Secondary Data Review
GENDER-BASED VIOLENCE – Mozambique: Cyclone Idai and Floods
APRIL 2019

CRISIS OVERVIEW

Tropical Cyclone Idai made landfall on 14 March, in Beira city (Sofala province), Central Mozambique. As of 15 April, over 600 people are confirmed to have died in the cyclone and subsequent events. A total 1.5 million people are affected, and over 140,000 people are displaced in more than 120 accommodation centers, public buildings and schools in the affected provinces. Sofala province has the highest number of displaced population, followed by Manica province (INGC, 4/2019).

CRISIS IMPACT

Source: OCHA SitRep No.6 (as of 13 April 2019)

KEY TAKEAWAYS

This document consolidates information of the pre-crisis context and vulnerability of women and girls in Mozambique, and reviews all main post-disaster assessment results, field reports and other sources available on the disaster impact, needs and risks of the vulnerable groups.

Key Priorities

- Past lessons as well as assessment reports both highlight that women and girls and their families have been adopting negative mechanisms to cope with basic needs and economic hardship, including being exposed to sexual exploitation, sex work, early and forced marriage. Reviving livelihood and income generating activities are key to mitigate GBV risks.
- The displaced population living in sites are under stressed conditions, overcrowding and lack of wash facilities increase the risk of GBV. With sporadic ongoing relocation, women and girls are exposed to less safe and dignified environment.
- Living conditions are more severe and needs are largely unfulfilled in the communities outside the camps, especially in areas that are hard to reach. In these communities, a lack of basic needs including food and shelter has been reported, which increases risks of vulnerable population.
- The number of female-headed households as well as widowed women has increased in the aftermath of the disaster. Accompanied by a high number of pregnant women who are estimated to give birth, it is critical to ensure access to functional Sexual and Reproductive Health services and social care.
- Community-based referral and psychosocial support by local partners have been operational prior to the cyclone. As they act as the main first contacts for vulnerable groups in the communities, more resources and capacity building on GBV in emergencies are needed to scale up the existing community-based services.

Key Vulnerable Groups:

Female-headed households; single women, adolescents
Operating Environment - Contextual Review

LEGAL SYSTEM AND JUSTICE
Since independence in 1975, Mozambique has put in efforts to make strides in gender equality. Systems have been put in place, and achievements have been made, for example in political representation. Since 1994 the ruling party implemented a quota on the representation of women in the government. This has ensured that women have approximately one third of seats in the National Assembly. However, a lot of progress still needs to happen to reach gender equality – not just in systems and institutions, but also at a community level (Tvedten 2008).

Rule of law: After the civil war (1984–1992), which had a large impact on the Central Provinces, turnover in the government has been democratic (Tvedten 2008).

Women’s rights:
- The 2004 constitution upholds the principle of gender equality and prohibits discrimination based on sex.
- Mozambique has ratified CEDAW, as well as the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (Government of Mozambique 2012).
- Polygamy has been prohibited by the Family Law (2004), yet is commonly practiced. In effect, polygamous unions are not legally recognized, but there are no legal restrictions against the practice itself (CAR 29/03/2019).
- The Act on Domestic Violence Perpetrated Against Women was passed in 2009, criminalizing domestic violence including physical abuse, sexual abuse, emotional and psychological abuse, stalking, harassment, intimidation, damage to property, and other controlling or abusive behavior (UNWOMEN 2009).
- The Land Laws of 1997 specifies that, although land belongs to the state, legal measures can help communities and individuals (men and women) to obtain land without requiring written proof of use. However, in reality the gender equality in land ownership is not reflected as patriarchal cultures still favor land ownership for men (SIDA 2006).

Access to justice: Although the Mozambican government has put into place efforts to combat violence against women, women have difficulty accessing courts for various reasons (details in below content “GBV PROTECTION NEEDS”). Instances of GBV including rape, are more often settled through informal local/community courts, or privately through financial remuneration (Slegh 2010; US Department of State 2017).

SOCIODEMOGRAPHIC ENVIRONMENT
Female-headed households: As of 2015 approximately 36% of households in Mozambique are female-headed (DHS 2015).

Economy: In 2008, a study found that approximately 79% of women were economically active. Women are largely responsible for the household. This may also be included into the high percentage for economic activity – although returns on this are low. Furthermore, employed women mostly work in the agricultural sector (89%), a sector in which they form a large share of unskilled labor (59%). This shows that, though women may take up a large part of economic activity, they may not take home a large amount of money. Women active in agriculture work an estimated average of 14 hours per day, which also leaves them little time for partaking in public participation or education (Tvedten 2008; SIDA 2006).

When employed, women are often performing unskilled jobs, which are low-paid. In addition, in 2008 only around 4% of women were employed in the government, public, or private sector. These jobs entail a fixed monthly salary with predictability and more certainty (Tvedten 2008).

Education: Literacy rates in Mozambique stand at 70.5% for the population aged 15–24. When only looking at the population over 15, the literacy rate stands at only 56%. Women are significantly less literate than their male counterparts. High discrepancies in literacy rates among men and women can point to inequality, where girls tend to be the first who are denied access to education, or taken out of school as their education is not prioritized.
Despite changes at an institutional level, Mozambique remains a highly patriarchal society where men dominate power positions in communities and the household.

**GBV perception**: While more updated data is not available, in 2009 an estimated 70% of perpetrators of GBV against their partners never faced charges. The reasons for this included that the survivor has to deal with the case alone or through the family (47%), the act was not deemed serious (15%), the act was considered a private issue (9%), or the survivor feared retaliation and reprisal (11%) (UNIFEM 2009). This indicates that in Mozambique, GBV is being normalized, and a GBV case is considered a family or private affair without much institutional and systematic support. However, the Multisectoral Mechanism for Integrated Assistance to Women Victims of Violence was established in 2012 and strives to provide accessible and integrated services for vulnerable people and more systematic fighting against GBV.

In addition, an anthropological study found that generally in Mozambique, a 'good woman' submits to her husband, other male relatives, and the husband's family. Male dominance in the household is seen as a given, and maltreatment of women is often seen as a result of their own behavior. These socio-cultural explanations about women's role in society justify acts of gender-based violence as natural and private matters (Slegh 2009).

**Gender roles**: Generally, men are still seen as the power-holders and the culture in Mozambique is patriarchal and male-dominated. This may be rooted in historical influences when political powerholders were men in charge of chieftainships. On top, Central Mozambique knew a more patrilineal system, meaning a woman belongs to the husband’s family – which has been symbolized through dowry (lobolo). Though at times women can be in influential positions (e.g. in clans) – these are usually not formalized positions of power (Tvedten 2008).

**Division of labor**: Generally, men and boys are responsible for working outside the home while women and girls take care of domestic issues. These include taking care of children and older people, as well as cooking, fetching water, and cleaning (CARE 29/03/2019). Reduced accessibility and availability of water and other household items are likely to put women and girls more at risk when performing domestic tasks.

**Household decision-making**: Despite women’s large participation in the household, their decision-making is described as limited (Phu 360 2013). This is backed up by data from the Demographic Health Survey (2013), which shows that men generally tend to take the decisions in the household regarding health expenditures and groceries. In Sofala, over 80% of men solely took the decisions in these areas.

**Political participation**: Mozambique has the 14th highest level of women’s participation in parliament in the world (World Bank).

**Traditional marriage practices**: Dowry, or lobolo still plays a large role in the central provinces including Sofala (Tvedten 2008). Though polygamy is not legalized in the Family Law (2004), it is still practiced. In these cases, the husband is only legally married to the first wife, but has multiple relationships outside the marriage. Polygyny is often recommended when the first wife is infertile – but is generally common in the patrilineal cultures (Arnaldo 2003). In the same Family Law, the age for marriage is set at 18.

**Harmful practices**: In some instances, widowhood can be seen as needing ‘purification’. This purification practice is common among the Sena ethnic group in Sofala. A woman, upon the death of her husband, needs to be purified by having sex with his male relative three times a day for a week. This practice called pita-kufa (or khupita-khufa) increases the risk of HIV and may cause unwanted pregnancy (IRIN 2008; Vera Cruz 2018).
Crisis Impact and Pre-Crisis Baseline

**BASIC NEEDS**

GBV does not happen in a silo and is never a standalone incident. Disasters, conflicts, pre-crisis vulnerabilities, stressed living conditions, and a lack of resources are all exacerbating factors for the manifestation of GBV and related negative coping mechanisms. Reduced availability and accessibility of basic services (source of income; health facilities, food, market etc.) as a result of the cyclone and floods increase the vulnerabilities of women and girls.

**Water, Sanitation, and Hygiene:** According to the Demographic Health Survey (2015), approximately 23.7% of people in Sofala did not have access to an improved water source. A further 23.1% used a hand pump. In previous years, during periods of drought, it was noted that during the water collection activities, girls faced increased risk of confrontations with wild animals and GBV (CARE, 2016).

Water

Over 50% of displacement sites assessed have water sources on site (DTM R2, 4/2019). As women and girls are responsible for fetching water, they are exposed to more GBV risks when looking for alternative water sources. The post-disaster multi-sectoral assessment (MRA) in six affected districts further noted that the availability of potable/drinking water has decreased significantly, particularly in Nhamatanda (MRA, 4/2019).

Sanitation and hygiene

Wash conditions are stretched and overcrowding is observed in sites in Beira. Wash facilities cannot be installed or completed and prepared in time with sporadic and rapid ongoing relocations (Protection cluster, 4/2019). In 20% of the sites assessed in DTM it is reported that nobody has access to bathing and shower facilities. Less than half of sites have gender-segregated latrines and bathing facilities (DTM R2, 4/2019). At new accommodation sites women are reported to be showering inside the latrines (Protection cluster, 4/2019). Recent research also shows that over 40% of women do not use latrines provided (CARE, 3/2019).

The MRA further noted that almost all assessed communities in Buzi, Gondola, Nhamatanda and Sussundenga districts are facing a major deterioration in the quality of sanitation facilities. Whereas previously all communities mostly used household latrines, they now have to resort to open defecation. It is reported that privacy for washing and defecating is an issue for women and girls, especially in Dondo and Nhamatanda (MRA, 4/2019).

The lack of safe and quality hygiene and sanitation facilities, latrines and bathing facilities that are not safely lit all lead to worsened hygiene condition and higher the risk to GBV. In addition, women and girls who cannot access safe facilities might face additional burdens as they may aim to limit their use of facilities, which can lead to reduced food and water intake.

**Health:** According to the existing referral mechanism in place by the Ministry of Gender, Children and Social Action (MGCAS), there are three entry points of services for any vulnerable groups and potential GBV survivors: health facilities, social action and the police. Health facilities with trained staff and post-exposure prophylaxis (PEP) kits for rape survivors to perform clinical management of rape (CMR), and specialized psychosocial intervention are only available at district or provincial hospital.

As social workers can be the first point of entry for many GBV survivors, they need to be trained to deliver psychosocial support. Pre-crisis reports further point out that specialized knowledge on treating survivors of GBV is often not sufficient in the health facilities: women who seek help after physical violence are not always properly consulted prior to being sent back home (Sieg 2010). Therefore, there is also a need to train personnel in health facilities.

Cyclone and floods have caused major damage to at least 93 health centers (Health cluster, 4/2019). More complete assessment on health facilities are ongoing, however field visits suggested that district level hospitals in Nhamatanda, Dondo, Buzi and Beira districts are functional, despite some structural damages. However information on the overall availability of stocks and supplies of PEP kits remains a gap (HeRAM, 2019). The administration of PEP within 72 hours of a reported rape case is vital to save lives of survivors, especially considering the high prevalence rate of HIV in the population. Preliminary health facility assessments have showed that around 55% of assessed health facilities in Sofala province do not have PEP kits available (FHI360, preliminary data on health facility assessments, 4/2019).

In the majority of displacement sites people reportedly have no problem accessing health facilities, and in more than 70% it is reported that health facilities have female staff. 80% key informants reported that women are seeing health professionals during pregnancy (DTM R2, 4/2019). The MRA findings in six districts show that in more than half of communities women have access to sexual and reproductive health care. In Gondola and Sussundenga districts, the nearest health facilities in most locations are reportedly very
difficult to access. As a result of the cyclone and floods, people in remote affected areas face challenges accessing district hospitals.

To ensure a private and protective environment, there is a need to refurbish the maternity wards, where the survivors are treated. Further, the administrative offices of the Women and Children's Protection desk need to be rehabilitated, so a private and protective environment can be restored for women and girls to report confidentially.

HIV: It is estimated that almost 1.6 million people, including more than 90,000 children, are infected with HIV in Mozambique. More than half of those infected are women, and 15% of pregnant women aged 15–49 are HIV-positive (ODI, 2014). The prevalence rate of HIV in the population aged 15-49 is 13.2% (15.4% in women and 10.1% in men). Sofala has a higher rate (16.3%) than other affected districts (DHS, 2015). Furthermore, women and girls are particularly affected by the epidemic because they usually lack the power to refuse unsafe sex, choose their partners or influence sexual behavior (ODI 2014).

Sexual and Reproductive Health: According to the latest estimation, about 438,000 women affected by the cyclone are of reproductive age (15-49). Among those, 64,000 women are estimated to be pregnant and more than 37,000 women in affected areas are estimated to give birth in the next three months. Among those giving birth, up to 9,600 may be at risk of complications during their pregnancy in the next three months. They will need access to functioning health facilities and care (UNFPA, 4/2019).

Shelter: According to the Demographic Health Survey some 28% of people in Sofala did not have electricity. A further 28.9% of people lived in a cement house, 36.9% in an earthen mud-house (DHS, 2015).

According to the latest DTM there are currently over 13,600 people hosted in 24 displacement sites in Beira (DTM R2, 4/2019). This includes five planned sites, the remainder are temporary transit sites including schools and public buildings. Site plans of the five accommodation centers suggest that currently up to 5–6 families are sharing one tent, and averagely 12m² space is available per person (calculated based on CCCM site plans and DTM Round 2, 4/2019). The SPHERE standards prescribe a minimum of 30m² for camp-like settlements. Overcrowding and inadequate privacy for women and girls are observed, which is a risk to GBV.

While the site plans are designed to follow minimum standards and provide suitable living conditions, many elements have contributed to increased vulnerabilities and overstretched capacity on site: ad-hoc relocation plans, lack of sensitization among surrounding communities, lack of communication to the population, and a lack of systematic allocation of tents (Protection Monitoring, 4/2019). It is also reported that more than half of the sites do not have adequate lighting in any common place; which is considered a major risk to GBV and can hamper the freedom of movement of women and girls (DTM R2, 4/2019). The MRA in Dondo district shows that in more than half surveyed locations, people have been sleeping in open areas. In Buzi all but one location there were surveyed families who reported they were sleeping outside (MRA, 4/2019). Sleeping out in the open is unsafe and can increase the risk of GBV to women and girls.

Documentation: The affected population have lost most or all of their documents during the cyclone. This include identity documentation and other vital certificates. An estimated 19% of people in Sofala already did not have birth certificates or registration in 2015 (DHS 2015). The lack of mechanisms to facilitate attainment of these documents is likely to hinder access to services, including enrolment in schools and engagement in some livelihood activities (Protection cluster, 4/2019). A lack of basic needs, or possibility to engage in livelihood activities, will lead to faster depletion of coping mechanisms of the affected population. This means that negative coping mechanisms including those that pose a higher risk to GBV will be adopted faster. A lack of engagement in school for children also increases the risk of child labor and exploitation.

Eviction: Assessments in the displacement sites suggested that 11 (3 in Nhamatanga district and 8 in Beira district) out of 41 sites reported there is an eviction threat (DTM R2, 4/2019). However the answer is perception-based and it is likely to indicate the lack of communication and sensitization to the displaced population. In multiple reports the importance for communities to get timely and clear information on relocation processes is emphasized (Protection cluster, 4/2019).

Child Protection: Over 28% of households in Mozambique have adopted children (DHS 2015). Almost 50% of young Mozambican women aged 20-24 years were married before the age of 18, while 14% were married before the age of 15 (CARE, 3/2019).

According to MRA in Dondo, among children under 14 years old, a total of 22.3% were orphan by father (13.2%), by mother (6%) or both parents (3%). The assessment further showed that in six affected districts, helping out the family by doing chores and other work are among the main reason children (both boys and girls) are not attending schools. In about 10% of locations assessed, communities reported that they have noticed there are children disappearing (or being trafficked). In almost 40% of assessed locations communities reported having come across children who are forced to work to provide.
food and other goods (MRA, 4/2019). Being out of school and engagement in other livelihood activities increase the exposure to GBV risks.

**GBV PROTECTION NEEDS**

Affected population, displaced population and estimated affected women at reproductive age who could be at risk of GBV in all affected provinces

<table>
<thead>
<tr>
<th>Affected Province</th>
<th>Affected Population (INGC Ponto de Situação, 10 April)</th>
<th>Total Displaced Population (INGC Novo Centro Update, 4 April)</th>
<th>Estimated affected women at reproductive age (15 – 49) (*Calculated based on two sources: Affected population[INGC] * % of women at reproductive age [2017 census])</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zambezia</td>
<td>6,035</td>
<td>5,235</td>
<td>1,417</td>
</tr>
<tr>
<td>Tete</td>
<td>54,721</td>
<td>2,655</td>
<td>12,021</td>
</tr>
<tr>
<td>Manica</td>
<td>262,890</td>
<td>13,115</td>
<td>60,040</td>
</tr>
<tr>
<td>Sofala</td>
<td>1,190,594</td>
<td>120,995</td>
<td>288,480</td>
</tr>
<tr>
<td>Inhambane</td>
<td>422</td>
<td>-</td>
<td>103</td>
</tr>
<tr>
<td><strong>Grant Total</strong></td>
<td><strong>1,514,662</strong></td>
<td><strong>142,000</strong></td>
<td><strong>362,061</strong></td>
</tr>
</tbody>
</table>

*Note on different data sources:

1. According to the latest DTM (round 2, 10 April) assessments in 41 displacement sites, there are a total 13,616 people who are displaced in 24 sites in Beira. The table above uses the INGC source for a more complete presentation of the displaced population across whole Sofala province. However, the INGC displacement data is dated 4 April for all provinces.

2. The number of estimated women at reproductive age (WRA) is based on a calculation of the affected population [INGC] * % of WRA [2017 census]. The total number is different than the UNFPA estimated figures in above paragraph, because the methodology of calculation and sources are different [INGC figures are not used in the latter calculation].

**Affected districts in Sofala Province – affected, displace population and estimated women at reproductive age**

<table>
<thead>
<tr>
<th>Affected District</th>
<th>Affected Population (INGC Ponto de Situação, 10 April)</th>
<th>Total Displaced Population (INGC Novo Centro Update, 4 April)</th>
<th>Estimated affected women at reproductive age (15 – 49) (*Calculated based on two sources: Affected population[INGC] * % of women at reproductive age [2017 census])</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beira</td>
<td>436,640</td>
<td>15,393</td>
<td>114,073</td>
</tr>
<tr>
<td>Nhamatanda</td>
<td>273,676</td>
<td>56,342</td>
<td>61,766</td>
</tr>
<tr>
<td>Dondo</td>
<td>166,511</td>
<td>19,737</td>
<td>39,880</td>
</tr>
<tr>
<td>Búzi</td>
<td>154,332</td>
<td>16,714</td>
<td>37,196</td>
</tr>
<tr>
<td>Marromeu</td>
<td>41,810</td>
<td>-</td>
<td>9,344</td>
</tr>
<tr>
<td>Muanza</td>
<td>36,525</td>
<td>7,635</td>
<td>7,869</td>
</tr>
<tr>
<td>Gorongosa</td>
<td>28,460</td>
<td>550</td>
<td>6,338</td>
</tr>
<tr>
<td>Maringue</td>
<td>26,900</td>
<td>-</td>
<td>6,085</td>
</tr>
<tr>
<td>Caia</td>
<td>12,040</td>
<td>-</td>
<td>2,751</td>
</tr>
<tr>
<td>Cheringoma</td>
<td>7,060</td>
<td>490</td>
<td>1,544</td>
</tr>
<tr>
<td>Chibabava</td>
<td>3,975</td>
<td>4,134</td>
<td>1,008</td>
</tr>
<tr>
<td>Machanga</td>
<td>2,335</td>
<td>-</td>
<td>552</td>
</tr>
<tr>
<td>Chemba</td>
<td>330</td>
<td>-</td>
<td>74</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,190,594</strong></td>
<td><strong>120,995</strong></td>
<td><strong>288,480</strong></td>
</tr>
</tbody>
</table>

**Gender based violence:** The post disaster multi-sectoral assessment (MRA) in Dondo and Buzi districts reported that families are resorting to negative coping strategies to meet their most basic needs and risks of GBV was reported (MRA, 4/2019). There were also cases of sexual exploitation and abuse by people in positions of power in the community and village chiefs when assigning relief items. This entailed forcing women and girls into sex in exchange for food and other relief items (Jornal de Noticias, 4/2019).
In times of disaster the prevalence of GBV increases and new forms of violence emerge. Rape, trafficking, early marriage and other forms of violence against women tend to increase in times of conflict and natural disasters (CARE, 3/2019). GBV happens everywhere in all contexts and is recognized as one of the most pervasive yet most under-reported forms of violence in the world. Any GBV prevalence data needs to be treated with extreme caution. Field visits to district hospitals suggest that the functional hospitals have received less cases in comparison to the pre-crisis situation, which can be an indication of increased challenges in access to services or increased reporting barriers for the affected population.

Stressed living conditions and tensions in communal living spaces expose people to a higher risk of GBV as people live in crowded and less safe environments. Economic hardship and loss of livelihood are likely to trigger negative coping strategies, like early and forced marriage, in the need to engage in survival sex or sex work for food and money etc.

Prior to the cyclone, women and girls already faced GBV protection needs: According to the latest Demographic Health Survey (2015), 24% of women aged 18 – 49 are estimated to have suffered physical violence since the age of 15. A further 6% of women aged 18–49 are estimated to have experienced sexual violence. 12% of women report having been forced to have sex in their lives. Those who experience physical violence only are more likely to seek help than those who only experience sexual violence. Among those who are survivors of physical violence within the marriage, an estimated 13% suffered from eye injuries, burns, or sprains. A further 23% is estimated to have suffered sexual violence as well (DHS 2015).

In Sofala, 6.5% of women aged 15–49 thought it was acceptable for a husband to beat his wife.1 When posed the same question, 13% of men in Sofala thought it was acceptable to beat their wife. In particular, arguing and refusing to have sex were seen as legitimate reasons to beat a wife (DHS 2015). Within this environment, keeping silent is the most adopted way for women to cope and is considered to increase their individual chance to survive (Slegh, 2009).

The challenges of survivors to seek help include but are not limited to access constraints to service providers, fear of stigmatization, and ostracization. With limited presence of district level services, most GBV cases are settled through traditional courts by community committees. It is critical to take into account the power dynamics of the households in any community engagement and programme design, survivors are not serviced properly when they need to risk their family’s protection in order to stand up for their rights (Slegh, 2009).

INFORMATION GAPS AND NEEDS

- Critical demographic data disaggregated by sex and age remains a gap for most vulnerable population groups, e.g. female headed households.
- More complete data on damage and impact is still to be obtained with improvement of humanitarian access.
- More granular level information needed at community level on GBV protection needs
- Assessment/survey data using different data collection methods that are not limited to key informants are needed. Surveys, FGD with women groups, community committee are recommended.

LESSONS LEARNED

- Adolescent girls are often at high risk of GBV, yet not always specifically targeted for provision of reproductive healthcare. Specific attention should be paid to adolescent girls who often do not access healthcare due to their age, lack of decision-making power, and limited access to care (UNFPA GBViE Minimum Standards 2015)
- The GBV prevalence rate in Sofala province is high. Strong evidence exists regarding the risks GBV poses for HIV, specifically among women, and numerous studies have highlighted the benefits of tackling GBV and HIV as twin epidemics (WHO, 2004). GBV integration into HIV prevention programmes that address social and cultural norms that support inequalities in the family,

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1 Thought it was acceptable for a husband to beat his wife in one or more of the following instances: burning food, arguing with husband, leaving the house without informing the husband, not taking care of the children, when hitting the children.
community and institutions (FHI360, 2015) should be included as a response strategy in the medium and long term.

- With the onset of the drought in Mozambique (2016), many families have used child marriage as a coping mechanism to raise income (through dowry) or to reduce the number of dependents per household (CARE, 3/2019). Girls are at increased risk of GBV as they are married off for dowry. As described above, many families have lost documentation as a result of the cyclone and subsequent floods. This makes it more difficult for children to attend school. In addition, many communities observed children who had to work. Being out of school exposes children to higher risks of GBV and may also contribute to more child marriage.

LIMITATIONS

- Prevalence of GBV or number of GBV cases reported are never an indication of needs or risks. Numbers should be interpreted in close reference to the context and it should be considered that GBV is underreported in most contexts.
Response Capacity

The response capacity to protection needs of women and girls are threefold in the aftermath of the emergency: government institutions which provide specialized health care, psychosocial support, social care, legal and judicial assistance; community-based organization, who work closely with relevant line ministries, and perform community-based case management and referral for vulnerable people in need; humanitarian partners (UN, INGOs etc.) who are providing support to disaster-affected population.

Humanitarian partners

- Currently provide limited and scattered services on prevention and mainstreaming, not response.
- Service provision is concentrated in Beira cities and evolved around accommodation centers/displace sites, non-specialized psychosocial support, psychosocial first aid is the most common service provided in and near sites.
- Community engagement through NFI distribution (dignity kits) is the main intervention for risk mitigation and has highest number of locations and beneficiaries reached, even still very limited in terms of quantity.
- Efforts are made towards strengthening and reinforcing the government-led integrated GBV services, including bringing government social workers to major sites for referral and case management.
- There is a need to provide more psychosocial support, more training on psychosocial first aid for community activities/volunteers and more specialized capacity in providing psychosocial intervention.
- With the unfold of the crisis and scale up of humanitarian response, more than 180 organizations and agencies are providing humanitarian assistance. More constant GBV mainstreaming and risk mitigation through all cluster response and humanitarian partners is required, especially when carrying out distributions, through site planning and programme designs.
- Many humanitarian agencies’ operations are time-bound and are subjected to funding status, which poses challenges on continuity and consistency. More capacity building of government counterparts and community-based organizations are needed for more sustainable and long term recovery.

Government Response

- The Multisectoral Mechanism for Integrated Assistance to Women Victims of Violence in 2012 outlines the three pillars of services/points of entry for integrated GBV response: specialized health services, social action and police. The system also encompasses further legal assistance if required by the victim/survivor.
- Within this integrated mechanism, the victim/survivor can seek help by contacting either of these services. Regardless of the service point of entry (health, social action or police), the respective service provider must ensure the victim/survivor/vulnerable individuals is referred to all other pillars of the service provision.

<table>
<thead>
<tr>
<th>National level</th>
<th>Specialized health service provider</th>
<th>Social Action, GBV service provider</th>
<th>Police</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health (MoH)</td>
<td>Ministry of Gender, Children and Social Action (MGCAS)</td>
<td>Ministry of Interior</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provincial level</th>
<th>Specialized health service provider</th>
<th>Social Action, GBV service provider</th>
<th>Police</th>
</tr>
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<tbody>
<tr>
<td>DPS</td>
<td>DPGCAS</td>
<td>Police</td>
<td></td>
</tr>
<tr>
<td>Servicios de Urgência nas Unidades Sanitárias; Centro de Atendimento Integrado (CAI)</td>
<td>Gabinete de Atendimento à Mulher e Criança (GAMC)</td>
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<table>
<thead>
<tr>
<th>District level</th>
<th>Specialized health service provider</th>
<th>Social Action, GBV service provider</th>
<th>Police</th>
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</thead>
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<td>DDS</td>
<td>DMCAS</td>
<td>Police</td>
<td></td>
</tr>
<tr>
<td>Health posts, clinics</td>
<td>Community committee, CBOs</td>
<td>GAMC</td>
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</tbody>
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Source: MGCAS, Mecanismo Multisectorial de Atendimento a Mujer Víctima de Violencia, 2012

Community based organizations

- Based in communities, with networks of trained community volunteers /activists for referral and case follow-up
- Depends on which line ministry CBOs are working with, some has focuses on SRH, some on GBV and others provide integrated services i.e. nutrition services, health, legal counselling.
- These CBOs train and maintain the activists network covering whole Sofala province, however the resources are limited, some have chosen to focus on building capacity of government counterpart (health staff etc.)
Secondary Data Review
GENDER-BASED VIOLENCE – Mozambique: Cyclone Idai and Floods
APRIL 2019

GBV Service Provision by Humanitarian Partners (District Level)

KEY FIGURES

- 9 Agencies
- 16 Districts
- 5 Integrated Protection Service Centers Planned
- 2,341 Dignity Kits distributed

OVERVIEW

Interventions are concentrated in Beira city and are evolved around relocation sites/accommodation centers. Non-specialized psychosocial support is the most common service delivery in site setting.

Information gap remains on the provision of specialized health service (clinic management of rape etc.) by humanitarian partners and emergency medical teams.

A total four national NGOs are providing community based case management services. Two national NGOs have community based network for referral at provincial level (Sofala).

Site Level (Accommodation Center)

Available GBV Services:
- Specialized health service (Clinic management of rape)
- Psychosocial support
- Case management
- Advocacy and messaging
- NFI distribution
- Safe spaces

For inputting in GBV service provision mapping, please contact:
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