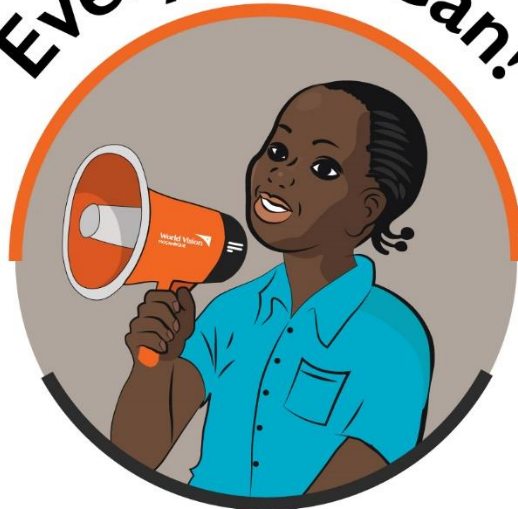

Baseline Report

MOZAMBIQUE

February 28, 2022

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Figure 2 EGC Baseline Study Timeline

Abbreviations & Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CeCAGe-UEM	Center of Coordination of Gender Issues- University Eduardo Mondlane
CIBS FM & MCH	Institutional Committee on Bioethics for Health
COVID-19	Coronavirus Disease 2019
CP	Child Protection
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organizations
DID	Difference-in-difference
EGC	Every Girl Can
FGD	Focus Group Discussion
FS	Field supervisors
GA	Gender Assessment
GE	Gender Equality
GEEHR	Gender Equality, Empowerment, and Human Rights
GEM	Gender Equitable Men

GBV	Gender Based Violence
HFA	Health Facility Assessment
HF	Health Facility
HIV	Human Immunodeficiency Virus
HOPEM	Men for Change Network
IMASIDA	Indicators on Immunization, Malaria and HIV/AIDS
INE	National Institute of Statistics
INS	National Institute of Health
KII	Key Informant Interview
LTGA	Light-Touch Gender Assessment
MISAU	Ministry of Health
MoH	Ministry of Health
NGO	Non-governmental Organization
OMM	Mozambican Women's Organization
PMF	Performance Measurement Framework
PPS	Probability Proportional to Size
PRM	Republic of Mozambique Police
PU	Premature Union
S4T	Savings for Transformation (savings groups)
SAAJ	Serviços Amigos e Adolescentes e Jovens
SGBV	Sexual and Gender-Based Violence
SBCC	Social Behaviour Change Communication
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TP	Teenage Pregnancy
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund

UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
WHO	World Health Organization
WVC	World Vision Canada
WROs	Women's Rights Organizations
WVM	World Vision Mozambique
YROs	Youth Rights Organizations

Executive Summary

Every Girl Can (EGC) is a five-year project funded by Global Affairs Canada. EGC is committed to improved gender equality and realization of adolescent girls' and young women's (8-24 years old) right to live free of sexual and gender-based violence (SGBV) and discrimination in Monapo, Murrupula and Nacaroa Districts, of Nampula Province. The project will also contribute to the COVID-19 pandemic response by raising awareness, supporting households in seeking health care and social protection services, and providing medical supplies and protective equipment and training to health facilities. This will be attained through three key results: 1) Improved effectiveness of government institutions to deliver gender-responsive prevention, early intervention, protection and response services related to SGBV, and COVID-19 and discrimination of girls and young women; 2) Enhanced agency and decision-making of girls and young women to protect themselves from SGBV and COVID-19 and to be active change agents in their communities; 3) Enhanced community support and systems that advance gender equality and girls and young women's agency, rights and protection from SGBV and gender discrimination and mitigate secondary impacts of COVID-19.

World Vision, in partnership with ActionAid and HOPEM expect to reach 146,777 primary direct beneficiary adolescents aged 8-24. The breakdown is as follows: 73,640 adolescent girls and 73,137 adolescent boys. These direct adolescent girls and boy participants will be empowered and supported to reach three of their peers with their knowledge of good practices in Sexual and Reproductive Health and Rights (SRHR), with a focus on girls and young women living free of SGBV, enabling full coverage of the district adolescent populations.

This report presents the results of the baseline study led by the University Eduardo Mondlane, Centre for Gender Studies and Coordination (CeCAGe-UEM) in partnership with local partners, World Vision Mozambique and the communities from November 22 to December 8, 2021. The main purpose of the baseline study was to determine the situation for girls and young women in the EGC target and comparison districts in terms of gender equality, SRHR and SGBV and to provide benchmarks against which to assess EGCs progress towards intended outcomes annually and its impact at the end of project implementation. Alongside the baseline, CeCAGE-UEM conducted an in-depth gender assessment to inform development of the gender equality strategy and project implementation. The recommendations below are influenced by the Gender Assessment (GA) results. This GA Report has been submitted to GAC separately and will be the basis for updating the project's gender equality strategy.

For the quantitative component of the Baseline Study, a quasi-experimental mixed method was used. A total of 2,144 girls and young women aged 8-24 participated in the survey, of whom 1,049 were from the Every Girl Can project districts, Monapo, Murrupula and Nacaroa, and 1,095 were from the comparison district of Erati. Among the sampled children 48.9% (n=1049) were between the ages of 8-14 and 51.1% were between the ages of 15-24. A total of 1,092 caregivers participated in the baseline study, 530 from the project sites and 566 from the comparison site. Quantitative Facility Assessments were also conducted: Health Centres, Schools, Gender-Based Violence (GBV) Units, Social Welfare Departments and Justice Facilities.

For the qualitative component of the Baseline Study, a variety of methods and techniques were employed, namely, literature research, self-photography, focus groups and semi-structured interviews with various

groups of actors. Twelve self-photograph sessions were conducted with adolescents and youths in-school and out-of-school in the condition of initiatives and non-initiatives; 14 semi-structured interviews were directed to a diversity of actors, namely from the education sector, health, Civil Society Organizations (CSOs), community and religious leaders, and masters of the initiation rites ceremonies; 45 focus groups involving adolescents, parents or guardians, community leaders, religious leaders, initiation matrons and health and education actors and CSOs.

Key Findings

Ultimate Outcome 1000: Improved gender equality and realization of adolescent girls' and young women's (8-24) right to live free of sexual and gender-based violence and discrimination in the Monapo, Murrupula, and Nacaroa districts in Nampula province

Experience of gender-based violence:

- 14.88% of adolescent girls (8-14) & young women (15-24) experienced GBV in the past 12 months in EGC project sites compared to 18.68% in the comparison site
- Slightly more girls 8 to 14 years of age reported experiencing GBV in both project and comparison sites (Project site: 15.11% of girls aged 8-14, 14.65% of young women aged 15-24; Comparison site: 20.16% of girls aged 8-14; 17.32% of young women aged 15-24).
- Qualitative Focus Group Discussions revealed that verbal harassment was frequent, in line with the quantitative results that 11.19% of project site respondents experienced at least one type of verbal harassment, such as humiliation in front of others, threat of hurt or harm, or insult, both within and outside the home. Other forms of violence that girls frequently experience include physical violence, which was associated with domestic violence, sexual violence, and theft. Some girls also included early forced marriage of girls as young as 10 or 11 to older men.

Intermediate Outcome 1100: Improved effectiveness of government protection institutions to deliver gender-responsive prevention, early intervention, protection and response services related to SGBV and COVID-19 and discrimination of girls and young women
Indicator Elements: SRHR health-seeking behaviour and utilization of and satisfaction with SGBV-related services

- 13.18% of young women in project sites aged 11-24, married or unmarried sought reproductive health care in the last 12 months compared to 21.59% in comparison sites
- 11.78% of baseline respondents used one of formal health, psychosocial or legal SGBV support services in the last 12 months compared to 20.29% in the comparison site
- Fewer girls aged 8-14 used these services in both project and comparison sites than young women 15-24 (Project Site: 10 girls 8-14, 106 young women 15-24; Comparison site: 33 girls 8-14, 178 young women 15-24)
- FGDs with Initiation Matrons mention violence taking place within the school environment. However, in the FGDs with girls and young women, schools were repeatedly mentioned as being as safe space for girls within the community.

- FGDs with teachers indicate that more exploration is needed to assess teachers' knowledge of and comfort with SRHR and SGBV subject matter and curricula, despite the school assessments reporting relatively high levels of teacher training on the subjects.
- FGDs with girls and young women highlighted that there is still a stigma around unmarried young women accessing reproductive healthcare, which is supported by the quantitative results. This is also the case with mental health services, suggesting that there is a difference in the number of girls and young women who need or want to access services, and those who actually do.
- FGDs with girls and young women found a general lack of awareness of, or at least a lack of ability to identify, services for SGBV support beyond health centres, which suggests that more awareness raising and outreach by these facilities to the local communities is needed

Intermediate Outcome 1200: Enhanced agency and decision-making of girls and young women to protect themselves from SGBV & COVID-19 and be active change agents in their communities
Indicator Elements: Confidence to seek help from duty bearers in SGBV and Child Protection (CP) incidents, decision-making and control of resources, decision-making and resource-control, advocacy group participation

- 5.62% of girls and young women in project sites feel confident to report and seek help from two or more duty bearers (e.g., teachers, health professionals, police, community leaders) with SGBV/CP incidents compared to 3.38% in comparison sites
- Fewer girls aged 8-14 feel confident in reporting in both project and comparison sites than young women aged 15-24 (Project Site: 2.09% of girls aged 8-14, 9.16% of young women aged 15-24; Comparison Site: 1.5% of girls aged 8-,5.1% of young women aged 15-24)
- 46.16% of girls & young women report having a say in important decisions (including decisions around SRHR, early marriage, initiation rites, etc.) compared to 41.69 % in comparison sites (Project Site: 24.14% of girls aged 8-10, 31.54% of girls aged 11-14, 63.17% of young women aged 15-24; Comparison Site: 19.67% of girls aged 8-10, 25.84% of girls aged 11-14, 58.32% of girls aged 15-24)
- 53.63% of young women aged 15-24 in project sites report adequate control over resources compared to 49.09% in comparison sites
- 15.01% of girls and young women in the project sites participate in advocacy groups compared to 18.39% in the comparison site. More girls 8-14 in both project and comparison sites participate in advocacy groups than the older age group (Project Site: 18.67% of girls 8-14, 10.5% of girls 15-24; Comparison Site: 21.6% of girls aged 8-14, 15.7% of young women aged 15-24)
- In FGDs with girls and young women, they were mostly unable to name specific reporting procedures. This might indicate a lack of awareness, although the threats of intimidation and violence towards those who report SGBV, raised in FGDs with community stakeholders, suggest this could also be due to a general community stigma around talking about and reporting acts of violence, particularly with formal reporting mechanisms.
- KIIs and FGDs with community stakeholders suggest that caregivers are often unwilling to report to formal systems and prefer to deal with issues at informal/community level. This also raises questions around how incidents of domestic/household violence are dealt with within the project site communities.

- KIIs and FGDs with community stakeholders highlight that in the project sites, decisions around those education, initiation rites, and marriage are characterized by a high degree of parental control and are often interrelated and intertwined.
- In FGDs with girls and young women, many highlighted their educational and career aspirations, though it appears many do not have the autonomy in decision-making or financial means to realize them.
- While KIIs with women leaders suggest that women do have a relatively high degree of control as to what to do with income that they themselves earn, that amount of control tends to be relatively small as there are few income generating opportunities open to women apart from small-scale trade. The quantitative baseline results demonstrate that though their degree over control over resources increases with age, just over 50% of young women in the project sites report having some decision-making power over household assets and resources.

Intermediate Outcome 1300: Enhanced community support and systems that advance gender equality and girls and young women's agency, rights and protection from SGBV and gender discrimination and mitigate secondary impacts of COVID-19
Indicator Elements: caregiver attitudes to gender equality, SGBV; WROs/YROs advocating for the rights of women; matrons/masters implementing improved practices in initiation rites

- 34.91% compared to 35.94% caregivers in project and comparison sites respectively show positive attitudes towards gender equality and reduction of SGBV compared to 35.94 (Project Site: 34.10% of female caregivers, 37.40% of male caregivers; Comparison Site: 35.93% female caregivers, 35.76% male caregivers)
- 62.50% compared to 66.67% of adolescent girls and young women in project and comparison sites respectively are satisfied with the quality of support they receive from the traditional community resolution systems (Project Site: 50.0% of girls aged 8-14, 66.67 % of girls aged 15-24; Comparison Site: 62.50% of girls aged 8-14, 69.23% of young women aged 15-24)
- FGDs and KIIs with community stakeholders both revealed that rigid gender norms around women's and men's roles in the community and household are still pervasive.
- The baseline study confirmed that initiation rites are an important community tradition across all three districts, and further revealed the complexities of the practice and the way it is viewed by various community members, and that many see it as having both positive and negative aspects.
- Initiation rites are not uniform or static across the districts, and while they are rooted in traditional practices, there is a certain degree of adaptability and willingness to adjust practices on the part of certain initiation matrons/masters and other community stakeholders.

Recommendations for the EGC project, emerging from this baseline study include:

- Further explore violence in schools to better understand the contradictions highlighted as the project engages with schools in early implementation phase.
- Assess teachers' knowledge of and comfort with SRHR and SGBV curricula and gender-responsive protocols

- Ensure better understanding of SGBV, SRHR, and mental health services referral pathways and links to make health care more adolescent-friendly, gender-responsive, and accessible
- Conduct training and sensitization on gender and child protection for health care workers
- Ensure geographic differences in accessibility are taken into account when implementing project activities related to health systems
- Conduct sensitization and awareness raising with caregivers around SGBV and reporting mechanisms
- Unpack nuances around girls' and young women's control over resources (their "own" versus the household) to better support project activities dealing with income generation and savings groups
- Explore further how engagement in collective action and advocacy groups affects girls' and young women's ideas of empowerment and agency
- Understand better the geographic nuances of the project sites to ensure the most isolated and vulnerable girls and young women are able to participate in project activities
- Ensure close coordination with Women's Rights Organizations (WROs), Civil Society Organizations (CSOs) and other groups already conducting awareness-raising and sensitization activities in the communities during project implementation
- Create opportunities and safe spaces for meaningful dialogues with a variety of community members (men, religious leaders, community leaders) to challenge rigid gender roles
- Carefully consider the nuances of the initiation rites across the districts is necessary to inform the implementation strategy for improved practices, identifying the key harmful elements to address and monitor in the social behaviour change communication (SBCC) strategy and mid and endline evaluations.
- More in-depth examination of the differences between male and female initiation rites, including any unconscious double-standards influencing the reform of initiation rites, with a view to exploring opportunities to challenge discourse that places greater burden on girls for sexual abstinence and avoiding pregnancy.

1. Background

1.1 Project Background

World Vision Canada (WVC) in partnership with World Vision Mozambique (WVM), ActionAid Mozambique and HOPEM, will implement the five-year project "Every Girl Can", funded by the Government of Canada. The project seeks to improve gender equality (GE) and realization of girls' and young women's (8 – 24 years old) right to live free of sexual and gender-based violence (SGBV) and discrimination. The project will also contribute to the COVID-19 pandemic response by raising awareness, supporting households in seeking health care and social protection services, and providing medical supplies and protective equipment and training to health facilities. The project, with a total budget of $13 million, will be implemented in three rural districts of Nampula province: Nacaroa, Monapo and Murrupula.

World Vision, in partnership with ActionAid and HOPEM expects to reach 207,272 girls and boys aged 8-24 (103,636 girls and 103,636 boys) in the three districts in Nampula. According to age cohorts, this

accounts for 108,596 girls and boys aged 8-14 and 98,676 girls and boys aged 15-24. Given that children as young as eight participate in initiation rites, WV adjusted the age-range to 8-24 years.

Every Girl Can will contribute to the ultimate outcome of improved gender equality and realization of girls' and young women's right to live free of SGBV and discrimination in Nampula Province. This will be attained through three key results: 1) Improved effectiveness of government institutions to deliver gender-responsive prevention, early intervention, protection and response services related to SGBV, and COVID-19 and discrimination of girls and young women; 2) Enhanced agency and decision-making of girls and young women to protect themselves from SGBV and COVID-19 and to be active change agents in their communities; 3) Enhanced community support and systems that advance gender equality and girls and young women's agency, rights and protection from SGBV and gender discrimination and mitigate secondary impacts of COVID-19.

Every Girl Can Logic Model: Ultimate, Intermediate, Immediate Outcomes

Ultimate Outcome	1000 Improved gender equality and realisation of adolescent girls' and young women's (8-24 years old) right to live free of sexual and gender-based violence and discrimination in Monapo, Murrupula and Nacaroa districts, in Nampula province						
Intermediate Outcomes	1100 Improved effectiveness of government protection institutions at the community level to deliver gender-responsive prevention, early intervention, protection and response services related to SGBV and COVID-19 and discrimination of girls and young women		1200 Enhanced agency and decision-making of girls and young women to protect themselves from SGBV & COVID-19 and to be active change agents in their communities		1300 Enhanced community support and systems that advance gender equality and girls and young women's agency, rights and protection from SGBV and gender discrimination and mitigate secondary impacts of COVID-19		
Immediate Outcomes	1110 Improved capacity of schools to provide gender-responsive, evidence-based information and protocol implementation related to the rights of women and girls', SGBV, SRHR and COVID-19 for girls/boys	1120 Improved capacity of public health, education, social welfare, and justice institutions to provide gender-responsive information, prevention and response services for girls/young women vulnerable to SGBV and COVID-19	1210 Improved life skills and knowledge among girls and young women regarding their SRHR, economic and protection rights and equitable access to COVID-19 prevention, tests and, treatment services including vaccines.	1220 Increased capacity of girls and young women to advocate for their SRHR, economic, protection and equitable access to COVID-19 test, treatment and vaccine rights	1310 Increased organizational capacity of local/community-based women's organizations to advocate for/promote the protection of the rights of women, targeting matrons and government and community actors at national/local levels	1320 Enhanced capacity of men, boys, parents, community, and traditional and religious leaders to take action to end SGBV and discrimination of girls, including harmful aspects of Initiation Rites	1330 Increased capacity of traditional community resolution systems to advance gender equality and deliver human rights-based and gender-responsive information and services on SGBV

This background will discuss i) Sexual and Reproductive Health and Rights of Adolescents ii) premature unions and early/teen pregnancy; iii) Gender-based violence and iv) COVID-19 in Mozambique

Figure 1: **Map of EGC Baseline Study Areas: Project District Sites (Monapo, Murrupula, Nacarôa) & Comparative District Site (Erati)**

Table 1: **EGC District Sub-Geographies, EGC Baseline Study, 2022**

EGC District Sub-Geographies			
District	**Administrative Post**	**Localities**	**Total Communities**
Monapo	3 (Monapo Hq, Netia and Itoculo)	10	445
Murrupula	3 (Murrupula Hq, Nihessiue and Chinga)	8	140
Nacaroa	3 (Nacaroa Hq, Inteta and Saua-Saua)	6	34 for EGC
Totals	**9 Admin Posts**	**24 Localities**	**619** *(310 communities will be the focus for community-level activities)*

1.2 Relevance and Context of EGC in Mozambique

1.2.1 Sexual and Reproductive Health and Rights of Adolescents

According to Mozambique the National Institute of Statistics (INE) (2013), the adolescent population of Mozambique is 5.7 million (24% of the total population). Projections indicate that by 2030 this group will reach 8.8 million, of which 4.4 million will be girls. This highlights the need to invest in the provision of SRHR services in early adolescence. Low access to education is another compounding factor. A UNICEF study (2011 op. cit. Pires and Josaphat (2016) determined that Nampula province has about 148,000 vulnerable girls between the ages of 15 and 19 who have not completed primary education. However, 109,000 girls aged 10 to 17 do not attend school.

Pires and Josaphat (2016) have shown that a significant percentage of adolescents have an early sexual debut. 11% of girls and 6% of boys between 15 and 19 years of age reported having had sex before the age of 15 years. 128,000 girls aged between 15 and 19 were victims of sexual abuse, while 59,000 were married by the age of 15. 37.5% of adolescents become pregnant for the first time between 15 and 19 years of age (Idem 2016). Many adolescent girls in Mozambique lack information about contraceptives

and their right to exercise full control over their bodies. This is reflected in the low contraceptive prevalence rate (CPR) of 14% among adolescents aged 15 to 19 years. It is also reflected in the high rate of teenage pregnancy, currently at 46% among adolescents aged 15 to 19 years (IMASIDA, 2015).

Mozambique is among the ten countries most affected by HIV in the world, with the world's sixth highest prevalence among adults aged 15 to 49. According to Muleia et al (2020), there is a greater burden of HIV/AIDS in the central and northern regions of the country. Adolescents and youth aged 15–24 are one of the most vulnerable populations. Adolescent women account for a disproportionate number of infections, with a prevalence (11.1%) three times higher than that of their male peers (3.7%).

Considering these numerous SRHR-specific challenges related to education levels, early sexual debut, adolescent SGBV statistics, early pregnancy, and incidence of HIV and AIDS; it is vital to address these issues through a comprehensive SRHR and SGBV approach that will enable women and girls to actualize their rights, including empowering them to make decisions about their future.

1.2.2 Premature Unions and Early Pregnancy

The lack or insufficiency of information on SRHR for adolescents and girls in particular contributes to the increase in cases of premature unions (PU) and teenage pregnancy (TP). PU is understood to be a union of one or both spouses under the age of 18 years. Pregnancy is considered premature when it occurs in girls aged 10 to 18 years (Hodges, 2015).

According to UNICEF Mozambique, the country has one of the highest rates of child marriage in the world, affecting almost one in every two girls, and has the second highest rate in the eastern and southern African sub-region (UNICEF, 2022). The data also show that 14% of women aged 20 to 24 years old were married before the age of 15 and 48% of women were married before reaching the age of 18. In the case of Nampula, the data show that 62% of girls were married before reaching 18 years of age, which raised concern to reflect and develop concrete actions to reverse the scenario. Despite several efforts by the Government, partners and civil society organizations (CSOs) involved in the fight against PUs, girls are still forced to marry against their will by their parents and guardians (Selemane, 2019).

These two issues are a serious violation of girls' human rights. Many girls who experience a premature union or early pregnancy are forced to stop school to take care of the home and some of them face complications during childbirth (Arthur, 2010). Therefore, it can be said that PU are endemic and reveal the existing discrimination in families and society due to the way they treat girls and boys. In this way, girls face deprivation and lack of opportunities compared to boys (Arthur, 2010).

Early/teenage pregnancy also causes several health problems (obstetric fistula, miscarriage, premature death). Teenage pregnancy and premature unions constitute obstacles for young people to follow their dreams compromising their future. These obstacles make adolescent girls drop out of school, reducing their chances of finding employment, and worsening vulnerability to poverty and social exclusion (Pires and Josaphat, 2016).

Pires and Josaphat (2016) highlight that the main causes of these two issues include premature menarche, poor information about pregnancy and contraceptive methods, low socioeconomic status, the existence of other cases of early marriage and conflicts and instabilities in the family. Additional contributing factors believed to contribute to premature unions, which affect 10% of girls aged between 15 and 19 years, are initiation rites and dropping out of school (Osório 2015; Josaphat and Maldonado 2017; Josaphat et al.,

2014; Assunção and Da Silva 2017). In contrast, other studies argue that initiation rites ensure cohesion and acceptance of adolescents in communities (Namuholopa 2017; Arnfred 2015; Guerra 2018).

1.2.3 Gender-Based Violence

The occurrence of sexual gender-based violence (SGBV) is registered in the context of changes in the social place of women, in the domestic space, for insertion in the labor market, as well as the fight for equal rights, (Gomes et al., 2015). Power relations place men in a privileged position in relation to women and explain the difficulty men have in assuming the changes that have been taking place in the social place of women. In this way, the androcentric socialization model that prevails in Mozambican society contributes to reinforcing the conviction of male superiority (Macia, 2013). Macia reveals that for some men the visibility of their masculinity is measured in terms of the degree of effectiveness in the absolute control they are able to exercise over women. So, for example, what men learn about male sexuality is that sexuality is to satisfy their desires, even if this involves violence against women.

1.2.4 COVID-19 in Mozambique

At the beginning of 2020, the World Health Organization (WHO) declared COVID-19 as a public health emergency of international character, then as a pandemic on March 11 of the same year. Coronavirus disease is an acute infection with coronavirus respiratory syndrome (Zhong et al., 2020).

Adolescents and young people, especially adolescent girls and young women, who already have a tendency to face high levels of domestic violence by their intimate partners, can experience even higher levels of violence due to quarantine and isolation, one of the measures issued by the authorities of the health for the prevention of COVID-19 (UNFPA, 2020). Many adolescents and young people in vulnerable situations live in conditions that put them at great risk of contracting COVID-19. They also have limited access to technology and alternate forms of education and information, including on how to mitigate exposure to COVID-19. However, a UNFPA report (2020) reveals that young people represent a valuable resource and network during public health crises and emergencies. With the right training on the disease and its transmission, young people can work together with the healthcare authorities to help break the chain of infection.

1.3 Baseline Scope & Objectives

The objectives of the baseline study were:

1) To document the status of key performance measurement framework (PMF) indicators for measuring all outcomes against set targets and extent of changes over the course of the project
2) To facilitate the use of baseline data for the periodic collection, analysis, interpretation, and use of monitoring data to improve program implementation
3) To facilitate the use of baseline data for periodic tracking, documentation, and communication of program results for accountability and to address emerging problems in a timely manner
4) To use the baseline data to identify impact pathways and ways to optimize capacity and increase impact

The Baseline was conducted using a mixed methods approach and the scope included:

- Quantitative surveys conducted through questionnaires with adolescent girls 8-14, young women (15-24), and caregivers of adolescents.
- Quantitative health and school facilities assessments conducted through interview with representatives from selected facilities in the project intervention and comparison areas
- Qualitative Assessment with purposively selected groups of adolescents, young people, parents, religious and community leaders and representatives from women's organizations and Child Protection Committees

2. Methodology

This section presents the methodology applied for the baseline assessment. The section describes the qualitative study design approach followed by the quantitative one.

2.1. Qualitative Data Collection Tools

2.1.1 Bibliographical Research

The literature search and subsequent literature review consisted of the collection of secondary information. The Web of Science, Google Scholar, Med pub and Direct Science platforms were used. Likewise, Ministry of Health (MoH) and National Institute of Health (INS) reports on the pandemic of COVID-19 and SGBV and monitoring reports of the programme implemented in response to COVID-19 as well as research reports and surveys on SSR, DSSR and GBV were consulted. Academic research in the focus areas of this study were also reviewed.

2.1.2 Auto-Photography

This tool was applied to all girls and boys involved in the immersion. The immersion aimed to gain the most in-depth knowledge about the aspirations, possibilities and limits of adolescent and young girls' and boys' lives in and out of school. The participants were asked to illustrate their dreams about their future life through photography. Finally, the participants were asked to present their photos where the researchers sought to understand the possibilities of achieving their dreams and hinderances, as well as the structural and personal limitations that influence their life. In the three study sites, a total of twelve self-photographs and their respective immersion were conducted.

2.1.3 Focus Group Discussions (FGDs)

The study used focus group discussions to gather data on the dynamics of the adolescents and young people aged 8 to 24 years and their guardians in order to capture possible contradictions, similarities and differences in the opinions of the participants. Thus, the following focus groups were administered at each research site: (i) Adolescents aged 8 to 10 years; (ii) Adolescents aged 11 to 14 years; (iii) Adolescents and young people aged 15 to 24 years and (iv) Caregivers. A total of 45 FGDs were held. To ensure engagement of the FGD and boost their participation, several introductory interactive activities were proposed, according to the age of each participant. The following procedures were applied for the different age groups:

For adolescents aged 8 to 10, activities were applied around what they like about being a boy/girl, mapping safe places in their community, notions about equal rights for boys and girls, discussion about

what they think about SGBV and the impact of COVID-19. Participatory exercises were part of the introductory section of all FGDs. The questions for adolescents aged 11 to 14 included notions and meanings about equal rights for girls and boys, vulnerability of the child, the use of SGBV and SRH case management services, their feelings about participating in the initiation rites processes and the impact of COVID-19.. Activities were conducted with adolescents and youths between 15 and 24 years of age around agency and empowerment, access and control of goods and services by boys and girls, perceptions about strong and weak boy and girl, notions and meanings about equal rights, vulnerability of the child, GBV case management services, SRH and the impact of COVID-19. Finally, with the guardians, exercises were applied around access to assets and resources in the community, initiation rites, the importance of marriage, the use of SRH services, community notions on GBV, the impact of COVID-19 and adolescent and youth use of SRH services.

2.1.4 Key Informant Interviews (KIIs)

Semi-structured interviews were conducted with key informants. The objective was to reveal the interests and perceptions of key stakeholders, including their suggestions and recommendations for ways to address the SRHR and SGBV-related issues. The semi-structured interviews with key informants, were used to collect data on: i) the functioning of health, education and social welfare services for adolescents and youth; ii) the established formal and informal intersectional coordination mechanisms in combating GBV; iii) level and scope of action of government partners on SRHR and SRH promotion materials, including school comprehensive sexuality education (CSE) curriculum; and iv) perceptions of key actors on local response mechanisms to COVID-19. A total of 14 interviews were conducted with key actors.

2.1.5 Sampling Strategies & Sample Size for Qualitative Study

The study applied convenience, intentional and snowball sampling (Gibson & Brown, 2009) to select the study participants. All participants who were available and willing to participate in the study were intentionally selected and the focus group sample was composed from them.

Table 2: Distribution of Focus Groups & KIIs, EGC Baseline Study, 2022

Target Group	Method	#	District
Adolescent girls 8-10	FGD	2	Monapo
Adolescent boys 8-10	FGD	2	Monapo, Nacaroa
Adolescent girls, 11-14	FGD	7	Nacaroa (2), Monapo(3), Murupula (2)
Adolescent boys, 11-14	FGD	9	Nacaroa (1), Monapo(3), Murupula (5)
Adolescent girls 15 – 24	FGD	6	Nacaroa (1), Monapo(2), Murupula (3)
Adolescent boys 15-24	FGD	6	Nacaroa (1), Monapo(2), Murupula (3)
Caregivers	FGD	5	Nacaroa(1), Monapo (2), Murupula (2)
Initiation Masters	FGD	3	Nacaroa, Monapo, Murupula
Initiation Matrons	FGD	2	Nacaroa, Monapo
Teachers	FGD	3	Nacaroa, Monapo, Murupula
Religious Leaders	KII	3	Nacaroa, Monapo, Murupula
Community leaders	KII	1	Monapo
Education Director	KII	3	Nacaroa, Monapo, Murupula
Women's Rights Org	KII	3	Monapo, Murupula

Civil Society	KII	1	Monapo
Health Service	KII	2	Nacaroa, Monapo
Justice Facility	KII	2	Monapo, Murupula
Social Action Facility	KII	2	Monapo, Murupula

When the research team arrived at each study site, they presented themselves to the local Government authorities (District Administrators) for approval of the study and then contacted the WVM contact person to obtain information on the identification of the institutions and the location of the study stakeholders as well as the research sites at the district and locality levels.

2.1.6 Ethical Approval and Informed Consent Procedure

The EGC Baseline Study protocol was submitted to the Institutional Bioethics Committee for Health at the Faculty of Medicine, Eduardo Mondlane University for ethical approval. The research protocol was composed of informed consent forms that were addressed and applied to all participants.

As per the Baseline Terms of Reference, the baseline study had to ensure appropriate, safe, non-discriminatory participation, stressing the views of all young women of reproductive age be collected. The study had to ensure that the process was of free and un-coerced consent and withdrawal and ensure the confidentiality and anonymity of participants. All facilitators in contact with children signed World Vision's Safeguarding Policy and Code of Conduct. All staff involved in data collection were trained by WVM Child Protection staff in safe data collection, informed consent and child-friendly participatory methodologies. Data collection teams were made up of female and male members. CeCAGe-UEM ensured that the participation of children was voluntary and not forced, and parental consent forms were signed and collected. The team also ensured child-friendly and child safety mechanisms during data collection and storage. Data collection tools and methodology were designed with child safety in mind, and facilitators were trained in safe data management.

For all participants below the age of 18 years, the research obtained parental consent through consent forms. All researchers involved in data collection were trained in data collection respecting the ethical principles of confidentiality, non-malfeasance, and respect for culture. CeCAGe-UEM have received commentaries from the Institutional Committee on Bioethics for Health (CIBS FM & MCH) and have submitted the feedback on the comment.

During the analysis phase the participants' personal data was coded to ensure anonymity and no more than three identifiers were used in the interview excerpts. For the quantitative data they were grouped into categories.

2.2 Quantitative Evaluation Design

The quasi-experimental mixed method was used for the girls and young women surveys.

The sampling strategy used stratified proportional conglomerates, with Administrative Posts or Localities as the primary sampling unit or "conglomerate". Sampling frames for all Administrative Posts listed within the intervention districts (Monapo, Murrupula, Nacaroa and Erati) are shown in Figure 1. The number of groups selected from each district was determined by the proportion of the population with each of these districts contributing to the combined population. The total population was determined separately for the

intervention, and the comparison district was based on the simulation shown in Table 3. Within each district, the required number of clusters was selected using Probability Proportional to Size (PPS).

Table 3: Difference in Difference Analysis Method Simulation

	Baseline	Endline	Difference
Treatment	50	100	50
Comparison	40	60	20
Difference	10	40	30 (DID)

DD: 50 – 20 = 30. We will express the percentages as proportion to calculate the size of the sample. SE = sqrt (p*(1 - p))/N) for p = 0.30 and n = 500. Sample size of 500 is sufficient to detect a difference of 30%.

The estimated sample sizes to measure differences in adolescents are 1,000 (500 for project and 500 for comparison sites) for adolescent girls aged 8 to 14 years and 1000 (500 for project and 500 for comparison sites) for young women aged 15 to 24. As shown in the simulation, this sample size will be sufficient to detect a difference of 30 percentage points. The same sample size of 500 was used for caregivers in both sites.

Sampling for school and health facility assessments was based on EGC implementation strategies targeting health centres and schools. The target group is comprised of focal persons in charge of health facilities and teachers in schools. Purposively selected samples of 31 health facilities and 75 schools from EGC intervention areas and 11 health facilities and 75 schools for comparison area were used for baseline assessment (Table 4).

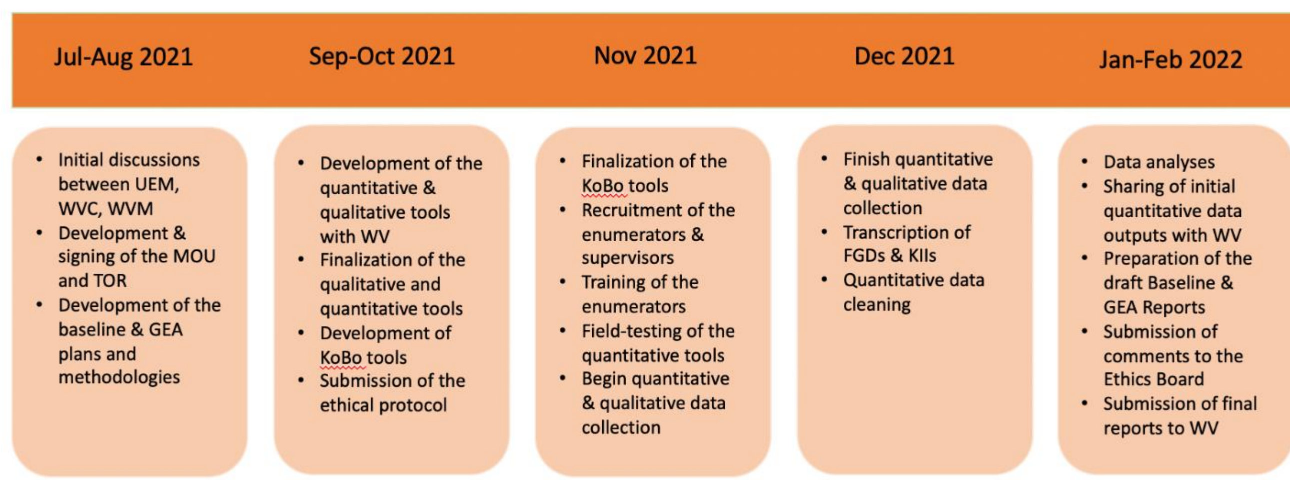
Table 4: Sampling Frames for all Intervention and Comparison Sites (Quantitative Surveys)

Quantitative Survey	Project Site	Comparison Site
EGC School Assessment	75 schools	75 schools
EGC Health Facility Assessment	31 Health Facilities	11 Health Facilities
EGC Young Women's Survey	500 girls 8-14 500 girls 15-24	500 girls 8-14 500 girls 15-24
EGC GEM & Attitude Survey for Caregivers	500 caregivers (250 Female, 250 male)	500 caregivers (250 Female, 250 male)

2.2.1 Quantitative and Qualitative Baseline Timeline

The EGC baseline activities took place from June 2021 to February 2022 and consisted of different stages outlined in the figure below.

Figure 2: EGC Baseline Study Timeline



Recruitment and training of enumerators, testing of tools: UEM utilized World Vision-trained enumerators and UEM recruited supervisors from the existing pool of casual CeCAGE-UEM staff, including male and female interviewers. The candidates, having field experience in similar studies to the EGC baseline and in the study areas, were recruited as interviewers. The supervisors also had prior work experience. Candidates with prior survey experience were given preference.

A team of professional researchers along with other functional and support teams were involved in this study. The UEM team has separate teams for core research, field operations and data processing and analysis. The members of the core research team and data processing and analysis team are permanent staff of UEM. However, the field operations team consists of both permanent and casual staff who were deployed for data collection. UEM deployed two separate teams for quantitative and qualitative data collection. The quantitative field team was composed of 25 enumerators and five field supervisors. To ensure the quality of data and adhere to the methodology of the study, the total data collection process was monitored by a UEM staff researcher.

For qualitative data collection, UEM team deployed four qualitative research assistants from its pool of casual CeCAGe staff. This team was supervised by one field coordinator and there was guidance and monitoring from the field operations team and core research team on the field work.

Training of Field Teams: The training of the quantitative survey team was conducted for four days from November 17-20 2021. Enumerators and the four qualitative researchers were trained by World Vision's Child Protection staff on safeguarding in data collection, particularly with children and vulnerable people as well as on SGBV, SRHR and COVID-19 preventive measures. All the members of survey team took part in the training.

Field data collection: The field work for this survey was conducted for 14 days from November 22-December 8, 2021. The quantitative data collection was done with individual/household interviews, and the qualitative data collection was conducted through KIIs and FGDs. The data collection for quantitative survey was done using KoBo software on tablets with individual/household interviews. The qualitative

approach followed different activities to facilitate interactive sessions among the moderators and participants conducting KII and FGD.

2.2.2 UEM Baseline Team

The baseline study team was composed of a diversity of researchers whose background is from Sociology, Anthropology and Gender Studies. Please see Annex 9 for a table summarizing the researchers and their roles.

2.2.3. Supervision and Quality control

Several strategies were taken to ensure quality data collection. Firstly, the main researcher monitored the data collection and daily regular meetings were held in order to share the difficulties of the field as well as to ensure data collection in line with the research objectives. Secondly, the research team was required to note down the observation elements in field diaries so that they would illuminate the data analysis steps. Thirdly, the researchers who participated in the data collection were trained to consider the research participants as active subjects and to develop skills in listening and acknowledging their voices rather than interfering with or opening on responses. Finally, the team involved in the analysis and reporting shared their beliefs prior to the data analysis to prevent them from interfering with the analysis and the process of triangulating. The points of view and analysis of each researcher were taken into account in the analysis which allowed for greater transparency in the process. All the researchers who participated in the data collection were involved in the process of elaborating the instruments and some of them were consulted in the analysis process.

2.2.4. Data Management and Analysis

Data were collected by four qualitative CeCAGe researchers and audio-recordings and field notes were taken. With respect to translation, four CeCAGe qualitative researchers relied on local translators, given that they were not from Nampula. As noted in the Limitations section below, given that the researchers from CeCAGe did not speak Macua, more Macua-speaking enumerators could have been allotted to the qualitative data collection.

Using audio-recordings, the qualitative data was then transcribed and saved into electronic files and stored by CeCAGe-UEM through the creation of a Dropbox and a hard disk and will be kept for seven years. During this period, the data will be password protected and only shared with WVC and WVM.

After being transcribed into word format, the research team started with a first reading to familiarise themselves with the data. Secondly, linguistic corrections were made without altering the meaning of the words in order to maintain the original participants' statements and the process of deep reading and grouping of similar words or phrases began. Finally, the categories and themes of analysis were created and reflected in the topics presented in the results section.

The content analysis method was applied to analyse the data collected on the basis of the literature survey and semi-structured interviews. Content analysis followed three main stages: (i) superficial reading and examination; (ii) in-depth reading and examination; and (iii) data interpretation (Braun & Clarke, 2019). After these steps, a manual content analysis was conducted, which consisted of organising the information into categories related to the research objective.

All quantitative data collection was done using KoBo software. The data was then transferred for cleaning, validation, and analysis. Data validation was carried out by the senior data analyst before analysis was conducted under the guidance of an expert panel.

Data sharing and protection: The CeCAGe-UEM team shared the database with World Vision in an excel format as required. As the data was collected in KoBo, it was stored in a cloud-based server which was accessible to a limited number of people on the study team. Therefore, the confidentiality of the data has been fully protected.

Analysis of quantitative data: Descriptive statistics and statistical inference were used as appropriate (frequency, mean, standard deviation, confident interval, etc.) to describe the socioeconomic characteristics of the respondents as well as to describe overall findings of the study.

Analysis was also done to provide estimates by location (project vs comparison sites), sex, age (where appropriate), and by category of respondents (adolescents and their caregiver, married/unmarried, etc.). Analysis also included the detailed outcome level indicators from the PMF following the appropriate disaggregation as suggested by the World Vision team.

2.2.5. Research Limitations

1. **Constraints related to long distances and poor road conditions:** The distance travelled and the condition of the roads led to the dispersal of participants from certain scheduled FGDs. It was also during the rainy season, and this constricted the time available to conduct the surveys. This could be addressed in future by aiming to conduct the midline and endline prior to the arrival of the rainy season without a significant departure from the baseline timeline to avoid effects of seasons.

2. **Transportation constraints:** In the district of Nacaroa specifically, there were difficulties in travel and delays because the qualitative study team had to share the same vehicle with the quantitative study team. This was not the case with the other two districts. This is a lesson learned for future logistical baseline planning.

3. **Lack of timely information about the study prior to the conduct of the data collection:** For some participants, the information about the type of participatory research that would be conducted did not reach the participants on time. WVM-EGC team including Community Mobilizers will help prepare communities several weeks in advance, prior to the midline and endline interviews.

4. **Challenges in translation during FGDs:** There were challenges with translations to Macua to Portuguese to English, with participants. Additionally, most translators were male, and as a result, some girls in focus groups may not have answered as openly as they might have done so if the translator was female. The CeCAGe-UEM team will overcome this constraint in the future by hiring female translators supported by WVM staff. In future, the CeCAGe staff alone will not conduct the qualitative interviews, there must be sufficient numbers of Enumerators involved who speak Macua. In this study, the experienced Enumerators worked with the quantitative data, but they should have been distributed amongst both data collection groups to ensure there were sufficient staff speaking Macua.

5. **Inability to conduct some interviews planned according to the research design:** It was not possible to conduct interviews with Republic of Mozambique Police (PRM) members in all research sites due to high levels of bureaucracy that prevented the arrangement of these interviews in the interval of the data collection in the three sites. It was also not possible to conduct interviews with more local NGOs as there were few in these particular project areas. For the midline, more advance information will be provided prior to data collection, and bureaucratic components will be addressed.

6. **Qualitative Data Analysis Challenges**: In relation to the translation challenges from Macua-to-Portugese-to-English, CeCAGe-UEM did not conduct a theme-based analysis as the typical first layer of qualitative analysis. Additionally, it was conducted manually, rather than with the support of qualitative evaluation software. They organized participant quotes in alignment with WVC's Gender Equality, Empowerment and Human Rights (GEEHR) framework, however there was no initial coding of themes. Because of this and the issues with translation, these transcripts have been challenging to analyze to achieve the first layer of analysis. Given these challenges, WVC technical staff had to work in-depth on the challenging transcripts for two weeks, while requesting an additional extension on the report submission from GAC. For the midline and endline, EGC will ensure that qualitative analysis software is utilized, in order to have a minimum dataset and codebook that all members of the research team can work from.

3. Key Baseline Findings

3.1 Characteristics of the Sample

A total of 2,144 girls and young women aged 8-24 participated in the survey, of whom 1,049 were from Every Girl Can project districts (Monapo, Murrupula and Nacaroa), and 1,095 were from the comparison district of Erati. Among the sampled children, 48.9% (n=1049) were between the ages of 8-14 and 51.1% were between the ages of 15-24. Overall, the average age of the adolescent (8-14) respondents was 10.8 years old, and the average age of young women (15-24) respondents was 19.3 years old. The average age was similar in project and comparison sites for both age groups. Table 5 presents the age distribution of respondents between project and comparison sites along with key characteristics of the sample.

Table 5: Characteristics of girls and young women respondents by project site, EGC baseline, 2022

Characteristics	Project Sites		Comparison Site	
	Girls 8-14	Young Women 15-24	Girls 8-14	Young Women 15-24
	% (n)	% (n)	% (n)	% (n)
Age	n=525	n=524	n=524	n=571
8-10	48.38 (254)		48.85 (256)	
11-14	51.62 (271)		51.15 (268)	
15-24		47.85 (524)		52.15 (571)
Level of education	n=525	n=524	n=524	n=571
Attending primary school	72.19 (379)	30.53 (160)	69.08 (362)	41.68 (238)
Completed primary school	6.48 (34)	21.95 (115)	12.21 (64)	24.69 (141)

Characteristics	Project Sites		Comparison Site	
	Girls 8-14	Young Women 15-24	Girls 8-14	Young Women 15-24
	% (n)	% (n)	% (n)	% (n)
Attending secondary school	1.71 (9)	8.78 (46)	0.76 (4)	4.38 (25)
Completed secondary school	0.19 (1)	1.34 (7)	0 (0)	0.53 (3)
Attending post-secondary/ vocational training	0 (0)	-	0 (0)	-
Completed post-secondary/ vocational training	0 (0)	-	0 (0)	0.18 (1)
No formal schooling	14.29 (75)	37.40 (196)	14.12 (74)	28.55 (163)
I'd prefer not to answer	5.14(27)	0(0)	3.82(20)	0 (0)
Marital status	n=525	n=524	n=524	n=571
Single, never married	88.00 (462)	33.21 (174)	88.74 (465)	29.77 (170)
Married	1.14 (6)	41.41 (217)	2.29 (12)	39.40 (225)
Live with a partner	0.57 (3)	21.56 (113)	1.53 (8)	26.80 (153)
Divorced	-	3.63 (19)	-	4.03 (23)
Widow	-	0.19 (1)	-	-
Respondents with children	n=525	n=524	n=524	n=571
Yes	1.71(9)	65.46 (343)	1.72(9)	67.43(385)
No	98.29(516)	34.54(181)	98.28(515)	32.57(186)
Number of children	n=9	n=343	n=9	n=385
1	66.67 (6)	42.98 (147)	66.67 (6)	49.22 (189)
2	33.33 (3)	28.65 (98)	22.22 (2)	28.91 (111)
3	-	18.71 (64)	-	14.32 (55)
More than 3	-	9.65 (33)	11.11 (1)	7.55 (29)
Participation in initiation rites	n=525	n=524	n=524	n=571
Yes	8.95 (47)	85.31 (447)	14.69 (77)	88.27 (504)
No	88.76 (466)	14.50 (76)	82.63 (433)	11.56 (66)
I don’t know	2.29 (12)	0.19 (1)	2.67 (14)	0.18 (1)
Participation in all phases of initiation rites	n=47	n=447	n=77	n=504
Yes	55.32 (26)	87.02 (389)	79.22 (61)	93.65 (472)
No	44.68 (21)	12.75 (57)	20.78 (16)	6.15 (31)
I don’t know		0.22 (1)		0.20 (1)
Currently working in a paid job				
Yes	1.14 (6)	16.03 (84)	1.34 (7)	12.78 (73)
No	87.24 (458)	77.10 (404)	88.74 (465)	83.19 (475)
Prefer not to answer	11.62 (61)	6.87 (36)	9.92 (52)	4.03 (23)

A total of 1092 caregivers participated in the baseline study, 530 from the project sites and 566 from the comparison site. All caregivers surveyed have children under the age of 18. Overall, 73.6% of the respondents were female, and the average age of female caregivers was 35.8 compared to an average age of 39.4 for male caregivers. At the time of the survey nearly 60% mothers in both project and comparison sites had no formal schooling (58.27% and 58.65% respectively) While more fathers completed primary and secondary schools than mothers, very few caregivers overall had completed secondary school. More than half of caregivers in both project and comparison sites (60.442% and 52.30% respectively) have children who have participated in initiation rites. Table 6 presents the sex distribution of respondents by project site along with key characteristics of the sample.

Table 6: Characteristics of caregiver respondents by sex and project site

Characteristics	EGC Project Sites		EGC Comparison Sites	
	Female (n=405)	Male (n=123)	Female (n=399)	Male (n=165)
	% (n)	% (n)	% (n)	% (n)
Age				
17-24	10.67 (43)	6.50 (8)	13.03 (52)	11.52 (19)
25-35	46.65 (188)	33.33 (41)	43.36 (173)	40.00 (66)
36-50	32.26 (130)	37.40 (46)	32.83 (131)	33.94 (56)
More than 50	10.42 (42)	22.76 (28)	10.78 (43)	14.55 (24)
Level of education				
Attending primary school	21.48 (87)	21.14 (26)	22.06 (88)	20.00 (33)
Completed primary school	14.07 (57)	34.15 (42)	17.54 (70)	37.58 (62)
Attending secondary school	2.96 (12)	11.38 (14)	1.00 (4)	8.48 (14)
Completed secondary school	2.96 (12)	4.07 (5)	0.50 (2)	7.27 (12)
Attending post-secondary/ vocational training	-	-	-	-
Completed post-secondary/ vocational training	0.25 (1)	-	0.25 (1)	-
No formal schooling	58.27 (236)	29.27 (36)	58.65 (234)	26.67 (44)
Marital status				
Single, never married	4.44 (18)	2.44 (3)	5.01 (20)	1.21 (2)
Married	54.07 (219)	57.72 (71)	54.39 (217)	62.42 (103)
Live with a partner	25.43 (103)	39.02 (48)	25.31 (101)	34.55 (57)

Divorced	10.62 (43)	-	10.03 (40)	1.21 (2)
Widow	5.43 (22)	0.81 (1)	5.26 (21)	0.61 (1)
Number of children				
1-2	24.57 (99)	25.20 (31)	27.07 (108)	29.27 (48)
3-4	31.27 (126)	26.02 (32)	31.33 (125)	29.88 (49)
More than 4	44.17 (178)	48.78 (60)	41.60 (166)	10.85 (67)
Children participated in initiation rites				
Yes	61.48 (249)	56.91 (70)	52.88 (211)	50.91 (84)
No	38.52 (156)	43.09 (53)	47.12 (188)	48.48 (80)
I don't know	-	-	-	0.61 (1)

Assessments were conducted of five different types of facilities: Health Centres, Schools, Gender-based Violence (GBV) Units, Social Welfare Departments and Justice Facilities. The distribution of the sampled facilities is presented in Table 7. A complete list of facilities assessed are summarized in Annex 8.

Table 7: Facility Assessment Sample Distribution, by study area, EGC baseline, 2022

Types of Facilities Assessed	EGC Project Sites	EGC Comparison Sites
Schools	40	17
Health Centres	25	6
GBV Units	7	-
Social Welfare Departments	4	-
Justice Facilities	7	-

3.2 Key Findings by EGC Project Outcomes

The following section presents the findings from the quantitative and qualitative analysis as they pertain to the PMF outcomes and indicators. See Annex 1 for a summary table of the indicators and detailed questions and analysis.

3.2.1 Ultimate Outcome

1000 Improved gender equality and realization of adolescent girls' and young women's (8-24) right to live free of sexual and gender-based violence and discrimination in Monapo, Murrupula, and Nacaroa districts in Nampula province

Indicator 1000.2: % of Adolescent girls & young women who experienced any form of GBV (physical or sexual) in the past 12 months

Adolescent girls (8-14) and young women (15-24) respondents were asked whether they had experienced different forms of violence in the last 12 months. A total of 14.88% of adolescent girls and young women in the EGC project sites had experienced at least one form of gender-based violence in the last 12 months, compared to 18.68% of adolescent girls and young women in the comparison site.

The difference between the two locations for the age group 8-14 is statistically significant (p value less than 0.05) but the difference for the age group 15-24 is not.

Table 8: Adolescent girls & young women who experienced any form of GBV in the past 12 months by study area, EGC baseline, 2022

Age Category	**EGC Project Site** n=525	**Comparison Site** n=524	**P -Value**
8-14	15.1% (76)	20.2% (104)	p=0.0261
	n= 524	n=571	
15-24	14.7% (75)	17.3% (97)	p=0.2576

National figures for physical and sexual violence from Mozambique are only available from the 2015 Survey of Indicators on Immunization, Malaria and HIV/AIDS. Comparable to the figure of 2.46% (Ministério da Saúde, 2018, p.266) of women in Mozambique aged 18-24 that experienced sexual violence in the last 12 months, 3.91% of study participants aged of 18-24 in EGC project sites experienced some form of sexual violence compared to 3.58% in the comparison site. In Nampula in 2015, 2% of women reported experiencing sexual violence in the 12 months prior to the survey. Data disaggregated by age was unavailable for Nampula as was national data for ages 15-18. Among baseline respondents who experienced sexual violence by someone other than a husband/partner, 54.55% reported that it happened within the household.

A total of 4.38% of all survey respondents experienced physical violence in project sites compared to 7.94% in the comparison site. Of the girls and women who experienced physical violence, 63.04% reported this occurring within the household. Among young women 18-24, 1.85% in EGC project sites compared to 4.11% in the comparison site experienced physical violence in the last 12 months. These figures are much lower than the most recent national figures of 17.46% for women aged 18-24 in Mozambique (Ministério da Saúde, 2018, p.249). According to 2015 figures, in Nampula 11.7 % of women 18-49 experienced physical violence in the 12 months prior to the survey. Not only was data unavailable for the younger age group (15-18) age disaggregated province specific data was also unavailable.

It is important to note that the national figures for physical and sexual violence used for comparison in this report are 7 years old. While similar indicators were not collected in a recent UN Women Covid-19 Rapid Gender Assessment Report, the findings note that GBV has increased since the onset of the pandemic. According to that report, close to 70% of women felt that GBV is a substantial problem in the country, and 44% of women 18-34 years of age felt that the incidence of GBV had increased. Thirty-one percent of women reported knowing of people who experienced some form of GBV (UN Women, 2020).

During focus group discussions, when asked about frequent types of violence that girls generally suffer, verbal harassment was raised in focus groups in all districts the most. This aligns with the quantitative results that a total of 11.19% of respondents from project sites reported experiencing at least one type of verbal harassment* (e.g., humiliation in front of others, threat of hurt or harm, or insult).

"… the frequent violence is when they go to school and come back people always insult them […] we are tired of seeing you passing by here, if you can find somewhere else to pass by, because we don't want to see you going to school, it's the frequent violence and these people threaten to beat them." (FGD, Girls 11-14, Murrupula)

Other forms of violence that girls frequently experience that were discussed in focus groups include physical violence, which was associated with domestic violence, sexual violence, and theft. Boys from Murrupula aged 11-14 shared that "rape was common," usually a male perpetrator with younger female victim. Please see Annex 3 for Girls and Young Women's Survey and Results.

Table 9: Adolescent girls' & young women's experience of any form of GBV (physical or sexual) by study area, EGC baseline, 2022

	EGC Project Sites		EGC Comparison Sites	
	Girls 8-14 (n=525)	Girls 15-24 (n=524)	Girls 8-14 (n=524)	Girls 15-24 (n=571)
Indicator	% (#)	% (#)	% (#)	% (#)
% of Adolescent girls & young women who experienced any form of GBV (physical or sexual) in the past 12 months	15.11 (76)	14.65 (75)	20.16 (104)	17.32 (97)
Variables				
Respondent experience of gender-based violence *In the past 12 months someone has anyone ever:*				
Said something to humiliate you in front of others*	5.52 (29)	6.49 (34)	8.59 (45)	9.46 (54)
Threatened to hurt or harm you or someone you care about*	3.24 (17)	3.05 (16)	6.68 (35)	4.03 (23)
Insulted you or made you feel bad about yourself*	6.48 (34)	7.06 (37)	10.31 (54)	7.88 (45)
Pushed you, shaken you, slapped or punched you or thrown something at you	6.10 (32)	2.67 (14)	12.02 (63)	4.20 (24)
Threatened to attack you with a knife, gun or other weapon	0.57 (3)	0.95 (5)	1.34 (7)	0.88 (5)
Ever been forced into unwanted sex or other unwanted sexual acts by husband/partner	-	1.72 (9)	-	2.28 (13)
Ever been forced to have sex by anyone other than your husband/partner	-	2.10 (11)	-	2.10 (12)

3.2.2 Intermediate Outcomes

1100 Improved effectiveness of government protection institutions to deliver gender-responsive prevention, early intervention, protection, and response services related to SGBV and COVID-19 and discrimination of girls and young women

Indicator 1100.1: Extent to which girls and young women are satisfied with SGBV/CP services

While a small number of survey respondents (2.09%) from project sites felt the need to access mental health or psychological services, even fewer (0.95%) accessed those services within the last 12 months. Among those who accessed services, 44% sought them at a health unit, and 40% were satisfied with the support they received. No respondents accessed services from the GBV units or social welfare departments that offer services in their respective districts.

The qualitative study found that there is a degree of stigma surrounding SGBV in the project sites, which would help to explain the low numbers of girls and young woman accessing SGBV/CP support services. This includes threats of further violence and intimidation which keeps girls from reporting and seeking help, as illustrated in the quote below from the female leader of a women's advocacy organization in Monapo:

"To say that gender-based violence is not something that we have experienced every day, it's just that many end up choosing to keep silent because they are afraid because they are threatened if you talk you will see, I'm going to beat you up, I'm going to choke you, you see, these are situations that have happened but many times it usually always happens, so it is a very difficult situation to overcome, because if the girl doesn't say anything, we don't know either, and many times when she comes to say it's already late, the thing has already passed, while if it was earlier we could intervene, be able to help, try to advise the family, so there are few cases that we manage to intervene right at the beginning, most of them we only discover after the girl is already in a very advanced situation." (KII, female leader of a CSO, Monapo)

Three FGDs conducted with girls 10-19 in Murrupula as part of the Light-Touch Gender Assessment (LTGA)[1] in June 2021 support these findings, as none of the girls were able to answer questions about being aware of any girl who experienced violence, or if they themselves knew where to go for help if they experienced violence. The three FGDs conducted in Nacaroa as part of the same exercise found slightly different results, with some of the girls being aware of violent cases, both physical and sexual, where the girls were able to get help from local leaders in the Rainha, Secretario and Lider Communitario. Overall, in both groups, facilitators noted that there was a lack of discussion around violence, though they were unable to confirm if this was due to the questions not being well understood, or to a general hesitancy to speak about violence.

Indicator 1100.2: % of young women aged 11-24, married or unmarried, who sought reproductive health care in the last 12 months

Among adolescents and young women, married and unmarried, 11 years of age and older, 13.18 % sought reproductive health care in the last 12 months in the project sites compared to 21.59% in comparison sites. The difference between the two study areas is statistically significant (p=0.0001). Among the younger age group of girls 11-14, a couple that were married sought reproductive health care and no unmarried girls sought care.

Focus Group participants were asked about their knowledge and experiences with SRH services. Young women 15-24 in Monapo were unaware of SRH services available for adolescents apart from services available at schools. Probing a little further, about where participants access menstrual hygiene products, girls in the younger age group in Monapo mentioned obtaining products from hospitals, local schools and from parents. Young women 15-24 in Monapo and Murrupula, shared about a lack of availability of menstrual hygiene products, and that girls use a *capulana*, a type of cloth/scarf.

"Products [are] not available at hospitals/clinics, it depends whether girls have money to buy" (FGD, Girls 15-24, Monapo)

"You said they wanted to have pads, but there is a lack. This capulana hurts a lot. They wanted a dressing, not capulana, because capulana harms women a lot: they get hurt." (Girls 15-24, Murrupula)

[1] Light-Touch Gender Assessment (LTGA). World Vision Mozambique & World Vision Canada. June 2021. The LTGA was conducted by WVM staff with support from WVC in June 2021. The results were used to inform the development of Project Implementation Plan, and to help inform the in-depth GEA conducted alongside the baseline study.

The results from the LTGA confirm what baseline FGD participants have shared. In both Murrupula and Nacaroa, girls reported challenges in obtaining menstrual hygiene products due to lack of products and money, however they are able to access cloth and soap (LTGA, June 2021). A further challenge mentioned in Monapo related to menstrual hygiene was gaining information from family, school, and clinics.

Table 10: Young women who sought reproductive health care in the last 12 months by study area EGC baseline, 2022

Age	Marital Status	EGC Project Sites		EGC Comparison Sites	
		n=	%(n)	n=	%(n)
11-14	Married	6	33.33% (2)	10	0
15-24	Married	205	29.27% (60)	217	33.18% (72)
11-14	Unmarried	218	0	228	6.14% (14)
15-24	Unmarried	284	11.27% (32)	337	25.22% (85)

Indicator 1100.3: Utilization of any one of the formal health, psychosocial, legal SGBV support services within the target population in the last 12 months

Overall, 11.78% of adolescent girls and young women from EGC project sites have accessed at least one formal health, psychosocial or legal SGBV support services in the last 12 months compared to 20.29% in the comparison site. In both the project and comparison sites, young women accessed these services more than the adolescent girls. Of the three types of services, health services were accessed by more respondents than psychosocial and legal SGBV.

Table 11: Utilization of health, psychosocial, legal SGBV support services by target population in the last 12 months

Indicator	EGC Project Sites		EGC Comparison Sites	
	Girls 8-14 n=475	**Girls 15-24** n=510	**Girls 8-14** n=477	**Girls 15-24** n=536
	% (n)	% (n)	% (n)	% (n)
Utilization of any one of the formal health, psychosocial, legal SGBV support services within the target population in the last 12 months	2.10% (10)	20.78% (106)	6.92% (33)	33.21% (178)
Variables	n=525	n=524	n=524	**n=**571
Respondents visited a health facility or doctor of any kind to receive services or information on contraception, abortion or sexually transmitted diseases in the last 12 months	0.57% (3)	17.56% (92)	2.67% (14)	27.67% (158)

Respondents accessed or had a SGBV case referred to the traditional community resolution system within the last 12 months	0.76% (4)	2.10% (11)	2.29% (12)	2.80% (16)
Respondent felt the need to access mental health or psychological services & accessed these services in the last 12 months	0.57% (3)	1.34% (7)	1.91% (10)	3.50% (20)

1200 Enhanced agency and decision-making of girls and young women to protect themselves from SGBV & COVID-19 and be active change agents in their communities

Indicator 1200.1: Girls who feel confident in their ability to report and seek help from [2 or more] duty bearers (teachers, health professionals, police, community leaders) with SGBV/CP incidents

Survey respondents were asked about formal (teachers, health professionals, police, community leaders) and informal (parents, community religious leaders, friends) sources of help they would feel comfortable reporting sexual abuse or harassment to. 5.62% of all respondents in EGC project sites, compared to 3.38% in the comparison site, felt comfortable reporting to two or more of the actors termed duty bearers, those who have legal obligations to report violence to the proper authorities. Overall, 42.99% of respondents in project sites were most comfortable reporting to parents followed by community leaders (31.93%) and then the police (10.29%).

Among those who felt comfortable to report incidents of SGBV to the police, 78.26% of girls 8-14 and 89.47% of young women 15-24 reported moderate or high confidence that the police would take action.

Table 12: Girls confident in their ability to report and seek help with SGBV/CP incident by study area, EGC baseline, 2022

	EGC Project Sites		**EGC Comparison Sites**	
	Girls 8-14 n=525	**Girls 15-24** n=524	**Girls 8-14** n=524	**Girls 15-24** n=571
Indicator	% (n)	% (n)	% (n)	% (n)
Girls who feel confident in their ability to report and seek help from [2 or more] duty bearers (teachers, health professionals, police, community leaders) with SGBV/CP incidents	2.09% (11)	9.16% (48)	1.5% (8)	5.1% (29)
Variables				
Groups/people respondents would you feel comfortable telling or reporting to if they experienced sexual abuse or harassment				
Parents	39.8% (209)	46% (241)	40.3% (211)	43.4% (248)
Teachers and/or school administration	1.3% (7)	1.0% (5)	1.1% (6)	0.4% (2)
Health centre	0.57% (3)	1.0% (5)	0.4% (2)	1.8% (10)
Police	6.1% (32)	14.5% (76)	3.6% (19)	9.6% (55)
Community leader(s)	19.4% (102)	44.5% (233)	18.1% (95)	35.9% (205)

Community religious leader(s)	4.4% (23)	7.4% (39)	3.1% (16)	4.7% (27)
Friends	4.19% (22)	5.73% (30)	2.48% (13)	4.73% (27)

Indicator 1200.2: Girls who report having a say in important decisions (including related to their SRHR, early marriage, initiation rites, etc.)

Decision making power and ability to influence decisions that impact girls and young women is an important indicator of empowerment. This indicator measures the level of involvement in decisions that also determine or influence empowerment including sexual and reproductive health, early marriage, household roles, education, and economic activity. Table 13 provides a summary of the findings on decision making. Overall, less than half of all survey respondents (46.16% and 41.69% of respondents in project and comparison sites respectively) report having a say in important decisions. The percentage of girls who have a say in decisions increases with age, with more young women between 15-24 making decisions by themselves or jointly with parents or spouses than girls 8-10 and 11-14. The differences found between the project and comparison sites are statistically significant (p=0.03943).

Indicator 1200.3: % of adolescent girls and young women with adequate control over resources (e.g., credit, savings)

Young women's control over resources was determined based on the level of their involvement in household economic decisions over consumption and expenditures. In EGC project sites, 53.6% of young women have adequate control over resources compared to 49.04% in the comparison site, meaning they make decisions themselves or jointly with parents or a spouse.

Table 13: Household & resource decision making by study area, EGC baseline, 2022

	EGC Project Sites			EGC Comparison Sites		
	Girls 8-10 n=254	**Girls 11-14** n=271	**Girls 15-24** n=524	**Girls 8-10** n=256	**Girls 11-14** n=268	**Girls 15-24** n=571
Indicator	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)
Girls who report having a say in important decisions (including related to their SRHR, early marriage, initiation rites, etc.)	24.14 (56)	31.54 (82)	63.17 (331)	19.67 (47)	25.84 (69)	58.32 (333)
% of adolescent girls and young women with adequate control over resources (e.g., credit, savings)	-	-	53.63 (281)	-	-	49.04 (280)
Variables						
Decisions made by the respondent or jointly with parents or spouse						
The decision to go to or attend school or a course	9.35 (49)	27.31 (74)	47.90 (251)	23.44 (60)	28.73 (77)	49.56 (283)
The decision to choose a partner	13.36 (70)	39.85 (108)	86.26 (452)	32.81 (84)	48.51 (130)	83.01 (474)
The decision to marry	13.55 (71)	39.11 (106)	85.31 (447)	33.59 (86)	43.28 (116)	79.16 (452)
The decision to initiate sexual activity	-	47.23 (128)	88.93 (466)	-	53.36 (143)	87.39 (499)

The decision about the tasks you do at home	11.64 (61)	33.95 (92)	80.34 (421)	17.58 (45)	34.70 (93)	78.28 (447)
The decision on the number of children you have	14.69 (77)	42.80 (116)	82.25 (431)	35.16 (90)	47.39 (127)	77.93 (445)
The decision to work (formal)	13.93 (73)	41.70 (113)	79.20 (415)	31.64 (81)	44.78 (120)	70.93 (405)
The decision to enter the initiation rites	8.02 (42)	15.50 (42)	31.87 (167)	12.50 (32)	14.18 (38)	31.17 (178)
The decision to begin contraceptive planning	-	35.42 (96)	80.92 (424)	-	31.72 (85)	70.40 (402)
The decision of how to manage the harvest	9.92 (52)	28.78 (78)	55.34 (290)	15.23 (39)	19.78 (53)	50.09 (286)
The decision of how to spend money for household and family needs	11.26 (59)	31.37 (85)	52.86 (277)	16.02 (41)	23.13 (62)	50.26 (287)
The decision of how to spend money borrowed or saved is the decision	11.07 (58)	32.84 (89)	54.58 (286)	16.80 (43)	24.63 (66)	51.84 (296)

Indicator 1200.4: % of girls who participate in advocacy groups, disaggregated by age

Collective action is a key dimension of agency, a powerful tool for transformational change of gender norms and power relations and fundamental to girls' and women's empowerment. In EGC project sites, 15.01% of respondents 8-24 participate in advocacy groups such as youth groups, child-rights focused groups or mutual benefit societies, compared to 18.4% in the comparison site. Girls aged 8-14 in both project and comparison sites participate in advocacy groups more than young women 15-24.

While participation in advocacy groups is lower among young women 15-24, the level of participation is higher in this age group compared with younger girls in the project site. 96.30% of young women 15-24 who participate in advocacy groups in the project site are somewhat or very active in group activities compared to 77.05% of girls 8-14. There is little difference between the level of participation among girls and young women in the comparison site.

The proportion of young women that participate in advocacy groups who also have a leadership role in the group is slightly higher in project and comparison sites compared to adolescent girls. While involvement in leadership roles among girls 8-14 is lower, still more than three-quarters in both project and comparison sites are somewhat or very active in these advocacy groups.

Table 14: Girls' level of participation and leadership in advocacy groups by study area, EGC baseline, 2022

	EGC Project Sites		**EGC Comparison Sites**	
	Girls 8-14 n=326	**Girls 15-24** n=267	**Girls 8-14** n=278	**Girls 15-24** n=331
Indicator	% (#)	% (#)	% (#)	% (#)
% of girls who participate in advocacy groups, disaggregated by age	18.7% (61)	10.5% (28)	21.6% (60)	15.7% (52)
Variables	n=525	n=524	n=524	n=571

Respondents participate in the following groups				
Youth Group	7.43% (39)	4.77% (25)	8.59% (45)	9.11% (52)
Child-rights focused group	4.19% (22)	0.57% (3)	2.86% (15)	0.18% (1)
Mutual benefit society (illness, health, self-help)	0.19% (1)	0	0	0
Level of involvement	n=61	n=27	n=60	n=52
Somewhat or very active in group activities	77.05% (47)	96.30% (26)	85.00% (51)	88.46% (46)
Leadership role in the group	n=61	n=27	n=60	n=52
Yes	26.23% (16)	44.44% (12)	35.00% (21)	40.38% (21)

1300 Enhanced community support and systems that advance gender equality and girls and young women's agency, rights, and protection from SGBV and gender discrimination and mitigate secondary impacts of COVID-19

Indicator 1300.1: Extent to which caregivers show positive attitudes and behaviors towards gender equality and reduction of SGBV, disaggregated by sex and age [measured using adapted GEM scale]

The baseline study engaged significantly more mothers than fathers in household surveys, with mothers making up more than 70% of the respondents in project and comparison sites.

Though initially developed for men, the Gender Equitable Men (GEM) scale has been adapted and used successfully with women to measure attitudes toward gender norms by asking respondents to rate their level of agreement with a collection of statements. Widely held norms, beliefs and practices can serve as a barrier to girls' and young women's agency, and therefore it's important to assess the extent to which key stakeholders particularly parents support equitable gender norms. The study revealed around one-third of caregivers have high support for equitable gender norms, with near similar results among mothers and fathers. There were no significant differences (p=0.36125) found between sexes or between the project and comparison sites.

Looking into the details of the GEM scale, there are some results that suggest conflicting attitudes. While more than 65% of caregivers (Female: 69.14%; Male: 66.66%) believe that a girl should be able to negotiate with her parents to delay marriage until she is ready, a similar proportion (Female: 66.92%; Male: 69.92%) agreed that a man should have the final word about decisions in his home.

A large proportion of caregivers (Female: 64.2%, Male: 65.86%) agreed with the statement that it is a woman's responsibility to avoid getting pregnant, which creates a disproportionate burden physically and emotionally on women to acquire birth control methods.

Most caregivers disagreed with the statement that a girl or boy should keep silent and not report if he/she is abused even if it is by his/her teachers or family members, more males disagreed with the statement than females (91.87% and 70.86% respectively). This is striking because qualitative discussions that referred to domestic violence often alluded to male members of the family being the perpetrators. While there are positive attitudes toward reporting violence faced by girls/boys, it is concerning that there are prevailing attitudes which accept violence toward women. For example, 28.15% and 20.32% of female and male caregivers respectively agreed that a man has right to sexual relations even if the woman refuses

and 25.19% and 19.51% of female and male caregivers respectively agreed that there are times when a woman deserves to be beaten.

Table 15: Caregiver attitudes toward gender equality and reduction of SGBV

Indicator	EGC Project Sites		EGC Comparison Sites	
	Females (n=405)	**Males** (n=123)	**Females** (n=399)	**Males** (n=165)
	% (n)	% (n)	% (n)	% (n)
Respondents with high support for equitable gender norms	34.16% (138)	37.40% (46)	35.93%(143)	35.76% (59)
Please see Annex 4 for Caregiver Survey and Results				

Indicator 1300.2: Adolescent girls and young women satisfied with the quality of the support they receive from the traditional community resolution systems

Although close to 15% and 19% of survey respondents in EGC project sites and comparison sites respectively experienced some form of GBV in the last 12 months, only a small number of girls accessed or had a case referred to the traditional community resolutions system. Of those cases that were referred, approximately half received action or follow up in EGC project sites whereas three-quarters received follow up in the comparison site. For those respondents whose cases received action or following up, close to two-third were satisfied with the support they received in both project and comparison sites.

Table 16: Adolescent girls' and young women's satisfaction with support from traditional community resolution systems

Indicator	EGC Project Sites		EGC Comparison Sites	
	Girls 8-14 n=2	**Girls 15-24 n=6**	**Girls 8-14 n=8**	**Girls 15-24 n=13**
	% (#)	% (#)	% (#)	% (#)
Adolescent girls and young women satisfied with the quality of the support they receive from the traditional community resolution systems	50.00% (1)	66.67% (4)	62.50% (5)	69.23% (9)
Variables				
Respondents that accessed or had a SGBV case referred to the traditional community resolution system	0.76 (4) n=525	2.10 (11) n=524	2.29 (12) n=524	2.80 (16) n=571
Respondents that have received action or follow-up	50.00 (2) n=4	54.55 (6) N=11	66.67 (8) N=12	81.25 (13) N=16
Satisfied with the support you received	50.00 (1) N=2	66.67 (4) N=6	62.50 (5) n=8	69.23 (9) N=13

3.2.3 Immediate Outcomes

1110 Improved capacity of schools to provide gender-responsive, evidence-based information and protocol implementation related to the rights of women and girls', SGBV and SRHR and COVID-19 for girls/boys

Indicator 1110.1: Target schools operationalizing gender-responsive safeguarding protocols on SGBV and SRHR

According to the school assessments conducted, approximately 67.50% of schools in EGC project sites are operationalizing gender-responsive safeguarding protocols on SGBV and SRHR compared to 94.12% of schools in the comparison site. The difference is not statistically significant ($p=0.0719$).

From the safe schools checklist, 77.5% of schools met the minimum criteria for the provision of emotional and psychosocial protection (Guiding Principle #1). In focus group discussions with girls, schools were mentioned as safe spaces in community for girls. Despite a relatively large proportion of the schools reporting child protection clubs and training for students on protecting themselves and peers from SGBV (more than three-quarters in the project site), there was little evidence from the girls' and young women's qualitative and quantitative data that would confirm efficacy of these programs or girls' participation in them. While the qualitative discussions with teachers revealed that students were taught to avoid early marriage, the full scope of the curriculum on SGBV is unclear. Furthermore, though girls reported participation in youth and child rights focused clubs, whether or not those clubs were school-based was not explored.

With regards to child, parent and community participation (Guiding Principle #3), 87.5% of schools in the project site met the minimum criteria. It was mentioned by teachers that disseminating information in the community, as well as campaigns on special holidays, were strategies employed to raise awareness about SRHR and SGBV. It is unclear if these strategies are still used, especially since the start of the COVID-19 pandemic. While many schools (82.5%) in project sites report that children, parents and community members are trained on SGBV and child protection and that they are involved in monitoring protection risks, there was insufficient evidence from caregiver focus groups to assess the level of involvement. Furthermore, teachers in both Murrupula and Nacaroa recommended that complementary education at the household and community level would improve the outcomes of the SRHR, SGBV and GE curriculum at school, which suggests that perhaps there is a disconnect between what is being taught at school and at home or in the community.

Table 17: Schools operationalizing gender-responsive safeguarding protocols on SGBV and SRHR

Indicator	EGC Project Sites	EGC Comparison Sites
	n=40	n=17
	% (#)	% (#)
Target schools operationalizing gender-responsive safeguarding protocols on SGBV and SRHR	**67.50 (27)**	**94.12 (16)**
Variables		

Guiding Principle 1: Emotional and Psychosocial Protection ***Positive and respectful interactions:*** Positive and respectful interactions between and with children are promoted at all times. Interactions are based on cooperation, trust and tolerance.	77.50% (31)	94.12% (16)
Student's code of conduct is in place to ensure that disciplinary measures are taken against bullying, sexual and gender-based violence or other forms of violence and abuse.	95.00 (38)	100.00 (17)
Child protection committees and clubs are formed inside schools to regularly engage students, teachers and administration on protection issues.	82.50 (33)	94.12 (16)
Students are trained on child protection—how to protect themselves from SGBV and their peers	77.50 (31)	94.12(16)
Guiding Principle 2: Physical Protection ***Safe and accessible learning spaces:*** Learning spaces are physically safe and accessible to all children. A safe environment is free from physical harm and provides protection.	87.50% (35)	94.12% (16)
A regular risk assessment and mitigation plan is conducted to ensure that physical space and activities are safe for children.	*90.00 (36)*	*100.00 (17)*
School infrastructure follows safety protocols and guidelines. This question has to do with safe building codes (for example, separate latrines, safe building structures, furniture, etc.)	90.00 (36)	94.12 (16)
Guiding Principle 3: Parents and Community ***Child, parent, and community participation:*** Children, parents and communities participate in learning and decision-making processes.	82.50% (33)	94.12% (16)
Parents and community members are trained on child protection, SGBV and how to keep children safe	82.50 (33)	76.47 (13)
Parents associations inside schools are involved in monitoring SGBV and other protection risks inside schools	82.50 (33)	94.12 (16)
Awareness-raising activities on SGBV and campaigns are regularly conducted inside schools and in the community	92.50 (37)	94.12 (16)
Guiding Principle 4: School Leadership and Management ***Inclusive and protective policies:*** Policies ensuring the inclusion, safety, and wellbeing of students and teachers are established and implemented. The leadership develop relevant protective and inclusive policies, such as gender policies and teacher and school codes of conduct.	85.00% (34)	100.00% (17)
The school has a child protection policy, code of conduct, and reporting mechanisms are in place to report SGBV violations and other protection risks. The policy and reporting mechanism are shared with everyone in the school.	87.50 (35)	94.12 (16)
Teachers are trained on positive discipline and protection from SGBV and gender empowerment practices	87.50 (35)	94.12 (16)
Protection from SGBV service mapping and referral mechanisms are in place inside schools	75.00 (30)	100.00 (17)
Teachers' wellbeing is promoted and supported	80.00 (32)	88.24 (15)

Please see Annex 5, School Facility Assessment.

Indicator 1110.2: % of targeted schools who report taking actions to reduce SGBV at school in the past 12 months

Of the schools assessed, 84.85% and 100% of schools in the project and comparison sites respectively report taking actions to reduce SGBV at school in the past 12 months. There were not statistically significant differences between the two sites (p=0.08516).

Through the qualitative study, teachers explained that gender equality (GE), SRHR and SGBV are generally taught through two subjects: Natural Sciences, where students learn about reproductive health; and Moral and Civic Education, where students learn about gender, rights and equality. While 60.00% of project site schools and 64.71 % of comparison site schools report having staff trained on gender-responsive information and protocols on SGBV and SRHR, it is unclear whether those subjects have dedicated teachers that are trained to teach the sensitive material in the SRHR, SGBV and GE curriculum. Responses from teachers in Monapo and Murrupula further suggest that not all teachers receive training in the curriculum. Rather, a focal person is selected to attend then training and then disseminate the learning to their peers. As the excerpt below demonstrates:

> *"There has been one and another training on the same subject, but it has not been in general for all teachers, there have been 2 or 3 chosen by the school, who from themselves make replicas with everyone at school of what they heard there in the training, but we never had it like this for all teachers." (FGD, Teachers, Monapo)*

The full scope of the SRHR, SGBV and GE curriculum is uncertain however teachers did emphasize that preventing early marriage, unwanted pregnancy and sexually transmitted infections (STIs) was a strong focus of what was taught to girls. Prior to the pandemic, content was taught through lectures in classrooms, campaigns on local holidays that celebrate women and through play-based approaches such as skits. An interview with an education director in Nacaroa revealed that community radio has also been used in the past to disseminate key messaging on SRHR to adolescents and youth. Teachers shared that the pandemic has forced a restructuring of the school week and day to accommodate smaller class sizes and insinuated that these subjects may not be given the dedicated time in school that they were once given.

The most common types of action reported to be taken by schools to reduce SGBV in project sites are the provision of counselling support (85.00% compared to 94.12% in the comparison site) followed by providing easily accessible, child sensitive and confidential reporting mechanisms (35% compared to 11.76% in the comparison site). While teachers confirmed across all focus groups that they play a role in advising students about the risks of early marriage, there was little mention of school-based reporting mechanisms. Teachers who were aware of incidents of early marriage or violence where the perpetrator is a member of the family expressed that they did not report the case out of fear of reprisal from the parents. These responses align with the quantitative finding on the referral of SGBV cases, with only 17.5% of schools reporting the referral of cases to police and health services.

The school assessment revealed that 55% of project site schools (compared to 29.41% in the comparison site) report sexual and gender-based violence in their school and in the last 12 months, 6 schools handled reported cases of violence. Comments made by initiation matrons in the qualitative study alluded to sexual harassment/violence occurring in schools. However, these conflicts with girls' responses about schools being safe spaces in the community.

Table 18: Schools taking actions to reduce SGBV at school

Indicator	EGC Project Sites	EGC Comparison Sites
	n=33	n=17
	% (#)	% (#)
Schools taking actions to reduce SGBV at school in the past 12 months	**84.85 (28)**	**100 (11)**
Variables		
Action trained staff have taken to reduce SGBV		
Creating safe and welcoming spaces	22.50 (9)	5.88 (1)
Curriculum approaches to preventing violence and promoting gender equality	25.00 (10)	52.94 (9)
Providing easily accessible, child-sensitive and confidential reporting mechanisms	35.00 (14)	11.76 (2)
Referral to law enforcement and healthcare services.	17.50 (7)	11.76 (2)
Providing counselling and support	42.50 (17)	52.94 (9)
Ensuring governing bodies and school management send strong messages that SGBV is not acceptable and is taken seriously	17.50 (7)	23.53 (4)
Developing and implementing codes of conduct	15.00 (6)	41.18 (7)
None	0.00 (0)	0.00 (0)

1120 Improved capacity of public health, social welfare, and justice institutions to provide gender-responsive information, prevention, and response services for girls/young women vulnerable to SGBV and COVID-19

Indicator 1120.1: Public health, social welfare, and justice institutions providing gender-responsive information, prevention, and response services for girls/young women vulnerable to SGBV

Four types of facilities were assessed for their provision of gender-responsive information, prevention and response services for girls and young women who are vulnerable to SGBV. Presented below are the results of the health facility assessment. The findings from the assessment of gender-based violence units, social welfare departments and justice facilities are presented in Annex 7.

Health facilities (HFs) were classified as providing gender-responsive information, prevention and response services if they provided at least 20 gender sensitive services. Of the health facilities assessed, 12 were classified as gender sensitive in the project site and 2 in the comparison site.

Nineteen facilities reported providing services to adolescent girls and boys (10-19), single women and widows, but only 17 have both male and female service providers. Eleven facilities report that health personnel (including supervisors of service programs) receive training in gender sensitivity.

Twenty-two facilities handle sexual violence cases; however only 12 facilities report that service providers receive training on sexual violence or other forms of gender-based violence and only 13 facilities have protocols/guidelines for the management of rape victims/survivors. In terms of services offered for victims of SGBV, 14 facilities offer pregnancy-related services to patients after rape (e.g., emergency contraceptives, pregnancy tests, counselling/information); 13 facilities provide STI-related services to the

victims of rape (e.g., prophylactic treatment, sending swabs to lab to test for STIs, referrals); and 10 offer prophylactic treatments to victims of rape (e.g., emergency contraceptives, antimicrobial regimen, post-exposure hepatitis B vaccination).

Twenty-two facilities report that they are considerate of women's practical needs and priorities while providing services to women and 16 HFs report that health workers use gender-sensitive protocols for one-on-one counselling (e.g., non-discriminating language, two-way communication, equal attention to men & women in counselling sessions for couples, women or men can receive gender-specific service providers on request). While there was insufficient evidence from qualitative and quantitative data from girls in this baseline study, girls from Murrupula who participate in the LTGA shared experiences that conflict with the HFA results sharing that health centre workers are rude and insulting, that there is a lack of privacy during consultations, lack of hygiene and cleanliness at the hospital and that there should be water taps and washing facilities as well as toilets and benches for patients.

Table 19: Public health, social welfare, and justice institutions providing gender-responsive information, prevention, and response services for girls/young women vulnerable to SGBV

Indicator	EGC Project Sites	EGC Comparison Sites
Type of facilities assessed		
Health Facility	12/25	2/6
GBV Unit	3/7	-
Social Welfare Department	4/4	-
Justice Facility	2/7	-
Note: Annex 2: Criteria for Gender-Responsive Information, Prevention and Response Services for Girls and Young Women Vulnerable to SGBV Annex 6: Health Facility Assessment		

1210 Improved life skills and knowledge among girls and young women regarding their SRHR, economic and protection rights and equitable access to COVID-19 prevention, tests and, treatment services including vaccines

Indicator 1210.1: Girls and young women with knowledge and skills to prevent, mitigate, and respond to SGBV

While FGDs show a general lack or limited information about support services for gender-based violence among girls, the survey results suggest that at least half (51.7%) of respondents in project sites and a little less than half (49.36%) in comparison sites reported knowing when, how, and to whom to report if they see an incident of SGBV.

Table 20: Girls and young women with knowledge and skills to prevent, mitigate and respond to SGBV

Indicator	EGC Project Sites		EGC Comparison Sites	
	Girls 8-14 n=360	**Girls 15-24** n=524	**Girls 8-14** n=363	**Girls 15-24** n=571

	% (#)	% (#)	% (#)	% (#)
Girls and young women with knowledge and skills to prevent, mitigate, and respond to SGBV	45.3%(163)	56.1% (294)	44.6%(162)	52.4%(299)

Indicator 1210.2: Girls and young women with access to informal financial services (S4T)

Currently, the number of young women involved in savings clubs is low in both project and comparison sites at 8.4% and 8.58% respectively. Though membership is low, the majority of those who do participate are somewhat or very active in group activities in both project and comparisons sites.

Table 21: Girls and young women's participation in savings & credit groups by study area EGC baseline, 2022

Indicator	EGC Project Sites	EGC Comparison Sites
	Girls 15-24 n=524	**Girls 15-24** n=571
	% (#)	% (#)
Young women that participate in savings and/or credit groups.	8.4% (44)	8.58%(49)
Level of involvement	N=44	N=49
Somewhat or very active	95.45% (42)	95.92% (47)

Indicator 1310.1: Extent to which women's rights organizations and youth-rights organizations trained on GE and SGBV are able to advocate for the protection of the rights of girls/young women against HTP

The study found it difficult to identify organizations in the project area that were explicitly working on women's rights issues in a formalized fashion. To comment on this indicator, KIIs were conducted with female leaders of local civil society organizations in the project districts, including a savings group in Murrupula and a district service circle organization in Monapo.

CSOs, such as savings groups, support women informally by giving them access to mechanisms for control over resources and a safe space for conversation and advice. They are also instrumental in helping women in the community direct and control their resources. As evidenced by the quote below, they seek to be inclusive of women in the community, regardless of their financial situation.

> *"These girls sometimes give up, because they don't have the funds to come and deposit and we go to meet them, we talk, we try to understand what makes them give up so in the middle, so after they clarify their doubts or difficulties, that's where we take the same money from savings, we deliver according to that person's capacity" (KII, female savings group leader, Murrupula)*

Though the savings groups provide opportunities for women to share personal issues and experiences, the group leader noted that they do not engage in formal complaint or justice system processes. In this way, they provide an informal support system for women in the community but tend to not actively engage in formal advocacy activities.

"It is an association… they are sisters. After saving or before, we sit down and talk, each one explains what is happening to them, the one who thinks she has to talk, share with others, and get a solution or advice, a decision, yes." (KII, female savings group leader, Murrupula)

"We never get involved, we deal with someone from outside, we don't get involved, we just listen and leave it to the authority to do its work, many times we get involved in cases involving people who are in our group, oh yes there's been advice, there's been conversation, there's been sharing of that information." (KII, female savings group leader, Murrupula)

Though relatively few, there are semi-formal organizations within the districts that are working on women's rights and child protection issues, including Organização da Mulher Moçambicana (OMM) in Monapo, and the Comite de Protecção a Criança in Murrupula. These organizations conduct lectures and sensitization sessions around SRHR issues, with a primary focus on preventing early marriage and child welfare. They conduct their sessions in schools and communities, with both young people and caregivers. They have leadership structures and relationships with local authorities to advocate for the rights and welfare of girls and young women.

They also intervene in situations of domestic or gender-based violence (including early or forced marriage), and work with the district authorities to resolve them, alongside local leadership. Where possible, they try to resolve situations by removing the girl from the abusive situation and mediating amongst the parties. They will escalate a case to "command" if it has progressed beyond the point where that is possible, but they are not involved in the legal follow-up once it is part of the formal system.

"One of the biggest challenges that OMM has is the fight against early marriage, because our own community is complicit, they hide it, so this is one of the biggest challenges we have, because even if we go there and give the lectures to them, few adhere, then they, as the local leadership, end up not adhering, so the situation becomes complicated." (KII, female CSO leader, Monapo)

As highlighted in the quote above, one of the biggest challenges that OMM faces in its work is the deeply ingrained social norms and beliefs held in the community. This was supported by a KII conducted with the Comite de Protecção a Criança during the LTGA, who commented that parents are often the biggest barrier to girls exercising their rights and accessing services (LTGA, 2021). Further, although these more formal organizations tend to have good relationships with the government and local authorities, there does not seem to be much coordination amongst similar groups across districts.

1320 Enhanced capacity of men, boys, parents, community, and traditional and religious leaders to take action to end SGBV and discrimination of girls, including harmful aspects of initiation rites

Indicator 1320.3: Extent to which initiation matrons and masters are implementing improved practices [i.e., age-appropriate info, info/practices that promote women/girls' control over their own bodies, incorporate messages that promote gender equality in intimate relationships, etc.]

FGDs were conducted with Initiation matrons/masters across all three of the project districts to gain further insight into the current practices of the initiation rites, and to better understand how the project can help improve those practices towards promoting gender equality and protecting girls and young women.

The FGDs with initiation matrons/masters in all three districts, as well as those with community leaders, boys and girls, and most other groups surveyed, all mentioned that the rites are an extremely important community tradition with a long history and a great deal of cultural significance. At the same time, there is an acknowledgement by a variety of respondents that there are both positive and negative aspects to them. There seemed to be a consensus across all groups that rites should be continued in some form, with varying ideas on what changes could be made.

> *"In my opinion, initiation rites are a good idea, it's just that we didn't know how to take advantage of that ritual." (KII, female CSO leader, Monapo)*

Some of the negative, and potentially harmful, aspects of the rites highlighted by FGDs and KIIs with community leaders include the focus on marriage as the ultimate goal for girls, and that sex education centres on the pleasure of the man. Further, one female leader in Murrupula pointed out that due the cost of the rites (usually comprised of three phases for girls), they often come at the expense of paying for further education for girls. Initiation rites were cited as a contributing factor to early marriage by multiple female community leaders across districts.

There is still a lot of secrecy around the rites and what happens during them, which was a reoccurring theme amongst the FGDs with the young people. Adults interviewed as part of the baseline were generally more open to talking about the content of the rites, but amongst the young people, there was a hesitancy to reveal much about their personal experiences, which adds an additional layer of complexity to changing the rites, as talking about the content of the rites remains somewhat taboo in most communities, particularly for young people.

FGDs with matrons/masters across the three districts revealed that the rites have changed over time. For example, the circumcision of boys is now conducted in a hospital by a health technician rather than in the bush. Further, multiple FDGs and KIIs with community members mentioned that the age of initiation has trended down in recent years as many girls are now menstruating earlier, the length of time spent during the rites for boys has decreased, and increasingly, rites are held in private houses in communities, rather than in more isolated locations. The findings of the qualitative baseline suggest that one of the major changes to the girls' initiation rites over the years has been dividing them into three different phases comprised of 1) Counselling in the preparation for the menstrual phase, 2) Counselling in the respect for others and 3) Counselling for the sexual life of the girl in her home. For the boys there is only one phase: Counselling for life and circumcision.

Splitting the rites into three distinct phases was done in response to concerns that girls were learning inappropriate details about sex at too young an age. However, it is worth noting that boys' initiation is still conducted in only one phase, which means that they recieve all the information about sex around the age of 10 or even younger. The KIIs and FGDs with matrons/masters and male youth suggest that boys leave the rites ready and in need of sexual activity, highlighting a pervasive community belief and potential double-standard that places more responsibility on girls and young women for the delay of sexual activity and marriage.

From a child protection and rights perspective, there are multiple concerns with the more harmful aspects of the rites, though these have been slowly changing due to interventions from church and civil society. For example, the Catholic church allows families to have their children initiated through a "revised" version of the rites that are done in collaboration with the church. However, those who have undergone

this revised version are sometimes viewed by other community members as "not fully initiated", and this approach is not widely adopted (LTGA, 2021).

Some of the more violent and harmful aspects of initiation rites rituals that have been the target of reform efforts by child rights advocates and religious groups– and that warrant closer monitoring periodically throughout the project– include the following:

- Girls being forced to stand naked in front of many people (including male and female family members) while having their labia stretched
    - This practice is slowly changing, with "many families allowing the girls to wear shorts or panties and pull their labia with a very restricted group." (LTGA, 2021)
    - KIIs with both matrons and child protection staff showed that this practice still happens, and as noted in the quote above even the efforts at reform still include labial stretching, a degree of nudity and public exposure (albeit reduced).
- In the past girls were instructed how to clean sperm off a man's penis with a live demonstration involving a man from the community. Some studies even suggest that initiates were forced to have sex with this man (Bagnol, 2018). Local child rights groups indicate this practice has largely changed with initiation matrons doing demonstrations with an object instead, but due to the degree of secrecy around initiation rites some advocates remain concerned as to whether or not this aspect of the rites has fully ceased.
- The baseline FGDs with boys indicate that they are often beaten, tied up and insulted as part of the male initiation rites.
- Practices with serious implications on gendered power dynamics and girls' empowerment that require further investigation for an effective reform effort within the rites include:
    - Teaching male initiates that the man should ejaculate over the woman, and that this is primarily for women's pleasure
    - Teaching that emphasizes male pleasure as the focus of sexual activity at the expense of women's autonomy and pleasure
    - Teaching male initiates that they have an obligation to pay a woman after sex

The findings of the baseline study and the LTGA would suggest that while there are a number of potentially violent and harmful aspects of the initiation rites, there is also some adaptability, and that the rites are not static over time. This finding that is further supported by KIIs conducted with leaders of girls' initiation rites in Muzorone, Nacaroa during the Light-Touch Gender Assessment. They noted that some of the initiation rites matrons benefitted from knowledge about the harm caused to girls through practices that encourage the practice of the sexual act; they added to their initiation rites program incentives for the girls to continue with their studies and talk about the risks to girls involved with the early start of sexual activity. They recommended supporting initiation rites counselors with a child protection package and improved initiation practices to disseminate this practice in other communities, particularly the most rural and isolated. (LTGA, 2021)

4. Discussion & Recommendations

The following section is a discussion of the results of the quantitative and qualitative baseline results as they pertain to the project's outcomes. It will discuss their implications for project activities and also provides recommendations for both project implementation, as well as areas for further research and project evaluation.

4.1 Discussion

1100 Improved effectiveness of government protection institutions to deliver gender-responsive prevention, early intervention, protection, and response services related to SGBV and COVID-19 and discrimination of girls and young women

The baseline examined three main categories of government institutions: schools, health facilities, and social welfare and justice institutions.

The baseline results of the school assessments, when combined with the qualitative FGDs and KIIs with community stakeholders (teachers, matrons/masters, girls and young women, and caregivers) reveal a number of contradictions that merit further exploration and analysis. For instance, with regards to violence in schools, in the school assessments, 55% of project site schools report sexual and gender-based violence in their schools, and FGDs with initiation matrons mention violence taking place within the school environment. However, in the FGDs with girls and young women, schools were repeatedly mentioned as being as safe spaces for girls within the community. Furthermore, the FGDs with teachers indicate that more exploration is needed to assess teachers' knowledge of and comfort with SRHR and SGBV subject matter and curricula, despite the school assessments reporting relatively high levels of teacher training on the subjects. One reason for such a contradiction could be that school assessments were conducted with school heads/administrators, and thus do not necessarily reflect the realities of the teachers themselves.

The results of the baseline around public health services found that a relatively low number of married and unmarried girls and young women were seeking reproductive health care in the last 12 months. The LTGA supplemented this finding with FGDs with girls and young women reporting differing abilities to access health care based on their location, with distances to health centres being a major inhibiting factor in more remote project areas. They also highlighted the need for training in providing adolescent-friendly and gender-responsive services, with some girls reporting negative interactions with health facility staff. Further, baseline FGDs with girls and young women highlighted that there is still a stigma around unmarried young women accessing reproductive healthcare, which is supported by the quantitative results. This is also the case with mental health services, suggesting that there is a difference in the number of girls and young women who need or want to access services, and those who actually do.

Overall, a better understanding of referral pathways and links within the network of health services in the communities is needed to aid in the implementation of activities that seek to make health care more adolescent-friendly, gender-responsive, and accessible.

The results of the baseline for social welfare and justice institutions revealed that although these services exist within all three districts, there are varying degrees of access to the services. For example, not all GBV units handle the same types of cases, which has geographic implications for access to services, and understanding these nuances will be key for implementing project activities. Further, FGDs with girls and

young women found a general lack of awareness of, or at least a lack of ability to identify, services for SGBV support beyond health centres, which suggests that more awareness raising and outreach by these facilities is needed in the local communities.

Recommendations:

- Further explore violence in schools to better understand the contradictions highlighted as the project engages with schools in early implementation phase.
- Assess teachers' knowledge of and comfort with SRHR and SGBV curricula and gender-responsive protocols.
- Better understanding of SGBV, SRHR, and mental health services referral pathways and links to make health care more adolescent-friendly, gender-responsive, and accessible.
- Conduct training and sensitization on gender and child protection for health care workers.
- Ensure that geographic differences in accessibility are taken into account when implementing project activities related to health systems.

1200 Enhanced agency and decision-making of girls and young women to protect themselves from SGBV & COVID-19 and be active change agents in their communities

The findings of the baseline study with regards to the confidence of girls and young women to report cases of SGBV raises some contradictions between the quantitative and qualitative results which need further exploration. In the quantitative survey, girls and young women indicated that they knew who to report to and when, however in the FGDs, they were unable to name specific reporting procedures. This might indicate a lack of awareness, although the threats of intimidation and violence towards those who report SGBV which was raised in FGDs with community stakeholders, suggest this could also be due to a general community stigma around talking about and reporting acts of violence, particularly with formal reporting mechanisms. This is supported by the quantitative results which show generally low levels of willingness to report incidences of SGBV to duty bearers, and a higher degree of willingness to report to parents. KIIs and FGDs with community stakeholders suggest that caregivers are often unwilling to report to formal systems and prefer to deal with issues at informal/community level, which suggests a need for project activities that raise awareness amongst caregivers and provide sensitization on how to deal with SGBV and facilitate access to the available services. This also raises questions around how incidents of domestic/household violence are dealt with within the project site communities.

With regards to girls' and young women's decision-making, the quantitative and qualitative findings suggest that while they have some ability to influence important decisions, there is still a high degree of parental control, particularly when it comes to education, initiation rites, and marriage. Further, the study's KIIs and FGDs with community stakeholders highlight that in the project sites, decisions around those three topics are often interrelated and intertwined. Fewer than half of girls and young women report having a say in important decisions, though that number increases with age, with older girls reporting having more say in decisions that impact their health. In the FDGs with girls and young women, many highlighted their educational and career aspirations, though it appears that many do not have the autonomy in decision-making that would them to realize these goals. This highlights the need for further sensitization and awareness raising with caregivers.

Interestingly, when it comes to control over resources, KIIs with women leaders suggest that women do have a relatively high degree of control as to what to do with income that they themselves earn, although that amount tends to be relatively small as there are few income generating opportunities open to women apart from small-scale trade. The quantitative baseline results demonstrate that though their degree over control over resources increases with age, just over 50% of young women in the project sites report having some decision-making power over household assets and resources. The nuances around control over resources need to be investigated further, but these findings do highlight the need for project activities centred around income generating opportunities and savings groups for girls and young women. Further, a KII with the leader of a savings group highlighted how the groups can be a form of informal support for women in the community and would perhaps a good platform for further training around women's rights.

The baseline study found that girls and young women have relatively low levels of participation in collective action and advocacy groups, with slightly higher rates found in younger girls. That being said, those who were involved reported a relatively high degree of engagement with the groups and being in leadership positions. As the project implements activities such as girls' groups, it would be interesting to explore further how participation in these groups impacts those involved, and how it ties in with ideas and feelings of empowerment and agency. It would also be interesting to get a further geographic disaggregation of involvement in these types of groups to see the differences in participation, particularly in more remote communities. Understanding these nuances will be key for the project to ensure that the most isolated and vulnerable are included in these activities.

Recommendations:

- Sensitization and awareness raising with caregivers around SGBV and reporting mechanisms
- Unpack nuances around girls' and young women's control over resources (their "own" versus the household) to better support project activities dealing with income generation and savings groups
- Further exploration of how engagement in collective action and advocacy groups affects girls' and young women's ideas of empowerment and agency
- Better understand the geographic nuances of the project sites to ensure the most isolated and vulnerable girls and young women are able to participate in project activities

1300 Enhanced community support and systems that advance gender equality and girls and young women's agency, rights, and protection from SGBV and gender discrimination and mitigate secondary impacts of COVID-19

When comparing the results of the caregivers GEM survey to the qualitative findings, some contradictions immediately become apparent. For example, while most caregivers indicated that children should not remain silent when experiencing abuse, FGDs with teachers and community leaders suggest that parents are often reluctant to report and are one of the biggest barriers to ending harmful practices such as early marriage. The GEM survey and FGDs and KIIs with community stakeholders both revealed that rigid gender norms around women and men's roles in the community and household are still pervasive. While there are WROs and CSOs working on awareness raising and sensitization around women's rights and child protection, these findings suggest that there is more work to be done on this front. This would seem to confirm the need for more opportunities for caregivers and community members to engage in more meaningful dialogues and discussions, such as through the Men2Men and community dialogue groups.

The qualitative baseline findings confirmed that initiation rites are an important community tradition across all three districts, and further revealed the complexities of the practice and the way it is viewed by various community members. They also further revealed that the practice of initiation rites is not uniform or static across the districts. This suggests that when implementing activities related to the rites, project staff need to carefully consider these nuances to inform their strategies for implementing improvements. Findings from the LTGA revealed that at least some initiation rites matrons/masters are open to adapting their practices; however, this does need to be approached with respect and an understanding of the importance these rites play within the communities.

Qualitative data confirmed the LTGA findings regarding the notable lack of rights-based language or concepts within the initiation rites and among initiation rites masters/matrons. While there is evidence that facilitators are integrating newer messaging within the rites that encourages girls to stay in school and avoid premature marriage after the rites, when asked whether or not girls are told about their rights during the initiation (for example, over one's own body), one group of matrons could only cite rights in terms of the financial support women should expect from men they sleep with, and more importantly that women should not expect financial support from men they "pick up out on the street." (FDG, initiation matrons, Murrupula)

Qualitative baseline findings, as well as those of the LTGA, also confirm that one of the major changes to initiation rites practices over the years has been the separation of girls' rites into three distinct phases so that girls learn specific information on menstruation, respect for others, and the sexual life of the girl in their home. However, it is worth noting that male initiation rites continue to be conducted in just one phase (between the approximate ages of 8 and 12, and sometimes younger). KIIs and FGDs with initiation matrons/masters and male youth suggest that boys leave initiation ready and in need of sexual activity. While this insight requires more sensitive inquiry to better understand boys' experiences following initiation, it does highlight the potential double-standard being applied to the reform of initiation rites, placing higher responsibility on girls for the delay of sexual activity and marriage.

Recommendations:

- Ensure close coordination with WROs, CSOs, and other groups already conducting awareness-raising and sensitization activities in the communities during project implementation.
- Create opportunities and safe spaces for meaningful dialogues with a variety of community members, including men, religious and community leaders to challenge rigid gender roles.
- Careful consideration the nuances of the initiation rites across the districts is necessary to inform the implementation strategy for improved practices, identifying the key harmful elements to address and monitor in the social behaviour change communication (SBCC) strategy and mid and endline evaluations.
- More in-depth examination of the differences between male and female initiation rites, including any unconscious double-standards influencing the reform of initiation rites, with a view to exploring opportunities to challenge discourse that places greater burden on girls for sexual abstinence and avoiding pregnancy.

4.2 CeCAGe-UEM Overall Project Recommendations emerging from this Baseline study include:

1. **Design strategies to address the barriers and constraints to adolescent SRHR:**

Work with government regarding initiation ages for girls and boys, work with community leaders and influential persons involved in initiation rites, sensitize education professionals on SGBV and SRHR, address girls' access to education, empower school councils and strengthen communication between teachers and parents. Ensure that rural vs. urban needs are accounted for and project interventions targeted to account for geographic areas of greater need.

2. Multi-sectoral initiatives targeting the enhancement of SRHR and addressing GBV:

Ensure GBV prevention and response including reporting and referral pathways and girls' capacity to report, GBV case resolution forums in media, GBV resolution facilities, integrate SRHR and GBV into education curricula, use mass media for SRHR and GBV issues, support continued education for girls and promote self-employment and entrepreneurship initiatives, and ensure child protection with a particular emphasis on children who are orphaned.

3. **Apply gender assessment information and analysis throughout the project cycle:**

Address the needs and rights of the most vulnerable within the target group, strengthen the Attendance Offices for GBV in enhanced services for adolescents, follow up on GBV cases processed in the formal and informal systems.

4. Strengthen the capacity of counterparts and partners for Conflict Resolution:

Build community capacity to support conflict resolution in formal and informal systems and supervise mobile trials.

4.3 Project Evaluation Recommendations

The following are recommendations for improving the quality of the project's evaluation activities and will help ensure that high quality data is captured to more deeply understand the changes in the three districts over the lifespan of the project.

- Develop a pool of local Macua – Portuguese translators, and conduct further orientation and training with them ahead of any future qualitative data collection.
- As a part of any future data collection training, conduct exercises with facilitators and translators about the nuances of language to ensure a common understanding of key concepts (e.g., agency, empowerment, etc.).
- Time any data collection to avoid the rainy season, school closures, holidays, and any other events that might disrupt the process.
- Conduct a full thematic coding of the qualitative data to provide further insights.
- Conduct further geographic disaggregation and analysis of the data to provide deeper insight into the differences between and within the project districts.

4.4 Conclusion

Overall, the quantitative and qualitative baseline study conducted for Every Girl Can revealed critical information and important findings for each of the three major pillars of the project. This information will aid the project's ability to monitor and evaluate its outcomes over time, and will also form an important

knowledge base to guide the modification of activities based on context and findings during project implementation and detailed annual activity planning.

As the project continues to engage with these findings and further explore the areas recommended above, EGC will be well-positioned to meaningfully contribute to the project's ultimate outcome of improved gender equality and realization of adolescent girls and young women's (aged 8-24) rights to live free of sexual and gender-based violence and discrimination in Monapo, Murrupula, and Nacaroa districts in Nampula province.

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6. Annexes

Annex 1: Summary of Baseline Indicators

Annex 1 - Summary of Baseline Indicators.

Annex 2: Criteria for Gender-Responsive Information, Prevention and Response Services for Girls and Young Women Vulnerable to SGBV

Annex 2 - Criteria for gender responsive inf

Annex 3: Girls & Young Women's Survey – Full Results

Annex 3 - Girls & Young Women's Surv

Annex 4: Caregiver Survey and Results

Annex 4 - Caregiver Survey - Full Results.c

Annex 5: School Facility Assessment

Annex 5 - School Facility Assessment.dc

Annex 6: Health Facility Assessment

Annex 6 - Health Facility Assessment.dc

Annex 7: Facility Assessment Report

Annex 7 - Facility Assessment Report.dc

Annex 8: List of Facilities Assessed

Annex 8 - List of Health Facilities and S

Annex 9: Profile of UEM Researchers & Roles

Annex 9 - Profile of CeCAGe-UEM Researc

Annex 10: EGC Performance Measurement Framework with Targets

Annex 10 - EGC-PMF_with Target