PATHFINDER INTERNATIONAL TECHNICAL BRIEF

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MULTISECTORAL RESPONSES TO GENDER-BASED VIOLENCE IN MOZAMBIQUE

Gender-based violence (GBV) is both pervasive and widely accepted in Mozambique. The complex and multifaceted structural and sociocultural factors that underlie and reinforce GBV warrant a strong multi-level and multisectoral response. Since 2010, Pathfinder International has pioneered the implementation of multisectoral approaches to GBV prevention and response in Mozambique across two projects: the "Enhancing Reproductive Rights to Reduce Violence against Women in Gaza Province" project (2010–2013), funded by the UN Trust Fund to End Violence against Women; and the "Enhancing Sexual and Reproductive Health and Rights of Women and Youth in Mozambique: Integrating Comprehensive GBV Services and Support and Safe Abortion Care in Inhambane and Gaza Provinces" project (2011–2013), funded by the Royal Norwegian Embassy. This technical brief offers a critical analysis of the projects' shared strategy and implementation experience, and discusses lessons learned and next steps for Pathfinder's GBV programming in Mozambique.

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UNITED NATIONS TRUST FUND TO END VIOLENCE AGAINST WOMEN

UN WOMEN
United Nations Entity for Gender Equality and the Empowerment of Women

EMBAIXADA DA NORUEGA

Context

Gender-based violence (GBV) is defined as "an umbrella term for any act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females."[1] Acts constituting GBV include intimate partner, sexual, and emotional violence, as well as harmful traditional practices, including female genital cutting and early marriage.* GBV is correlated with myriad adverse health outcomes including: unintended pregnancy; depression; substance abuse; sexually transmitted infections (STIs), including HIV; and maternal and child mortality.[2]

In Mozambique, one in three women aged 15–49 report having experienced physical violence since the age of 15, citing the husband or intimate partner as the perpetrator in 62 percent of these cases, and 12 percent of women report having experienced sexual violence since the age of 15.[3] Given the pervasiveness of stigma and underreporting, the actual prevalence of violence is likely much higher. Of equal concern is the widespread tolerance and acceptance of GBV, reflected in the fact that nearly one-third of women believe a husband is justified in beating his wife.[4]

Although widespread, GBV has historically been viewed as a private family matter in Mozambique and only recently started to gain recognition as a public health and human rights issue. Global momentum following the 1995 Beijing Platform for Action and the World March of Women in 2000 spurred a groundswell of Mozambican civil society organizations and activists to consolidate efforts to advocate for a national law on domestic violence. In the last five years, the government has demonstrated increasing commitment to combating GBV and protecting the rights of survivors, as evidenced by a number of recent laws and policies.†

The establishment of Cabinets of Assistance to Women and Children Victims of Violence (CAWCVVs) represents one of the most significant national initiatives for mounting a GBV response.[5] Overseen by the Ministry of the Interior and usually staffed by female police officers, CAWCVVs are private areas for survivors to report cases and are located either within police stations (cabinets) or in standalone buildings called "model cabinets." While a progressive step, CAWCVVs have been unable to offer survivors a comprehensive package of services (e.g., police services are available but with limited legal assistance, and with no connection to the various health services a survivor may require), subjecting survivors to the trauma of reliving their experience as they repeat their case at multiple service entry points, and leaving survivors without access to essential treatment, care, and support. This is particularly problematic given that the collection of forensic evidence and provision of many clinical services is time-sensitive (e.g., post-exposure prophylaxis [PEP] for HIV and STIs must be administered within 72 hours of exposure and emergency contraception [EC] within 120 hours of sexual intercourse).

Strategy Design

GBV is a multifaceted and complex issue, and efforts to prevent and respond to it require a comprehensive approach. Primary and secondary prevention are useful constructs for categorizing efforts to prevent and respond to GBV. As these terms carry slightly different meanings within the context of GBV, definitions are provided in the text box to the right.

Definitions of primary and secondary prevention in the context of GBV prevention and response:

- **PRIMARY PREVENTION:** Efforts to enhance the protective factors that prevent GBV (e.g., deconstructing harmful gender norms, education, gender equality, and non-violent conflict resolution)
- **SECONDARY PREVENTION:** Interventions that aim to moderate the immediate effects of GBV (i.e., a package of clinical services including provision of PEP for HIV and STI prevention and provision of emergency contraception, treatment of injuries, temporary shelter, forensic evidence collection where feasible, and psychosocial, police, and legal support)

A growing body of global evidence demonstrates the effectiveness of multisectoral approaches to GBV.[6,7,8] Multisectoral approaches seek to coordinate or co-locate the often disparate secondary prevention services that a GBV survivor may require (e.g., legal, psychosocial, health, and police services), thereby increasing the accessibility and availability of services, and diminishing re-victimization by reducing the need for survivors to re-tell their experience at multiple service entry points. Two widely accepted modalities for secondary prevention within a multisectoral model include: the "one-stop center" (OSC), touted as the gold standard for addressing the needs of GBV survivors,[9,10] where clinical services are co-located with police, legal, and psychosocial support services; and the "integrated services model"

* While GBV refers to violence perpetrated against women and girls as well as men and boys, and evidence on GBV perpetrated against men and boys globally has increased in recent years, this technical brief focuses on interventions to address women's and girls' experience of GBV in Mozambique. † Key laws and policies include: the 2009 Law against Domestic Violence, the National Plan to Prevent and Combat Violence against Women (2008–2012), the National Plan for the Advancement of Women (2010–2014), the Guidelines for Integrated Assistance to GBV Victims (2011), and the Multisectoral Mechanism for Integrated Assistance to Women Victims of Violence (2012).

where clinical services for GBV survivors are integrated into existing health services, and connected through referrals to appropriate police, psychosocial, shelter, and legal aid support. Ideally, a multisectoral approach also includes primary prevention, but in many settings the focus has been more on secondary prevention.

Pathfinder International employed a multisectoral model when designing the implementation strategy for two projects in Gaza and Inhambane provinces.[¥] Rather than addressing discrete underlying risk factors for GBV in isolation or strengthening single-sector secondary prevention services, Pathfinder's multisectoral model married essential primary and secondary prevention efforts with salient services from relevant sectors (e.g., legal, health, and police) into an overarching, holistic strategy that is responsive to the manifold needs of survivors.

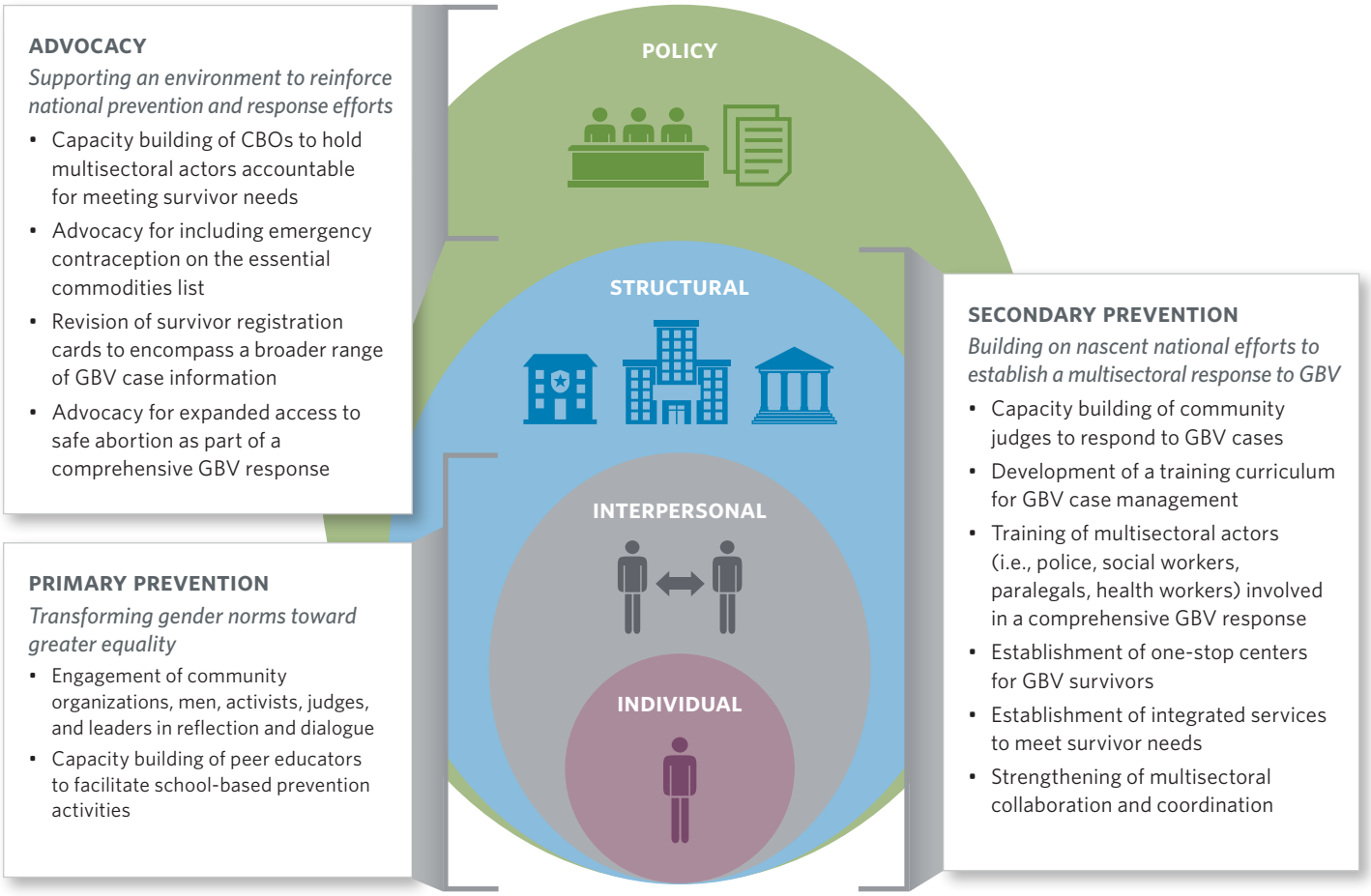
As illustrated in Figure 1, the projects' strategy included: primary prevention efforts (working with different community-based organizations [CBOs], leaders, and actors, as well as engaging youth in schools to transform harmful norms and foster gender equality); secondary prevention efforts (building on nascent national efforts to establish a multisectoral GBV response); and working with national coalitions, CBOs, and women's rights organizations to conduct sustained advocacy for a supportive and enabling environment to reinforce GBV prevention and response efforts.

Implementation

Primary prevention

Gender norms are learned behaviors emulated by individuals as a result of the gendered dynamics and practices that they are

FIGURE 1: KEY COMPONENTS OF THE PROJECTS' MULTISECTORAL APPROACH TO GBV PREVENTION AND RESPONSE



¥ The two projects were: (1) "Enhancing Reproductive Rights to Reduce Violence against Women in Gaza Province" (2010–2013), and (2) "Enhancing Sexual and Reproductive Health and Rights of Women and Youth in Mozambique: Integrating Comprehensive GBV Services and Support and Safe Abortion Care in Inhambane Province" (2011–2013). The strategy components discussed herein are common across both projects and so individual project names will not be referenced.

PHOTO: Vicente Telles

Audience member participating in community theater in Xai Xai market. The theater uses a participatory technique with audience members encouraged to interact with the actors to spur discussion.

socialized to accept as normal. Harmful gender norms perpetuate acceptance and tolerance of GBV. Under both projects, Pathfinder designed primary prevention interventions to challenge these deeply entrenched gender norms and foster greater gender equality by working with communities, students in secondary schools, men, and community judges.

COMMUNITY ENGAGEMENT

To develop relevant primary prevention interventions, Pathfinder facilitated a mapping exercise with 22 male and 14 female local leaders to identify the drivers of GBV within project catchment areas. Using information garnered from this exercise, as well as findings from the population-based baseline assessment, Pathfinder developed a training manual for CBOs, community activists, community health workers (CHWs), and CHW supervisors. This manual covered: gender; GBV; sexual and reproductive health and rights; relevant Mozambican GBV laws; male engagement; the role of the community in facilitating or mitigating GBV; and how and where to refer survivors for care and support. Following training, CBOs, activists, and CHWs led one-on-one and group mobilization and sensitization sessions, fostering opportunities for dialogue and self-reflection with more than 75,000 individuals.

SCHOOL-BASED PREVENTION

Recognizing the importance of shifting attitudes surrounding gender norms and GBV at an early age, both projects built the capacity of CBOs to recruit and train peer educators who then led school-based activities exploring gender norms within 15 secondary schools (9 in Gaza and 6 in Inhambane). Following training, peer educators developed action plans with interventions of their own design (e.g., theater performances, video screenings, debates, health fairs, and sport competitions) to increase their peers' knowledge and understanding of sexual and reproductive health and rights, gender, GBV, and services available for survivors. School-based activities were overseen by teachers and school administrators in partnership with local youth associations, and peer educators had more than 55,000 contacts with students.

ENGAGING MEN

Recognizing that men—especially male community leaders—play an important role in safeguarding sociocultural norms and values, Pathfinder supported CBOs to engage male community leaders in discussion and dialogue, and collective and self-reflection on gender norms and GBV. These discussions helped to inform intervention design, including the utilization of specific spaces where large concentrations of men congregate (e.g., community forums, garages, and repair shops) as opportunities for street theater performances and broader discussions about gender and GBV.

Pathfinder also built the capacity of 161 community judges (52 from Inhambane and 109 from Gaza) to support survivors, shift gender norms, and advocate for the elimination of GBV within their communities. Pathfinder engaged judges in activist trainings and discussion forums that covered the range of acts that constitute GBV, the harmful effects of GBV, and the broader consequences of GBV not only for survivors, but also for families and communities. In doing so, the projects aimed to embolden community judges to speak out against gender inequality and break the silence surrounding GBV.

Findings from the population-based endline assessment from the project in Gaza revealed a significant increase in gender-equitable attitudes and norms following the interventions. The assessment used an adapted version of the gender-equitable men scale[§] to explore attitudes pertaining to equity, joint household decision making, and non-violent conflict resolution. The total gender-equitable men score increased from 27.7 at baseline to 46.2 at endline (out of a range from 1 [low equity] to 72 [high equity]), and increased across all demographic variables (i.e., age, religion, marital status, education).

Secondary prevention

To develop a comprehensive multisectoral response to GBV, Pathfinder strengthened the capacity of communities and the legal, police, and health sectors to address the manifold needs of survivors. Pathfinder also integrated clinical services for GBV survivors into other health services and built on nascent national efforts, such as the CAWCVV model, to establish OSCs.

[§] The gender-equitable men scale was originally developed in 2008 by Julie Pulerwitz of Population Council/PATH and Gary Barker of Instituto Promundo. Using a 24-item scale, it assesses gender attitudes and norms using concepts such as sexual and reproductive health, violence, and women's roles and responsibilities. See: *Measuring attitudes towards gender norms among young men in Brazil: Development and psychometric evaluation of the GEM Scale.*

COMMUNITY RESPONSE

As aforementioned, Pathfinder engaged community judges to strengthen both primary and secondary prevention of GBV at the community level. Wielding significant influence in their communities, these judges operate within informal community courts that have historically prioritized restoring the relationship between the perpetrator and the survivor over pursuing punitive action. Pathfinder built the capacity of these judges not only to speak out against the perpetration of GBV, but also to apply relevant GBV laws when adjudicating cases brought before them and to refer cases to the formal court system as necessary. The projects trained judges on the application of laws against GBV, the flow of GBV cases through the judicial system, and processes for referring GBV survivors to additional services.

In addition to these trainings, community judges participated in bi-monthly technical update meetings during which community court competencies were clarified and specific laws surrounding GBV were analyzed and applied to case studies. Observational evidence from CBOs and police cabinets suggests an increase in the proportion of GBV cases reported to the police via community judges over the course of implementation. Reflecting the judges' growing willingness to refer cases, a special form was introduced in Xai Xai City to monitor cases referred by community judges toward the end of the projects.

BUILDING MULTISECTORAL PROVIDER CAPACITY

Strengthening and at times establishing multisectoral services for GBV survivors began with the training of providers across legal, police, social affairs, and health sectors. Pathfinder adapted the existing Ministry of Health (MOH) GBV training curriculum to make it relevant for providers across multiple sectors, and trained 97 paralegals, 183 police officers, and 145 health providers from diverse cadres on: psychosocial support for GBV survivors; gender inequality issues within a human rights framework; implications of the Domestic Law on Violence against Women; and GBV case management. As was the case for training community actors for primary prevention, participatory methodologies were again utilized to engage participants in collective and self-reflection on their knowledge, attitudes, and perceptions of gender inequality and GBV.

In addition to the multisectoral provider training, Pathfinder facilitated a supplementary training specifically for health providers that reinforced clinical skills for providing quality services to GBV survivors and the provision of an integrated package of clinical services with multisectoral referral linkages.

ESTABLISHING OSCs AND INTEGRATED SERVICES

In line with the MOH's commitment to promoting a comprehensive response to GBV, Pathfinder built on the CAWCVV concept to establish the country's first OSC at Chokwe rural hospital in Gaza. Not only are OSCs the gold standard for GBV response, but their visibility also publicly signifies the government's stance against GBV, elevates public awareness of the severity of GBV, and helps to shift the perception of GBV from a private family issue to a matter of public concern. This initial OSC was well received by other multisectoral actors—in particular, the police—and services provided to GBV survivors at the rural hospital in Chokwe were found to be of high quality according to an assessment carried out by staff from the Gaza Provincial Directorate of Health.

In collaboration with the Provincial and District Directorates of Health and Social Welfare, the Provincial Directorates of Women and Social Affairs, the Provincial Directorate of Justice in Gaza and Inhambane, the police, and health facility administrators, Pathfinder established a total of five OSCs (three in Gaza and two in Inhambane) throughout the course of the two projects' lifecycles. In addition, Pathfinder supported facilities with OSCs to integrate services in the maternity and emergency wards, given that survivors frequently access these service delivery entry points. The projects also supported one additional rural hospital in Gaza with no OSC to integrate GBV services. Pathfinder then collaborated with the health, legal, police, and social sectors to strengthen the multisectoral referral network and fortify the linkages among these sectors, as well as among the various entry points that a survivor might access (e.g., community support structures, CHWs, peer educators, and CBOs).

Dr. Momade Correia, medical doctor at the Provincial Hospital of Xai Xai (Gaza Province) and GBV focal point

PHOTO: Estrella Alcalde

MULTISECTORAL COORDINATION

To foster coordination of the multiple sectors involved in the GBV response, Pathfinder supported the establishment of Multisectoral Committees responsible for providing oversight for the planning, implementation, and monitoring of OSCs. Committees were composed of representatives from health facilities, the justice sector, government stakeholders, and CBOs. Participation increased over time and the meetings became a crucial forum for: monitoring the progress of multisectoral responses to GBV; disseminating learning from project implementation; collaborating and coordinating across sectors and stakeholders; and building the knowledge base surrounding GBV laws and policies. The perceived importance of the committees also grew over time, evidenced by the fact that in Gaza, the chair facilitation role transitioned from Pathfinder to the Provincial Directorate of Women and Social Action in 2013. In addition, Pathfinder disseminated among relevant stakeholders the National Multisectoral Mechanism—a document approved by the Council of Ministers in 2012 that describes each sector's roles and responsibilities, clarifies the flow of services between sectors, and outlines strategies for multisectoral collaboration.

The projects' robust approach to primary prevention resulted in noteworthy attitudinal shifts surrounding sexual violence.

Advocacy

To foster a sustainable enabling environment for preventing and responding to GBV, Pathfinder pursued a strong advocacy agenda to underpin its multisectoral model. Both projects collaborated with local legal and human rights organizations to build the capacity of CBOs to advocate for sexual and reproductive health and rights, the elimination of GBV, and the need for comprehensive care and support services for survivors. The CBOs then conducted advocacy events addressing a wide variety of influencing actors (e.g., government bodies, churches, traditional healers, media, and the private sector). These events disseminated information about the Domestic Violence Law, highlighted cases in which laws surrounding GBV were not implemented appropriately, advocated for judicial redress of cases where gaps in the justice system did not fully protect the rights of the survivor, and pressured the justice system to increase community-based services and other forms of retribution for perpetrators.

CBOs also assumed the role of 'watchdogs,' ensuring that health facilities, police, paralegals, and community courts were meeting the needs of GBV survivors. For example, project-supported CBOs reported to the government that some health facilities were denying assistance to GBV survivors who presented without a police report. As a result, an internal memo was sent by the MOH to the provinces to clarify that health services are appropriate initial entry points for GBV survivors, regardless of whether the survivor has reported the case to the police.

Through both projects, Pathfinder worked with the MOH to improve the accuracy of reporting by revising survivor registration cards at health facilities and OSCs to allow for reporting of specific types of GBV (moving beyond collection of data on sexual violence only), and also revising the CAWCVV reporting form to allow for the collection of age-disaggregated data. Pathfinder also successfully advocated for the addition of One-Dose Sekure (a dedicated product for emergency contraception) to the MOH's list of essential commodities. This was a significant achievement given the importance of ensuring access to EC as part of a comprehensive clinical service package for survivors. Finally, recognizing that access to safe abortion is an essential component of a comprehensive GBV prevention and response effort, Pathfinder worked with frontline advocates through the national Sexual and Reproductive Rights Coalition to advocate for greater access to safe abortion and to ensure recognition of women's and adolescents' rights to live lives free of violence.**

Lessons Learned

Pathfinder's experience pioneering a multisectoral approach to primary and secondary prevention of GBV demonstrates both the need for and the challenges inherent in preventing and responding to GBV in Mozambique, and raises important questions for further consideration.

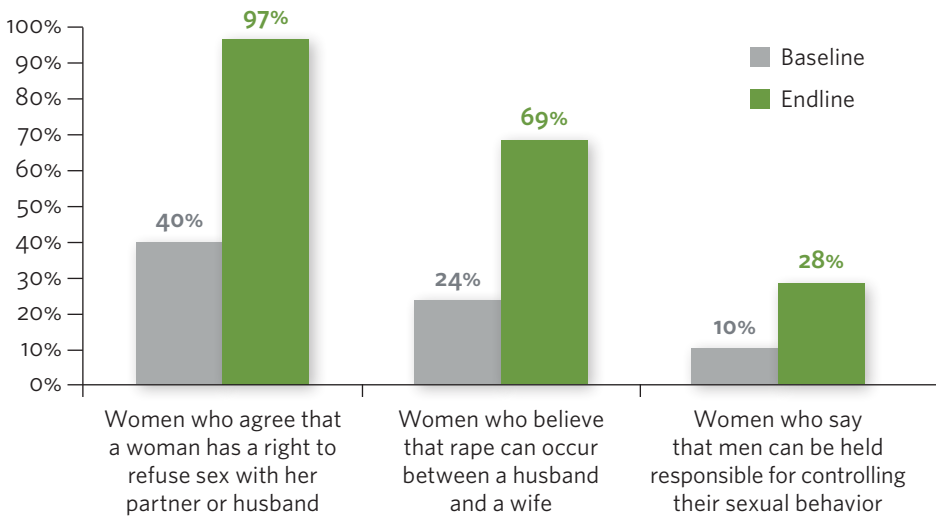
As shown in Figure 2, the projects' robust approach to primary prevention resulted in noteworthy attitudinal shifts surrounding sexual violence. For example, the proportion of women who believe that a woman has a right to refuse sex, that rape can occur between a husband and wife, and that men can be held responsible for controlling their sexual behavior increased from baseline in 2011 to endline in 2013. These substantial shifts are particularly notable given the short timeframe during which they occurred. Despite these positive findings, challenges remain in changing attitudes and norms pertaining to the acceptability of non-sexual physical violence. In fact, the endline study revealed a negative increase in the proportion of female respondents who believe that a man is justified in beating his wife under certain circumstances (from 51 percent at baseline to 62 percent at endline). This finding may reflect the widely held perception that GBV is confined to sexual violence, as well as the deeply entrenched acceptance of physical violence in Mozambique.

** The Coalition's sustained advocacy contributed to a revision to the Mozambican penal code broadening the conditions under which abortion is allowed and expanding availability of safe abortion services to lower-level facilities. The penal code revision was approved by parliament in July 2014 and was signed into law by the president on December 18, 2014.

Disaggregating the data by age, religion, and marital status also revealed notable and conflicting findings. For instance, the proportion of female respondents who believe a man can be held responsible for controlling his sexual behavior increased three-fold (from 11 to 36 percent) among 45–49-year-olds, but increased by just 2 percent (from 20 to 22 percent) among 15–19-year-olds. Similarly, the endline assessment revealed conflicting shifts in attitudes among Muslim women as compared with Catholic and Protestant women. These differences underscore that gender is not just about women and men; rather, it is about the complex intersectionality of various sub-components of identity (e.g., religion, age, socioeconomic status, education) that affect power dynamics, and the social norms, attitudes, and perceptions that perpetuate GBV. These findings suggest that more intentional and greater coverage of primary prevention is essential, and that discussions and dialogue about GBV should be grounded in exploration of power dynamics so that people are better able to understand the links between gender norms and GBV.

With regard to secondary prevention, while 5,985 survivors accessed services through a project-supported service delivery point, just 264 presented at the OSCs. This disproportionate uptake of services at other project-supported service delivery points can be partially attributed to the fact that OSCs were established incrementally throughout the lifecycles of the two projects and thus were not fully operational for the duration of the projects. Additionally, widespread flooding in early 2013 caused OSCs in Gaza province to close for five months. Keeping these extenuating circumstances in mind, a supplementary review of Pathfinder's implementation experience offers additional explanations for the observed underutilization of OSCs and their attenuated effects.

FIGURE 2: SELECT BASELINE AND ENDLINE INDICATORS



While it was envisaged that OSCs would have extended operating hours, in practice, they followed the schedule for non-emergency services and were only open from 7:30 a.m. until 3:30 p.m. Given this narrow window of time, it is reasonable to assume that some survivors sought services at other times in the day and found the centers closed. Another consideration is the feasibility of stationing health workers at OSCs given severe health worker shortages. Mozambique ranks 163rd out of 175 countries for health worker density[11] and the shortage of health workers posed a nearly insurmountable challenge to ensuring consistent health worker staffing at OSCs. Given shortages, the standard practice at OSCs was for the police officers, social workers, and/or psychologists who were consistently available at OSCs to call the health provider when a survivor presented for care and treatment. Notably, a much larger and more consistent flow of survivors accessed treatment via the integrated services available in the maternity and emergency wards of the hospitals where OSCs were located, suggesting that survivors were able to access the facility itself, but were bypassing the OSC or alternatively, sought services when OSCs were closed (integrated services followed an extended timetable). Finally, the fact that OSCs are standalone, well-marked sites may have undermined survivors' confidence that they would be able to confidentially access services at OSCs, thereby deterring them from seeking services. These issues were further exacerbated by challenges with collecting accurate data—particularly given the added complexity of tracing referrals across multiple sectors.

A final contextual factor to consider is that health workers are not commonly perceived as a source of support for GBV survivors in Mozambique. In fact, the baseline survey from the project in Gaza found that just 2 percent of respondents mentioned a health worker as someone who could help women who experience violence.†† Project data corroborated this; a much larger proportion of women sought services from police cabinets than from health facilities. While health workers are currently gaining ground as an acknowledged source of support for GBV survivors, a general disinclination to seek services from a health worker could also be an explanatory factor for underutilization of services at OSCs as all of them were located in a health facility.

†† Most commonly, respondents mentioned family members (78%), community leaders (43%), police (26%), and friends (21%) as sources of support for women who experience violence.

Next Steps

Pathfinder is currently implementing the "Bolstering Multisectoral Action to Address Gender-based Violence and Advance Sexual and Reproductive Health and Rights" project (2014–2017). Under this subsequent phase of programming funded by the Royal Norwegian Embassy, Pathfinder is utilizing lessons learned from its previous two projects to inform program design. Given the challenges associated with the OSCs, Pathfinder is now investing more heavily in the integrated services model and is also expanding beyond hospitals to integrate services at lower-level, peripheral facilities to increase accessibility of services. At the same time, Pathfinder is strengthening the functionality of existing OSCs. For example, in hospitals that house OSCs, Pathfinder is supporting the introduction of active screening for GBV at other service delivery points to facilitate internal referrals of survivors to the OSCs.

Pathfinder is also assessing the feasibility of supporting additional training on violence against children for psychologists and social workers who currently staff the OSCs.

Project data show that a significant proportion of cases at OSCs involve sexual violence of children and providers currently do not feel prepared to appropriately handle these cases. Pathfinder is exploring potential partnerships with organizations that support orphans and vulnerable children to complement existing efforts to reach young survivors of violence.

Finally, recognizing that a significant proportion of survivors initially access services at police cabinets, Pathfinder is also addressing access barriers to EC by working to make One-Dose Sekure available at the CAWCVVs (given the short timeframe for efficacy). Laws preventing non-health providers from dispensing EC have hindered these efforts; however, Pathfinder continues to discuss this issue with relevant authorities.

Through the "Bolstering Multisectoral Action to Address Gender-based Violence and Advance Sexual and Reproductive Health and Rights" project, Pathfinder is expanding the multisectoral approach to primary and secondary prevention of GBV to Maputo and Cabo Delgado provinces. As this project progresses, Pathfinder will continue to routinely assess implementation experience to evaluate relevance and impact, with the goal of contributing to the global evidence base and informing GBV response and prevention efforts.

ENDNOTES

(1) UN Inter-agency Standing Committee, *Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies* (2005). **(2)** Population Reference Bureau, Gender-based Violence: *Impediment to Reproductive Health* (USAID/Interagency Gender Working Group, 2010). **(3)** Moçambique Inquérito Ministerio da Saude (MISAU), Instituto Nacional de Estatística (INE), and ICF International (ICFI), *Demográfico e de Saúde 2011* (Calverton, MD: MISAU, INE, and ICFI, 2012). **(4)** Ibid. **(5)** A. Rock, *National Response Efforts to Address Sexual Violence and Exploitation against Children in Mozambique: A Desktop Study* (Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1, 2013). **(6)** *WHO Multi-country Study on Women's Health and Domestic Violence against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses* (Geneva: WHO, 2005). **(7)** E. Fulu, A. Kerr-Wilson, and J. Lang, "Effectiveness of interventions to prevent violence against women and girls: A summary of the evidence" in *What Works to Prevent Violence* (UK Aid, Sexual Violence Research Initiative: 2014). **(8)** J. Keesbury, et al., *Comprehensive Responses to Sexual Violence in East and Southern Africa: Lessons Learned from Implementation* (Lusaka: Population Council, 2011). **(9)** J. Keesbury, et al., *A Review and Evaluation of Multi-sectoral Response Services (One-Stop Centers) for Gender-based Violence in Kenya and Zambia* (Nairobi: Population Council, 2012). **(10)** CARE, "One-stop Model of Support for Survivors of Gender-based Violence: Lessons from Care Zambia" (CARE, 2013). **(11)** WHO, "World Health Statistics 2014: Part III Global Health Indicators" (Geneva: WHO, 2014).

ABOUT THE PROGRAMS: Funded by the UN Trust Fund to End Violence against Women, the "Enhancing Reproductive Rights to Reduce Violence against Women in Gaza Province" project (2010–2013) aimed to build the capacity of the government, multisectoral actors, and civil society organizations to prevent and respond to violence against women in a coordinated manner in Gaza Province. Funded by the Royal Norwegian Embassy, the "Enhancing Sexual and Reproductive Health and Rights of Women and Youth in Mozambique: Integrating Comprehensive GBV Services and Support and Safe Abortion Care in Inhambane and Gaza Provinces" project (2011–2013) focused on integrating high-quality, youth-friendly safe abortion care services into a comprehensive GBV prevention and response in four sites in Gaza and Inhambane Provinces.

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COVER: Police officers associated with the Cabinet of Assistance to Women and Children Victims of Violence (Inhambane province) PHOTO: Estrella Alcalde