability inclusion committees have been created to strengthen decision-making in camp management in some displacement sites, such as in Katapua and Meculane in Chiure district [57]. Additionally, the World Food Programme (WFP) and its partners encourage the formation of Community Committees for projects' management (*Comitê Comunitárias de Gestão de Projetos*) to facilitate participation in and community feedback about food assistance-related issues. Committee members must sign a code of conduct and are elected by the community every 6-12 months. Women must represent at least 50% of the members and representatives from vulnerable groups (people with disabilities, the elderly, and adolescents) need to be included. Such committees are not yet present in all districts.

> she slept with him, he would give her food and a house. She accepted. She had to sleep with the man. She slept one, two times with him. He only gave food to her'.
>
> (GBV case worker, international organisation)

Family members might also submit their children to sexual exploitation or force them into sex work.

> 'We met a case of a displaced adolescent girl of 13 years old who lived in a house with her sister-in-law. The sister-in-law forced the girl to have sex with an older foreign man in order to contribute to household expenses [...]. The girl got pregnant. The sister-in-law accompanied the girl to the hospital to do an abortion. The girl did not want to meet the man anymore. [...] The case was referred to the GBV services.'
>
> (Community outreach volunteer, local organisation)

Respondents also pointed out that individuals who perpetrated this kind of exploitation in host or IDP communities were often economically vulnerable themselves and sought to take advantage of displaced women and girls often to benefit from the assistance and services provided [35].

ECONOMIC VIOLENCE

Economic violence is a major form of GBV experienced by women and girls in the resettlement sites. It is related to factors that were present before the conflict, such as gender inequality regarding access to education, the formal and informal labour sectors, and **discriminatory practices relating to inheritance**, property rights, access to land for widows and personal maintenance in cases of divorce.[16]

> 'A displaced woman was expelled with her children from her house after the death of her husband. The husband's family deprived the woman of her husband's death certificate, the bank cards. The cousin of the husband wanted to marry her, but [...] she did not want to be forced to marry another man'.
>
> (Legal Aid Coordinator, government service)

Other factors relate directly to the current context of increased economic vulnerability caused by conflict and displacement and the ways humanitarian assistance is provided to communities. Poverty and food insecurity – exacerbated by reduced food assistance and compounded by pre-existing gender inequalities[17] – can inevitably worsen women's vulnerability to GBV. Humanitarian assistance gets distributed to households and men are typically identified as the heads of households on humanitarian assistance lists which affects women's ability and agency to safely access resources. Respondents frequently described men who abandoned their wives and children during flight or relocation movements, expelling female family members from their homes, and **denying or restricting funds needed for necessities** such as food, clothing, and shelter. Men

Displaced woman wearing a PSEA hotline T-shirt in Mapupulo IDP site, Montepuez District, Cabo Delgado, Northern Mozambique. ©UNHCR/Martim Gray Pereira.

16. Mozambique's federal laws provide important protection and opportunities for equitable property and inheritance rights, including for women in cohabitation without marriage. However, customary law – which often acts to the detriment of women and children – remains dominant, especially over inheritance practices and property rights, in many areas of the country [58, 59].
17. The World Food Programme (WFP) has been providing half monthly rations in food in Cabo Delgado since July 2021 through October due to limited resources [60]. Other humanitarian organisations are providing food assistance and the government have started distributing seeds and other agricultural inputs to beneficiaries. Humanitarian assistance needs are, however, expected to remain high and food insecurity is likely to become a trigger for the movement of IDPs. People in Cabo Delgado are expected to be in Integrated Phase Classification (IPC) phase 3-crisis for food insecurity through May 2022 [61].

can also use the assistance they receive for other uses (e.g., alcohol) instead of providing support to the family, selling it without informing their wives or sharing it with other partners, as indicated by community volunteers in Metuge and Montepuez.

> **'We met many cases of displaced single women and girls abandoned by their [male] partners when the latter discovered that they were pregnant. Women and girls therefore have to take over the responsibility to provide for the basic living expenses of the children. We also met some cases of inheritance after the husband's death. In some areas the husband's family inherit the family assets and gets primary custody of the children [...]'.**
>
> (Legal assistance project coordinator, local institution)

In assessments conducted by other organisations, **women** said that unemployment and the limited income generating opportunities in IDP sites make them **dependent on their male intimate partners** [49]. One respondent from a women's rights organisation reported that many women seek jobs to earn small amounts of additional income, although they frequently face opposition from their husbands who prefer their wives to stay at home, as confirmed by female community volunteers during an FGD in Montepuez. During an FGD a community volunteer in Montepuez mentioned that a displaced man left his wife without sharing any income from the family harvest. This not only affects their socio-economic autonomy, but also increases their risk of being forced to stay in violent relationships due to their economic dependency [49].

The **disruption of education services** in conflict-affected areas, communities hosting IDPs and IDP sites in Cabo Delgado[18] particularly affects adolescent girls. They are consequently more likely to be kept at home to help with childcare and domestic responsibilities (e.g., caring for younger siblings, cooking, fetching water, getting firewood, working in the fields), as mentioned by some girls in Montepuez in another assessment [38].

Women and girl sex workers are highly exposed to socio-economic violence linked to stigma and discrimination attached to their occupation as sex workers and their displacement status. Representatives of the sex workers' rights platform described how displaced sex workers may be extorted for money. Clients, especially displaced men who are often poor, might steal money or belongings from sex workers. They might also not pay, or pay less than the agreed price, especially if sex workers are young or new to the job and do not have much negotiation experience.

Threats of economic violence may also be perpetrated by armed actors who may take advantage of IDP women's vulnerability. For example, a service provider described how a woman who was beaten by her husband in public was then asked to pay a fine by law enforcement actors for disturbing the public peace and disorderly conduct.

Displaced girl collecting water in Najua B IDP site, in Ancuabe District, Cabo Delgado, Northern Mozambique. ©UNHCR/Martim Gray Pereira.

18. Although the majority of child IDP population have access to education services (in 85% of sites), in some sites education services are not available. Some schools may not be functional; where schools exist, children may face some barriers to access education, such as lack of documentation (e.g., birth certificate which is necessary to be enrolled), shortage of teachers, lack of space and resources for school materials, long distances to reach schools [11].

EARLY AND FORCED MARRIAGE

Early and forced marriage are common experiences in conflict and displaced settings in Cabo Delgado. Prior to the conflict, around 18% of women married before the age of 15 and 60% married before 18 years old.[19] Comparable data are not available since the start of conflict in 2017, though reports of child marriage to a national child helpline increased in the 2018-2020 period.[20]

In conflict zones, **forced marriage of abducted women and girls to non-state armed actors** has been frequently reported [22, 26][21]. Very few GBV service providers have heard directly from displaced people about their abduction or forced marriage experiences. Displaced people are very reluctant to speak about it, for fear of being identified by non-state armed groups after escaping captivity [22] or to be considered their collaborators by other armed groups and host communities.

In other cases, **early marriage is often associated with certain factors that were present before conflict,** such as gender inequality and household poverty made worse by recent climatic crisis (Cyclone Kenneth in 2019), which have been further exacerbated by the conflict. Early marriage is often a means for displaced families to cope with economic hardship by reducing the economic burden that daughters place on their families [38] and service providers reported hearing of adolescents being promised in marriage by families having to split up while fleeing conflict. Some parents also reportedly use the early marriage of their daughters as a strategy to access safe passage to more secure areas [64], as well as to access humanitarian assistance.

Girls separated from their families may be forcibly or deceptively enticed to get married during flight and in IDP sites. Unaccompanied girls may also voluntarily engage in early marriage as a coping strategy to ensure their financial security or perceived protection within a marriage relationship.

> **'A girl of 14 years old ran away from the conflict zone. When she arrived in a site alone, she met an older man and she married him as she did not know where her mother and her family members were.'**
>
> (GBV case worker, international organisation)

Early marriage might also be driven by the negative impact of conflict and displacement on women and girl's access to services, particularly those related to sexual and reproductive health, and opportunities. The loss of education and livelihoods opportunities for displaced adolescents can motivate them to enter into early relationships which can result in early or unplanned pregnancies and marriages. Conflict and displacement have also splintered family and community networks and several respondents pointed out that children now spend more time unsupervised. They might therefore be exposed to sexual abuse. Early relationships and sexual abuse can result in a pregnancy, with early marriage used by the families to prevent the stigma and hardships of continuing pregnancies outside of marriage, as mentioned by community volunteers during an FGD in Metuge.

19. In Mozambique the most recent data available are over a decade old, pre-dating the outbreak of current conflicts in the Cabo Delgado Province. According to a 2015 UNICEF publication based on data from the Demographic and Health Survey (*Inquerito Demográfico e de Saúde (IDS)*) for 1997, 2003, 2011, Multiple Indicator Cluster Surveys (MICS) for 2008, projections from the 2007 Census and administrative data from the Ministry of Education, in Cabo Delgado 17.6% of women married before reaching the age of 15 and 60.7% before the age of 18; 11.4% of girls tend to get pregnant before 15 years and 40.2% before the age of 18 [62].
20. Between February 2018 and November 2020, the non-profit organisation, *Linha Fala Criança* (Hotline Child Speaking), which provides a free telephone helpline to report abuse of children, recorded 648 cases of early marriage in Mozambique. They noticed an increase in number of cases reported to them over this period, potentially related to greater awareness linked to approval of new legislation against early marriage in 2019 as well as sensitization campaigns by humanitarian actors following the Idai and Kenneth cyclone crises in 2019, though the crises themselves could also be compounding factors [63].
21. In 2020 *Observatório do Meio Rural* (Rural Environment Observatory), a national NGO, conducted interviews with 23 women and girls aged 15 years and above from Mocímboa da Praia, Quissanga, Macomia and Ibo, who were attacked or kidnapped by non-state armed groups and who were able to escape captivity and move to other displacement areas. A woman reported that abducted women and girls were forced to become "wives" to the insurgents, to follow the most radical rules of Islam, or, if they are Christian and do not want to convert, they become their slaves [22]. In the BBC Africa Eye investigation [26], women who were abducted reported that *'When women are taken to Mocímboa, first they are treated like slaves, they cook, fetch water, are taken for military training; then, they marry the Al-Shabaabs. When they come back from training, they can no longer dress like us, they must wear the burqa, clothes, socks, gloves on their hands, only the eyes are left visible'.*

Displaced community attending a Prevention of Sexual Exploitation and Abuse session prior to the distribution of Core Relief Items, Ngalane IDP site, Cabo Delgado, Northern Mozambique. ©UNHCR/Martim Gray Pereira.

Table 2. GBV risks for conflict-affected people in Cabo Delgado identified through the assessment

At-risk groups	Examples of GBV exposure	Key GBV risk factors
Adolescent girls	• Sexual violence • Sexual exploitation and abuse • Sex trafficking • Early and forced marriage • Intimate partner violence	• Age and gender • Disruption of family, community, and peer networks of support and protection • Increased controlling behaviours by family and community members • Limited access to education and social assets • Poverty, food/shelter insecurity • Increased domestic responsibilities • Presence of armed combatants • Problematic layouts of IDP sites (scarce lighting at night; latrines not adequately separated and far from living areas; lack of doors and locks for latrines and houses; overcrowded accommodations; limited availability of firewood, food and non-food items inside IDP sites) • Early pregnancies and motherhood • Engagement in transactional sex and sex work • Limited access to reproductive health and GBV information and services • Some discriminatory gender-related discourses and practices in initiation rites
Women and girl heads of household	• Sexual violence • Sexual exploitation and abuse • Early and forced marriage	• Age and gender • Poverty, food/shelter insecurity • Gender discriminative systems of assistance provision • Disruption of family, community and peer networks of support and protection • Social stigma by armed actors and host communities because of being associated with non-state armed groups • Presence of armed combatants • Engagement in transactional and sex work • Space and physical camp/site layout

Separated or unaccompanied minors (girls and boys)	· Sexual violence · Sexual exploitation and abuse · Sex trafficking · Early and forced marriage	· Age and gender · Loss of family members, particularly immediate caretakers (i.e. parents) · Early pregnancies and motherhood · Poverty, food/shelter insecurity · Engagement in transactional and sex work · Problematic space and physical camp/site layout · Presence of armed combatants
People with disabilities*	· Sexual violence · Sexual exploitation and abuse · IPV	· Age and gender · Isolation and disruption of family, community and peer networks of support and protection · Limited access to reproductive health and GBV information and services due to discrimination · Poverty, food/shelter insecurity · Social stigma and discrimination because of being considered not sexually active or at risk · Space and physical camp/site layout
Men and boys	· Physical violence · Sexual violence	· Gender · Presence of armed combatants · Limited access to reproductive health and GBV information and services
Lesbian, gay, bisexual, transgender, intersex (LGBTI) people and those with any other gender identity	· Physical violence · Psychological violence · Sexual Violence	· Discrimination based on sexual orientation and/or gender identity · Isolation and disruption of family, community and peer networks of support and protection · Limited access to reproductive health and GBV information and services due to discrimination · Poverty, food/shelter insecurity · Engagement in transactional and sex work
Sex workers	· Physical violence · Sexual violence · Socio-economic violence	· Age and gender · Social stigma and discrimination by communities · Presence of armed combatants · Lack of identification documents · Isolation and limited peer networks of support and protection · Limited access to reproductive health and GBV information and services due to discrimination and isolation

* Violence against men with disabilities was not reported by service providers interviewed. This however, most likely reflects that it is not often disclosed.

2 The GBV response in Cabo Delgado

In Cabo Delgado, GBV services are provided by both government and humanitarian actors. Dedicated government GBV services covering safety, legal assistance, medical, psycho-social, and case management support tend to be located in district capitals while additional front-line support may also be available in government health centres and police stations throughout the districts.

Since 2017, government GBV services have been extensively disrupted due to violent attacks while also facing rapid and sustained increases in their workload due to conflict and displacement. A variety of humanitarian actors have been working to strengthen government services or introduce supplemental entry points for GBV survivors in areas serving large populations of IDPs. GBV survivors typically access formal government and humanitarian response services through community-based structures such as community-based volunteers and other health actor networks (such as government health outreach workers (*Agentes Polivalentes Elementares*/Elementary Multipurpose Agents) or traditional midwives (‘*matronas*’), women’s and girls’ safe spaces (WGSSs), community-based complaint mechanisms (such as the United Nations free hotline, *Linha Verde* (Green Line), local community committees for the protection of children (*Comités Comunitarios de Proteção da Criança (CCPC)*), or youth groups. These structures are often organised by humanitarian programmes in collaboration with the government structures. GBV survivors may also seek help informally from families, local leaders, friends and other social and peer networks.

See Table 3 for a snapshot of key structures that were commonly mentioned as having a mandate for or role in GBV response in Cabo Delgado. Key access barriers to GBV services and gaps in the response are presented in Sections 3 and 4.

GBV SAFETY SERVICES

The police have dedicated GBV focal point representatives. They are based within the Government’s provincial and district Offices of Assistance to Families and Children Victims of Domestic Violence (*Gabinete de Atendimento a Mulher e Criança*) in Pemba and Montepuez) and the District Police Command Centre in Metuge. They facilitate access to justice for GBV survivors as well as referrals to other services such as medical support, social support, or free legal assistance. Services at the district offices are designed to be available 24 hours per day, seven days per week, with one female GBV focal point assigned per station. GBV survivors can also report experiences of violence to any police post, which are often closer to the IDP sites, although they may not necessarily meet police officers who are trained on GBV and GBV referral. Most IDP sites do not have police posts on their premises, therefore, survivors living in IDP sites instead tend to report these experiences to other government services, such as **local administrative leadership.** According to some assessments [38, 43, 44], in the absence of police posts, community members in some IDP sites see **community policing councils** (*Conselhos de policiamento comunitário*) as a potential solution to extend GBV policing structures, particularly for sexual violence against women and girls. Community volunteers during FGDs mentioned that GBV survivors may also seek help with humanitarian organizations in the absence of police services in the IDP sites.

Table 3. Overview of structures involved in government and humanitarian GBV responses

Elements of GBV care	Government GBV structures	Humanitarian GBV structures
Safety	Assistance offices for women and children victims of violence (*Gabinete de Atendimento à família e menores vitimas de violência*) Police stations	
Legal and justice	Provincial & district delegations of the Sponsorship and Legal Assistance Institute (*Instituto de Patrocínio e Assistência Jurídica (IPAJ)*)	Paralegal services available at Women's and Girls' Safe Spaces Other paralegal services available across the province through women's rights organizations Mobile legal clinics
Medical and mental health and psycho-social support (MHPSS)	Provincial & district health directorates (*Direcção Provincial e distrital de Saúde*) Province and district hospitals Health centres	Sexual and reproductive health (SRH) and mental and psycho-social support (MHPSS) services available at Women's and Girls' Safe Spaces, through mobile and static health clinics and other actors
Case management Social services	Provincial departments of Gender, Children and Social Action (*Direção Provincial do Género, Criança e Acção Social*) Provincial & district Social Affairs Services (*Serviços Provinciais de Assuntos Sociais*)	Case management services at some Safe Spaces including referrals to core GBV services (health, MHPSS, legal and safety) as well as integrated psychosocial support

GBV JUSTICE AND LEGAL SERVICES

Limited publicly-provided legal assistance for GBV survivors is available in the region. GBV survivors can access free legal assistance through organisations such as the Government's Sponsorship and Legal Support Institute (*Instituto para o Patrocínio e Assistência Jurídica do Estado*, or IPAJ). The IPAJ provides support through juridical technicians who may also include women (as in Pemba, Metuge and Montepuez where at least 1 female juridical technician is present in each district). IPAJ local staff are, however, based in the district capitals and they are rarely able to do outreach on legal rights

UNHCR project helps internally displaced acquire identity documents. Mozambique. © UNHCR/Juliana Ghazi.

awareness due to lack of funding and limited human resources, as reported by a respondent. Limited free legal counselling and assistance is also provided by **local and national civil society groups.** One local university – the Catholic University of Mozambique (*Universidade Católica de Moçambique,* or UCM), offers a mobile clinic to help survivors access identity documents from both displaced and host communities in Pemba, Metuge and Montepuez. This mobile clinic may also provide legal advice for GBV disclosures such as domestic violence, early and forced marriage, parental abandonment, and inheritance issues. They collaborate with government actors, who may also join the clinics. In some locations, local women's rights organisations can provide legal advice through paralegals and juridical technicians who work under the supervision of lawyers. In Pemba and Metuge, some female community volunteers who are responsible for women's and girls' safe spaces have been trained as paralegals who can help survivors navigate the government justice system.

GBV survivors may also seek help from **community leaders** or **community courts**,[22] particularly in cases of sexual violence, IPV or sexual abuse, if the cases cannot be solved between the survivor and/or the families and the perpetrator. According to service providers, in many situations of GBV, community justice structures are preferred instead of government police and district courts for a variety of reasons. With community courts having apparently been set up in IDP sites, as reported by some respondents engaged in the legal response to GBV, they are geographically accessible which reduces transportation and opportunity costs, and people convening the courts are fluent in local dialects. They are also able to offer immediate solutions compared to the formal justice system. Moreover, they may be approached because GBV is often perceived as a 'private' matter and 'officially' reporting a GBV case to police could incur additional stigma and social costs for the survivors and their families.

GBV MEDICAL AND MENTAL HEALTH AND PSYCHO-SOCIAL SERVICES (MHPSS)

Limited medical and mental health and psychosocial support (MHPSS) is available. These services are available in three locations – the government hospitals in Pemba and Montepuez, and the health centre in Metuge. Dedicated GBV focal points in these health care facilities offer GBV survivors emergency medical care (including medication for clinical management of rape, when available) and mental health and psycho-social support. They may also refer the survivor to other GBV services such as police, social support, or free legal assistance. There are two GBV focal points in Pemba, Metuge and Montepuez (including one medical and one psycho-social) and the medical staff often arrange a substitute delegate if the GBV focal points are unavailable. The medical GBV focal points are always female, while the psychosocial support focal points may be female or male. In other health facilities, GBV services tend to be organised through maternity wards for GBV survivors, including male and transgender persons, although GBV focal points may not necessarily be identified. Some facilities at province and district levels, such as the hospitals in Montepuez and Pemba, have dedicated confidential spaces to provide health care to survivors, while other health facilities may not have designated safe spaces, as mentioned by some health GBV service providers.

Some humanitarian actors have been working alongside government health actors to a limited

22. Access to formal state justice systems is limited in Mozambique, including for cases of GBV [65, 66], and most people prefer to use a variety of locally available justice providers [67], including traditional authorities, local administrative authorities and community courts. Community courts have been empowered under the Law (no 4/92 6 May 1992) [68] to resolve minor disputes (familial and marital disputes, land and resource disputes), although in reality they may deal with more serious offenses, such as sexual and physical assault [65, 67]. Court judges are usually composed of locally elected members, the majority of which tend to be male. Women are rarely members, although in some cases women's organisations may be present, such as in cases of family conflicts and sexual crimes against children and young people [65].
The courts' main objective is to achieve reconciliation between parties by applying traditional notions of justice and 'common-sense' principles. The plaintiff may bring the case before the court via the head of the community court directly or via the community authority in the area. If the head of the court considers the case is within his jurisdiction, he will ask the defendant to appear in court, usually the following day. The law enables the community courts to administer alternative penalties (e.g., public reprimand, community work for a period not exceeding 30 days, a fine whose value does not exceed 10,000 MTZ/USD$155.). The decisions of the community courts are binding only if both parties agree. If one/both parties do not agree or if the defendant refuses to appear in court, the case can be transferred to police and to a district court. Community courts operate predominantly orally and few documents are produced apart from those recording the verdict. By law, a tax between 100 and 500 MTZ (approximately USD$1,50-8) has to be paid to the community courts for the service provided [68, 69]. In the area of gender, informal justice processes, including community courts, tend to reproduce gender social inequality, although this may vary depending on the forum and the different positions of the justice providers [65, 67].

extent. This includes strengthening the GBV response by documenting the GBV referral pathway in Montepuez through Standard Operating Procedures. At the time of research, some were planning trainings for government healthcare providers (e.g., on clinical management of rape). Some humanitarian medical actors also contribute to the creation of dedicated GBV safe spaces within health centres (e.g., the Rural Hospital in Montepuez). Others implement mobile health clinics targeting IDP sites, using community volunteers to raise awareness about GBV and offering basic SRH medical care (treatment of injuries, post-exposure prophylaxis (PEP) for HIV, screening/testing for STIs, evaluation for and prevention of STIs, and family planning or emergency contraception). They may also help survivors obtain access to additional services at government health services (particularly for forensic evidence collection and safe abortion) and offer a range of medical follow-up and psycho-social support through phone calls and home visits alongside referral to legal and social services. Such support was appreciated by several research participants based in government facilities:

> **'I also think that the presence of humanitarian assistance actors helps. In the IDP sites much violence occurs but how can they reach me? I need the help of community workers, radio sensitizations, a campaign to spread the message to come.'**
>
> (GBV focal point at health centre, government service)

GBV CASE MANAGEMENT SOCIAL SERVICES

A key task of dedicated GBV focal point representatives within government social affairs offices is to provide case management services and accompany GBV survivors throughout the referral pathway. Based in the main provincial and district cities, however, they are only rarely able to travel to IDP sites due to financial and human resources constraints. In Metuge and Montepuez, humanitarian actors endeavour to extend the reach of these government services to displaced adult GBV survivors and children through outreach programmes, mobile tents, and within women's and girls' safe spaces, however this is often ad hoc as sufficient resources are unavailable. Among humanitarian actors involved in the provision of GBV case management, a key role of staff is to help survivors obtain access to holistic services such as medical care, legal assistance and reporting, food assistance, hygiene items and dignity kits, shelter provision, and family reunification through coordination with government services and other humanitarian actors, although no standardized referral pathways are in place. Case management services usually provide psychological first aid, while a few programmes are able to offer integrated MHPSS support and follow-up meetings with GBV survivors in clinics, safe spaces or home. Occasionally, some service organisations also provide GBV survivors with a cash assistance to ensure they can reach services or to respond to some immediate basic needs.

COMMUNITY ENTRY POINTS

GBV response services in IDP settings and host communities are available through a variety of entry points supported by government and humanitarian actors.

Community-based volunteers *('activistas')*. Many humanitarian assistance actors and government social services collaborate with *activistas* in IDP settings. These *activistas* were widely reported to be responsible for referring most GBV cases to formal structures in the province. Female *activistas* in Montepuez explained this by referring to the similar circumstances and connection that *activistas* have to other women as survivors of the conflict, with one saying,

> **"We are women, we are survivors, and we are here to assist each other".**
>
> (Women's FGD, Montepuez)

Activistas in Metuge also felt that survivors prefer to seek help with them rather than other people, such as community leaders, when they are present and officially recognised, as in IDP sites.

> **'I go house to house to raise awareness about the work I do. If a survivor listens to what I do, then she starts to open up to ask for help. [...] Many people know that there are 'activistas' [in the IDP sites], they may know me. [...] They see me as part of the referral system. [...] If we go to the houses, a survivor may feel comfortable to speak'.**
>
> (Women's FGD, Metuge)

These community-based volunteers are trained by government and humanitarian assistance agencies to deliver their services, including for GBV. Selection criteria, as well as roles, responsibilities, and training differ between organisations. *Activistas* are usually adult volunteers, may be female or male, and may be recruited from host or displaced communities. Some community workers from specific groups (sex workers and LGBTI people) are only based in Pemba. Most have a medium to low level of formal education. In general, community workers hold information and awareness raising activities in the communities on GBV related issues and, when they receive a GBV disclosure, with the consent of the survivor, they refer the survivor to GBV case management. In some cases, they may be asked to escort GBV survivors to referral services and provide basic translation support, as well as to conduct some home-visits. Compensation for their work may include cell phones and airtime or a monetary incentive, varying according to the different actors.

Women's and girls' safe spaces (WGSS). Safe spaces aim to provide a confidential and non-stigmatizing entry point to access GBV case management services. At the time of the research, safe spaces had been created in Cabo Delgado in collaboration with international and national organisations and the support of local governments, yet an up-to-date mapping of these services could not be provided. Safe spaces may take the form of a house or tent in IDP settings or host communities. They tend to operate Monday to Friday, from early morning to late afternoon and offer a variety of activities targeted at different age groups covering: life skills and recreational activities, income generating activities, awareness raising and education on GBV, women's rights and sexual and reproductive health. In some centres group psycho-social support activities and sexual and reproductive health SRH care (such as family planning) may be available. Safe spaces are staffed by dedicated community-based volunteers (both women and men from local and host communities), who receive a monetary incentive, and are remotely supervised by female supervisors based at district level. In some safe spaces GBV case managers can work side by side with community volunteers. Other staff specialized in supporting mental health and psycho-social support (MHPSS) may occasionally (e.g., fortnightly) visit safe spaces to provide one-to-one counselling services. If case managers or community volunteers receive disclosures from GBV survivors, they can refer them to other available GBV services.

Sexual exploitation and abuse (SEA) community complaint and feedback mechanisms. This includes a toll-free hotline set up by the Protection from Sexual Exploitation and Abuse (PSEA) Network[23] (the *'Linha verde'* or Green Line) and complaints boxes in areas targeted for distribution of food and core relief items. Community workers from both government and humanitarian services may also receive complaints from affected community members and assist with the referral. Assistance for identified survivors is facilitated through GBV and child protection programming. Between May and October 2021, 8 cases of gender-based violence (GBV) in Cabo Delgado were reported through the hotline [71-77]. No assessment is available of how or to what extent this system contributes to improving women's and girls' ability to access GBV response services.

Community committees for the protection of children (CCPC). In cases where the GBV survivor is a child, support may be sought through Community Committees for the Protection of Children (CCPC). CCPs report to the Ministry of Gender, Children and Social Action and are implemented by partners working in child protection. They bring together a wide range of community representatives, including children, women, and local leaders, having a role in preventing and responding immediately to cases of child protection incidents, including GBV.

Youth groups. Some youth groups (targeting adolescents 10-19 years old) have been created in IDP sites by humanitarian actors with a mandate to address GBV. In Montepuez, an organisation created eight youth groups for adolescent boys and girls[24] who participate in education activities on GBV and other related topics (sexual and reproductive health and child marriage, risks associated with transactional sex, and available GBV services).

INFORMAL ENTRY POINTS FOR GBV RESPONSE

GBV survivors usually approach their own **families** for immediate support, especially in case of IPV, sexual violence and sexual exploitation [44, 49]. For example, a GBV case manager reported that a survivor who was expelled from her home by a violent husband sought refuge with her sister who also provided her with emotional support. In many cases, supportive families may offer immediate psycho-social and material support to GBV survivors (e.g., a safe place to stay, food and clothes, and escort them to medical services or police). However, families may also not always be equipped to address GBV in gender-sensitive and survivor-centred ways and become a barrier to GBV assistance.

23. The PSEA Network, established in Mozambique in 2019, serves as the primary body for coordination, support and oversight in relation to sexual exploitation and abuse. In Cabo Delgado it is co-chaired by UNHCR. It brings together focal points from UN agencies and national and international NGOs. The existing network implements prevention and response mechanisms against SEA by developing inter-agency SOPs, referral pathways for complaint handling and training programmes for PSEA focal points/network members. Since the start of 2021, UNHCR provided training about PSEA principles and reporting mechanisms to over 250 members of partner organisations, local authorities, and members of IDP and host communities [70].
24. Ntele, Mapupulo Piloto, Nicuapa/Nacaca, Nacate, Napai, Merige, Ncoripo.

GBV survivors (or their carers if they are children) may also seek help from **local leaders**, who are predominately men, especially in cases of IPV, sexual and economic violence. Some community leaders are aware of GBV issues and available services and refer cases to formal GBV structures, particularly medical service providers and police. For instance, one service provider in the justice field reported being approached by a community leader to settle a case of an early marriage involving a displaced girl. In other cases, community leaders have referred GBV survivors to the main hospital or called an ambulance [38]. Community leaders may also be approached by GBV survivors or their carers to access justice in community courts. Community leaders may, also, however be a deterrent to care-seeking. Some service providers reported that leaders may ask for money to assist with referrals or provide letters 'legitimizing' GBV cases as true and some survivors feel they have to seek leaders' permission to go to the hospital or police. In some cases, community leaders are the perpetrators.

Women and girls especially may also seek help from trusted **friends or other informal social networks**. In displacement settings, informal support networks among women and girls who share similar cultural-linguistic backgrounds may exist, as described by a GBV coordinator below and in other assessments [43, 49].

> 'Women often seek support from other women in the community. [...] They go to each other's houses, to meet each other. And especially if a woman is upset or something has happened to a woman or a woman comes to them saying she experienced violence, especially from a husband, they can sit together. They even do things like they sing together; they cook together, you also hear of situations where maybe an elder woman or maybe a woman who is more informed in the community who talked to the women about hospital as an option or the doctor, just totally informally. They may even accompany her to the hospital and go together with them'.
>
> (GBV coordinator, international organisation)

Women with similar life and work experiences, such as sex workers, may also support each other by sharing information about sexual and reproductive health and GBV services or helping each other to seek help when they experience violence. A sex worker peer recounted that she often helped other displaced sex workers survivors of GBV by telling them how to seek medical care or report violence to police and even escorting them to those services. She said that they sought support with her because they consider her 'one of us'.

> 'As a sex worker, it would be difficult go to the neighbourhood secretary to seek help [in case of violence]. The secretary does not know anything about sex work [...] The help must come from a sex worker, not another woman in the community, a sex worker like me can help her. She will think: 'She is not lying to me, because she is 'one of us''.
>
> (GBV focal point, sex workers' community)

In other assessments [44], girls have reported that GBV survivors prefer seeking help from community-based health actors such as **traditional birth attendants (*'matronas'*), masters of initiation ceremonies (*'madrinas'*) [49], or government volunteer community health workers, such as Elementary Multipurpose Agents (*Agentes Polivalentes Elementares*)**,[25] rather than personnel at health centres who are predominantly male. They also fear that health staff may require a 'letter' from their community leader or from police to access health care with the risk that the GBV event becomes 'public'

25. The Elementary Multipurpose Agents (*Agentes Polivalentes Elementares (APEs)*) Programme is an important component of health service provision in rural communities in Mozambique. Community health workers are trained in a variety of topics, including health promotion, disease prevention, diagnosis and treatment of malaria, diarrhoea and dehydration, detection of acute respiratory infection and danger signs in children, adults and pregnant women. They are volunteers and receive an allowance or subsidy and free health care at the local primary health centre or dispensary. Their supervision relies on health workers – usually qualified nurses – from the health facilities of reference. However, many challenges have been identified regarding the successful implementation of the program, including the irregular and infrequent supervision, delayed subsidies, the work overload of APE supervisors, lack of resources (e.g., transportation) and the weak referral systems [78].

knowledge. During a FGD with community volunteers in Pemba, some *'matronas'* reported that adolescent girls in early marriages often seek help from them when they are pregnant or have other sexual and reproductive health needs, being closer to the community than other health structures. Very few other service providers interviewed were aware of the roles that *'matronas'* may play in supporting GBV survivors and no respondent mentioned government Youth Friendly Health Services (*Serviços Amigos dos Adolescentes e Jovens,* or SAAJ) nor the help protection desks as entry points to GBV services.

Displaced girl and her brother in Ngalane IDP Site, Metuge District, Cabo Delgado, Northern Mozambique. ©UNHCR/Martim Gray Pereira.

3 Barriers to care seeking for GBV survivors among IDPs

While the increased presence of assistance actors in Cabo Delgado and support to community-based volunteers has improved access to GBV services, many barriers persist and make it difficult for GBV survivors to seek help.

Key issues identified by service providers as leading to GBV may also pose a barrier to reporting GBV and seeking care. They include self-stigma among GBV survivors and social stigma by families and communities as well as discriminatory attitudes and negative working practices by service providers. The lack of family and community support, which is often disrupted by conflict and displacement, may also reduce survivors' access to help. GBV survivors may not have easy access to information about possible health consequences or available services, particularly when communication barriers exist due to language differences and inappropriate information mechanisms. Poverty, food insecurity and the limited availability of shelter alternative opportunities are also important deterrents for GBV survivors to seek help. The assistance-related costs and the geographical accessibility of the services may also play an important role in limiting survivors' access to support, particularly for those living in the most remote areas.

BARRIERS TO CARE SEEKING

Police reporting requirements as a barrier to accessing health care

Providers in this study, as well as displaced women and girls in assessments [38, 42, 44] often mentioned that health care providers request police certificates or documents from community leaders certifying that they are residents in a certain IDP site as a condition to obtain medical care. In an assessment, some service providers also mentioned that health care staff may refuse to offer medical care to GBV survivors until the police arrive, for fear of affecting evidence collection and legal processes [35].

Consequently, GBV survivors may prefer not to seek care, particularly early medical care, for fear of being forced to deal with reporting to police or other authorities. Moreover, women and girls may not trust police or military forces, with regard to reporting some incidents of violence they may have experienced or witnessed [38]. Alternatively, FGD participants discussed how some GBV survivors may seek medical care but refuse or be reluctant to speak out about whether it relates to GBV which can hinder further support and referral.

There is also a lack of clarity and awareness among GBV survivors and/or their carers about the requirement criteria for legal reporting and access to assistance. Many adult GBV survivors, especially those involved in IPV situations, are very reluctant to take legal action.

> 'Women fear to go to police because they are afraid that their husbands will be arrested. When women get to the health centre, they do not tell the truth, they invent excuses only to receive healthcare and to cover their husbands. [...] they are worried about divorce'.
>
> (Women's FGD, Montepuez).

The decision to take legal action is often the result of a long process of acknowledgment of one own's experience and the evaluation of a variety of conditions

(e.g., losing access to financial support/shelter from the partner or to humanitarian assistance in cases of sexual exploitation and intimate partner violence (IPV), fear of retaliation from perpetrators and/or family members, fear of stigmatization/social isolation in their families/communities, a lack of trust in the criminal justice process), which survivors may not necessarily take into consideration when they seek medical help.

Fear of retaliation and limited protection for GBV survivors who decide to seek help

Service providers felt that many women in Cabo Delgado are very reluctant to seek care, especially from law enforcement forces, because they feel at risk of further violence and reprisals from the GBV perpetrator and people protecting the perpetrators, such as community leaders, once the violence is made public. Their families may also be threatened with violence.

There is no dedicated GBV safe shelter in the province, so service providers must improvise temporary safe shelter options such as letting a survivor spend a few days at health facilities or in a room at police posts. Longer-term solutions may involve transfer to another IDP site, town, district or province where the survivor has identified a support network, building a new house for the survivor, or placing them with host families[26]. Survivors tend to be very reluctant to seek help if they are not sure where they, and potentially their children, can be safe. They therefore may decide to find a safer place by themselves while compromising their access to holistic support services.

Displaced boys in Ntele IDP site, Montepuez District, Cabo Delgado, Northern Mozambique. ©UNHCR/Martim Gray Pereira.

26. Based on a service mapping conducted by UNHCR [35] and information collected through the interviews conducted in this rapid assessment, few shelter options seem to be available in the study areas: accommodation for a limited number of nights is available in the Offices of Assistance to Family and Children Victims of Violence (*Gabinetes de atendimento a família e menores vítimas de violência*) in Pemba and Montepuez, as well as children's activity rooms, although conditions are often not adequate (e.g., limited presence of private dedicated rooms, WASH facilities) [35]. A network of community and faith-based organisations provides shelter options in Pemba, however they usually support cases of child protection or vulnerable families more broadly. Lack of shelters for GBV survivors has already been identified as a national problem by CEDAW whose committee also highlighted that the few shelters currently available in the country are mainly addressed to women and girls' survivors of trafficking and sexual exploitation [79].

> **'We had a case of a survivor raped by a humanitarian worker in an IDP site. When police went to the IDP site, they called us saying that she was not there anymore. A friend of hers reported that she was threatened by the humanitarian assistance worker. She therefore preferred to leave the site'.**
>
> (GBV case worker)

Moreover, as described by a law enforcement representative, when GBV survivors decide to take legal action, the responsibility to inform the perpetrator about the report or precautionary measures (such as a condition of bail not to contact the survivor directly or indirectly) may fall on the survivors themselves, if police or courts lack the logistic and financial means. This exposes survivors to further violence.

Even if the violence is reported to police, according to FGD participants, judicial processes are often very slow, and without sufficient protection mechanisms in place, this can expose the survivor and the family to repeated attacks and intimidation until they withdraw the complaint.

> **'We had a case of a girl who was a survivor of sexual abuse by her legal guardian. We referred the case to the health centre and police [...] The perpetrator is still free [... and] is continuously threatening them [the family] asking to withdraw the police report, to forget what happened, if not he will kill them.'**
>
> (Child protection coordinator, international organisation)

Moreover, perpetrators are often able to escape legal consequences associated with their actions. This can demotivate GBV survivors to press charges and encourage others to commit similar offences due to risks of impunity.

Absence/limited information about existing GBV services and how to access them

Despite increased community awareness raising on GBV services in IDP settings, many displaced people still do not know about available GBV services, especially the importance of seeking medical care within 72 hours for survivors of sexual violence. According to service providers in towns and cities in Southern districts of Cabo Delgado, this knowledge gap is especially acute for people newly arrived from rural northern areas where GBV services have historically been rare.

> **'Displaced people come from areas where basic services are absent, [they cannot] imagine GBV services.**
>
> **It is difficult for them to know that there are mechanisms to protect them. In particular, for women'.**
>
> (Legal project coordinator, local institution)

Consequently, GBV survivors (or their families in the case of children) often seek medical help too late, when some prophylaxis may not be useful anymore or it is too late to offer safe abortion within the legal time frame.

Communication barriers

Service providers tend to ensure that community sensitization activities as well as GBV services are provided in the different languages spoken by displaced people (e.g., *Emakua, Shi-Makonde, Ki-Mwane, Ki-Swahili*) and that survivors have access to interpreters and translators, including for GBV survivors who might have special needs such as those with hearing and/or visual impairments. However, activists or other colleagues who might help with translation do not necessarily have adequate sensitization and training on GBV. Moreover, interpreters of the same sex of survivors may not always be available. Therefore, GBV survivors may be reluctant to seek help if they are not sure they can speak in their own language and to an interlocutor of the same gender. Some service providers, especially from the government who may face greater financial and human resources constraints compared to humanitarian assistance actors, often improvise solutions for interpretation that are not always of benefit to survivors, like asking any available colleague who speaks the survivor's language to help translate.

Moreover, GBV awareness-raising activities are generally not adapted to the different target populations and the variety of their needs (e.g., adolescent girls, male survivors, survivors with disabilities, and those who identify as LGBTI) [80], which means information about key GBV services may not reach these groups. Some reporting mechanisms, such as hotlines and suggestion boxes to report cases of sexual exploitation and abuse (SEA), may not be easily usable by some GBV survivors, especially women and girls and people with some disabilities who often have limited access to mobile phones, and credit and have limited literacy [38].

> **'If you are Mwani like a lot of people from Mocimboa da Praia and you are in a community that is largely Emakua or Makonde, it is quite hard for you to engage or to understand where you can turn to if you have significant concerns [...]**
>
> **Most of the time, women do not have the same education levels [...] So, they end up being quite dependent on the local leaders, the majority of whom are men'.**
>
> (Gender and Protection Advisor, international organisation)

Discriminatory attitudes towards GBV from service providers

Service providers often described survivors of sexual exploitation, early and forced marriage, IPV and emotional violence as silently 'submissive' to traditional patriarchal gender norms. Service providers also sometimes believed that survivors did not seek help because they consider gender inequality as 'natural' or 'normal'. Faced with stigma, dominant social norms, and discriminatory practices, GBV survivors may actively choose to comply with dominant unequal gender norms and roles. However, this does not necessarily imply that they are unable to recognise the negative consequences of GBV rooted in patriarchal systems. Culturalist explanations of GBV by service providers can prompt GBV survivors to avoid care because they may feel misunderstood or judged.

Similarly, service providers often conflated transactional sex and sex work with sexual exploitation, especially when it involves children which is prohibited under Mozambican law. Provider discourses tended to condemn every form of sexual exploitation and abuse in contexts of highly unequal social and economic gender norms, further exacerbated by conflict and displacement. However, such a position may also be perceived by those engaged in transactional sex and sex work as a moralistic condemnation towards their choice. People who engage in transactional sex and sex work to address their economic and social vulnerability do not always consider themselves as coerced, exploited, or abused. Discriminatory discourses by service providers towards GBV survivors engaged in selling or exchanging sex may therefore deter such survivors from seeking care to avoid being judged, reprimanded for their compromised sense of morality or even blamed for any negative consequences that may arise from their behaviours.

Many service providers and community volunteers perceived GBV including sexual violence, IPV and early marriage as an issue which should be solved through law enforcement and justice. Sensitization activities that they were involved in consequently tended to focus on violations of law or criminalizing GBV to deter perpetrators (such as family members, neighbours, strangers, or community leaders who officiate early marriages). However, in a context where norms and law may be out of step, impunity is common and the judicial processes are often slow, GBV perpetrators may act without fear. For example, some service providers in Metuge during a FGD explained that early marriages are sometimes conducted clandestinely in the camps. An assessment conducted on Ibo Island found that early marriages are sometimes celebrated on a different island to get around controls [81]. Provider discourses focused on law enforcement and justice may deter many survivors from seeking help if they worry about causing trouble for their families due to police involvement and perceived public shame for them.

Health workers can also have discriminatory understandings of what qualifies as sexual violence, particularly for cases of sexual violence concerning adolescent girls. Community members reported that virginity testing, administered by health staff at health facilities, was used as part of the evidence gathering for female sexual violence survivors [35]. In other cases, healthcare providers' attitudes towards sexuality, particularly of marginalised groups,

such as girls or women with disabilities, may lead to discriminatory attitudes and further harm. One community volunteer reported that she helped an adolescent girl – who was forced by her sister-in-law into sex work – to approach health services to request a report that could be used to pursue legal action against a man. The health centre staff, however, said that since the girl had sexual intercourse previously with other men, what she experienced was not sexual violence so she would not be able to seek justice.

> **'The health report [diário clínico/clinical diary] said that the girl was already having sexual relationships and that she was not raped [... so] it was not necessary to bring the case to justice [...] But the girl said that [...] that man abused her'.**
>
> (Women's FGD, Montepuez)

More generally, service providers may harbour discriminatory attitudes about specific health services necessary to respond to GBV or particular groups that may be at risk of it. For example, a GBV focal point reported that a displaced girl recounted to her that access to a specific family planning method had been denied to her but not to a woman in the host community. Health centre staff have also been reported to ask for bribes to facilitate clients' access to health services [49] or to pay for medication that should be free, as shared by community volunteers during a FGD. LGBTI and sex workers' representatives reported that their GBV experiences may be minimized or belittled by service providers. LGBTI people in particular may receive homophobic or transphobic comments by health service providers. One disability-focused agency mentioned that the same can happen to people with a disability who may experience discrimination by some service providers owing to unconscious biases about disabled people's sexuality.

GBV survivors may also be concerned by any breach of confidentiality. GBV service providers reported situations where some GBV service provider staff did not keep GBV cases confidential, putting the credibility of their services at risk. Moreover, GBV cases are sometimes received in spaces which do not enable the service provider to offer care, treatment, and counselling that is private and confidential, due to limited financial resources and availability of physical spaces.

Service-related costs and geographic accessibility of care

Many women and girls do not have money to pay for transportation to reach GBV services which are often

Rosa Lazaro, midwife IDP in Metuge, Cabo Delgado. © UNHCR/Martim Gray Pereira.

situated in the main towns or district capitals, far away from many IDP settings. Moreover, survivors often have to travel multiple times to different places (e.g., for medical follow-up or legal support), which can increase costs and deter them from seeking help or proper follow-up. Service providers, particularly those involved in GBV health care and case management, said that emergency transport assistance as well as basic cash assistance is rarely available for GBV survivors. While most GBV-related services are free in Cabo Delgado, there may be other indirect costs associated with them. For example, a service provider mentioned that survivors may be asked for a 'declaration of poverty' document to access free legal services which might not always be provided for free by the competent authorities.

Stigma

Social and self-stigma likely plays a significant role in determining whether GBV survivors seek care or not. With survivors of IPV and sexual violence by strangers often viewed as having brought it on themselves, during some assessments [38], adolescent girls shared their fear of not being believed or being blamed in cases of sexual violence as among reasons not to report incidents or to seek care.

> **'The young adolescents who are sexually abused usually do not seek help [...] They feel ashamed to be discriminated in the community. [...] Men can also use offensive language against them'.**
>
> (Women's FGD, Metuge)

> **'Shame is a barrier. There are people that if women tell them what happened, they would laugh at them, they would speak ill at them. [...] People do not understand, they judge.'.**
>
> (Women's FGD, Montepuez)

As highlighted by a service provider working on disability issues, women and girls with disabilities are commonly assumed not to have a sexual life and therefore risk not being believed when reporting cases of GBV. A sex worker representative said that displaced women and girls, especially if they are new to transactional sex or sex work, may also be reluctant to seek help for GBV for fear of having their 'non-conforming' sexual practices disclosed to the family and the community.

Families and GBV survivors may want to keep information about violence within the family or use informal or community justice mechanisms to avoid making the problem 'public' and putting at risk the reputation of the survivor and family.

> **'When someone identifies a case and reports it to police, the family [of the perpetrator] can stay against the person who reported the case and defend the perpetrator. This is what happens [to us] in the majority of cases. [Families] are against the activists. [They say]: "How is it that you bring this case to police. This case must be solved within the family'.**
>
> (Women's FGD, Montepuez)

Service providers report that such justice solutions may include pressuring survivors of IPV to return to abusive relationships or forcing GBV survivors, especially in cases of early pregnancies, sexual abuse or violence committed by men in the family or the community, to marry the perpetrator or to accept a damages payment. One service provider involved in the legal response mentioned that, especially in cases of sexual abuse and rape against children, families prefer to solve the case with payments. Women and girls who have been abducted and sexually abused by non-state armed combatants have said that they prefer not to speak about it for fear of being accused of being collaborators or traitors [22].

GBV survivors and their families may also be concerned about confidentiality breaches by service providers, which could lead to further victimization or stigma by other potential sources of support within families and communities. Some female community volunteers during a FGD mentioned that GBV survivors might not feel comfortable to seek help with a community volunteer from the same community for fear of their situation being made public and the consequent social stigma.

Limited family and community support

Limited family and community support, which has often been disrupted by conflict and displacement, can make it difficult for GBV survivors to seek help. One service provider shared that a woman who was beaten by her husband reported that she did not know where to seek help because she did not have any other family in the IDP site. Sex workers and LGBTI people may feel particularly isolated in IDP sites without peer support. Many survivors may also decide not to seek help fearing it could lead to ostracization from their community, especially in cases of IPV.

> **'What we have to perceive, including from a perspective of psycho-social support, is that these women are inserted within a specific community and that the simple fact of reporting a case of GBV is an act of rupture in itself towards the community, the community leader. Approaches to the response to GBV are often focused on the individual...to remove the person from the risk situation, to give support to that person. But it may end up increasing the division between the survivor and her/his community.'**
>
> (Psycho-social support programme coordinator, international organisation)

In a situation of limited or stressed family networks, single women and unaccompanied children who experience sexual exploitation by community members and leaders or are involved in early marriages may prefer not to disclose violence they experience because of the risk of compromising crucial material and social support.

> **'There was a girl she was living with an adult man and her little sister. Together with the government services we thought about the possibility to remove the girl from that situation since child marriage is a crime. But there was a challenge. The girl told us: 'Well, you want to help me to leave this relationship with this adult man. But tomorrow what will I eat? Because this person is the one who ensures my sustenance as well as that of my little sister'. [...] Therefore, survivors inevitably decide to stay in the relationship'.**
>
> (GBV Coordinator, international organisation)

Displaced and host community girls playing football in Ngalane IDP site, Metuge District, Cabo Delgado, Northern Mozambique. ©UNHCR/Martim Gray Pereira.

4 Gaps in the GBV response

Most participants in this assessment felt that there were many urgent needs of GBV survivors that existing services were unable to address because of a lack of organisational capacity and the overwhelming burden of need.

> **'In the beginning we did not have specific services; we did not have GBV partners upfront able to deliver quality services. [...] most of the partners did not have sufficient technical expertise [...] for example psycho-social support, case management.'**
>
> (GBV Programme Coordinator, international organisation)

> **'In terms of cooperation, there is an expectation that referrals are solved but there is a lack of understanding of the context, that all the organizations are overstretched [...] I can call a colleague [...] but she may have who knows how many cases on her hands'.**
>
> (Programme Coordinator, international organization)

Moreover, many participants pointed to the reality that GBV responses would be needed for a long time to come. This was an especially common viewpoint held by activistas, as alluded to in the following quotes from FGDs.

> **'The end of the case is when there is no more violence'**
>
> (Women's FGD, Pemba)

> **'GBV is a pain that will never go away, but we must support'**
>
> (Men's FGD, Pemba)

For many service providers who participated in interviews and FGDs, there did not yet appear to be a comprehensive or well-connected GBV response 'system'. Service providers in one area of service provision often have limited knowledge about the different roles, responsibilities, and referral procedures followed by other actors involved in GBV. Formal information sharing through government reporting mechanisms is also weak.

> **'Coordination should improve. The organisations do very good work. But we often do not have any information [from them].'**
>
> (GBV Focal point, government institution)

While government and some humanitarian agencies have developed internal GBV standard operating procedures (SOPs) and identified key referral pathways to other actors in their area, many *activistas* tasked with carrying out these SOPs stated in FGDs that they were not always aware of other organizations working on the ground and that they were not sure how to refer community members for some key services. Harmonized guidelines presenting principles and procedures relevant to all the actors working in the GBV response did not exist at the time of our research, but are currently being developed.[27]

Moreover, GBV services in Cabo Delgado are unlikely to be reaching all at-risk groups. Service providers conceptualise the primary focus of GBV services to

27. The GBV Area of Responsibility (GBV AoR) in Cabo Delgado is currently developing Standard Operating Procedures (SOPs) for Prevention of and Response to gender-based violence.

be on women and girls, while information on services reaching other groups including men, boys, and LGBTI people was difficult to identify, suggesting they may not be accessing care. Further research is needed to understand the barriers to accessing care for marginalised groups and how to best address them. Specific challenges in GBV services provision for each sector are described below.

HEALTH CARE AND PSYCHO-SOCIAL SUPPORT

Limited awareness raising activities tailored to the needs of certain risk groups

Research participants widely stated that greater information is needed for crisis-affected communities about available sexual and reproductive health (SRH), mental health and psycho-social support (MHPSS) and other health services for GBV survivors, including options for urgent medical care in cases of sexual violence. Awareness of holistic GBV case management services, including pathways that link survivors to both health and social services, appears to be particularly limited, as reported in some assessments [35, 44] and by other organizations [64]. Moreover, GBV awareness activities are not always adapted to some target groups, such as adolescents, people selling or exchanging sex, men, people with different sexual orientations and gender identities, the elderly, and people with disabilities.

A common solution volunteered to increase GBV service awareness was through increasing the numbers of trained community volunteers, though specific challenges in recruitment were also raised. Some specialist organisations (e.g., those targeting sex workers, LGBTI people) who are mainly based in province capitals, were not able to recruit new community workers among displaced populations due to a lack of funds which limited their ability to support survivors in IDP sites.

Few organisations reported working with community volunteers who are adolescent girls or women/girls with disabilities, which limits their ability to support these vulnerable groups.

Landscape of 25 de Junho IDP Site, Metuge District, Cabo Delgado, Northern Mozambique. ©UNHCR/Martim Gray Pereira.

Limited entry points for specific groups

In general, access points for GBV-related health and MHPSS care are mainly women-oriented, which may deter men, boys, and LGBTI people from seeking help through them. An interview respondent said that a male survivor of sexual violence was ashamed to speak about his GBV experience to a female nurse in a health tent in a IDP site and that he was able to share his story only when offered the opportunity to speak to a community volunteer of the same gender.

> **'We had a case of a boy raped by a group of armed actors while he was running away from the conflict areas. It was not simple for him to speak about what happened. [...] I think he was reluctant to talk to me because I am a woman. He spoke to the male *'activista'*, who was about his age.'**
>
> (Coordinator, national organisation)

Post-sexual violence health care is often linked with maternity-related services. Some respondents, especially those working in safe spaces, mentioned that adolescent girls may also not feel comfortable to seek help through adult women-oriented health services for fear of stigma. Even if male survivors or girls seek help through available services, staff are said to be rarely trained to address their specific needs.

Lack of clarity about obligations of health care providers to report GBV to police

There is a lack of understanding and clear guidance among most health staff about survivors' obligations to see police before seeking health care and the requirement for reporting, which results in different and often contradicting practices among health staff[28]. Most healthcare providers are said to take a survivor-centered approach and prioritize health care and adult survivor consent in reporting, nevertheless, this is not always the case in health centres with limited GBV sensitization, training and support. A community volunteer in Montepuez mentioned during a FGD that a survivor of intimate partner violence (IPV) had been asked to supply a police referral document by staff at a health facility in order to obtain access care.

> **'A neighbor was physically assaulted by the husband. She had injuries [six stitches in her head]. She was asked to go to police to obtain the police referral form before being attended.'**
>
> (Women's FGD, Montepuez).

Limited GBV protocols, private and confidential spaces, trainings, female staff, and medical supplies

Health service providers reported that while the main district hospitals and some health centres supported by humanitarian programs have improved their capacities to respond to GBV, most other health centres in the province face challenges applying GBV protocols and training staff to properly manage cases of GBV and follow referral pathways.

> **'We did a short assessment when we arrived here [...]. We visited the largest health centre. When we asked [...]: 'What do you do when you receive GBV cases?', they answered: 'We normally do not receive these cases [...] We give them prophylaxis and then we send the survivors to police to do the report'.**

28. While there is certainly mandatory reporting for health staff in case GBV survivors are children (Law n. 7/2008 on the Promotion and Protection of the Rights of the Child., art. 20) [41], – as it is also indicated in the 2012 Ministry of Health (MoH) Guidelines for Integrated care for Victims of Violence [82] –, the legal framework requiring mandatory reporting for cases against adult people is not certain. In the 2012 MoH Guidelines (p. 25), health staff are required to 'suggest' an IPV adult survivor to report to police and to inform police about the event. In the 2012 policy about the multi-sector integrated care mechanism for women victims of violence, health staff are asked to inform police and social services about the case (p. 29-30) while in the same document (p. 53-54) it is indicated that only in case the case concerns a child, they must report to police [34]. Such contradictory indications may therefore certainly create confusion among health staff.
Concerning the involvement of police before seeking health care, the multisectoral policy before mentioned, and the MoH guidelines and the MoH and Ministry of Gender, Children and Social Action (MGCAS) leaflets [83-86] on how to support survivors of sexual violence do not reference police reporting as requisite for accessing health care. For instance, all the leaflets suggest men, women and community leaders who identify a GBV case to firstly refer the survivors to the health facilities. Furthermore, in 2013 MoH published a Circular Prioritizing Clinical Care for Victims of Violence in health units (*Priorização do Atendimento clínico às vítimas de violência nas unidades sanitárias*) [87] which confirms that it is common practice in health units to firstly refer the GBV survivor to police before offering health care and it highlights that this is counterproductive since it delays needed medical treatment. The circular therefore asks the health staff to prioritize clinical care of GBV survivors before any referral to police.

> **But they could not explain us what the prophylaxis was exactly. It showed that they did not know the protocols.'.**
>
> (Medical expert, international organization)

GBV focal points may not necessarily be identified in all health centres and female staff may not always be available. Confidential private examination rooms may not always be provided. Trainings on GBV emergency healthcare, psycho-social support, and appropriate referral may have been provided in the past in some health facilities but some research participants reported that many health workers lack practical experience (for example, in supporting safe abortion care) or that there is high staff turnover. Financial constraints may also make it difficult for healthcare personnel to simply send forensic reports to the competent authorities, which therefore accumulate in healthcare facilities.

Health staff working in government services mentioned that medicines needed to ensure comprehensive treatment to GBV survivors may be missing or expired. Pregnancy tests are often not available and women may be asked to purchase them. While emergency contraception is said to be usually offered and available, safe abortion[29] was reported as rarely offered as an option to GBV survivors. A health GBV focal point mentioned that she does not feel comfortable offering abortion options because medication may be unavailable, or staff lack appropriate training and experience. On the other hand, survivors, especially adolescent girls, often seek help at an already advanced stage of a pregnancy, which may imply that they were not informed about the lawfulness of abortion, the availability of services and the time limit (16 weeks for cases of sexual violence). Antibiotics for STIs and post-exposure prophylaxis (PEP) for HIV are often replenished in the district hospitals and in some health centres by medical NGOs and the government. Some other stock outs of medication affect the comprehensive care kits for GBV survivors (including medications for STI treatment and Tetanus and Hepatitis B immunization). Condoms and lubricants seem to be rarely available in IDP sites. Some medical humanitarian actors are attempting to address these supply gaps through provision of safe abortion medication and refresher trainings and stocking GBV care kits in both health centres and mobile clinics.

Difficult medical and MHPSS follow-up of GBV survivors

Humanitarian programmes try to ensure GBV survivors have at least one follow-up visit after an initial health consultation. Government services, however, are rarely able to do home visits or to provide transportation assistance to survivors for follow-up. A GBV focal point from a health facility mentioned that it is difficult for her to reach survivors even for a phone follow up both because she may not have a mobile phone or credit to make a call, or because survivors do not have access to a mobile or may change their mobile number. In displacement contexts, longer term-follow up may not be feasible due to transport issues and the high mobility of displaced people.

Availability of psycho-social support for both GBV survivors and GBV actors

Although community volunteers play an important role in providing basic MHPSS to GBV survivors as first line responders, they often lack specific training to deliver it to both adult and child survivors, as community volunteers themselves highlighted during FGDs. Some service providers involved in the implementation of safe spaces reported a need for further MHPSS training for their community volunteers and case workers. Service providers have limited time availability, low technical competencies, and insufficient logistical and financial means to provide continuous training on GBV-sensitive psychological

29. Mozambican law has allowed abortion since the 1980s. In 2014 a more liberal abortion law was established in the country (Law n. 35/2014) [39] and its guidelines (Ministerial Diploma n. 60/2017 de 20, vol. I) [88] were published in 2017. Women and girls are allowed to have an induced abortion: (1) if women requested it and it is performed during the first 12 weeks of pregnancy; (2) in the first 16 weeks if the pregnancy results from rape or incest; (3) during the first 24 weeks if the woman's physical or mental health is at risk or in cases of disease or anomaly of the foetus. Women younger than 16 years of age or women who are not able to decide by themselves need parental or guardian consent. Despite progress, access to safe abortion remains controversial. In 2019 the CEDAW shared its concern about *'the persistently high rate of maternal mortality and limited access to safe and legal abortion in the State party, the shortage of trained health professionals, including midwives, in rural areas and the lack of confidentiality in relation to abortion'* [79] (p. 11). Some studies showed also that the level of knowledge on the abortion law and the availability of abortion services is still low which – together with other social, economic and structural factors – can increase the risk for women and girls of searching unsafe abortion [89-91].

first-aid nor to adequately supervise and support community volunteers and service provider staff.

Psycho-social support available from specialised health-centres is often provided by male psychologists, which many service providers highlighted could deter women GBV survivors. Government psycho-social actors are also often limited in number, overloaded with work and mainly based at district level, which can make it difficult to provide gender-sensitive, regular and *in-situ* psycho-social care to persons residing far from district capitals.

> **'I realized that women do not feel very comfortable [when the psychologist is a man]. [...] When we ask to be sent a female psychologist, the department of health always sends us a man. I think there are no female psychologists or they are not available'.**
>
> (Project coordinator, Women's and Girls Safe Space)

Psycho-social support interventions available for GBV workers themselves is also rarely available. Staff involved in the GBV response may develop work-related stress, including burnout, compassion fatigue, and vicarious trauma. Some GBV actors, like community volunteers, may have experienced conflict and displacement. Health staff may have gone through stressful circumstances, such as heavy workloads. Participants in interviews and FGDs also discussed how some GBV service providers, particularly community volunteers and case managers, are subjected to threats when they engage in care for GBV survivors by perpetrators of the GBV or other family and community members. A service provider reported a case of a community volunteer who a community leader threatened to murder after having reported a case of early marriage to police. Such situations not only expose community volunteers to security risks but also to further stress and anxiety which may impact on their work and personal lives. They may need safe spaces where they can receive support to be aware of these risks and take action to maintain their well-being.

GBV CASE MANAGEMENT

Women's and Girls' Safe Spaces (WGSSs)

WGSS locations are rarely selected in consultation with the potential beneficiaries. Very few safe spaces have dedicated confidential rooms to receive survivors and those that are available may lack confidentiality. There do not seem to be standard terms of reference or training for staff working in WGSSs and standard operating procedures and reporting tools are not harmonized for all the safe spaces. In some safe spaces, community volunteers take-on responsibilities handled by GBV case workers in other spaces, but are not commensurately compensated. They may also be asked to conduct activities for which they are not sufficiently trained on (e.g., identification of cases, referral or running support groups) or that can expose them to further risks without adequate training and support (e.g., house visits to GBV survivors). In some safe spaces, the majority of volunteers engaged are male, which can deter female beneficiaries to access them. Community volunteers working in safe spaces seem to rarely come from the most at-risk groups, including adolescent girls, women with disabilities, sex workers, and LGBTI people.

Availability of GBV case management services and trained staff

Despite humanitarian support to extend government case management services outside of district capitals, many remote IDP settings remain only partially or mostly uncovered by case management services. Staff with specialist training are scarce, meaning that both government and humanitarian-run programmes rely on the support of community volunteers, who do not always have the necessary knowledge and skills to ensure proper GBV case management and follow-up. For instance, not all community volunteers participating in the FGDs acknowledged having received training on GBV. Interviewees also said that some humanitarian actors new to GBV case management possessed limited GBV programming expertise, particularly in GBV risk assessment and provision of MHPSS in conflict and displacement.

> **'We work with technicians but they do not have a specific training on social services. It is like making someone work as a nurse without being trained on nursing. [...] I have just enrolled some new people. Most of them are new to the job, they have been working with us for less than one year, they are learning with us. Therefore, it is a challenge that they are able to deal with GBV cases'.**
>
> (GBV focal point (or social worker), government services)

Moreover, case management actors in all sectors and levels are said to sometimes hold some paternalistic attitudes towards GBV survivors and unequal views on gender relationships and GBV which may impact on survivor's wellbeing.

Availability of dedicated services tailored to specific target groups

Case management services and practices are not specifically tailored to some of the most vulnerable groups, particularly adolescent girls, men and boys, people with disabilities, LGBTI people, people selling or exchanging sex. Case workers have often not received training or guidance on how to support survivors from these vulnerable groups using existing guidelines [31, 32], equally case workers themselves may not reflect the diversity of different groups.

Limited access to in-house resources to meet urgent basic needs of survivors

Case management services do not always have in-house resources to meet urgent basic needs of GBV survivors, such as vehicles or money for transportation, service-related fees, clothes, food and shelter. Resources are sometimes made available through humanitarian structures (e.g., assignment of land plots from Camp Management and Camp Coordination (CMCC) actors, construction materials from shelter actors, separate ration cards from Food Security and Livelihood actors). However, referral pathways for GBV survivors to other sectors for support are not fully operational, can be slow and are rarely standardized. Some service providers therefore feel forced to advance or give money out of their own pockets. GBV case management services also have to deal with the current reduction of food and voucher assistance due to lack of overall humanitarian funding.

Limited capacity to provide a safe shelter

Case management services are not always able to offer a temporary safe shelter to survivors and, if necessary, to their children.

> **'We do not have a safe shelter, not even a temporary one. We had a case of a child of 14 years old. She was raped. She did not have family here. [...] Police accompanied the girl to the hospital. We offered her medical care. But the girl did not have somewhere to go. She stayed at the hospital for four days in a department that was not safe. We had to give food to her. I also brought some food for her from home. [...] There is a shelter at the police stations but it does not offer the adequate conditions to host someone.. [...] A shelter at the police station may offer security. But the survivor might not feel comfortable due to the fear.. knowing that she is in a police station'.**
>
> (GBV focal point, government service)

Temporary shelters may be available at police stations but their accessibility depends on the survivor's willingness to report incidents of GBV.

Displaced women from Palma hosted at the Temporary Centre in Pemba, Cabo Delgado, Northern Mozambique. ©UNHCR/Martim Gray Pereira.

Law enforcement actors reported that displaced people, particularly women and girls and their children, may not feel comfortable to spend a night in a place with mainly male armed people. The absence of dedicated GBV safe shelters and the lack of rapid and safe shelter alternatives for survivors may thus deter service providers from making referrals to law enforcement for fear of putting survivors at risk of further violence and retaliation.

Lack of clear policy guidance about community-based justice and mediation

Staff in GBV case management services may sometimes comply with survivors' requests for mediation or community leaders' interventions. Community volunteers in Metuge and Montepuez reported during FGDs that they sometimes suggest GBV survivors, particularly in cases of IPV, to first find a solution within the family if possible, such as via family chiefs or even with the husbands. A case worker reported that she accepted to comply with the request of a survivor to involve a community leader in order to stop her husband from stalking her. However, no clear guidelines exist on how to respond to requests for mediation or community-based justice in a survivor-centred manner that take into consideration the grave risks of further harm, or the mandate and capacities of the community justice processes themselves.

Limited capacity to ensure follow-up of GBV survivors

Few case management services can ensure proper follow up of GBV survivors, mainly due to limited human, financial and logistic resources. Additionally, providers emphasised that for GBV in this context, sufficient follow-up was not only about ensuring survivors completed referrals and follow-up appointments set by service providers. It was also about providing survivors with continuous emotional support, and building survivors' skills, strengths and social networks within an empowerment approach to GBV response to more sustainably reduce the vulnerability of survivors. This was considered vital in Cabo Delgado given that most survivors must continue to live in difficult social and economic circumstances in displacement and in the context of ongoing armed conflict.

LAW ENFORCEMENT AND LEGAL SUPPORT

Availability of legal information, trained staff and services in IDP sites

Legal support actors' presence in IDP sites is still limited, mainly due to logistical and financial constraints. Government actors in particular face challenges to access displaced people, due to the limited possibility to undertake outreach work or to have community volunteers engage in awareness-raising in the communities, as respondent said.

> **'We have juridical technicians, a certain number of lawyers [...]. But how to move these people to the [IDP] sites? In our institution, we have to share the means of transport, I have to ask for a ride'.**
>
> (Legal assistance, government institution)

Although legal counselling may be available in IDP sites, legal services (e.g., prosecution service, court) are available only at district level and in some cases not even in each district, such in Metuge where there was no functioning court at the time of assessment. GBV survivors are therefore forced to travel to district capitals if they want to access state legal services, while they do not always have the time and financial resources to do so.

Service providers from the legal field who were interviewed highlighted that GBV case managers and volunteers working as general paralegals in safe spaces rarely receive specialised training in GBV legal frameworks (e.g., IPV law, family law, child marriage law, inheritance law) or legal procedures in relation to GBV cases. They are therefore mostly able to provide effective legal guidance to survivors in the absence of a lawyer or a juridical technician, and risk providing incorrect or potentially harmful advice.

Availability of specialized staff to represent GBV survivors in courts is also largely limited to the province capital, Pemba. For example, two women's rights organisations providing legal support to GBV survivors said that they rely on the support of one lawyer each to cover their activities in the entire province. In one

case, the lawyer (a man) works part-time and he is able to visit the IDP sites only occasionally. A respondent mentioned that during a recent training on GBV addressed to a group of state court magistrates in Cabo Delgado it emerged that they were not really sensitized on GBV and not aware of the additional vulnerability of women and girls in the current humanitarian context nor of the existing legal framework for cases of conflict-related sexual violence.

> **'We organized a training with judges from the different districts. The main objective was to train them on the new law on child marriage. We realized that they had very little information, cases of child marriage were not being reported. [...] A local women's rights organization presented the assessment conducted with IDPs. We wanted them to understand gender-based violence in the context of emergencies and humanitarian situations [...] They were not aware of this [...] Some of them were surprised with the information shared, the abuses happening in this context'.**
>
> (Programme Coordinator, international organization)

Availability of trained law enforcement actors in IDP sites

Most IDP sites do not have police posts and if GBV survivors want to report their allegations to police, they often must travel to district capitals. A service provider from the legal field reported that if GBV survivors have no identification document, police often ask them to come back with a declaration form from the village chief certifying they are hosted in a IDP site or host community or with two witnesses. GBV survivors may therefore feel forced to disclose their case to village chiefs, risking breaches in confidentiality and re-victimization from being forced to discuss their sensitive incident multiple times. There is no clear legal framework permitting police to request identification documents for IDPs to access policy services.

Police staff often do not have the logistic and financial capacity to support GBV survivors who seek help with them, some respondents said. They may not have the possibility to accompany them to hospital or any other service or to escort them home, which can expose survivors to the risk of not accessing the care they need, or retaliation from the perpetrators. Police staff may be trained on GBV but their training may have taken place a long time ago with no refreshers, supervision is rarely provided, and new staff may have joined in the meantime and may need training.

> **'I always say that the survivors of yesterday are not the survivors of today. The conditions of violence change every day. Therefore, we need trainings to learn how to deal with these changes. We had the last training in 2017 or 2018 [...] there are new members who need a specific training [on GBV]. [...] But we do not have funds to organise trainings'.**
>
> GBV focal point, law enforcement actor

Bottlenecks in formal justice systems with limited GBV capacity

The formal justice system often runs slowly and inefficiently and legal support actors may not be able to ensure proper follow up of GBV cases. Survivors are said to become emotionally weary in the process and delays in obtaining a sentence can expose her/him to further violence and risks which can also affect their families and others who may be involved as witnesses. Alleged perpetrators often remain at liberty until a court decision is made and the precautionary measures that can be taken in the meantime are often lacking enforcement. In the meantime, the survivor often remains without the emotional support required to fully engage in lengthy and complex GBV judicial process.

In cases of sexual exploitation, cases committed by government actors (e.g., community leaders, armed forces) are usually solved through the government judicial system, and so are often subject to delays and outcomes are unclear. It was reported by interviewees that as of publication of this study, no cases have been closed with the condemnation of the perpetrator. There were no reports received from interviewees of cases of sexual exploitation and abuse having an outcome or any justice for the survivor.

GBV survivors may therefore opt to present their cases to community courts instead.

Limited GBV sensitivity in community-based courts

Although some community leaders may take decisions which support GBV survivors wishes and protection, such as in a case reported by a service provider of a community leader who stopped a man from stalking her wife, in general, community leaders and community courts are rarely sensitized on GBV. Community judges also do not often interact with other GBV actors in the area, which means community justice solutions lack a survivor-centred approach. Local leaders and community courts tend to simply focus on a temporary solution through mediation which risks harm to survivors as they are not usually in a position to negotiate with perpetrators who have a position of power over them.

During a training addressed to GBV service providers in July 2021, many participants shared their concerns about how local justice mechanisms often favour the perpetrator rather than securing redress for the GBV survivor [92]. These concerns have also been shared by some male community members during an assessment conducted in Metuge where they said that community leaders are often male and so often rule in favour of men perpetrators [44]. Selection criteria for the members of community courts, especially within IDP sites, are not very clear and women usually cover only secondary roles, such as secretaries of the community courts.

> **'Community leaders do not understand women's perspectives. If a woman says to a community leader: 'My husband raped me. He came, he wanted to have sexual intercourse with me, I refused and he hit me', he may answer that the husband was right; she is the wife and she always has to serve the husband'.**
>
> (GBV case worker, government service)

This may result in courts adopting blaming attitudes towards GBV survivors which can further marginalize the survivors and make it more challenging for them to come forward and seek help if GBV occurs again. This is especially important in cases of IPV which is rarely an isolated event. It can also reinforce some manipulative tactics that perpetrators use to control their partners to discourage them from seeking support.

Displaced and host community girls playing in Ntele IDP site, Montepuez District, Cabo Delgado, Northern Mozambique. ©UNHCR/Martim Gray Pereira.

Recommendations

Practitioners

ADAPT service provision models, based on an inclusive assessment, to ensure appropriate and quality survivor-centred services are accessible to all vulnerable communities. Social, cultural, resource and capacity-based barriers preventing access to GBV services need to be urgently addressed through a coordinated approach. This should be a collaborative process led by UN technical agencies, involving government stakeholders and civil society organisations, with robust participatory community engagement. GBV service providers and response programs more broadly must remain flexible to adapt program approaches to ensure that barriers and facilitators driving service use are addressed. Service providers should ensure that women, girls and other high-risk groups are involved in program design and implementation. Diversified entry points need to be created so that GBV services are accessible and appropriate for specific groups who may not access feel comfortable accessing existing services, particularly adolescent girls and boys, men and LGBTI persons.

ENSURE that all service providers working with GBV survivors have the appropriate training and resources available. Capacity building efforts should be informed by robust organisational capacity assessments. GBV capacity building requires dedicated technical resourcing, and an approach that includes longer-term capacity building, follow-up to check if learning goals were achieved, and ad-hoc trainings to address changing needs. Service providers should have the training and resources to address critical GBV survivor needs including healthcare, legal and protection assistance in conflict-affected and displacement settings. Training and resources for interpreters is also needed to ensure that survivors can safely share their needs.

IMPLEMENT a coordinated GBV response across Cabo Delgado through a review and evaluation of protocols to ensure quality, accessible and survivor-centred service provision. This includes a review of existing service provision protocols and guidance to assess gaps, and a plan to implement training. Clear and standardised guidance needs to be provided to GBV service providers to harmonize practices and provide accurate information to communities. This includes providing clear guidance on any GBV reporting requirements. Donors and technical experts should evaluate the quality of their GBV programs against international survivor-centred standards and support any needed technical support.

SEEK to safely and inclusively engage with all GBV survivors. This includes service providers working with all vulnerable groups by creating accessible services in locations of heightened risk, and ensuring access for those with limited access to support. Groups that are less likely to access GBV services include sex workers, women and girl heads of households, unaccompanied and separated children, LGBTI persons, persons with disabilities, and men and boy survivors. Additional, dedicated technical and funding resources should be provided to support these groups alongside funding for core services to reach women and adolescent girls who remain the groups at highest risk. A collaborative consultation is also recommended to understand how to ensure services are inclusive for all survivors.

IMPLEMENT evidence-based GBV response models using community engagement to transform harmful gender norms and other barriers to accessing support. Such models must be developed through robust

active consultation with the community, in particular with vulnerable groups to adapt to their specific needs and commit to the monitoring of impact. These models should be tested and adapted as needed. Equally, community workers ('activistas') are a key entry point for GBV survivors to access services and community awareness activities. They require a clear job description, practical and robust technical capacity-building skills (particularly in psychological first aid), strong and supportive supervision mechanisms, and the harmonization of GBV key awareness raising and education messages. The safety and emotional wellbeing of community outreach volunteers is paramount and supervising organisations must also monitor this and provide immediate responses to any concerns identified.

FOSTER strong linkages with livelihoods and development actors to address socio-economic vulnerability as an important GBV risk factor and integrate survivors into tailored economic empowerment models as part of integrated response services. This approach requires dedicated resourcing and coordinated joint assessments between GBV and livelihood actors to develop models that are adapted to the needs of survivors and consider the specific risks of GBV related to socio-economic vulnerability.

Donors, Policy Makers and Coordination

PROVIDE urgent and needed funding to scale up existing survivor-centred GBV response service provision. Funding is needed to support the provision of survivor response services including healthcare, psychosocial support, case management social services, and legal services. Funding for response services and capacity building should prioritize the integration of IDP and vulnerable host communities in all GBV response efforts, and equally commit to longer term capacity building support of existing government and NGO services.

PRIORITISE funding, resources, and capacity building to bridge gaps in the provision of essential services for GBV response. This includes addressing the urgent lack of access to holistic GBV case management services, safe shelter, and legal protection for GBV survivors. This should be accomplished using an integrated approach to the greatest extent possible. Equally, health care service providers must receive appropriate training on working with GBV survivors. Funding support is also needed for essential medical supplies to provide basic GBV clinical care to all survivors.

MAINSTREAM GBV risk reduction programs (especially protection from sexual exploitation and abuse (PSEA) programs) across all humanitarian sector programs to ensure GBV survivors have safe access to assistance. Humanitarian coordination leads for each sector should ensure adequate resourcing at the coordination level, and within programs, so that GBV mainstreaming and commitments are implemented in practice, with dedicated technical support.

COORDINATE GBV prevention and response programs between government, NGO actors, and the community. In response to displacement related to the Cabo Delgado conflict, coordination mechanisms should be set up at the field level to coordinate GBV response activities which adhere to core GBV guidelines. Equally, information regarding services and activities must be shared between all actors, community outreach workers, and communities to improve access and reduce gaps. These coordination gaps must be filled with dedicated UN and government GBV technical leadership centrally and from direct service providers.

SUPPORT stronger assessments, coordinated data collection, and data sharing to inform programming and coordinate ongoing response. This can be supported through existing GBV coordination mechanisms

with inputs from all practitioners. Established mechanisms, such as the GBV information management system (GBVIMS), should be used for the safe and ethical information management of GBV data so that trends of GBV incidences can be regularly assessed to inform GBV services.

Researchers

Further research is urgently needed in Cabo Delgado to develop effective and appropriate programmes and projects. A mixed-methods approach should be adapted and where feasible, incorporate longitudinal outcomes.

Areas of further research include understanding the:

DRIVERS of GBV, especially of conflict related GBV, IPV and early and forced marriage, in the current context of conflict and displacement. Further research is needed to be identify drivers and risk factors that can be targeted by interventions in the current context of conflict and displacement.

EXPERIENCES of adolescent girls and other marginalised groups. Adolescent girls were identified as one of the highest risk groups. However, no detailed knowledge about their GBV experiences and needs is available in Mozambique. Data on needs of men, boys, and other marginalised groups such as LGBTI people, the elderly, people with disabilities, and sex workers are also missing. Additional research is therefore needed to understand the impact of conflict and displacement on their GBV experiences and how to address their specific GBV service needs.

INFLUENCE of community actors and local justice forums. Further research is needed to understand how community actors such as traditional healers, birth attendants, and initiation rites masters, may be important entry points. They can be essential support for referrals and basic support to GBV survivors but further research is needed to ensure how to provide appropriate engagement and training. Additional research is needed to understand how GBV cases are handled within local justice forums. This includes community courts and community policing groups.

Rosa Lazaro, midwife IDP in Metuge, Cabo Delgado. Mozambique. © UNHCR/Martim Gray Pereira.

Appendix: Further detail on data collection methods

Interview and FGD data collection

Given safety and international travel concerns related to the COVID-19 pandemic and the armed conflict in Cabo Delgado, interviews were conducted remotely by LSHTM researchers with support from UNHCR on the ground to reach some informants in government departments, in English and Portuguese.

FGDs with community workers were conducted in person by UNHCR GBV technical staff who had training on the safe handling of GBV disclosure in groups settings. FGD were held in Pemba, Metuge and Montepuez. They were conducted in Portuguese with local language interpretation when required, and with men and women participants separately for gender inclusiveness, and lasted between 60 and 120 minutes. Holistic referral pathways were in place for any required referral of participants for support.

Interview participants were invited to select a location that would support privacy and open information sharing. The location for FGDs was selected by UNHCR with the same criteria.

Study participants were informed of all aspects of the project, including the purpose and nature of the rapid assessment, the broad subject matters to be discussed during data collection, the methods, the potential risks and benefits, the precautions being taken to protect confidentiality, how and with whom information would be shared, and the expected time taken. All participants provided written or audio-recorded verbal consent to participate in interviews or FGDs. Two participants declined to be recorded; data for these interviews were instead collected by hand-written notes.

No incentives were provided for participation.

Semi-structured interview and FGD topic guides were followed, based on the rapid assessment's objectives and research questions, developed through a collaborative process between LSHTM and UNHCR investigators. Topic guide themes included: types and contexts of GBV experienced by IDPs; facilitators, barriers and challenges to disclose, report and seek care for GBV within the current humanitarian emergency; gaps and challenges in GBV service provision and future interventions priorities. GBV service providers and community workers were not asked to speak about their personal GBV experiences but were asked to speak about GBV among IDPs, in general.

Full verbatim transcripts were not produced as this was a rapid assessment. Rather, detailed notes were taken during and after each interview and FGD, with selected portions of audio recordings transcribed to provide verbatim quotes and expand researchers' understanding of key topics.

Given the ongoing conflict, we did not quote the names of participating organisations to protect the anonymity of participants. We also excluded or edited some quotes about specific incidents of GBV to protect survivors' confidentiality.

Participant characteristics

Thirty-nine interviews were conducted. Inclusion criteria consisted of: aged 18 years or older; and employed in a programme relevant to the GBV response at the time of the rapid assessment. This included GBV programming, coordination and service provision, in government

30. In this rapid assessment we considered as GBV responders GBV service providers who are knowledgeable about official mechanisms of GBV response (e.g., government institutions, UN agencies, international non-UN organisations, international/national NGOs). We acknowledge the various ways people care for each other informally or through local social structures when GBV occurs in conflict and displacement affected areas and that therefore community members are also knowledgeable about GBV in conflict. A 'local public authorities' lens is useful for helping to recruit participants and understand complex social phenomena in local context. According to the public authorities' framework, this implies a focus on understanding and actively including people from existing local social groups and structures which allow for mutual or collective action beyond the immediate family with a degree of consent [93]. Such authorities can include clans, religious institutions, assistance agencies, civil society organisations, commercial collectives, to formal and semi-formal mechanisms of government. Understanding the perspectives of local actors is therefore essential. However, it falls out of our available remit and technical capacities on the ground. We may consider this for future research.

institutions or non-governmental organisations (national or international) providing health care psycho-social support or case management for GBV survivors, protection and security, justice and legal aid services, women's and girls' safe spaces or material support.[30]

Five FGDs were conducted with 33 people (19 women, 14 men) from three main categories of community workers who engage with UNHCR GBV programmes through volunteer or paid roles in government services, or with non-governmental organisations (national or international): 'activistas', traditional midwives ('matronas'), and GBV case workers. Participants were included from both male and female genders, aged between 18 and 65, and came from IDP and host communities living in Pemba, Montepuez and Metuge. IDP participants were displaced from Mocimboa da Praia, Macomia, Mueda, Muidumbe, and Quissanga.

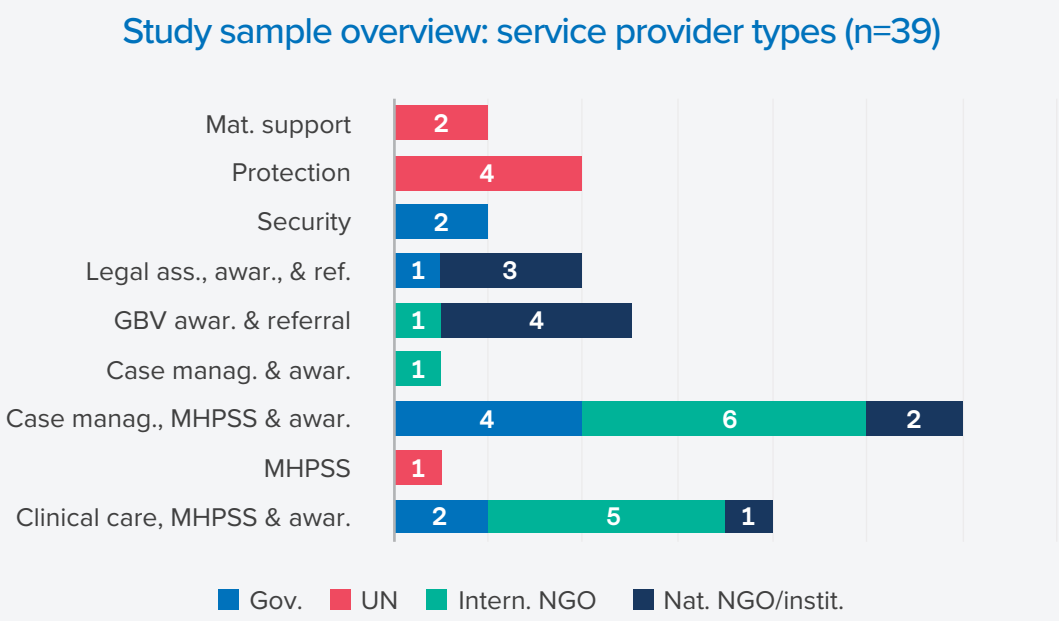

Figure 1. Study sample overview: Service provider types interviewed.

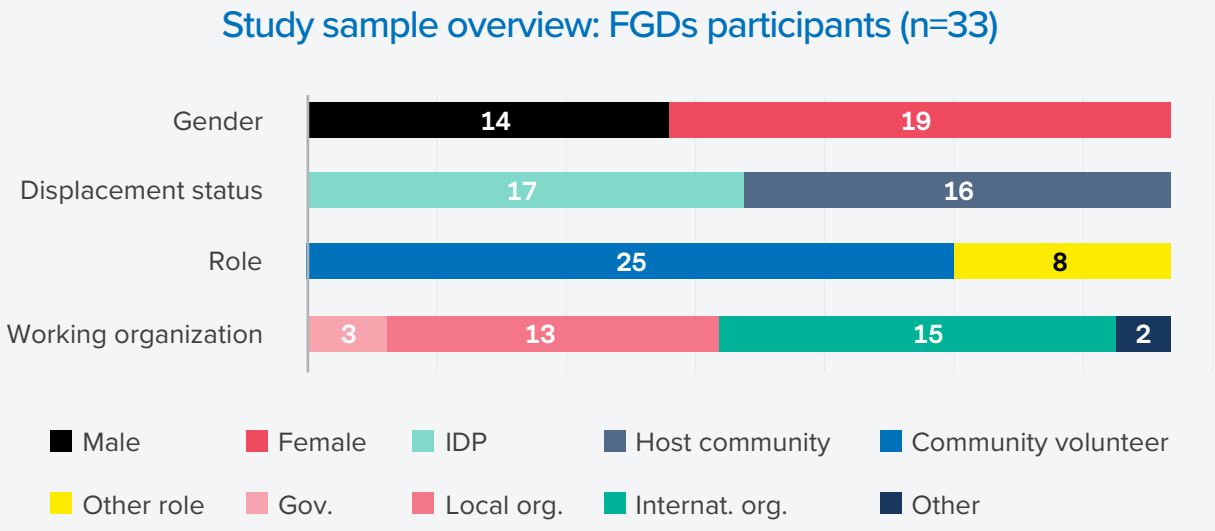

Figure 2. Study sample overview: FGDs participants.

None reported having any disability. 4 FGDs were conducted in Portuguese; 1 FGD was conducted in both Portuguese and Mwani through interpretation.

Figure 1 and 2 display characteristics of participants of interviews and FGDs.

Documents reviewed

Reviewed documents included those produced by some of the organisations participating in the rapid assessment within the frame of their regular monitoring activities for programming. UNHCR-produced materials consisted of a GBV service mapping (Pemba, Metuge, Chiure, Montepuez, Mueda) [unpublished], a report of a training in Pemba with GBV service providers from Pemba and Metuge [unpublished], and seven GBV Safety Audits from six IDP sites in Metuge (Ntokota, Ngalane), Montepuez (Ntele, Nicuapa A) and Chiure (Marrupa, Meculani) which collected data from 192 IDP and host community members (women, men, boys and girls) [unpublished]. Safety audits, which are typically carried out in camps or settlements during displacement but can be used to assess safety and security concerns for women and girls in any geographic location with specific boundaries, follow a standardised approach consisting of 'safety walks', community mapping exercises and FGDs (typically 4 in each site with women, girls, men and boys respectively) [94]. Reviewed documents from other organisations, included: a gender and GBV rapid risk assessment using 10 FGDs with participants from both host and displaced communities in Metuge and Montepuez [49]; an assessment on the impact of violence on women and girls in Pemba and Metuge using 28 FGDs with women and men IDPs, 5 in-depth interviews and participant observation [unpublished]; and a consultation report on the access to sexual and reproductive for people with disabilities in Pemba (1 FGD with women and men) [unpublished].

Suabo, a midwife residing in a IDP settlement of Cabo Delgado, takes care of her friend's baby during a PSEA training conducted by UNHCR. Mozambique. © UNHCR/Juliana Ghazi.

Data analysis

UNHCR researchers analysed data collected in FGDs, while LSHTM researchers took responsibility for analysis of interview data, the document review and incorporating information from all parts of the study into the final report.

Data analysis used pre-specified codes based on research objectives, existing government policies [34] and UN Guidelines. Categories of GBV types and risks were adopted from the Inter-Agency Standing Committee (IASC) Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action [1]. The categories used to analyse facilitators and barriers of access to GBV services and the main standards of service delivery were adopted from the Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming [30] and the Inter-Agency Gender-Based Violence case management guidelines [33]. Some specific operational guidelines were also used to inform analysis concerning sex work and transactional sex in humanitarian settings and disability in emergencies, particularly the Operational Guidance for Responding to the health and protection needs of people selling or exchanging sex in humanitarian settings [31], the IASC Guidelines for the Inclusion of persons with disabilities in humanitarian action [32] and the WHO Clinical management of rape and intimate partner violence survivors [95]. Producing a detailed, comprehensive listing of actors, services and referral pathways in each study district was beyond the scope of this rapid assessment.

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London School of Hygiene
& Tropical Medicine
Keppel Street, London WC1E 7HT
United Kingdom

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