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POST-RAPE CARE FOR CHILDREN IN MOZAMBIQUE

ASSESSMENT REPORT

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

JULY 2013

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ACRONYMS

CSO	civil society organization
GAMCVVD	<i>Gabinete de Atendimento a Mulher e Criança Vitima de Violência Doméstica</i> (Office to Assist Women and Children Victims of Domestic Violence)
GBV	gender-based violence
HDI	Human Development Index
MINED	Ministry of Education
MinJus	Ministry of Justice
MISAU	Ministry of Health
MINT	Ministry of Interior
MMAS	Ministry of Women and Social Action
ML	<i>medicina legal</i> (legal medicine)
OVC	orphans and other vulnerable children
PIC	<i>Polícia de Investigação Criminal</i> (Police Criminal Investigation)
PEP	post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PRC	post-rape care
RENAMO	<i>Resistência Nacional de Moçambique</i> (National Resistance of Mozambique)
SGBV	sexual and gender-based violence
SDMAS	District Services of Health Women and Social Action

EXECUTIVE SUMMARY

This assessment focused on current availability and practices of post-rape care (PRC) for children in two provinces of Mozambique, Zambezia and Sofala, and in the capital city of Maputo. On the basis of individual in-depth interviews and focus group discussions, this assessment aimed to highlight what supports and hinders provision of services for children who have experienced sexual violence and exploitation. In particular, the assessment examined the role of the current legal and policy framework vis-à-vis perceptions of community and institutional actors about the problem of sexual violence and exploitation against children and the connection with actual service provision practices. The assessment was conducted primarily to support USAID/Mozambique's planning in this area of development. It does not evaluate any program or service. Rather, it provides a snapshot of key issues that affect access to and provision of PRC and suggests recommendations to stimulate further action to benefit the children of Mozambique and the development of the country more broadly.

Sexual violence and exploitation against children is steeped in contextual determinants that a number of previous studies and assessments have highlighted: the socio-economic development and legacy of the civil war and war-time sexual violence, the intersections of HIV and sexual and gender-based violence (SGBV), gender relations in Mozambique, and the social vulnerability of children to sexual and economic exploitation. The legal framework relevant to child sexual violence and exploitation is not immune from influence by these factors, and civil society in Mozambique has been very vocal in criticizing the inadequacies and ambiguities of the penal code, which was being revised at the time this assessment was conducted. The legal definitions of what constitutes types of sexual violence and exploitation against children are mostly based on the age of the victim instead of on the nature of the offense, and on the virginity of the girl child. This legal framework appears to impact the policy guidance for service provision, and it can be argued that both still suffer from the influence of inequitable gender and sexual norms. This is also evidenced by the almost non-existent focus on sexual violence and exploitation against boys.

Inequitable gender and sexual norms are among the key contextual determinants of sexual violence and exploitation against children, and play a major role in shaping attitudes and perceptions toward children, including children's rights and entitlements. In Mozambique, children—especially girls—are largely considered their parents' property. Girls are still seen and treated as commodities that can be exchanged for cash or goods through early marriage arrangements. However, these practices are mostly viewed as an early marriage problem and not through the lens of sexual violence and exploitation. The limited understanding of the law in the community is compounded by inconsistencies in its application by law-enforcing agencies and the judicial system. This situation in turn discourages reporting cases. Many people feel that the only cases of sexual violence and exploitation that reach the courts are those involving a death or severe injuries, and that wealthy and influential perpetrators can get away with paying a fine. Most families still try to negotiate privately with perpetrators and report to the police only when these negotiations fail. By then, it is too late to collect forensic evidence and to provide some key elements of medical treatment. Informal justice structures often breach their mandate, which is limited to facilitating the reporting of cases to the authorities, and become involved in mediating between the families and the perpetrators. Unfortunately, even law enforcement officers and other institutional actors at times still participate in these negotiations, especially if the perpetrator is wealthy or influential.

There are positive developments, such as the establishment of the *Gabinete de Atendimento a Mulher e Criança Vitima de Violência Doméstica* (GAMCVVD or Gabinete, Office of Women and Children's Services Victim of Domestic Violence). These are police units specifically mandated to respond to SGBV, and they are now present in all districts of Mozambique, although their capacity and resources vary considerably. An important factor influencing their effectiveness is leadership. The effectiveness of the Gabinetes's response is often due to the personal commitment of one or a few individuals, which raises the question of what happens if they leave.

There have been recent positive developments in service provision, such as the approval of the Multisectorial Mechanism, which standardizes integrated services for victims across the Ministry of Interior (police and the Gabinete), Ministry of Health, and Ministério da Mulher e Acção Social (MMAS—Ministry of Women's Affairs and Social Action/Services). At the time of this assessment, this Mecanismo Multisectorial was being tested as well as the newly drafted Padrões Mínimos de Atendimento a Criança (Minimum Services Standards for Children's Care). However, none of the individuals interviewed for this assessment was able to answer an important question: Who is in charge of following the case from start to end?

Lack of capacity and resources (human, financial, as well as physical infrastructure) continue to undermine the goodwill and initiatives of policymakers, providers, and community actors. However, there are many opportunities to re-think and improve the capacity of current activities to more effectively focus on inequitable gender and sexual norms. These norms create the social ecology conducive to sexual violence and exploitation against children and make it very difficult to affirm and realize children's rights.

GLOSSARY OF TERMS

ADULT: Any person 18 years and older.

CHILD: Any person under the age of 18. The following definitions clarify the term “child” with regard to age and developmental stages for guiding interventions and treatment:

- Children = ages 0 to 18, as per the Convention on the Rights of the Child
- Young children = ages 0 to 9
- Early adolescents = ages 10 to 14
- Later adolescents = ages 15 to 18

CHILD WHO HAS EXPERIENCED SEXUAL VIOLENCE AND EXPLOITATION: A person under the age of 18 years who has experienced an act of sexual abuse. Child exploitation is the use of children for someone else’s economic or sexual advantage, gratification, or profit, often resulting in unjust, cruel, and harmful treatment of the child. This is the predominant term found throughout this document (Day and Weeks 2013).

CHILD SEXUAL ABUSE: The World Health Organization defines child sexual abuse as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child, who by age or development is in a relationship of responsibility, trust, or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to:

- the inducement or coercion of a child to engage in any unlawful sexual activity
- the exploitative use of a child in prostitution or other unlawful sexual practices
- the exploitative use of children in pornographic performance and materials (WHO 1999; Day and Weeks 2013).

COMMUNITY ACTORS: In this report, community actors refers to respondents from civil society organizations or respondents from community structures like community courts, community child protection committees, and community health councils/committees.

GENDER-BASED VIOLENCE: In the broadest terms, gender-based violence (GBV) is violence that is directed at an individual based on his or her biological sex, gender identity, or his or her perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life.

- GBV takes on many forms and can occur throughout the lifecycle, from the prenatal phase through childhood and adolescence, the reproductive years, and old age (Moreno 2005).

Types of GBV include female infanticide; harmful traditional practices such as early and forced marriage, “honor” killings, and female genital cutting; child sexual abuse and slavery; trafficking in persons; sexual coercion and abuse; neglect; domestic violence; and elder abuse.

- Women and girls are the most at risk and most affected by GBV. Consequently, the terms “violence against women” and “gender-based violence” are often used interchangeably. However, boys and men can also experience GBV, as can sexual and gender minorities, such as men who have sex with men and transgender persons. Regardless of the target, GBV is rooted in structural inequalities between men and women and is characterized by the use and abuse of physical, emotional, or financial power and control (Khan 2011).

INSTITUTIONAL ACTORS: In this report, this refers to respondents from formal justice structures (e.g., the Gabinete), health services, social services, and education.

INTRODUCTION AND BACKGROUND

Both the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Health Initiative have prioritized monitoring and responding to gender-based violence, particularly focusing on strengthening post-rape-care services, including the provision of HIV post-exposure prophylaxis (PEP), screening and counselling for gender-based violence (GBV), and strengthening linkages among health, legal, law enforcement, and judicial services and programs to mitigate GBV. An increased focus on sexual violence against children is also based on evidence in sub-Saharan Africa that children constitute a significant portion of survivors of sexual and gender-based violence (SGBV) seeking services (Murray 2009).

Child sexual violence and exploitation has been recognized as a critical developmental and human rights issue with important implications for HIV prevention, care, and treatment. Globally, an estimated 150 million girls and 73 million boys under the age of 18 have experienced some form of sexual violence and exploitation (Pinhero 2006). A literature review on child sexual abuse conducted by the East, Central, and Southern Africa Health Commission (ECSA-HC 2011) further suggests a high prevalence of all the forms of sexual violence and exploitation against children in sub-Saharan Africa.

Significant barriers impede the provision of meaningful, effective services for children and adolescents who have experienced sexual violence. Barriers include concerns about confidentiality, availability of PEP, training for providers in effective medical protocols (where they exist) for children who experience sexual violence and exploitation, collaboration among medical, legal, social welfare services and community-based prevention and support, and policy responses to SGBV (Kilonzo 2009). Even when available, adult-oriented services are often unprepared to meet children's complex needs (Keesbury and Askew 2010). Child sexual violence and exploitation differs in many ways from that of adults and therefore cannot be handled in the same way.

Globally, sexual violence and exploitation against children is unique due to children's economic dependence, weak social position (especially girls), and gender inequalities, including high rates of GBV, and the severe consequences of the HIV epidemic on family and community structures. Not unlike GBV against adults, GBV against children is surrounded by a culture of secrecy, stigma, and silence. It is viewed as a private matter, especially when the perpetrator is a family member. There is a need to strengthen awareness of child rights, what constitutes violence, and when and how to report it (ECSA-HC 2011 as noted in Day and Weeks 2013).

AIDSTAR-One undertook a number of activities in 2011 and 2012 to address some of the needs of children who have experienced sexual violence and exploitation. These began with the development of *The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs* (Day and Weeks 2013). In April 2012, PEPFAR's Gender, Orphans and Vulnerable Children and Pediatric Treatment Technical Working Groups convened a one-day expert meeting to draft these Technical Considerations. It was coordinated with AIDSTAR-One and the Together for Girls partnership, which was formed to end violence against children and

includes five UN agencies, led by UNICEF, the U.S. Government through PEPFAR and its implementing partners, The Centers for Disease Control Division of Violence Prevention, the Department of State's Office of Global Women's Initiatives, and the private sector. The meeting brought together 28 people, including representatives from PEPFAR, the U.S. Government, and Together for Girls, as well as experienced providers (clinicians, behavioral scientists, and social workers) with expertise in child protection, sexual exploitation and abuse, care for survivors of violence, emergency pediatrics, child-focused clinical services, HIV prevention, care, and treatment, fistula treatment, and distribution of PEP for HIV. Participants represented eight countries—Democratic Republic of Congo, Lesotho, Kenya, Mozambique, South Africa, United States of America, Zambia and Zimbabwe. The Technical Considerations focus on care for children that is implemented and linked to other critical services, such as psychosocial care and legal support.

Concurrent with the development of these Technical Considerations, USAID/Mozambique requested that AIDSTAR-One conduct a situational analysis to ascertain what supports and hinders effective care for children who have experienced sexual violence and exploitation. The results will provide information on how to make the Technical Considerations more feasible, relevant, and operational in Mozambique and on how USAID/Mozambique should move forward with activities for children who have experienced sexual violence and exploitation.

MOZAMBIQUE CONTEXT

A few important factors intersect in creating vulnerability and risk for sexual violence for children in Mozambique:

Socioeconomic development and legacy of the civil war and war-time sexual violence

In 2012, the Human Development Index (HDI)—a measure of human development that comprises three key domains (health, education, and income)—ranked Mozambique at 185 out of 187 countries, well below the regional average HDI for sub-Saharan Africa (UNDP 2012).

The legacy of the civil war in Mozambique is powerful, with regards to the psychological and physical trauma of children and adults, degradation of the health and social systems, and disruption of cultural practices that impact health. For example, the war normalized violence as a means to manage interpersonal relations, and increased the numbers of orphans and vulnerable children (Igreja 2006). Both boys and girls were deeply involved in the war, as members of ravaged communities and of the fighting forces (Denov 2008). Recruitment of child soldiers in Mozambique was well known, although child soldiers were not initially recognized in demobilization efforts by the Resistência Nacional de Moçambique (RENAMO), the government, or the international community. Children also experienced sexual violence as a result of peacekeeping efforts. It is documented that soldiers of the United Nations Operation in Mozambique recruited girls aged 12 to 18 into prostitution after the signing of the peace treaty in 1992 (Machel 1996).

HIV and AIDS and SGBV

The *2009 National Survey of Prevalence, Risk Behaviors, and Information about HIV and AIDS in Mozambique* found that the median age of first sexual intercourse is 16.5 for girls and 17.7 for boys. The proportion of 15- to 24-year-olds who reported having had sexual relations before the age of 15 was 25 percent among women and 24.8 percent among men. For women, this proportion decreased as wealth quintile and level of education increased, but this correlation was not found among men. Over a third (36.6 percent) of women aged 15 to 24 who had no schooling and 10.7 percent who had

secondary or higher-level education reported having had sexual relations before the age of 15. Among 12- to 14-year-olds, 9.2 percent of girls and 15.3 percent of boys reported having had sexual relations (INS, INE, e ICF Macro 2010).

Among 15- to 19-year-olds, 2.6 percent of females and 1.1 percent of males reported having been physically forced to have sexual relations. Among 15- to 49-year-olds, these proportions were greater in urban than rural environments for both women (3.4 percent vs. 1.6 percent) and men (2.1 percent vs. 1.4 percent) and varied across provinces, from 0.1 percent in Tete to 4.6 percent in Maputo city among females, and from 0.1 percent in Cabo Delgado to 4.3 percent in Inhambane among men (INS, INE, e ICF Macro 2010). A 2007 cross-sectional survey that used a facilitated self-administered questionnaire among in-school youth indicated a considerably higher level of forced sex amongst youth: 27 percent of 16-year-old male students (472) and 21.5 percent of female students (290) of the same age reported experiencing forced or coerced sex (Andersson et al. 2012).

With regards to gender-based domestic violence, 31.5 percent of women and 11.5 percent of men aged 15 to 49 who were currently or previously married reported having suffered from domestic violence in the 2011 DHS. That includes more than one out of five (22.2 percent) females aged 15 to 19 versus 1.3 percent of males the same age (Instituto Nacional de Estatística Maputo, Ministério da Saúde, MEASURE DHS/ICF International 2012).

There were 453 cases of sexual violence in Maputo, Sofala, and Inhambane provinces during 2004-05 reported to the Gabinetes de Atendimento às Mulheres e Crianças Vítimas de Violência Doméstica (Offices to Assist Women and Children Victims of Domestic Violence). Of these, 125 were cases of sexual violence against children under age 12, 211 were cases of sexual assault, and 91 were cases of rape. The number of reports of sexual violence are likely unrepresentative of the true, higher incidence. The rape of girls (more than 200 cases) and of orphans and other vulnerable children (OVC) for both sexes are the cases reported most frequently for children (Arthur and Mejia 2006).

Gender relations in Mozambique and women's vulnerability to HIV

In 2012, Mozambique received a ranking of 39 out of 86 in the Social Institutions and Gender Index, which aims to reflect discriminatory social institutions, such as early marriage, inequitable inheritance practices, violence against women, son preference, restricted access to public space, and restricted access to land and credit. Mozambique's Gender Inequality Index score placed it 125 out of the 146 countries with data. In 2012, the OECD Development Centre reported that Mozambique had created legislation and policy to raise women's status and many civil society organizations advocated for women's and human rights in Mozambique. Indicators of wage equality, income, educational attainment, and political participation favored men. The same source also confirmed that socio-cultural determinants of HIV vulnerability among women include norms that perpetuate men's control over women's sexuality and fertility and acceptance of gender-based violence, especially in rural regions. However, it has also been observed that young women of higher socioeconomic status may challenge these traditional gender norms, giving them more agency and power in negotiating sexual relations (Monteiro 2009).

PURPOSE OF THE ASSESSMENT

A desk review conducted in preparation of this assessment revealed a significant number of fact-finding and research activities conducted in Mozambique in the last few years on contextual issues relevant to sexual violence against children. Data provided by UNICEF Mozambique confirmed that between 2000 and 2011 nearly 80 such reports were completed (Muzzi and Miranda 2012). Many of these assessments and studies have focused on uncovering and analyzing sociocultural factors creating vulnerability and risk for sexual violence on children. They have looked at the interconnections with such issues as domestic and sexual violence against women, child labor, early marriage practices, commercial sexual exploitation of children, transactional and cross-generational sexual relationships, and trafficking of body parts.

Although only a few of these activities were conducted nationally, they provide a useful body of information about key sociocultural determinants of sexual violence and exploitation against children. In contrast, there is still a need to analyze how care and support is provided to children who have experienced sexual violence, the role of community structures in facilitating access to services, the coordination among key actors, and ways to enhance the response that these actors provide.

In this context, the USAID OVC Technical Working Group and the Gender Technical Working Group agreed to conduct an assessment of PRC service provision in Mozambique with technical support from AIDSTAR-One. The focus is specifically on service provision for child survivors of sexual violence and on the linkages and coordination of institutional and civil society actors on enabling access to prevention and care. The purpose of this assessment was defined as follows:

To assess what supports or hinders effective care and support for children who experience sexual violence, with a focus on community-level systems and structures.

METHODOLOGY AND GEOGRAPHIC COVERAGE

A concept note developed by AIDSTAR-One was approved by USAID/Mozambique and USAID/DC. USAID Mozambique, in collaboration with AIDSTAR-One, coordinated the geographical coverage and selection of sites and respondents. The methodology consisted of approximately 50 in-depth interviews using an interview guide developed in consultation with USAID/Mozambique (attached in Annex 1).

The interviews explored two overarching issues:

- Social and cultural perceptions influencing timely referral and provision of child's PRC
- Perceptions of how current structures and systems are supporting timely referral and provision of child's PRC.

Each of these issues was explored in-depth through a number of questions, for a total of about 30 potential prompts.

The assessment was conducted from October 15 to 30, 2012, in Maputo (urban) and in selected districts of Zambezia and Sofala provinces. In Zambezia, the assessment team worked in Quelimane (provincial capital), and in select rural sites in the Mopeia and Morrumbala districts. In Sofala the

assessment was conducted in Beira (provincial capital), and in select sites in the Gorongosa (rural) and Nhamatanda (peri-urban) districts. Respondents were selected among relevant government agencies and services at the central, provincial, and district levels, as well as USAID implementing partners, civil society organizations, community structures, and UN agencies. The table below lists respondents by organization (please note that often, more than one respondent was interviewed in each organization).

MAPUTO	Gabinete de Atendimento a Mulher e Criança Vitima de Violência Doméstica (GAMCVVD – Office to Assist Women and Children Victims of Domestic Violence)
	Ministério da Mulher e Acção Social (MMAS – Ministry of Women’s Affairs and Social Action)
	Associação Nacional dos Enfermeiros de Moçambique (ANEMO – National Nurses’ Association of Mozambique)
	UNFPA
	UNICEF
	Save the Children
	JHPIEGO
	JHUCCP (Johns Hopkins University Center for Communications Program)
	FDC (Foundation for Community Development)
	ROSC – Rede de Organizações da Sociedade Civil para os Direitos da Criança (civil society network for children’s rights)
	Central Hospital of Maputo – Pediatrics
	Central Hospital of Maputo – Legal Medicine
	Central Hospital of Maputo – Gynaecology
	Rede Came - Rede Contra o Abuso de Menores (civil society network against abuse of minors)
	CAP (FHI 360 Capable Partners Program)
	HACI (Hope for African Children Initiative)
	Human Rights League in Mozambique
	Debrief at USAID/Mozambique
ZAMBEZIA PROVINCE	Arrival in Quelimane, Zambezia provincial capital
Quelimane, provincial capital of Zambezia	GAMCVVD provincial department
	Direcção Provincial de Saúde (DPS - Provincial Directorate of Health)
	International Center for AIDS Care and Treatment Programs (ICAP)
	Community Committee
	AMME (Mozambican’s Women Education Association)

Morrumbala district	Serviços Distritais de Saúde, Mulher e Acção Social (SDSMAS- District Services of Health, Women and Social Action)
	GAMCVVD district department
	Child Protection Committee
Mecanje, Morrumbala	Local Health Council
Mopeia district	SDSMAS
	GAMCVVD district department
	A Vida Começa Assim (community association)
SOFALA PROVINCE	Arrival in Beira, capital town of Sofala province
Beira, provincial capital of Sofala	Associação Juvenil para o Desenvolvimento Comunitário (supported by FHI 360)
	Direcção Provincial de Saúde –DPS: Provincial Directorate of Health
	Associação Luz na Comunidade (Acampamento de Mulheres, supported by the Roads Project – FHI 360)
	Christian Council of Mozambique
	Fambisanai Association (community and religious leaders and members of the local Community Court)
	Hospital Central da Beira
	SOPROC:Rede Provincial dos Direitos da Criança de Sofala (civil society network)
	Provincial Directorate of the Ministry of Education (meeting hosted by CHASS-SMT)
	Provincial Directorate of the Ministry of Women’s Affairs and Social Action – MMAS (meeting hosted by CHASS-SMT)
	GAMCVVD provincial department
Gorongosa district	Community Court members of Púnguè locality
	SDSMAS
	GAMCVVD district department
Nhamatanda district	SDSMAS
	Igreja Visão Cristã (Religious leaders and members of Community Committee)
	Direcção Distrital de Educação, Juventude, Ciências e Tecnologia (District Directorate of Education, Youth, Science and Technology)

LIMITATIONS OF THE ASSESSMENT

The findings from this assessment are based on a total of about 50 in-depth interviews carried out only in selected geographical areas of Mozambique. Nonetheless, important similarities, issues and challenges in service provision and coordination emerge from the findings across geographical locations. Although limited in scale, the assessment's findings appear useful to further analyze potential factors hindering effective provision of care and support for children who have experienced sexual violence and exploitation in Mozambique.

The assessment had limitations, namely:

- The assessment team did not interview any children directly, and thus did not get their perspectives first hand. Information related to children and caregivers was gathered from stakeholders, and particularly from service providers from health services, social welfare, and the Gabinete, as well as from community respondents, civil society organizations (CSO), and representatives of UN agencies who are in regular contact with children and caregivers. As a result, this situation analysis does not include a direct discussion of the perspectives of children and caregivers. However, the development of the assessment was informed by a thorough analysis of research that organizations like UNICEF and Save the Children have conducted in recent years in Mozambique, including research and needs assessments which have directly involving children who have experienced sexual violence and exploitation. In all of the selected sites, the assessment team interviewed the key institutional actors involved in providing and coordinating services for children who have experienced sexual violence and exploitation, as well as many community respondents engaged in informal structures such as community courts and community child protection committees.
- The analysis findings cannot necessarily be generalized to all of Mozambique, as interviews were limited to people physically located in Maputo and in the selected sites in Zambezia and Sofala provinces.
- As stated above, the team was able to interview a relatively small number of facility-based providers. They interviewed the key institutional actors involved in service provision in all the selected sites, but due to inability to obtain permission from the Ethical Commission at Ministry of Health within the assessment time period, they did not corroborate interviews with direct observation of service provision.
- Finally, although the assessment team made repeated attempts, it was not possible to interview any representatives of the Ministry of Education at the central level. The team tried to interview representatives of the judicial sector, especially at district level, but their tight schedules precluded them from participating.

FINDINGS

MAIN ACTORS IN SERVICE PROVISION FOR CHILDREN WHO HAVE EXPERIENCED SEXUAL VIOLENCE AND EXPLOITATION: A SUMMARY OVERVIEW

This assessment took into consideration the debate in Mozambique around some of the key issues that these findings highlight, such as the challenge of ensuring effective coordination of the key actors involved in providing care and support.

Main institutional actors include:

The government's efforts to address violence and abuse against children have focused on prevention and response to sexual violence and exploitation. The response is led by five line ministries: the Ministry of Women and Social Action (MMAS), the Ministry of Health (MISAU), the Ministry of Interior (MINT), Ministry of Education (MINED), and the Ministry of Justice (MinJus).

Ministry of Women's Affairs and Social Action (MMAS): This Ministry is responsible for coordinating service provision for children who have experienced sexual violence and exploitation. However, they have very limited capacity and resources (human and financial). Many respondents also pointed out that the policy framework that MMAS developed continues to construct sexual violence and exploitation against children as a side issue to violence against women, and this contributes to diluting the response. Furthermore, the assessment team found that MMAS's policy framework focuses almost exclusively on girls, which contributes to maintaining silence and inaction about sexual violence and exploitation against boys. At the time of conducting this assessment, MMAS was piloting the Mecanismo Multisectorial de Atendimento Integrado à Mulher Vítima de Violência (Multisectoral Mechanism), a new protocol to improve the coordination of key institutional actors (especially health, police, and social welfare) in providing care and support to women and children who have experienced sexual violence. MMAS was also overseeing the finalization and pilot testing of the Padrões Mínimos de Atendimento a Criança, the Minimum Standards of Care for Children.

Ministry of Health (MISAU): Due to MMAS's lack of resources, health services in reality provides most coordination of the service provision. Medicina Legal (ML), the equivalent of forensic medicine, is responsible for coordinating service provision within the health sector. This is a relatively new process and was established at the same time that this assessment was underway. There are, however, very few forensic medicine specialists in Mozambique and most of them are located in hospitals at central or provincial levels. The other main health services involved in the response include emergency, maternity/gynecology, and pediatrics. Under the MOH is the Serviços Distritais de Saúde, Mulher e Ação Social (SDSMAS—District Services of Health, Women and Social Action). This is the structure that exists at district levels to coordinate all types of health and social service provision, including those for children who have experienced sexual violence and exploitation. An

SDSMAS usually includes health services (including forensic medicine if available) and social action (MMAS), and works very closely with the Gabinete in responding to children who have experienced sexual violence and exploitation. These structures are located in the district capital towns and have very limited human resources and infrastructure. Districts are often very large, and it is almost impossible for an SDSMAS to reach people living far away.

Ministry of Interior (MINT): In 2000, the MINT developed the Gabinete de Atendimento a Mulher e Criança Vítima de Violência Doméstica (GAMCVVD), Office to Assist Women and Children Victim of Domestic Violence. These are police units in all districts of Mozambique with the specific mandate to respond to sexual and gender-based violence, especially against women and children. Most of these units operate from police stations and only in a few places (such as in Maputo and in Beira) do they have their own separate offices. The main role of the Gabinete is to facilitate reporting and to work in a coordinated fashion with MMAS and health. The Gabinete uses the medical examination from health services to develop the initial police report, which is then submitted to the Polícia de Investigação Criminal (PIC), the criminal police. Both the Gabinete and the PIC are overseen by the MINT. PIC is responsible for transmitting its completed reports to the judicial courts, but in many cases it cannot provide complete reports. This is because of lack of capacity and resources to collect evidence or because the cases were reported too late to collect evidence.

Ministry of Education (MINED): MINED is responsible for preventing child sexual violence and exploitation within the education system and ensuring a safe school environment in which children are not abused by teachers or other members of staff. Similar to all the other actors, they focus almost exclusively on girls. Their mandate also includes helping girls to stay in school as long as possible when abuse results in a pregnancy. MINED has a zero tolerance policy of sexual abuse in schools and in 2003 and 2008 issued decrees against it. MINED led the development of a national mass media and interpersonal communication campaign, “Zero Tolerance to Violence and Sexual Abuse against Children,” to affect social norms and behaviors and promote a culture of zero tolerance. The campaign, which was launched in June 2011 by the Minister of MINED, was designed to be implemented over four years. Its aim is to prevent sexual abuse against girls aged 12 to 16 through support and scaling up of existing interventions, such as participatory child rights clubs, community theater performances, rural outreach through mobile units, and public service campaigns. The campaign was the result of collaboration among five line ministries and civil society organizations, through the children's rights network Rede de Organizações da Sociedade Civil para os Direitos da Criança (Civil Society Network for Children’s Rights or ROSC), Child Friendly Journalist Network, and UNICEF.

Ministry of Justice (MinJus): MinJus oversees the judicial courts, which exist at the central, provincial, and district levels. These courts receive the reports from the PIC and are responsible for scheduling the court hearings. Many respondents, both institutional and community, complained that the judicial courts are too slow to process cases of sexual violence against children. Respondents claimed that the timely scheduling of court cases depends on whether the local judge is sensitive to sexual violence against children. If there is no such sensitivity, it may take up to three years to schedule a court hearing. Many respondents view such a long time gap as one of the factors discouraging reporting of violence against children. However, the team also heard that in many cases the judicial courts cannot proceed to administer justice because the reports they receive from the PIC are often incomplete and do not allow the courts to comply with current legal requirements.

Main community structures:

Community Courts: These are informal justice structures that can be found either in a suburb (bairro) of large urban centers or in the district capital towns. Usually their membership includes men and women who are considered influential community leaders (e.g., religious leaders, former freedom fighters, activists, initiation counsellors, traditional leaders). Community courts are expected to follow the specific guidelines issued by the Ministry of Justice. In regard to child sexual violence and exploitation, these guidelines preclude community courts from becoming involved in any negotiation between perpetrators and families. Community courts are mandated instead to help reporting cases to the Gabinete.

Community Child Protection Committees (CCPC): These community committees support the implementation of the National Plan of Action for Children and the Plan of Action for Orphans and Vulnerable Children. Although their establishment started around the time the National Plan was issued in 2006, the guidelines for their management were developed by MMAS in collaboration with Save the Children in 2010. According to these guidelines, a CCPC “is a group of people in the community responsible for child protection in the context of community involvement in care and child protection. Its action is aimed at developing physical, mental and social development in harmony.” (Save the Children and Ministry of Women and Social Action 2010)

Community Health Councils: Most of these community committees are active only when there is a funded project that provides support, for example by integrating these committees in the project’s activities and thus providing resources for their existence. Most of their activities focus on disseminating health information to prevent diseases such as HIV, malaria, tuberculosis, nutrition, and cholera.

THE CURRENT LEGAL AND JUDICIARY FRAMEWORK, AND REPORTING PATHWAYS

Summary of key findings:

- Largely held view is that CSOs have played a key role in providing vision and mobilizing political will to address child sexual violence and exploitation.
- Both institutional and community respondents stressed the still unmet and urgent need to clarify how the relevant laws should be interpreted and applied.
- Many respondents identify the cause of the lack of clarity to be the different provisions for different age groups, as current laws (and especially the *Codigo Penal*, i.e., the Criminal Code) define types of abuse and violence according to the age of the victim and whether or not she was a virgin. If the victim is older than 12 and minor than 18 and she is a virgin, the violence is considered *estupro*, i.e., statutory rape. Only if the victim is below age 12 is the violence considered rape.
- *Codigo Penal* in its current state requires the victim to marry rapist.
- Often the same respondents pointed to the fact that frequently families try to get compensation from perpetrators before reporting the case. Thus the complex nature of the law and the lack of its understanding is not the only factor undermining its application.
- Current laws almost completely ignore sexual violence and exploitation against boys and define sexual violence and exploitation only as indecent exposure. *Codigo Penal* is completely void of references to sexual abuse against boys.
- The assessment team found that when the perpetrator is a person of influence, it is more likely that even institutional actors become involved in negotiating an agreement with the family without considering the will or the needs of the child. Several respondents, both institutional and community, stated that this situation discourages reporting because of a perception that only very dramatic cases resulting in death or severe injury or cases in which the perpetrator cannot pay compensation go to court.
- In different ways, all of the above issues affect negatively the reporting of cases within the first 72 hours. Very few cases are reported within this timeframe.

Understanding and perceptions of Mozambique's key laws and international conventions relevant to sexual violence and exploitation against children, and how they are interpreted and applied

Mozambique has ratified the Convention on the Rights of the Child as well as the African Charter on the Rights and Welfare of the Child.

Respondents both from the government and the civil society sectors identified the following laws as the most important pillars of the legislation relevant to sexual violence and exploitation against children introduced in recent years by the Government of Mozambique:

- Law on Promotion and Protection of the Rights of the Child, Law No. 7/2008 of 9 July 2008: translates CRC principles into national child protection legislation (Rede da Criança 2009).
- Law on the Jurisdictional Organization of Minors, Law No. 8/2008 of July 15 2008: establishes basis for the protection of children in criminal and civil matters (Rede da Criança 2009).
- Law on Preventing and Combating the Trafficking of People Especially Women and Children, Law No. 6/2008 of 9 July 2008: prohibits recruiting or facilitating the exploitation of a person for purposes of prostitution, forced labor, slavery, or involuntary debt servitude. Article 10 prescribes penalties of 16 to 20 years in prison for violations (U.S. Department of State 2012).
- Mozambican Children's Act, 2008: rearticulates responsibility of school management to report cases of mistreatment of students to appropriate authorities (UNICEF 2011a).
- Family Law, Law No. 12/2004 of 25 August 2004: changed the legal age of marriage from 14 to 18 (Arnaldo 2005).
- Civil Registry Code, Law No. 12/2004 of December 8, 2004: extends the free birth registration period from 30 to 120 days after birth and decentralizes registration activities to improve public access (Rede da Criança 2009).

National laws, as well as all official guidelines and protocols currently in use across the spectrum of government institutions and services that the assessment team investigated, clearly define a child as 0 to 18 years. However, the implementation of these guidelines still clashes with practices pre-dating the introduction of the 0 to 18 age framework through Law No. 8/2008.

There is general consensus acknowledging the role that civil society organizations have played in mobilizing political will and action to promulgate these laws. At the time of this assessment, many civil society and some international organizations were concerned about the on-going revisions to the penal code, which were expected to be discussed by Parliament around the end of 2012. Civil society groups were lobbying the government to clarify aspects of these laws that are generally perceived to be either detrimental to addressing sexual violence and exploitation against children or outdated or ambiguous. Civil society organizations expressed concern about some of the proposed revisions to the penal code, namely decriminalizing abuse and violence if the perpetrator takes responsibility for the crime, and the proposed criminalization of sex workers but not of clients. There was consensus among these groups to increase the punishment for statutory rape.

However, none of the respondents was able to clarify whether any of the current relevant laws include provisions to punish family members or service providers if they know that a child has experienced sexual violence or exploitation and fail to report it within the first 72 hours. This timeframe is essential to provide critical services such as PEP for HIV as well as to gather evidence of the violence. None of the institutional respondents appeared to have even considered this issue. This may indicate that even among them there is a perception that failure to report is not seen as contributing to perpetuate abuse or neglect.

Many respondents stressed that there is still an unmet and urgent need to clarify how the relevant laws should be interpreted and applied. For example, some institutional actors said that the interpretation and application of the laws by the courts is not supporting an environment to address

effectively sexual violence and exploitation against children. Many community respondents echoed these concerns, especially about the lack of transparency in the interpretation and application of laws. In these respondents' views, the current laws contribute to poor understanding, misconceptions, and conflict of interest, due to the different provisions for different age groups, as mentioned above.

Issues influencing reporting pathways:

- Most cases are reported to the police (mostly the Gabinete where it is available) either by families (and often only when they can't get compensation from perpetrators) or health providers, and sometimes by social services. Fewer cases are seen first by health services, which then refer to the Gabinete.
- Many respondents cited the lack of feedback once the cases are reported to the Gabinete as a factor discouraging reporting.
- Gabinete officers observed that most people in the community equate their institution with the justice system as a whole and don't know that the Gabinete is often cut out of the feedback loop once it refers a case to the criminal police.
- Both institutional (including police) and community respondents pointed to the lack of transparency in the application of the law as a factor that discourages reporting, citing for example how the courts can transmute prison terms into a fine, especially if the perpetrator is a wealthy or influential individual.
- Most respondents confirmed that in many cases families report cases only when their private negotiations for compensation with perpetrators do not succeed.
- Additional barriers to reporting include fear of stigma and discrimination. For boys, reporting a case may mean a stain on their masculinity. For girls, it may mean ruining marriage prospects.
- The assessment team found that very few cases are reported within the first 72 hours, irrespective of geographical location. All respondents, including the Gabinete officers, confirmed that of the cases reported, most are reported after the 72-hour window, often much later.

In discussing the law and its implementation, many respondents cited the lack of feedback once the cases are reported to the Gabinete as an issue that undermines the will to report. Respondents from various Gabinete offices confirmed that this perception exists in the community. The Gabinete is often the first point of contact in cases of violence. Thus Gabinete officers feel that most people identify their institution with the justice system as a whole and have limited understanding of how a case is processed. Gabinete officers observed that there is limited understanding in the community of their role, which is to record a case, refer those who experienced sexual exploitation and violence to care and support services, and prepare the initial report that is sent to the criminal police, who are responsible for referring to the courts. Once the Gabinete refers a case to the criminal police, they often are cut off from the information chain. The lack of continuity of feedback through this chain is seen by many respondents as an important cause of under-reporting. In the words of a Gabinete officer, *"once a case is reported, people often feel that it gets lost in the system."* Lack of continuity of feedback is a multi-faceted challenge that affects not only reporting but also service provision, as detailed in section 2.3.

Many respondents said that often the child is not the main focus of concern. Rather, the main concern is to ascertain if she were a virgin to determine how much compensation the family can claim from the perpetrator. In turn, a significant amount of time is used for the negotiations between the family and the perpetrator, which delays reporting within the first 72 hours. The police (Gabinete) are often perceived to become involved in these negotiations, especially at district level. This depends on their understanding of the law, and their attitudes about the application of the law to different cases. The assessment team found that when the perpetrator is a person of influence, it is more likely that even institutional actors are involved in negotiating an agreement with the family without considering the will or the needs of the child. Respondents, both institutional and community, said that this situation discourages reporting because of a perception that only very dramatic cases resulting in death or severe injury or cases in which the perpetrator cannot pay compensation go to court. UNICEF confirmed that these perceptions reflect reality.

One of the most common complaints about the implementation of the law concerns the lack of information about what happens to a perpetrator once a case is reported. The assessment team uncovered many layers to understanding this problem. In some cases, as outlined above, the identification of the Gabinete with the justice system as a whole and the insufficient collaboration with the criminal police is perceived as a setback by the victims and their families. It was cited as a factor that discourages reporting. However, in many instances families report sexual violence and exploitation against children only when their private negotiations for compensation with perpetrators do not succeed. By then it is often too late to collect evidence and build a legal case. In other instances, some law enforcement respondents expressed concern about how the courts interpret the law and transform a potential jail sentence into a fine, creating a perception that wealthy or influential perpetrators can circumvent the law. Also, there are different perceptions in law enforcement about what should be done with perpetrators (i.e., only punishment or punishment and rehabilitation).

Additional barriers to reporting include fear of stigma and discrimination. For boys, it may mean a stain on their masculinity. For girls, it may mean ruining marriage prospects. It is important to note that the current laws only marginally address sexual violence and exploitation of boys and only in terms of indecent exposure. It is as if even the law reflects the taboo nature of discussing these issues, and consequently they remain invisible and unreported.

As previous assessments and studies showed, children are often at risk of sexual violence and exploitation in the family. The assessment confirms this reality. Many interviewees said that mothers often do not report what happens to their children for fear of seeing their husbands or male breadwinners go to prison. They also fear being branded bad mothers. In the words of one male interviewee: *"If the children do well, the fathers take the credit. If anything bad happens, the mothers are blamed."*

There may be an assumption that people in rural areas face additional barriers to reporting due to geographical isolation, lack of transport, and lack of services outside of district capital towns. However, as explained in the relevant sections below, the assessment team found that very few cases are reported within the first 72 hours, irrespective of geographical location.

PROVISION OF PRC AT THE HEALTH FACILITY LEVEL

Summary of key findings:

- At the time of conducting this assessment, efforts were underway to develop a coordinated multi-sectoral response to PRC through the introduction of Mecanismo Multisectorial de Atendimento Integrado a Mulher Vítima de Violência (Multisectoral Mechanism for Integrated Services to Women Victims of Violence).
- Although on paper the MMAS has the responsibility to oversee this new approach, they lack financial and human resources. Moreover, the Mecanismo Multisectorial focuses on women and many respondents were critical of its constructing child sexual violence and exploitation as a side issue to violence against women.
- Within health, ML has been given the responsibility to coordinate service provision for PRC.
- All the sites visited have started implementing a multi-sectoral approach by establishing multidisciplinary teams. They lack capacity and resources, and continuity of feedback remains a major challenge.
- There are very few experts in legal medicine/forensics (ML) in the country and most of them are in the main urban centers.
- Central and provincial hospitals are the only places where all services exist (pediatrics, gynecology, legal medicine, psychological support, and coordination with police).
- At district level, services are available in the district capitals where SDSMAS provides management and coordination of both health and social services. Outside of district capitals, there is almost no availability of services.
- Psychological support is available only at hospitals and only for the immediate and short-term period.
- Provision of PRC is also influenced by the available entry points, which in the health system may include emergency, maternity or gynecology, pediatrics, and in a few cases, ML, mostly for boys.
- In reality there are only two services providing 24/7 help: police and health. The typical pathway for victims of child sexual violence is from the police to the hospital, or directly to the hospital. The response at the hospital depends on capacity and what is available.

Introduction of the multi-sectoral mechanism for PRC service provision

At the time of this assessment, efforts were underway to develop a multi-sectoral response for PRC service provision. The key framework for this is the Mecanismo Multisectorial, which provides guidance for implementing a unified and coordinated response by the police (the Gabinete), health sector, social services, and the Ministry of Justice. The aim is to move toward a case management model to ensure continuity of care and coordination. The Mecanismo is the main guide informing the response for children at the facility level.

This is a significant improvement in coordination, but with many challenges. At central level, MMAS has the responsibility to coordinate this approach, but they recognize that they do not have sufficient capacity and resources.

In order to strengthen coordination and the feasibility of the approach, ML has been given the responsibility for overall coordination within the health system. However, there are very few ML specialists in the country and most of them are at central and provincial levels. The Ministry of Health has plans to develop *Peritos Ocasionalis*, expert medical practitioners who receive training in forensic medicine and can use their skills to examine children who have experienced sexual violence and exploitation. They can also be called to testify in court. However, even these are few in number, approximately 36 throughout the country.

All the sites the assessment team visited (central, provincial, and district levels) have started implementing the Mecanismo Multisectorial by establishing multidisciplinary teams. However, the composition of these teams depends on the human resources available. Coordination with the Ministry of Justice also depends on whether the local judicial courts are sensitive to the problem of sexual violence against children.

Some of the most important issues that the assessment identified in discussing the implementation of this approach include:

- Lack of continuity of feedback among the multi-sectoral actors, often due to lack of capacity and resources; this in turn reduces accountability of the response. A critical question remained unanswered: Who is in charge of following the case from start to finish?
- Even within the health system there is no continuity of feedback once the victim leaves the services at all levels (central, provincial, district).
- MMAS has extremely limited capacity to provide social support, at all levels.
- Psychological support is available only at hospitals and only for the immediate and short-term period.

In addition, some institutional actors feel that there is still a problem in coordinating their multi-sectoral response, especially if any of these actors become involved in agreements between families and perpetrators or if they understand the law differently.

In reality there are only two services providing 24/7 help: police and health services. The typical reporting pathway for children who have experienced sexual violence and exploitation is from the police to the hospital, or directly to hospital. The response at the hospital depends on capacity and what is available.

Tools to implement the Mechanismo Multisectorial and for data collection

The basic tool used by the multi-sectoral teams is the paper *Ficha de Notificação de Casos de Violência* developed with support from Jhpiego at the time of this assessment. It is a very useful innovation that for the first time is enabling all the services involved in multidisciplinary teams to collect and share a case's information on one form. It provides the basis for developing the police report for transmission to the courts.

Once a month the district multidisciplinary/multi-sectoral teams prepare a summary of data and send it to the provincial directorates of health. The directorates in turn prepare their summaries and send them to the central level. However, all interviewees at the central, provincial and district levels stated that currently there is almost no capacity to record and analyze data disaggregated by different categories. Hence it appears there is no capacity to use data for planning and decision making.

How PRC is currently provided at the health facility level

Central and provincial hospitals are the only places where all the services exist (pediatrics, gynecology, legal medicine, psychological support, and coordination with police). At district level, services are available in the district capitals where SDSMAS (Serviços Distritais de Saúde Mulher e Acção Social) provides management and coordination of both health and social services. Outside of district capitals, almost no services are available.

Provision of PRC is also influenced by the available entry points at health facilities. For example:

- Maputo Central Hospital: in principle, entry points include emergency, gynecology, pediatrics, and in a few cases ML
- Provincial hospitals: same as Maputo Central Hospital
- District level: emergency or maternity.

However, in discussing entry points to PRC, most respondents stressed that in reality the police (the Gabinete where it exists, or otherwise a police station) are often the first point of contact. Clearly, as highlighted in the section about the law, how the Gabinete and the criminal police manage the immediate response can have a major influence in access to PRC. The assessment team found that the response of most of the Gabinetes visited depends on the leadership and the commitment of the senior officer, often a woman, and on the capacity development opportunities they have accessed, usually from a project by implementing partners. Most of these officers are very engaged and committed, and in some cases have been able to expand the services of their Gabinete by creating a room to ensure privacy and confidentiality and even short-term shelter for victims. In most cases, however, they face a chronic shortage of resources and support.

Provision of PRC at Maputo Central Hospital

At Maputo Central Hospital, the multidisciplinary response team provides services for girls and boys in different ways:

- Girls: gynecologist performs medical examination, clinical assessment, and tests; when possible, the ML doctor is also present at this stage; if the girl is below age 14, she is referred to pediatrics, which is responsible for the follow up; psychological support is provided by ML.

- Boys: ML is responsible for coordinating service provision with pediatrics; they have seen very few cases.

Provision of PRC at provincial hospitals: Quelimane

- Multidisciplinary team established.
- When a child arrives at hospital before 3 p.m., she or he is seen jointly by the ML doctor and by the psychologist, who refer to gynecology or pediatrics for clinical tests. If the case presents after 3 p.m., gynecology conducts the clinical assessment and if within the first 72 hours, also performs tests and provides PEP; the next day, the child is seen by the ML doctor and the psychologist.

Provision of PRC at provincial hospitals: Beira

- Multidisciplinary team established.
- Usually the emergency department is the first point of contact and refers to gynecology (girls). Gynecology jointly with ML conducts the clinical assessment and tests.
- Next, the person is seen by the psychologist but not necessarily on the same day of arrival at the hospital.
- For boys, the response is coordinated by ML.
- After 3 p.m. there is no ML doctor and psychologist (similar to Quelimane).

Provision of PRC at district level: Typical model found

- Multidisciplinary team response: health, social action, and Gabinete. Some teams have a psychologist. No availability of ML specialists, but some teams have perito ocasionais.
- Main entry points at district hospitals are emergency and maternity.
- The teams use a flowchart to provide all the recommended tests and treatments. They also treat physical injuries. However, they are not able to fully implement the clinical care protocol especially for pediatric PEP for HIV (reasons cited: lack of capacity to provide follow up for the whole treatment period; lack of enough trained providers; lack of social services in the community; and most cases are not reported within the first 72 hours).

Key challenges in providing PRC at health facility level

- Irrespective of geographical location, very few cases are reported within the first 72 hours. Therefore in most cases it is not possible to provide PEP for HIV.
- Some facilities, especially at district level, have difficulty in procuring drugs for pediatric PEP for HIV (Zambezia).
- In some places, clients have to buy their pregnancy test (Beria Provincial Hospital).
- Most service providers lack ability to detect signs of sexual violence and exploitation that are not obvious.
- In most health facilities, infrastructure does not ensure privacy and confidentiality.

- In some health facilities, there is a lack of basic facilities to store drugs safely.
- Almost all sites expressed a need for training in pediatric PEP for HIV.
- All sites commented on the lack of psychologists and ML experts.
- The lack of social workers is a major barrier to provision of psychosocial support in all sites.
- Most sexual violence and exploitation against boys goes undetected.

REPORTING, REFERRALS AND THE PROVISION OF PRC SERVICES AT THE COMMUNITY LEVEL

Community structures and the formal justice structures:

- Community courts are the most relevant informal justice structures recognized by the Ministry of Justice.
- The Ministry of Justice guidelines for the community courts mandate that they should not become involved in negotiations to settle damages with perpetrators. Their role is to help refer cases to the Gabinete. In reality, community court members continue to mediate disputes over division of assets and goods, including those that are used to settle damages with perpetrators of child sexual violence and exploitation. This contributes to delays in reporting and to undermining reporting altogether.
- Other structures such as child protection committees and community health councils/committees also claim to play a role in identifying and referring cases to the police and services. However, respondents in the Gabinete and health services did not confirm that any of these community structures play a significant role in reporting or in helping to access services.

Most community respondents confirmed that the establishment of the Gabinete has been a major step forward in advancing the response to sexual violence and exploitation against children. All respondents also stressed that civil society actors have been very vocal in mobilizing political will and resources to strengthen the response and to promote the law, its application and improvement. However, respondents from several of these civil society organizations observed that they tend to be more active and have more capacity at central and provincial levels. At district level, their influence and capacity is much weaker. These CSOs include networks such as Rede Came, Rede das Organizações da Sociedade Civil para os Direitos da Criança, and Rede Provincial dos Direitos da Criança de Sofala. Other organizations are very well known for their long-standing engagement on these issues, for example, Save the Children and UNICEF.

Community courts are the most relevant informal justice structures recognized by the Ministry of Justice, which has also developed guidelines specifying their roles and responsibilities. Concerning sexual violence and exploitation against children, the Ministry of Justice guidelines give the community courts a focus on referring cases to the authorities, primarily to the Gabinete. Most respondents from community courts knew that these guidelines do not authorize them to become involved in negotiations to settle damages. But when probed in depth, members of these community structures admitted that it is still common to breach the guidelines. For example, they told the assessment team how they become involved in mediating disputes over division of assets and goods, including those that are used to settle damages with perpetrators of child sexual violence and exploitation.

In addition to the community courts, other community structures that claim to play a role in identifying and referring cases to the police and services include the child protection committees and community health councils/committees or similar structures with different names under the auspices and support of specific projects. The assessment team found these types of structures in all the

localities visited, and in some places there were more than one supported by the same implementing partner. These community structures too showed a lack of clarity about how they perform their mandate. For example, a prominent member of one of these community structures, who also is an influential religious community leader in the Zambezia district, confirmed that all these community structures should help facilitate the reporting of sexual violence and exploitation against children to the police. However, he disclosed that in reality often members of these structures become involved in mediating agreements between the families of the abused children and the perpetrators, especially if the latter are people of economic means. When questioned about how this practice reflects the official role of the committee in supporting the implementation of the law, he justified the committee's action. He cited the need to preserve and support peace and harmony in the community and in the families of children who have experienced sexual violence.

All these community structures claim to play an important role in preventing child sexual violence and exploitation and access to care, and especially in strengthening reporting and referrals. However, when asked if this were true, respondents in the Gabinete and health services did not confirm it. In reality, despite claims to the contrary, the assessment team found that most cases are referred to the police either by families (and often only when they can't get compensation from perpetrators) or by the health sector, and sometimes by social services.

Most of the activities carried out by these community structures are focused on awareness raising, particularly on increasing awareness of the problem of early marriage, and dissemination of information about children's rights. However, when asked what they considered to be an acceptable age for a girl to get married, most respondents in these groups said age 16 and did not see any potential contradiction with their stated focus on preventing early marriage, promoting children's rights, and helping with the reporting of sexual violence and exploitation against children. Moreover, all of these groups acknowledged that they have not really paid any attention to boys who have experienced sexual violence and exploitation, or to helping boys develop alternative attitudes conducive to more equitable relationships with girls.

Some of these community groups have been in existence for many years, although their activities depend on being supported by a project. Therefore, there are periods when they are not fully operational. Most members of these groups also recognized that they need capacity building, and when asked in which areas, they invariably identified understanding the law and how it is applied. It appears that there is limited capacity for coordination among community structures and services, even when they are geographically close to each other.

Community structures and psychosocial support (short and long term)

In terms of psychosocial support, provision of follow-up varies depending on what is available where. It is very difficult for services at all levels (central, provincial and district) to provide follow-up after the immediate response. This is due to lack of human resources, inadequate infrastructure, equipment and supplies, and lack of transport. A major issue undermining follow-up is the lack of continuity of feedback linking different actors. No respondent was able to answer a central question that the team kept asking: *Who is in charge of following the case from start to end?*

Community structures, child protection, and temporal care

An issue of concern is what happens to children who have experienced sexual violence and exploitation if it is unsafe for them to return to their families. Some of the Gabinete stations have set up a room for temporary shelter, but they can provide this support only for the first 24 to 48 hours, and have to rely on other services to feed the children being sheltered. Often, the Gabinete senior

officer has no other choice but to take the child home, and share this burden with the local social worker if there is one. In most cases, the elderly nursing home (if there is one) is the only place where these children can be housed temporarily. The Gabinete and social services reported that often they do not see any other option than to try to reintegrate the child into the family, even if the perpetrator is still there, unless there are other relatives or neighbours willing to help out.

Community structures, child protection, and schooling

Interviews with representatives of the Education Ministry, mostly at the district level, highlighted that their main concern is to ensure that survivors remain in school and that pregnant girls complete their education. (Again, almost no attention is paid to sexual violence and exploitation against boys). These respondents claimed that sexual violence and exploitation perpetrated by teachers and school officials is a thing of the past, but they could not explain the basis for their claim other than saying that stricter rules have been introduced to punish offenders. It was unclear what systems are in place in the education system to coordinate with the other sectors, and none of the multidisciplinary teams interviewed ever mentioned any collaboration with the education system.

SOCIAL AND CULTURAL PERCEPTIONS INFLUENCING TIMELY PROVISION OF AND REFERRAL FOR PRC

Summary of key findings:

- In rural areas, it is still common to consider a girl as a child only between the ages of 0 to 12. Starting menstruation often marks the transition from childhood into adulthood for girls. This in turn plays a role in both maintaining early marriage practices as well as undermining the implementation of laws relating to child sexual violence and exploitation.
- In urban areas, a girl child is often defined as 0 to 15 years. The education and advocacy activities of CSOs have contributed to increase this age span, especially for girls.
- In both rural and urban areas, respondents did not state an established age span defining the boy child. They cited having the means to acquire a wife as the key mark into adulthood.
- Initiation rites focusing on first menstruation to mark a girl's transition into adulthood continue to be practiced.
- The main achievement of programs working with “initiation counsellors” to change these practices is to reduce duration of the initiation rites. Instead of four weeks, the rites last for a maximum of two weeks or less, where these programs have been implemented.
- Implementers recognized that the design of their interventions usually does not include any significant component of values clarification or values reconstruction—and the use of power associated with these—which perpetuate a social ecology conducive to sexual violence and exploitation against children.
- The dissemination of information on children's rights tends to focus almost exclusively on girls' issues and boys remain invisible. The lack of understanding of how boys can be affected by sexual violence and exploitation was one of the most striking findings of the team's assessment.

Who is a child? Perceptions among community respondents

In rural areas, first menstruation often still marks the transition into adulthood for the girl child. First menstruation can happen as early as age 10, and once this happens, girls are often expected to assume adult responsibilities. In turn, this means that parents can enact early marriage arrangements made with older men when their daughters were much younger.

Traditional practices such as initiation rites continue to have a significant role in maintaining these perceptions and practices. Initiation rites include separating girls from their families when they first menstruate, whether or not a girl gives her consent or understands what is going to happen to her. Older women in the community (called initiation counsellors) instruct girls for up to four weeks on

their role as women and especially on relations to men. Traditionally, this induction into womanhood ensures that the girls conform to socially established gender and sexual roles of subordination to men—including viewing domestic and sexual violence as an often unavoidable feature of relationships. It includes as well subordination to family structures, including the acceptance of early marriage arrangements made on the girls' behalf. Initiation rites are still largely practiced and not recognized—even by many institutional actors—to be a type of emotional and psychological abuse to manipulate and control a child's identity, reinforcing the gender and sexual norms for girls and boys, and enabling an environment for sexual violence and exploitation against children. This is despite the fact that the Convention on the Rights of the Child includes the right **to** participation, to express opinions, be listened to, and to take part in making any decisions that affect them.

Implementing partners and other civil society actors have been working with initiation counsellors to change these practices. Interviews with these implementers revealed, however, that the major impact achieved so far is to reduce the duration of the initiation rites. Where these programs have been implemented, the rites last for a maximum of two weeks or less instead of four weeks. In discussing their programs, the implementers recognized that the design of their interventions usually does not include any significant component of values clarification or values reconstruction with initiation counsellors or with families around the gender and sexual norms and roles—and the use of power associated with these. These perpetuate a social ecology conducive to sexual violence and exploitation against children. Although this assessment was not designed to evaluate the work of implementing partners or civil society actors, the assessment team found that some of these community actors currently engaged in programs that ostensibly aim to reorient attitudes in fact complained that girls and boys are not exposed to these traditional practices as in the past. They blame mostly the girls for bringing sexual violence and exploitation upon themselves because they want to follow fashion and youth culture.

In urban areas, it appears that dissemination of information about children's rights, sexual violence, and exploitation against children, and the negative impact of early marriage on girls is contributing to changing perceptions of the girl child. Urban community and institutional respondents felt that this explains why at the community level in urban areas the age span defining the girl child is increasing up to 15 years of age.

Who is a child? Perceptions among institutional respondents

- When first asked, most institutional actors defined a child per international conventions and current national legislation as aged 0 to 18 years.
- However, at central and provincial hospitals, children who are older than 14 are sent to the adult wards.
- Also, sometimes people in charge (e.g., at a Gabinete de Atendimento) interpret the law defining a child in their own way.

All official guidelines and protocols currently in use across the spectrum of government institutions and services clearly define a child as aged 0 to 18 years. However, the implementation of these guidelines still clashes with established practices pre-dating the introduction of the 0 to 18 age framework. For example, at the central hospital in Maputo, although officially the providers state that a child is any person aged 0 to 18, the practice at the Pediatrics Department is still to refer a child above age 14 to the adult ward.

Capacity and resources also influence how institutional actors are able to provide care and support and ensure adherence to the 0 to 18 year definition a child. The clarity and effectiveness of the legal and policy framework is also an important factor.

At district level, the influence of traditional cultural attitudes and beliefs about a child still play a major role in how local influential institutional actors interpret and apply the current legal framework and related guidelines. For example, a social worker reported that when she referred a raped child to the local police, the policeman in charge at the time dismissed the case because in his view the 13-year-old girl was not a child.

Another important finding is the insufficient emphasis on values clarification and attitude re-orientation in most of the capacity-building activities currently being implemented. This is especially true for the gender and sexuality norms that undermine child protection, including from sexual violence and exploitation. The report will expand on this issue in Section 3.

Perceptions about children’s rights and implications for prevention and mitigation of sexual violence and exploitation against children.

There is widespread good will to promote children’s rights in Mozambique. Most respondents acknowledged that promotion of children’s rights has contributed to shifting perceptions of the age span defining a child. However, even among respondents in community groups and structures who received orientation and training, there is still limited capacity to even articulate children’s rights and understand their practical use.

Almost all respondents asked to identify children’s rights could name the right to have a name, the right to education, and the right to play. No respondent was able to go beyond these examples and make connections to important rights such as the right to be free from coercion and violence. This suggests that both at institutional and community levels, the understanding of children’s rights is still limited and often clouded in confusion about what constitutes a right.

The assessment team found that children’s rights are often being promoted without sufficient support to help institutional and community actors understand how social and cultural norms, and especially gender and sexual norms, hinder the realization of such rights. In turn, these dynamics perpetuate power relationships inside and outside of the family that place children at risk of sexual violence and exploitation. For example, none of the respondents was able to connect children’s rights to any other human rights, including the right to health. No one (even among respondents from the health sector) articulated any connection with reproductive and sexual health rights, such as the right to make informed and voluntary decisions about one’s own reproductive and sexual health or the right to decide when to have sex and with whom.

DISCUSSION

The challenges in interpreting and applying the laws transparently and effectively need to be examined in the context of what shapes attitudes toward children. Attitudes affect views about children's rights, the gender and sexual norms that facilitate and perpetuate children's exploitation (both girls and boys), the gendered use of power in relationships and access to decision making, and how these issues intersect with other drivers of vulnerability.

The assessment revealed a major missed opportunity to use the promotion of children's rights as a strategic entry point to affect root causes of violence and exploitation against children. The need to connect the legal definition of a child and children's rights to a broader human rights and gender equality framework becomes very important in light of other findings, such as:

- Children, especially girls, are still largely seen as property of their parents, who can do what they want with them.
- As a result, often parents arrange marriages especially for daughters through financial or in kind (or both) agreements with older men, even when the girls are only 4 to 5 years old. However, most community respondents do not see this as a type of abuse per se, but recognize it as an early marriage practice problem. Similarly, institutional actors recognize the early marriage problem, but do not necessarily see it as an abusive practice. Nobody appears to view this practice as potentially being a type of trafficking for sexual or economic exploitation. This is despite the fact that the Convention on the Rights of the Child includes the right to protection from any form of exploitation.

As detailed in the section on the law, the provisions about sexual violence and exploitation mostly revolve around the age of the child and her virginity. This legal framework appears to impact the policy guidance for service provision. For example, if a girl is above age 14, she is sent to the adult ward or the police may dismiss the case entirely. It can be argued that both the legal framework and the service policy guidance still suffer from (and contribute to perpetuating) the influence of inequitable gender and sexual norms. The fact that very few cases are reported within the first 72 hours is evidence of this, as well as the fact there is almost no focus on boys who have experienced sexual violence and exploitation.

The assessment team found many institutional actors who were committed and engaged, but their main resource was often themselves. Where the response is better provided and coordinated, it seems to be due to the leadership and commitment of one individual or a very small group of people. If they leave, what happens? This also raises the issue of providing supportive supervision and recognition to those individuals with personal motivation and inner drive.

Assessment findings suggest that the lack of strategic guidance on comprehensive child protection perpetuates both a limited understanding of sexual violence and exploitation against children and the inadequate response to it. Although elements of a coordinated response to child protection exist, they are fragmented across several national documents:

- Plano Nacional de Acção para a Criança II (in draft form at the time of this assessment).
- Padroes Mínimos de Atendimento a Criança (being tested by MMAS at the time of this assessment).
- Mecanismo Multisectorial de Atendimento Integrado a Mulher Vítima de Violência.
- Plano Nacional de Acção para a Prevenção e Combate da Violência Contra a Mulher (2008–12).

However, even these documents address sexual violence and exploitation against children generically and sometimes as a side issue to violence against women.

Ultimately, the lack of comprehensive strategic guidance remains a major challenge to effective coordination of PRC service provision across different actors, and to useful linkages between formal and informal structures. Comprehensive strategic guidance would resolve the lack of continuity of feedback among institutional actors in service provision, the often inappropriate involvement of some community structures with families and perpetrators, and the missed opportunities to use capacity-building efforts to influence gendered root causes of sexual violence and exploitation against children.

A number of USAID-funded projects have the potential to reach many institutional and community actors and leaders and reorient their understanding of their role in addressing these issues. But it appears that these programs have conducted a limited analysis of gender and related socio-cultural issues to inform their messages or activities. For example, the assessment team found that these programs use very generic messages about children’s rights. When queried about them, the target community respondents were unable to identify specific rights other than to stay in school or to have a name. The team also found that these programs do not have content addressing the specific issues of girls and boys in relation to sexual exploitation and violence, both in terms of vulnerability and risk. For example, there is emphasis on addressing the immediate care needs of girls who have experienced sexual violence, however their views are very rarely sought and all the decisions are made by either their families or the service providers. Moreover, many types of sexual violence and exploitation of girls that are not obviously identifiable as rape remain undetected. Providers attribute this to lack of capacity, but the assessment team contends that it is also due to the limited gender analysis that informs the response which continues to be focused around ascertaining if the girl was a virgin.

The team also found unaddressed social constructs of masculinity, which contribute to perpetuate silence and lack of action to detect sexual violence and exploitation of boys. Similarly, there are few projects to work with parents—and particularly with fathers—to understand how some gender and cultural constructs of women and men impact parenting. For example, understanding how coercion and violence is used to manage relationships can contribute to sexual violence and exploitation against children. There is an urgent need to help parents develop awareness of these issues as well as skills to manage their parenting roles in ways that do not harm children.

Although almost every single respondent (both institutional and community) asked for additional capacity building and support, none asked for help to change the gender and sexuality norms that underpin sexual violence and exploitation against children and the denial of children’s rights. This raises the question of whether the projects that are supporting these groups have created a meaningful awareness of these issues.

A major problem is the lack of a strategic approach to promote children's rights within a context of gender equality. This is visible in the absence of any significant program working with boys and men on issues of masculinity and sexual roles and norms, how these connect with power in relationships, decision making, gender inequity, and in turn the potential connections with denial of children's rights and vulnerability and risk for sexual violence and exploitation. Most of the community groups the assessment team interacted with—most of which were being supported by implementing partners—were in fact reproducing patriarchal power dynamics in which the men either occupy most of the positions or control the conversation, or both.

RECOMMENDATIONS

STRATEGIC FRAMEWORK AND COORDINATION

The highlighted problems present an opportunity to consolidate and improve what currently exists into a national strategy. Therefore, the main recommendation is to support the development of a comprehensive national strategy for child protection that would:

- Contextualize sexual violence and exploitation against children as one of the issues for comprehensive child protection.
- Enable clarification of the legal framework.
- Provide clear guidance on the roles of institutional and community actors, identifying responsibilities and mechanisms for overall coordination of the strategy, incorporating and improving existing good practices and tools.
- Identify capacity and funding priorities (for example, supporting tertiary and on-the-job training of social workers and forensic medicine experts, incorporating a specific technical focus on sexual violence and exploitation against children).
- Identify the type of data, instruments, and systems needed for planning, and monitoring and evaluation.
- Provide guidance for capacity building in a coordinated and synergistic way.

SERVICE PROVISION AND COORDINATION

- Support the implementation and revisions of the Mecanismo Multisectorial within this comprehensive national strategy for child protection in order to strengthen feedback among multi-sectoral teams and develop capacity for multi-sectoral supportive supervision (inclusive of police and courts of laws and building on models already being tested).
- Conduct a national health facility assessment of PRC provision with observation checklists, for example building on the *Lista de Verificação do Atendimento Integrado às Vítimas de Violência Sexual e Profilaxia Pós Exposição Não Ocupacional ao HIV* already approved by the Ministry of Health. This is a checklist, developed with technical assistance by Jhpiego, to observe and assess how services are provided in an integrated and coordinated fashion to people who have experienced sexual violence. The MOH was introducing it at the time of this assessment. This tool is not focused specifically on children, but it provides a potential model for adaptation and further development, including an overall methodology and process for facility assessment, data analysis, and follow-up.
- Ensure that multi-sectoral teams and community structures coordinate through clearly defined mechanisms, which ideally would be identified in the recommended national strategy for comprehensive child protection. These mechanisms should help inform the capacity building of all these actors.

CAPACITY BUILDING—USAID PROJECTS

- Map currently USAID-funded projects to identify potential entry points to address issues relevant to child protection, including sexual violence and exploitation against children.
- Identify areas of duplication, synergy, and gaps, and ways to address these.
- Support USAID-funded projects to strengthen their gender analysis with a focus on implementing gender transformative approaches integrated with children’s rights as well as a broader relevant rights framework (e.g., reproductive and sexual health rights). This will address specific contextual determinants of sexual violence and exploitation against children (e.g., power in family interactions, specific gender-related risk factors for girls and boys, values clarifications and reconstruction for key institutional and community actors and structures) with emphasis on ethics and social behavior change.
- Support and strengthen current efforts to expand availability of social workers and ensure that these efforts incorporate a specific technical focus on sexual violence and exploitation against children.

BUILDING THE EVIDENCE BASE

- Support prevalence studies, such as the Violence Against Children Survey, to mobilize action as well as track progress.
- Conduct qualitative research to better understand the circumstances surrounding violence and action research to identify cost-effective prevention interventions and care and support strategies (Together For Girls 2012).
- Continually analyze sexual violence and exploitation data from government databases, disaggregated by sex, age, and other factors, to provide updated information to government and development partners that can be used to raise awareness of issues around sexual exploitation and violence against children, and help target budget allocations.

CONCLUSIONS

Gender and sexual norms intersected with the denial of basic rights are key determinants of sexual violence and exploitation against children. They also play a significant role in provision and access to PRC. These issues are not receiving the attention they warrant in Mozambique. Unless this changes, the investment in preventing and mitigating sexual violence and exploitation will not yield its full potential.

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APPENDIX I

INTERVIEW QUESTIONS

INTERVIEW QUESTIONS

I. SOCIAL AND CULTURAL PERCEPTIONS INFLUENCING TIMELY PROVISION OF AND REFERRAL FOR CHILD'S POST-RAPE CARE (PRC).

Key questions and probes:

1.1 What is the prevailing social and cultural definition of who is a child?

- What is the age span that defines being a child? When and how does a child become an adult in this community? What defines this transition? How is this transition related to sexuality, becoming sexually active, getting married or having other types of sexual relationships? How is it different for girls and boys?

1.2 What are the prevailing social and cultural definitions of child sexual abuse and rape that influence access to PRC?

- What types of behaviors are understood to be child sexual abuse, and why? What is understood to be a rape, and why? How is it different for girls and boys?
- Which of these definitions of child sexual abuse and rape hinder the seeking of care for survivors of abuse, and why? How is it different for boys and girls? (Note: explore issues like physical, emotional, sexual violence and how they are seen connected; difference in age of perpetrator and victim; social standing of perpetrator and victim; economic conditions of the child's family; level of acquaintance between the perpetrator and the victim; role of key actors in defining what sexual abuse is e.g. traditional healers and traditional healing)

1.3 What are the main social and cultural issues that support or hinder the prevention and mitigation of child sexual abuse, including child rape?

- What initiatives or activities are taking place that can help prevent or minimize child sexual abuse and rape? How? How is it different for girls and boys? (Note: How do these initiatives increase awareness of what child sexual abuse is? How do these initiatives increase awareness of health and social consequences of child sexual abuse? Who are the actors involved in these initiatives? How effective are these initiatives? What feasible actions can be implemented to improve these initiatives? Why? How would they benefit both girls and boys?)

1.4 What practices by key actors in the community influence reporting of child sexual abuse and access to PRC?

- What practices in the community hinder reporting of child sexual abuse and rape? (Note: explore role of key actors in influencing attitudes to and practices about reporting including health providers, teachers/educators, NGOs, police and legal, community structures and leaders such as traditional healers and their role in conflict resolution; role of power in family structures and decision-making in hindering or enhancing child protection).
- Which actors in the community are promoting children's rights, and which rights? (Note: explore informed decision, informed assent and consent; consensual sexual relationships and marriage; role of parents, guardians, educators, and other important adult figures in the community to ensure that children are protected from coercion and sexual abuse)
- Which actors in the community are facilitating the reporting of child sexual abuse and child rape? How do they do this? How is it different for girls and boys?
- What are the main issues that children and their families have in reporting child sexual abuse, including rape? How is it different for girls and boys? (Note: explore fear of stigma and discrimination in immediate and long term; concerns about health of the child immediate and long term; whether reporting to police is pre-condition to access care and support; lack of understanding of the role of formal justice system; lack of understanding of children's rights; concerns about what will happen to the perpetrator and how these concerns influence other decisions for the welfare of the child; concerns about how their statements are collected; concerns about the involvement of witnesses; concerns about preparing their case for the courts and getting support; concerns about cost of care and support in immediate and long term; concerns about what children and families do not understand in terms of next steps in the process)
- Which of these fears are being overcome and what makes it possible? How is it different for girls and boys? (note: explore how these changes are improving reporting and access to medical care, psychosocial support, return to the community, access to and utilization of immediate and long term care and support)

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