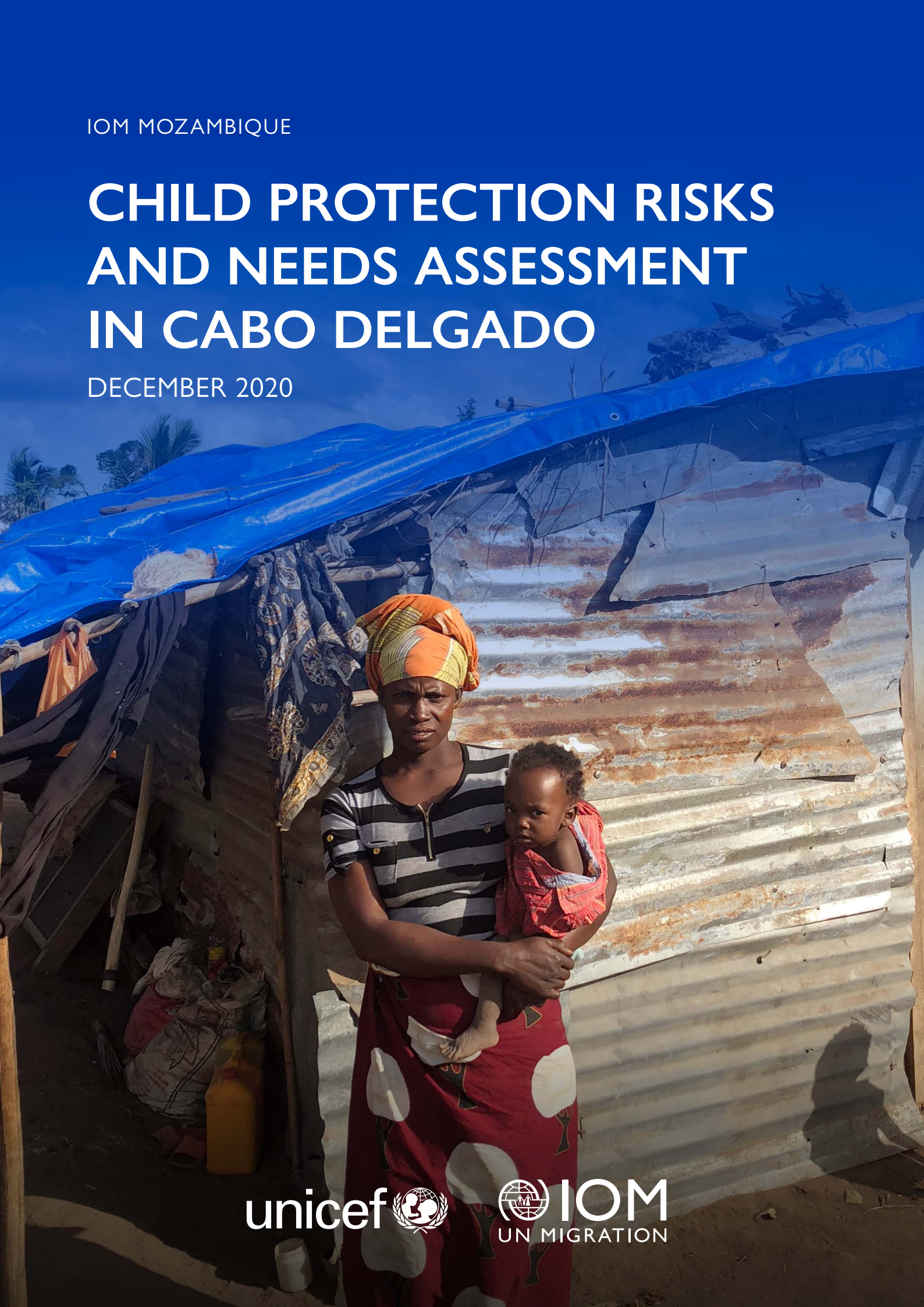
IOM MOZAMBIQUE

CHILD PROTECTION RISKS AND NEEDS ASSESSMENT IN CABO DELGADO

DECEMBER 2020



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EXECUTIVE SUMMARY

OBJECTIVE OF THE ASSESSMENT

The assessment aims to provide an evidence base for protection and child protection (CP) risks and needs in Cabo Delgado to inform humanitarian planning and to advocate for increased funding in addressing and mitigating the risks.

CONTEXT

The humanitarian situation in Cabo Delgado has rapidly deteriorated in the first six months of 2020 due to an increase in violent attacks and insecurity, leading to a significant increase in displacement across the province and a consequent rise in protection risks for the most vulnerable people – including both those displaced and those who remained in insecure areas.

According to the DTM baseline assessment (December 2020), the current situation resulted in the **displacement** of 669,256 individuals[1], from which 607,100 internally displaced persons (IDPs) are currently in Cabo Delgado, 59,960 IDPs in Nampula, 1,084 in Zambezia, 978 in Niassa, and 134 in Sofala.[2] The number of IDPs more than tripled since April 2020 when an estimated 172,186 IDPs were identified in the Cabo Delgado province.

METHODOLOGY

The assessment was designed with the help of the Global Child Protection Area of Responsibility and the Global DTM Senior Data Quality Expert, using the Needs Identification and Analysis Framework (NIAF) approach. The NIAF respects the Protection Information Management (PIM) process, and has been adopted by the Global Protection Cluster and Global GBV AoR. The NIAF describes the technical and coordination steps required to identify child protection needs for strategic decision making, and outlines how to analyze proxy indicator data to interpret CP risk (rather than without ethical considerations collect data on under-reported sensitive issues). More information on the NIAF may be found on the CPAoR webpage.

24 CP Specialists Provincial and district-level government, NGO/INGO and UN staff, were interviewed either in person or by phone calls with the help of semi structured interview guides with open ended questions. Questionnaires with single or multiple-choice response options were used to interview 1,337 heads of IDP HH and 111 KI, including local authorities, village and neighborhood chiefs, and other relevant actors in 11 Districts (and 84 localities) of the Northern province of Cabo Delgado, in Mozambique: Ancuabe, Balama, Chiure, Ibo, Mecufi, Metuge, Montepuez, Mueda, Namuno, Nangade, and Pemba. The prioritization of districts was mainly based on accessibility and numbers of internally displaced persons. 6 districts were not covered by this assessment as they were considered inaccessible due to insecurity at the time of the assessment: Macomia, Meluco, Mocimboa da Praia, Muidumbe, Palma, and Quissanga. It was possible to get qualitative information in the form of phone interviews from CP Specialists KI for Mocimboa da Praia, Muidumbe, Palma, and Quissanga.

CHILD PROTECTION RISKS AND NEEDS

Displaced HHs' predominate concerns regarding children's health and safety are about access to food (88% of households), access to medicines (52%), education (42%) and healthcare (33%). The main needs of IDPs expressed through KI are as follows: Access to food was the top priority (92% of localities), followed by shelter (88%), drinking water (31%), NFI (23%), and health, hygiene and sanitation (19%). This demonstrates that immediate concerns are mainly about survival and education rather than direct child protection risks, such as violence, neglect, abuse and exploitation. However, it may also signal that there is a lack of awareness about CP risks for children or that these risks are underestimated compared to what are understood to be "immediate survival needs".

Interviewed CP Specialists mentioned separation, sexual abuse and violence, child trafficking, sexual exploitation, and child labor as the highest **child protection risks,** followed

1 As to the latest DTM data from December 2020, the number of IDPs has increased significantly from 527,975 to 669, 256 IDPs.

2 DTM Baseline Assessments, Round 9, December 2020.

by physical abuse and violence, neglect, early unions and lack of documentation. Preexisting main CP concerns and violations have been exacerbated or are at risk of being exacerbated by displacement.

Displaced children, especially children with disabilities and children younger than 10 years, are generally **at heightened risks to suffer CP violations** compared to children from host communities. However, there is a possibility of an increased risk of all forms of violence and crime for host community children due to the influx of people and the subsequent increased population in the communities and scarcity of resources. Teenage girls are most vulnerable to sexual exploitation, early unions.

According to KI, most **unaccompanied minors** are in Montepuez, followed by Pemba and Ancuabe. Most separated children are in Montepuez, follow by Ancuabe and Nangade. Most of the separations were unintentional / not planned. Children the most at risk of separation are children younger than 10 years and children with disabilities. Separation has increased the risk of other CP violations, including child labor, trafficking and physical and sexual abuse and exploitation.

Whereas children would contribute to household tasks and carry out chores already before the emergency, they seem to have become **increasingly involved in domestic work and in small informal business** to help the family make a living and cover basic needs. CP Specialists raised concerns about the increased number of children, especially boys, who are engaged in street vending.

There is a lack of data on **child trafficking,** but several CP Specialists concurred that there is anecdotal evidence of trafficking and that the risk of child trafficking has increased, especially for displaced, unaccompanied and separated children, teenage girls and children with albinism. The dire situation, the lack of food and the scarcity of basic services as well insecurity may encourage parents or children to accept offers for children to work away from their homes.

No data is available on the **recruitment of children by Non-State Armed Groups,** but CP Specialists for the Districts of Quissanga, Ibo and Mocimboa de Praia, mentioned this issue as a serious risk and provided anecdotal evidence.

CP Specialists in Pemba, Ancuabe, Quissanga, Montepuez, Muidumbe, Palma Ibo and Nangade mentioned the risk of **sexual exploitation** in the form of transactional sex for food and money as a coping mechanism for displaced families. One CP Specialist in Pemba raised the specific concern about transactional sex for humanitarian aid.

Adolescent girls and younger children, as well as girls with intellectual disabilities, are most at risk for **sexual abuse.** Long distances to fetch water and firewood exacerbate the risk posing a possible risk to women, girls and boys for sexual abuse as well as other CP violations, including abduction and trafficking. Sexual abuse can lead to **early unions,** where – as CP Specialists underlined – there is a tendency that families agree that the perpetrator marries the girl, if he pays a "fine" to the parents. This practice is also perceived to "save the honor" of the family.

CP Specialists raised concerns that displacement may exacerbate **neglect and abuse.** Younger children may be left alone in shelters when parents are out to look for income generating activities, try to find food and fetch water and thus expose children to potential risks of violence from strangers.

A high number of households (HH) have a child, or children, living with one or more **disabilities.** Based on the interviews with displaced households, it is estimated that 32% (428) of households have at least one child with disability[3]. Among these 428 households a total of 721 cases of disability were identified, corresponding to at least 10-12% of all children. Walking and hearing were the most common type of impairment, followed by learning, speaking and seeing. In addition, it is estimated that 3% of households have a child living with albinism Children with disabilities are at special risk during displacement due to mobility constraints, communication and attitudinal barriers, more vulnerable to neglect, stigma and abuse, and are exposed to harm when left without support, since they may not be able to care for themselves, run away from danger or defend themselves in case of attempted violence, as well as face barriers in reporting violations. Specifically, girls with intellectual and hearing disabilities were mentioned to be at an increased risk of sexual abuse. It might also be difficult or impossible for children with disabilities to access food, water and sanitation and basic health services.

Interviews with heads of HH confirm that **mental health issues** and stress are affecting children living in their households. All interviewed households reported that a child/children in their households is experiencing at least 1 symptom of stress, and heads of HH reported that children suffer from headaches (41%), are withdrawn from family and friends (37%), cry excessively (28%), are startled easily (23%), have changes in appetite or eating habits (21%), new or reoccurring fears (16%), an upset stomach (15%), and nightmares or sleep disturbances (12%).

3 The number of cases of disabilities is higher than the number of households, as some households have more than one children with disability, and some children may have more than one disability.

The limited presence of CP and social services or their current inactivity due to the crisis is likely to have led to significant gaps. According to KIs, the most severe gap is in the provision of mental health and psychosocial services, with only 13 localities out of 111 (12%) having access to these services. Despite the high number of unaccompanied and separated minors, services for the identification of these children are only available in 26 localities (23%) and family tracing and reunification is only available in 28 localities (25%). The provision of services for case management is available in 47 localities (42%), social workers in 50 localities (45%), legal support in 52 localities (47%), and healthcare in 54 localities (49%) is better but remains unavailable in over half the localities assessed. CP experts agree that CP services are insufficient, and that all services are currently overstretched. Generally, services and local resources are limited and may not be able to cover the local population as well as all IDPs.

There are **few specialized services for children with disabilities.** Children with disabilities use the same services as other children but face many challenges, including difficulties in accessing services and communicating their needs. There is a general lack of special training on working with children with disabilities. In addition, there is a lack of access to assistive devices as well specialized services from government sources/health services.

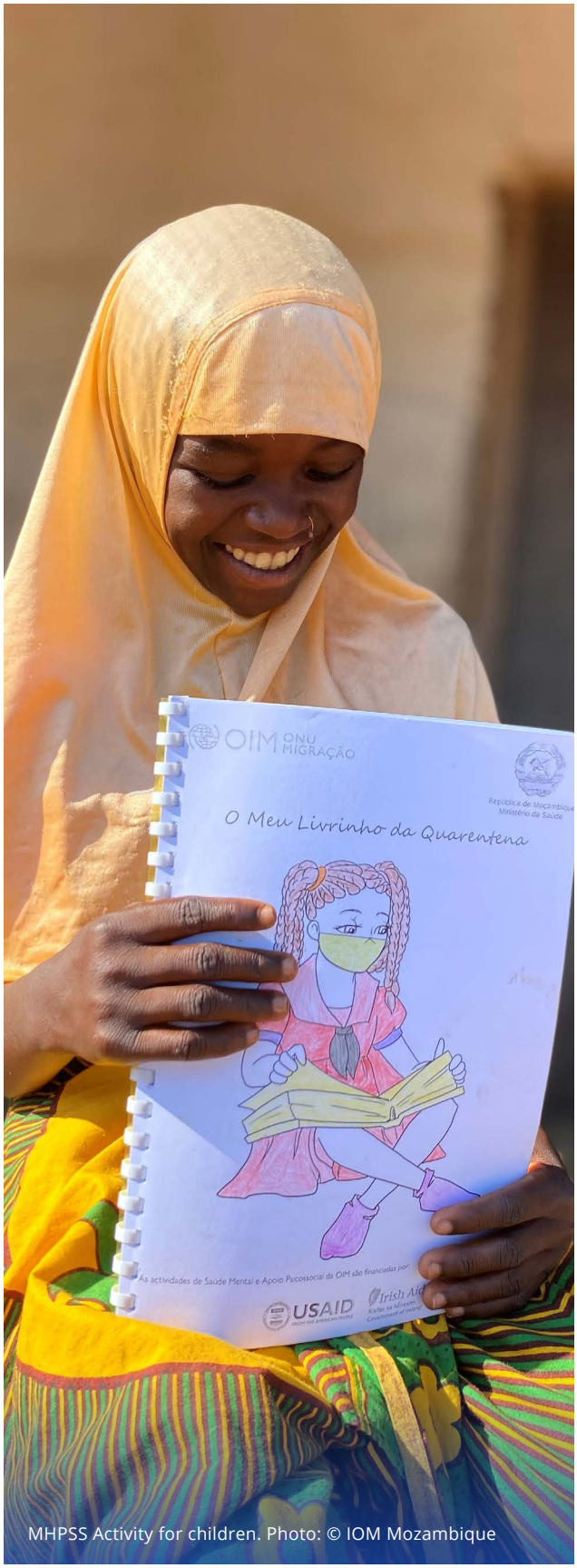
Most IDPs are provided with **shelter,** but gaps still remain. According to local KI, none of the IDPs **sleep** outside in 62 localities while "a few" IDPs sleep outside in 22 localities, about half of the IDPs sleep outside in 18 localities, "most" in 8 localities, and everyone in one locality. From KI demographic data, the number of IDP children sleeping outside or in emergency shelters is roughly estimated at115,314 IDP children (or 63% of the child population), who are therefore exposed to greater risk of GBV or other forms of violence due to shelter-type.

Walking distances for displaced HH to get **drinking water** are longer than 500 meters in 43 localities, where approximately 23% of IDP children are currently residing. This poses a potential threat to women and children, especially girls, who, according to KI fetch water in 99, 28 and 13 localities, respectively.

Photo: © IOM Mozambique

KEY CONCLUSIONS

- The enormous scale of 'immediate survival needs' such as food, shelter, water and sanitation' obscure the sensitivity of families and communities about child protection issues, demonstrating **lack of awareness or underestimation of CP risks.** The interviewed CP Specialist testified that **already pre-existing CP violations have been exacerbated or are at risk of being exacerbated by displacement.**
- Interviewed CP Specialists mentioned separation, sexual abuse and violence, child trafficking, sexual exploitation, and child labour as the highest child protection risks, followed by physical abuse and violence, neglect, early unions and lack of documentation.
- Unaccompanied minors and separated children, adolescent girls and children with disabilities are most exposed to all risks for all CP violations.
- **Teenage girls** are at heightened risk to **sexual abuse and exploitation** and to be forced into early unions. **Sexual exploitation** in the form of transactional sex for food and money as a coping mechanism for displaced families.
- Families rely on children's contributions to cover the daily needs, which leads to an increase in children's involvement in domestic work and in small informal business.
- The dire situation, the lack of food and the scarcity of basic services as well insecurity may encourage parents or children to accept offers for children to work away from their homes.
- Anecdotal evidence indicates a risk of recruitment of children by Non-State Armed Groups.
- The long distances to fetch water pose risks to women, girls and boys for sexual abuse as well as other CP violations, including abduction and trafficking.
- Heads of HH report a high number of children with disabilities. Whereas children with disabilities are especially vulnerable to various CP risks, specifically to separation and sexual abuse, there are only few specialized services, that cater for their protection, health, mental health and education.
- Heads of HH confirm that **mental health issues** and stress are affecting children living in their households.
- The **limited presence of CP and social services** or their current inactivity due to the crisis led to significant gaps. The most severe gap is in the provision of mental health and psychosocial services and identification and FTR services for UASC.



MHPSS Activity for children. Photo: © IOM Mozambique

ACRONYMS AND GLOSSARY OF KEY TERMS

AoR	Area of Responsibility
CP	Child Protection
DTM	Displacement Tracking Matrix
CPKI	Child Protection Key Informant
HH	Household
ICRC	International Committee of the Red Cross
INAS	National Institute for Social Action (Instituto Nacional da Acção Social)
INGO	International Non-governmental Organization
KI	Key Informant
IDP	Internally Displaced Persons
GBV	Gender-Based Violence
IOM	International Organization for Migration
MHPSS	Mental Health and Psychosocial Support
MPA	Migrant Protection and Assistance
NGO	Non-Governmental Organization
NIAF	Needs Identification and Analysis Framework
NSAG	Non-State Armed Groups
PSS	Psychosocial Support
SCI	Save the Children International
SRH	Sexual and Reproductive Health
SDMS	District Service of Health and Social Affairs
UAM	Unaccompanied Minor
UASC	Unaccompanied and Separated Children
UNICEF	United Nations Children's Fund

Child: A child means any person under the age of 18, unless under the (national) law applicable to the child, majority is attained earlier (United Nations Convention on the Rights of the Child, or UNCRC, Article1).

Children's Rights: Children's rights are enshrined in international law, including in the UNCRC. The UNCRC outlines the fundamental rights of children.

Child Protection: The term 'child protection' refers to prevention and response to violence, exploitation and abuse of children in all contexts. This includes reaching children who are especially vulnerable to these threats, such as those living without family care, on the streets or in situations of conflict or natural disasters. Child protection violations include violence, child labor, trafficking, sexual exploitation, female genital mutilation/cutting and child marriage.[4]

Child protection means to take measures and structures to prevent and respond to abuse, neglect, exploitation and violence affecting children. Child protection means safeguarding children from harm. Harm includes violence, abuse, exploitation and neglect. The goal of child protection is to promote, protect and fulfil children's rights to protection from abuse, neglect, exploitation and violence as expressed in the UNCRC and other human rights, humanitarian and refugee treaties and conventions, as well as national laws.[5]

Internally Displaced Person: The definition used to define Internally Displaced Persons (IDPs) is as follows: any "persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border".

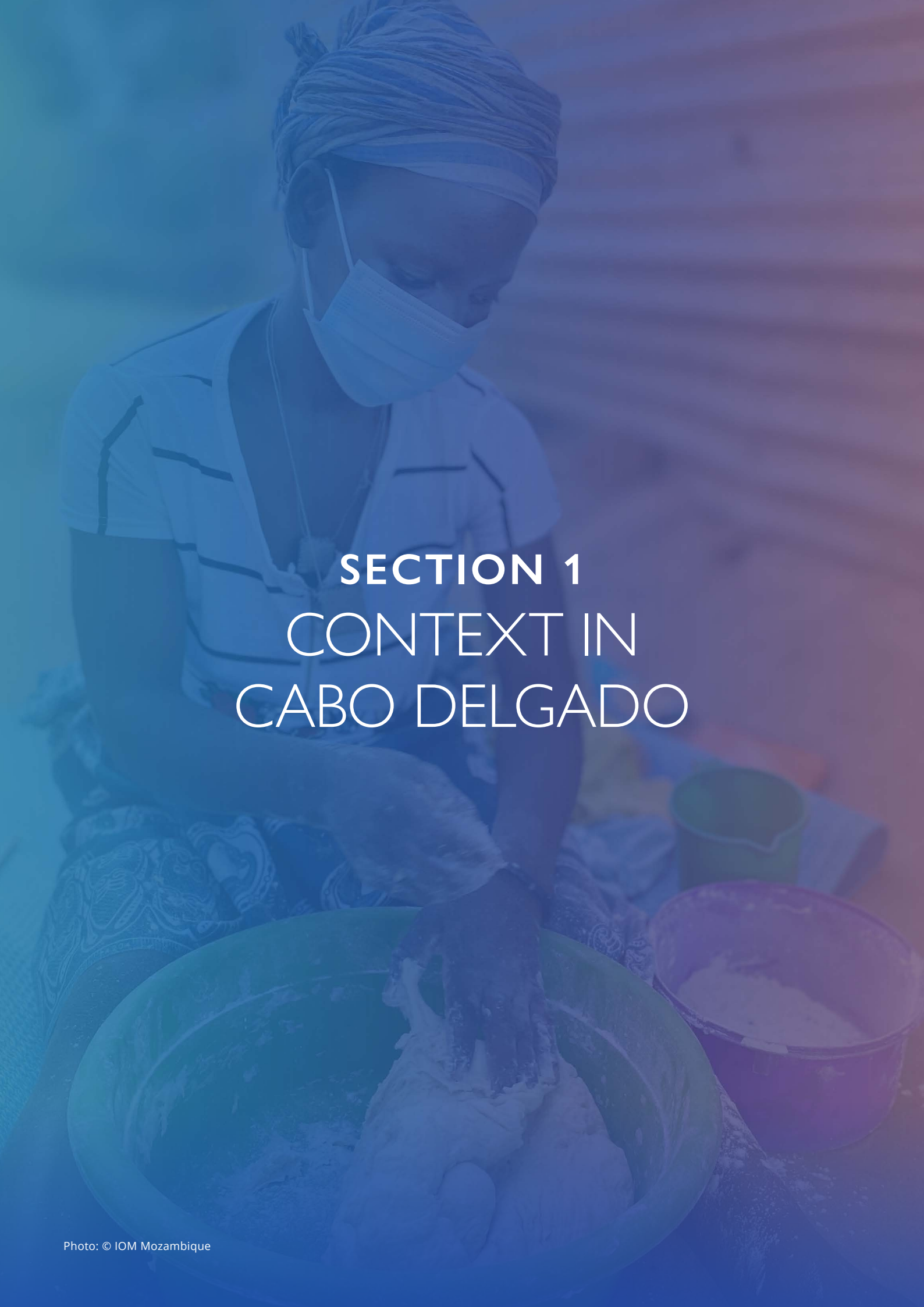
Separated Child: Separated children are those separated from both parents, or from their previous legal or customary primary caregiver, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members. (Interagency Guiding Principles on Unaccompanied and Separated Children[6]).

Unaccompanied Minor: Unaccompanied children (also called unaccompanied minors) are children who have been separated from both parents and other relatives and are not being cared for by an adult who, by law or custom, is responsible for doing so. (Interagency Working Group on Unaccompanied and Separated Children).

4 https://data.unicef.org/topic/child-protection/overview/

5 https://resourcecentre.savethechildren.net/library/save-childrens-definition-child-protection

6 The members of the IAWG-UASC are the International Committee of the Red Cross, International Organization for Migration, International Rescue Committee, Save the Children, United Nations Children's Fund, United Nations High Commissioner for Refugees and World Vision International.



SECTION 1
CONTEXT IN CABO DELGADO

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1. CONTEXT

1.1 SITUATION IN CABO DELGADO

The increase of security incidents in northern Mozambique since 2017 resulted in population displacement as well as subsequent humanitarian needs in virtually every humanitarian sector.

The humanitarian situation in Cabo Delgado has rapidly deteriorated in the first six months of 2020 due to an increase in violent attacks and insecurity, leading to a significant increase in displacement across the province and a consequent rise in protection risks for the most vulnerable people – including both those displaced and those who remained in insecure areas.

According to the latest DTM[7] baseline assessment (December 2020), the current situation resulted in the displacement of 669,256 individuals, from which 607,100 internally displaced persons (IDPs) are currently in Cabo Delgado, 59,960 IDPs in Nampula, 1,084 in Zambezia, 978 in Niassa, and 134 in Sofala.[8] The number of IDPs has more than tripled since April 2020 when an estimated 172,186 IDPs were identified in the Cabo Delgado province.

Since April 2020, the DTM reported a continued trend of IDP movements towards southern districts and urban centers to find safer locations. These movements followed the increase in insecurity in the northern part of the Province and intensified after Mocimboa da Praia fell under the control of Non-State Armed Groups. Continuous attacks have pushed entire villages' population to leave the districts of Mocimboa da Praia, Muidumbe and some parts of Nangade and Mueda. In the central area of the province, part of the population of Quissanga and Macomia districts also fled to Pemba and Metuge, leaving these districts almost abandoned. More recently, following attacks in Palma, the local population had to seek refuge in the district capital. The entire coastal area located north of Pemba is now affected by insecurity, and it is estimated that between 500 and 700,000 individuals lived in these affected zones.

In addition, as highlighted in the 2021 Humanitarian Response Plan (HRP), the crisis in Cabo Delgado is first and foremost a protection crisis and children represent 45 per cent of the people affected by violence in Cabo Delgado. Women and girls are at risk of gender-based violence and exploitation, such as rape, forced marriage, forced sex work and kidnapping, while men and boys are at risk of being killed or recruited by armed actors. At the same time, heightened pressure on meagre resources significantly increases protection risks for girls as families may adopt negative coping mechanisms, including child labor and early unions.[9]

1.2 SCOPE AND OBJECTIVE OF THE ASSESSMENT

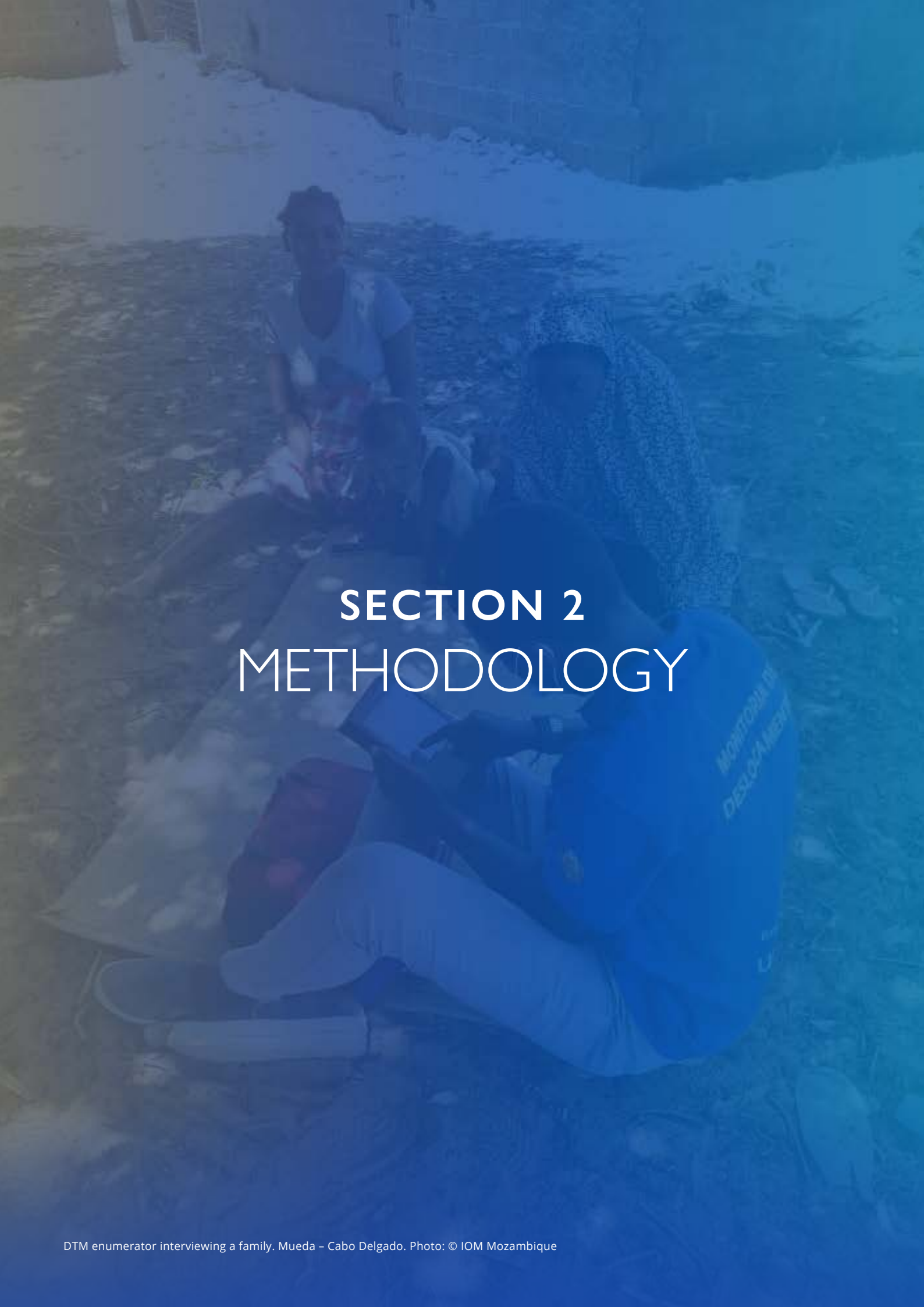
This assessment aims to provide an evidence base for protection and child protection (CP) risks and needs in Cabo Delgado to inform humanitarian planning and to increase donor interest in addressing and mitigating the risks. Building on the International Organization for Migration's (IOM) presence and Displacement and Tracking Matrix (DTM) capacity in Cabo Delgado, the assessment findings are summarized in this report. This report aims at contributing to strengthening the prevention of and the response to neglect, abuse, exploitation, and violence against children in Cabo Delgado.

7 The Displacement Tracking Matrix (DTM) is a system to track and monitor displacement and population mobility. It is designed to regularly and systematically capture, process and disseminate information to provide a better understanding of the movements and evolving needs of displaced populations, whether on site or en route.

8 DTM Baseline Assessments, Round 9, December 2020.

9 Whilst the government of Mozambique uses the term "early union" rather than child marriage, this report uses early union and child marriage interchangeably.

SECTION 2
METHODOLOGY



DTM enumerator interviewing a family. Mueda – Cabo Delgado. Photo: © IOM Mozambique

2. METHODOLOGY

2.1 NEEDS IDENTIFICATION AND ANALYSIS FRAMEWORK (NIAF) APPROACH

The NIAF is a 7-step conceptual framework that fosters a common approach between child protection (CP) coordination and response actors on defining child protection needs for strategic decision making.

The NIAF includes (but is not limited to) guidance and tools on how to define information needs including the interpretation of proxy indicators to assess the degree of CP risk (for sensitive under-reported violations for which primary data cannot be ethically collected). It also provides step by step guidance on how to determine the most affected geographic areas, most-affected population groups, priority issues, calculating children in need, calculating activity targets and activity costing.

Using the CPAoR's NIAF approach, colleagues from the Global CPAoR and Global DTM teams facilitated meetings with UNICEF CP experts and DTM to identify the strategic and programmatic decisions that UNICEF CP experts were required to make, then mapped out the information needed to make those decisions.

The key identified decisions were:

1. Priority geographic areas to set up case management
2. Priority geographic areas to set up MHPSS
3. Priority geographic locations to set up alternative care for UASCs
4. Integrated programming (CP mainstreaming and identifying the root causes of child unions and child labour)

2.2 GEOGRAPHICAL COVERAGE

The assessment targeted the Northern province of Cabo Delgado, in Mozambique. Specifically, and considering the security situation in the province, the prioritization of districts was mainly based on accessibility and numbers of internally displaced persons. The following 11 districts were fully or partially covered:

- 7 districts fully accessible and targeted by this assessment: Ancuabe, Balama, Chiure, Mecufi, Montepuez, Namuno, and Pemba;
- 4 districts with partial accessibility and partial coverage under this assessment: Ibo (7 localities), Metuge (4 localities), Mueda (11 localities), and Nangade (1 locality);
- The remaining 6 districts were not covered by this assessment as they were considered inaccessible due to insecurity at the time of the assessment: Macomia, Meluco, Mocimboa da Praia, Muidumbe, Palma, and Quissanga. Yet, it was possible to get qualitative information in the form of phone interviews from CPKI for Mocimboa da Praia, Muidumbe, Palma, and Quissanga.

2.3 DATA COLLECTION LEVEL

Data collection was undertaken at the locality *(localidade)* and displacement site (accommodation centers, resettlement sites) levels.

Further interviews were conducted, by calls or in person, by IOM's Protection/ Mental Health and Psychosocial Support (MHPSS) staff at province level and the level of district capitals where CP Specialists and Government Key Informants (KI) are located.

Specific locations were defined based on the list of localities hosting IDPs, as identified by the DTM baseline.

Map 1. Assessment geographical coverage

2.4 DATA COLLECTION METHODS, TOOLS AND SOURCES

The main data collection methods of this assessment were key informant and household interviews. The tools and sources used were as follows:

- Semi structured interview guides for CP Specialists/KIs with open-ended questions. The CP Specialists work in CP at Cabo Delgado province level or in the targeted districts; they were selected based on a list defined by IOM's Protection/MHPSS and Migrant Protection and Assistance (MPA) Units and UNICEF CP Section. These KIs were interviewed by IOM's MPA unit;
- Questionnaire for (General) KI interviews with (binary/general) yes/no or multiple-choice response options. General KI for each target location were identified and mapped by the IOM field team in localities based on criteria of political balance, neutrality and objectivity, knowledgeable by profession and academic background, integral role in the community, active works on public interest, and gender balance. Local KI usually included neighborhood and village chiefs, local authorities, NGO workers, etc.
- Questionnaire for household interviews with (polar/general) yes/no or multiple-choice response options for heads of displaced households. Heads of displaced households were targeted using a random sampling of displaced families (based on the number of IDPs per district, as identified by the sixth round of DTM Baseline assessments conducted in September 2020). The form was administered at the locality and site levels, in locations that host displaced persons. A modified/contextually-adapted version of Washington group questions were used for identification of children with disability.

Considering the topic covered by this assessment, enumerators were encouraged to interview women and mothers for the household interviews, as well as persons with disabilities for the KI interviews.

Target Population Groups

The assessment solely targeted internally displaced households (HH) residing in the selected districts of the Cabo Delgado province. The baseline data collection to measure this IDP population is the DTM assessment conducted in December 2020 (Baseline Round 9).

2.5 SAMPLE

24 CP Specialists were interviewed either in person or by phone calls. These CP Specialists are government, NGO/INGO or UN staff, either based in or responsible for the districts of Ancuabe, Balama, Chiure, Ibo, Metuge, Mocimboa de Praia, Montepuez, Mueda, Nangade, Pemba, Palma and Quissanga. Some CP experts also represent the province level.

1,337 HH and 111 KI, including local authorities, village and neighborhood chiefs, and other relevant actors were interviewed in 11 Districts: Ancuabe, Balama, Chiure, Ibo, Mecufi, Metuge, Montepuez, Mueda, Namuno, Nangade, and Pemba.

Table 1. Sources, tools, sample and location for Child Protection Risks and Needs Assessment in Cabo Delgado data collection

SOURCE OF INFORMATION	TOOL	SAMPLE	LOCATION / DISTRICT
Child Protection Specialists	Semi structured interview guide with mainly open-ended questions	24	Ancuabe, Chiure, Balama, Ibo, Metuge, Mocimboa de Praia, Montepuez, Mueda, Nangade, Pemba, Palma and Quissanga, Cabo Delgado province
General Key informants	Questionnaire with single or multiple-choice response options	111	Ancuabe, Balama, Chiure, Ibo, Mecufi, Metuge, Montepuez, Mueda, Namuno, Nangade, and Pemba
Heads of displaced households	Questionnaire with single or multiple-choice response options	1,337	

2.6 CHALLENGES AND GAPS

2.6.1 Challenges in Data Collection

Due to the current security situation in the Cabo Delgado province, certain districts could not be accessed for this assessment. In addition, some districts that were originally targeted had to be omitted due to significant attacks at the beginning of the assessment. In other instances, interviews had to be primarily conducted in urban centers as parts of the districts, specifically rural areas, were considered inaccessible.

Logistical constraints resulting from the security situation further posed challenges for this assessment, and specifically for the deployment of enumerators to some locations in the Northern part of the province.

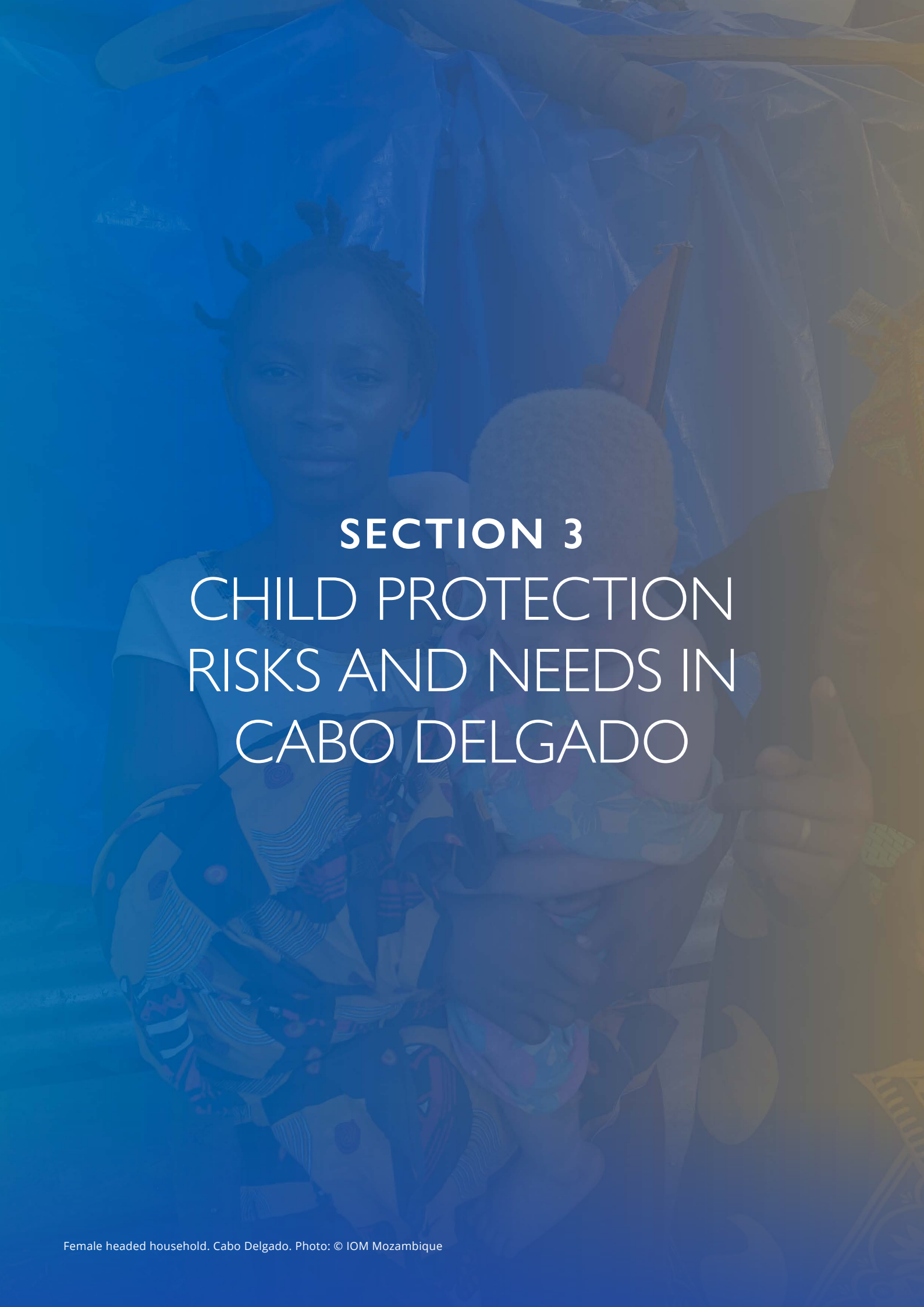
Finally, the assessment was conducted in the context of the COVID-19 pandemic. The DTM enumerators were trained in COVID-19 prevention and protective measures in two instances (two trainings in Pemba city). Protections items (mostly alcohol- based hand gel and face masks) were purchased and distributed to local enumerators to guarantee both theirs and beneficiaries' safety and well-being.

2.6.2 Gaps / Limitations

- Child protection needs analysis is **risk** based, which means that data on the number of children that have reported surviving a CP or GBV incident is not needed to prove that CP and GBV response services are required. The IASC[10] and NIAF both stress that for ethical reasons (and because accurate data cannot be obtained for under-reported sensitive issues), questions relating to sensitive CP/GBV issues should not be asked at household level. As such, the assessment cannot provide data on the scale/prevalence of sensitive CP/GBV issues, however qualitative information on these issues was obtained from CP Expert Key Informants in Cabo Delgado.
- As mentioned above, IOM managed to conduct data collection for this assessment in 11 districts of the province while 6 other districts could not be accessed. As such, the geographical coverage of this assessment, while being significant, remains partial.
- While this assessment focuses on CP, children themselves were not interviewed due to internal protection and data protection guidelines and specifically sufficient training on ethics in research with children, child safeguarding issue and child specific consideration related to "do no harm" that are needed for such interviews. Instead, information was collected through heads of households, general key informants, and CP Specialists. This led to certain limitations, including getting specific information on children with disabilities, as the questions regarding disability were asked at household level (e.g. how many children in the household have difficulty walking) and not at the level of individual children.
- The information collected through direct interviews of displaced HH was collected and analyzed through a sample, which always include a margin of error.
- Social desirability bias may have influenced HH responses on sensitive topics, including early union and child labour.
- Question on school attendance were not included, as schools were closed due to COVID-19.
- Data and information collected in interviews with KIs may not always accurately represent the needs and child protection vulnerabilities across an entire district. KIs have a limited viewpoint. and limited access to information and data and do not represent all population groups and needs which reduces the overall data quality.
- Organizations of persons with disability were not included as key informants.
- It is not possible to assess the precise number of unaccompanied children without implementing a comprehensive IDP registration exercise, in which children are interviewed by CP Specialists. The data obtained from Key Informants on the estimated number of unaccompanied children is used to assist with prioritizing locations for follow-up on the need for alternative care, and not to be used as prevalence of the issue.
- According to the DTM baseline assessment (December 2020), there are 669,256 **displaced individuals** from which 607,100 IDPs were identified in Cabo Delgado. The highest increases recorded since the previous round are Metuge (35,596 individuals or 31%), Chiure (8,897 individuals or 28%), Mueda (6,012 individuals or 9%), and Quissanga (3,994 individuals or 56%). It is worth noting that those three districts are among the ones that host the highest numbers of IDPs. The continued increase of the IDP population highlights the growing urban nature of this displacement, as well as the continued trend of movements towards southern districts and urban centers to find safer locations. Moreover, 66,844 IDPs are currently in hard to reach areas (Macomia, Muidumbe, Palma and Quissanga).

It is important to note that the aim of this exercise was not to assess displacement stocks but to focus on CP risks and needs. For precise up-to-date information on internal displacement in the Northern region of Mozambique, please refer to the latest available DTM Baseline Assessments Report.

10 IASC, Guidelines on Integrating Gender-based Violence Interventions in Humanitarian Action (2015), viewed on Oct 1 2018, https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf



SECTION 3
CHILD PROTECTION RISKS AND NEEDS IN CABO DELGADO

Female headed household. Cabo Delgado. Photo: © IOM Mozambique

3. CHILD PROTECTION RISKS AND NEEDS IN CABO DELGADO

3.1 DEMOGRAPHIC ASPECTS OF HOUSEHOLDS AND DISPLACEMENT

The household level assessment was carried out in 84 localities in 11 districts, with 54% of the localities based in rural and 46% of localities based in urban areas. Interviews with heads of HH were held with 1,337 heads of households (HH), representing a total of 11,218 members (of which 5,809 were children).There are 940 children aged 0-2 years, 1,249 aged 3-5 years, 2,940 aged 6-14 years, and 691 aged 15-17 years.

The average head of HH is 39 years old, the youngest 18. At an average, four (4.3) children live in each HH, out of which 50% are girls with an average age of 7.6 years, and 50% are boys with an average age of 8.1 years.

The vast majority of the children (98% of girls and 98% of boys) are single. This trend continues when counting only children older than 14, with 94 per cent of girls and 95 per cent of boys being single. However, 15 girls were identified as married/in an early union in the districts of Ancuabe, Balama, Chiure, Ibo, Namuno, and Mueda, while 12 boys were identified as married/in an early union in the districts of Ancuabe and Mueda.[11] There are 53 "don't know" responses, perhaps indicating an unwillingness to report being in a union. There are also 59 children who are either separated (58) or divorced (1).

Interviews conducted with displaced HHs show a **high rate of secondary or multiple displacement,** with nearly half (46%) of the interviewees having been displaced already once before they have settled in their current location, 28% displaced two (2) times and 26% displaced three (3) times or more often, before their current displacement. Only 1% of interviewees had never been displaced before their current displacement.

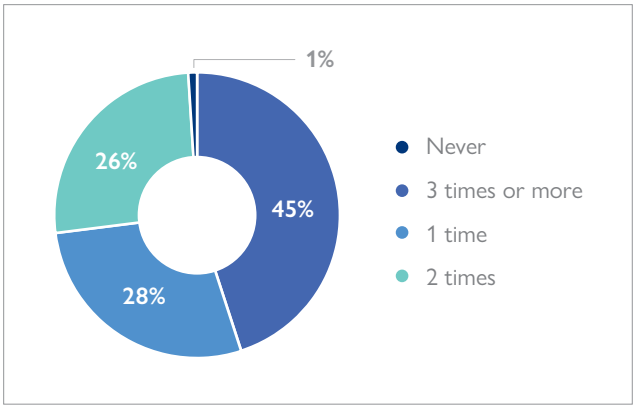
Multiple displacement rates are especially high for IDPs currently living in the districts of Pemba, Ibo, Chiure and Mueda.

According to KI data, women and girls make up 56% of the IDP population while men and boys represent 44%. In addition, 47% of the IDP population are children, (26% girls and 21% boys), while 50% are adults aged 18 to 59 years, and 3% are elderly (>60 years).

Table 2. Number of households, members of household and average size of household

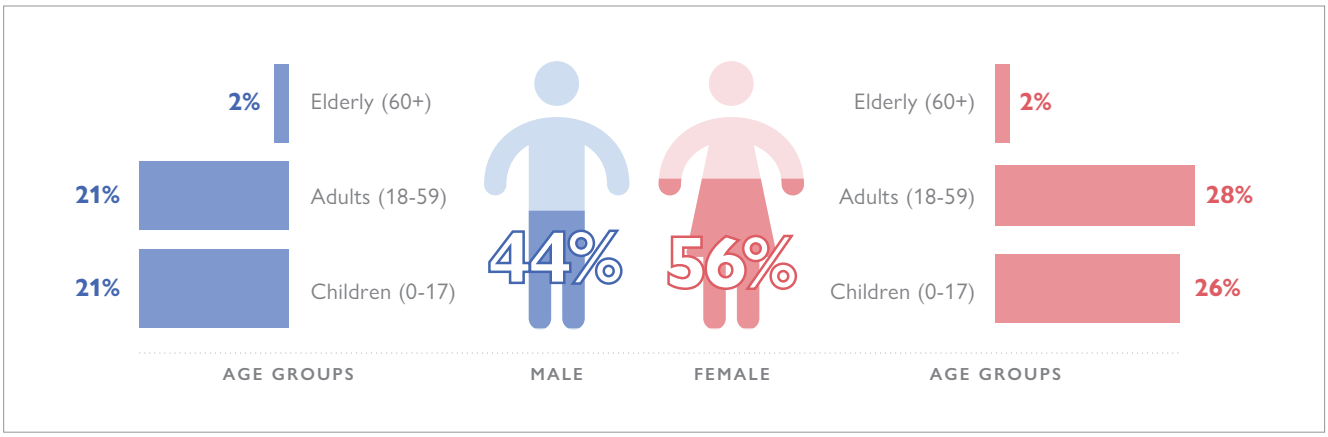
DISTRICTS	# OF HH	# OF MEMBERS OF HH	AVERAGE HH SIZE
Ancuabe	105	960	9.1
Balama	92	583	6.3
Chiure	145	1,043	7.2
Cidade De Pemba	175	2,250	12.9
Ibo	150	1,045	7.0
Mecufi	101	967	9.6
Metuge	122	1,097	9.0
Montepuez	112	955	8.5
Mueda	148	1,038	7.0
Namuno	77	394	5.1
Nangade	110	886	8.1
Grand Total	**1,337**	**11,218**	**8.4**

Graph 1. Number of times HH have been displaced before their current displacement



11 This contradicts the findings from the 2011 DHS Final Report, according to which child marriage is a widely spread practice in Cabo Delgado province. As to a publication by UNICEF, based on DHS data, 17.6% of women married before reaching the age of 15 and 60.7% before the age of 18, while 5.2% of men married before reaching the age of 18. This contradiction may be explained by the fact that the question related to the civil status of children was asked to displaced head of HH, who may have altered their responses as early union is illegal and/or to provide a socially acceptable and desirable response.

Graph 2. Demographics of IDPs (Key informant information)



Based on the information collected through KI, most of the IDPs originate from Macomia (23%), Quissanga (21%), Ibo (20%) and Mocimboa Da Praia (18%).

Reasons for Displacement

According to information from general KI, 99% of IDPs are displaced due to the conflict, while 1% are displaced because of the lack of food (in the posto of Metoro, in Ancuabe district).

3.2 NEEDS AND PROTECTION RISKS

Displaced HHs' predominate concerns regarding children's health and safety are about access to food (88%), access to medicines (52%), education (42%) and healthcare (33%), demonstrating that immediate concerns are mainly about survival and education rather than direct child protection risks, such as violence, neglect, abuse and exploitation. It may also signal that there is a lack of awareness about CP risks for children or that these risks are underestimated compared to what are understood to be "immediate survival needs". When it comes to protection risks, mental health issues, together with "emotional harm" concern HH the most.

The main needs of IDPs expressed through KI are as follows: Access to food was the top priority (92% of localities), followed by shelter (88%), drinking water (31%), NFI (23%), and health, hygiene and sanitation (19%).

Other needs included access to income (14%), civil documents (7%), education (5%), child protection services (5%), financial support (2%), and cooking/washing water (1%). MHPSS support and legal help were not perceived as priority urgent needs as none of the key informants mentioned them. However, as later elaborated, many heads of households mentioned changes in children's behavior, which clearly shows that there is a need for focused MHPSS services. As with heads of HH, KI do not express CP as top priority needs. Similarly, as to heads of HH, this could mean that the awareness of the existence of CP risks is low or underestimated.

Table 3. Main concerns about health and safety of children

MAIN CONCERNS ABOUT HEALTH AND SAFETY OF CHILDREN	% OF HHS
Lack of appropriate food	88%
Lack of medicines	52%
Lack of education	42%
Lack of healthcare	33%
Stress/nightmares/sadness and other such signs	11%
Emotional harm	10%
Living in dangerous situation for a prolonged period of time	10%
Interruption of rehabilitation services for children with disabilities*	8%
Physical harm	7%
Children going missing	2%
Discrimination from the rest of the community	2%
Stigma	0%

* As percentage of households with children with disabilities.

Table 4. Top 3 needs of IDPs identified by key informants

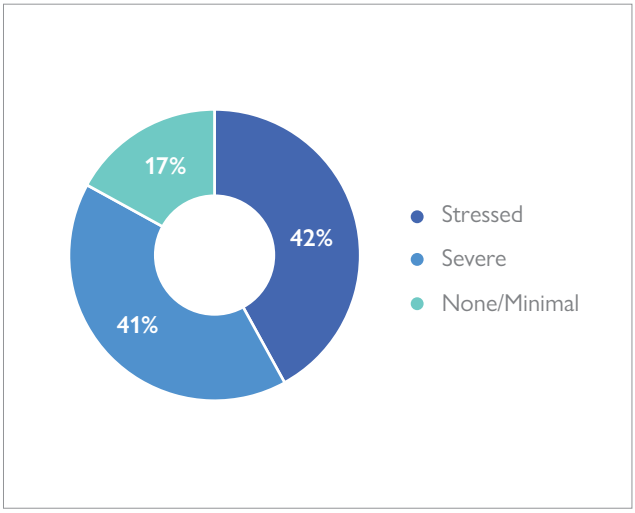
NEEDS	KEY INFORMANTS
Food	92%
Shelter/housing	88%
Drinking water	31%
Household Items (NFI)	23%
Health/Sanitation/Hygiene	19%

Through this assessment, displaced HH were asked questions as part of the "Reduced Coping Strategy Index" (RCSI) in order to assess their level of food security / insecurity. Different indicators are used to measure how often coping strategies have been used by households in the last 7 days.

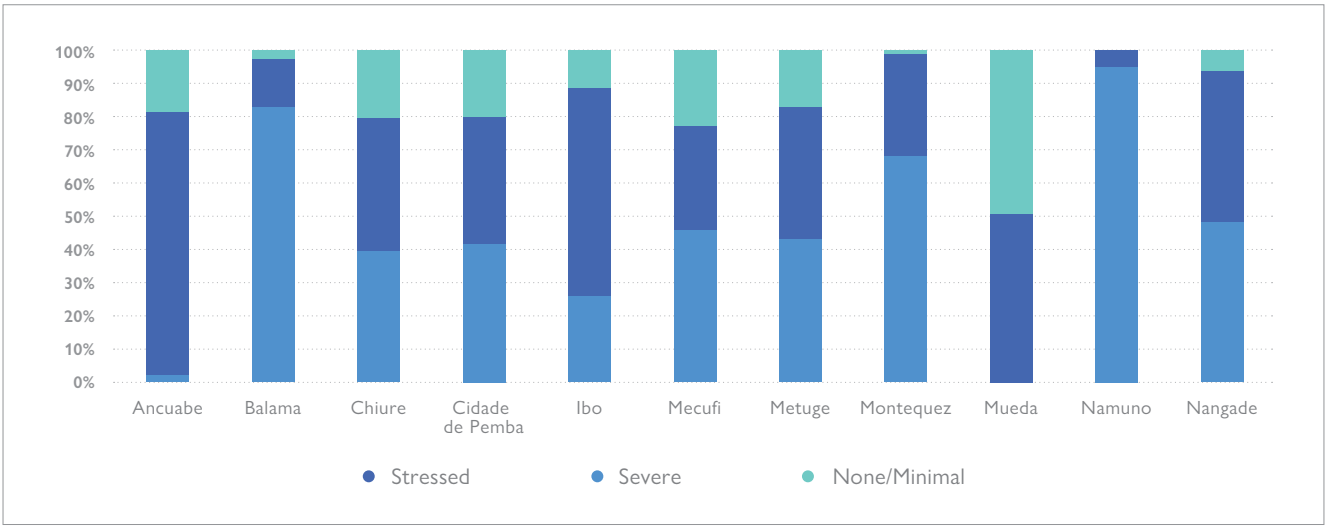
The total weighted score of the RCSI for each household ranges between 0 and 56, in which a higher number means that the household is resorting to more severe/harmful coping mechanisms in order to meet their food needs. While the overall food security situation in the Cabo Delgado province seems intermediate, of the households that were interviewed, an exceptionally high proportion fall within 'stressed' or 'severe' food insecurity classification, amounting to 83% of the interviewed households is shown in Graph 3.

Although most interviewed IDP households are experiencing food insecurity, a higher-than-average proportion of IDP households currently residing in Balama, Iba, Montepuez, Namuno and Nangade are facing food insecurity. CP Specialists in, Montepuez and Ibo mentioned the risk of sexual exploitation in the form of transactional sex for food and money as a coping mechanism for displaced families.

Graph 3. Proportion of households per food insecurity classification



Graph 4. Proportion of households in each food insecurity classification per location



Eighty-eight per cent of interviewed HH reported that they were concerned about a lack of appropriate food. To better assess food insecurity, the RCSI Index was used, with the score/grading determined by the Food and Nutrition Technical Assistance (FANTA) Project. This represents the vast majority of the interviewed households. Of the households that stated that they were concerned about food, 15.8% were categorized as not food insecure, 41.3% were stressed, and 43% had severe food insecurity, which aligns with the averages of all households interviewed (first graph).

Due to the very high proportion of IDP households experiencing food insecurity, it was also not possible to extrapolate a correlation between the household RCSI score and the following indicators[12]:

- Household size and food insecurity
- Chores outside of the house (like fetching water and firewood) and food insecurity
- Child work/labour and food insecurity
- Child unions and food insecurity
- The number of child stress symptoms per household and food insecurity
- Secondary displacement and food insecurity
- Child disability and food insecurity

3.3 CHILD PROTECTION RISKS

3.3.1 General

Interviewed CP Specialists mentioned separation, sexual abuse and violence, child trafficking, sexual exploitation, and child labor as the highest child protection risks, followed by physical abuse and violence, neglect, early unions and lack of documentation.

According to CP Specialists, most CP risks that already existed prior the crisis have increased in the current situation of displacement. In addition, the same KI added that displaced children are generally at heightened risks to suffer CP violations compared to children from host communities.

However, it was also stated that there may be an increased risk of all forms of violence and crime for host community children due to the influx of people and the subsequent increased population in the communities and scarcity of resources.

CP Specialists further declared that children with disabilities and children younger than 10 years were at a heightened risk to suffer CP violations. In addition, all adolescent girls are especially vulnerable to specific risks, particularly sexual abuse and exploitation as well as early union.[13]

Finally, displaced children also have less opportunities to access basic services, food, shelter and safe drinking water, which makes them in turn more vulnerable to CP violations. Several of the CP Specialists mentioned that in response to this vulnerability, displaced children and/or their parents are more likely to accept or encourage transactional sex to secure the family's basic needs. For this same reason, displaced children may also be more vulnerable to child labor and to being lured away from their families by promises of work or education opportunities.

Table 6. Main child protection and child rights concerns raised by Child Protection Specialists*

CHILD PROTECTION AND CHILD RIGHTS CONCERNS RAISED BY CP SPECIALISTS	INCREASED DUE TO EMERGENCY / DISPLACEMENT	MAY INCREASE FURTHER
Separation	13	
Sexual abuse and violence	12	
Trafficking	10	
Sexual exploitation	7	
Child labor	8	1
Physical abuse and violence	5	2
Neglect	4	2
Early union	3	4
Lack of documentation	3	
Mental health	2	
Early pregnancy	2	
Stigma	1	
Abandonment	1	
OTHER CHILD RIGHTS CONCERNS		
Access to food	10	
Access to education	4	
Access to health	3	

* All CP Specialists mentioned more than one CP violation.

3.3.2 Separation

"Amongst displaced children, there are many children who got separated from their parents. Separation happened because the parents were killed in their communities or when trying to escape from the insecurity or just 'disappeared'. There are cases of displaced children who are in the care of social services as well as with host families. Displaced children have many vulnerabilities due to a lack of access to basic services such as access to food, health, clothes and hygiene."
– CP Specialist, Pemba

12 Correlation analysis between the RCSI score and the listed indicators was not possible, as the vast majority of IDP households experienced food insecurity. Therefore the sample of households not experiencing food insecurity was too small to extract a meaning comparative analysis.

13 More detailed information will be provided under the specific CP violations, as elaborated further, below, in this report.

According to key informants, most of the UAM currently live in Montepuez, followed by the City of Pemba, Ancuabe and Nangade. Furthermore, of all separated children, most are in Montepuez, Ancuabe, Nangade and the City of Pemba.

The information received from Child Protection Specialists on UASCs gathered by the CP Area of Responsibility (AoR), child services as well as the FTR working group, most children are reunited with their families or inserted with their relatives soon after arriving at accommodation/relocation sites.

As indicated in KI data, most of the separations (74%) were unintentional / not planned while only 3% were well planned (i.e. children are in regular contact with family, have money for travel, have planned assistance at destination). KI did not know the response for 23% of the separations.

CP Specialists reinforced that there are many children who are separated from their parents. Displaced children are in the care of social services[14] as well as with host families. Children the most at risk of separation are children younger than 10 years[15] and children with disabilities.

> *"Children between 1-10 years are the most vulnerable… they just live as kids"*
>
> – CP Specialist Pemba.

> *"Separation has increased because during the attacks children got separated from their parents. Once the boats for retreat are full, they just leave, and sometimes leave the children with neighbors. Some of the children don't have family members anymore. Separation is a heightened risk for children during displacement, obstacles of mobility and other disabilities can lead to separation. It's very common that IDP children arrive alone or with neighbors in new camps."*
>
> – CP Specialist, Ibo

> *"Children can't find their parents, it's difficult to know how many children lost their parents. We are in a situation where we can't say how many of the parents have died or are still alive, the numbers are uncertain, and it has been difficult to have access to these numbers."*
>
> – CP Specialist, Montepuez

Whereas some CP Specialists stated that they do not know what the actual number of UASC (Montepuez) is, others (Pemba, Quissanga, Ibo, Chiure, Mueda and Nangade) stated that most UASC were able be reunited with their parents,

> *"Some children who are separated and not unaccompanied were able to be reunited with their families."*
>
> – CP Specialist, Pemba

According to CP Specialists, separation has increased the risk of other CP violations, including child labor, trafficking and physical and sexual abuse and exploitation. In the absence of parents who care and cater for the children's basic needs and ensure their protection, children rely fully on themselves and on strangers, and could be easily lured into transactional sexual, abusive labor relationships or follow false promises of work and/or education opportunities.

> *"There is a heightened risk of human trafficking for the recruitment by armed groups, for labor exploitation in the villages or in Pemba, and for sexual exploitation. People offer education opportunities, but children end up doing other things and are being exploited."*
>
> – CP Specialist, Pemba

Cases of unaccompanied children with disabilities are particularly challenging, particularly in case of children who do not speak and cannot provide information about their parents. Finding host families and accessible accommodation for them is another significant difficulty.

3.3.3 Child Work and Child Labor

> *"Parents need all the help they can get to ensure the family's needs are covered."*
>
> – CP Specialist, Pemba

Whereas children would contribute to household tasks and carry out chores already before the emergency, they seem to have become increasingly involved in domestic work and in small informal business to help the family make a living and cover basic needs. According to CP Specialists, boys aged 10 to 17 are also vulnerable to be pulled into street vending or to carrying out various work within the community without any or adequate remuneration. The increase of children carrying out household chores and involved in street vending may also be connected to the school closures caused by the COVID-19 pandemic and effects of the conflict.

14 Social services, also referred to as "Social Action" (Accão Social") are part of the Ministry of Gender and Social Action. The Ministry has Provincial Directorates (Direcção Provincial de Género, Crianças e Accão Social) in all provinces. At district level the function is carried out by District Service of Health and Social Affairs (Serviço Distrital de Saúde, Mulheres e Accão Social, SDSMAS).

15 Several CP Specialists perceived children younger than 10 years as more vulnerable, due to their development stage.

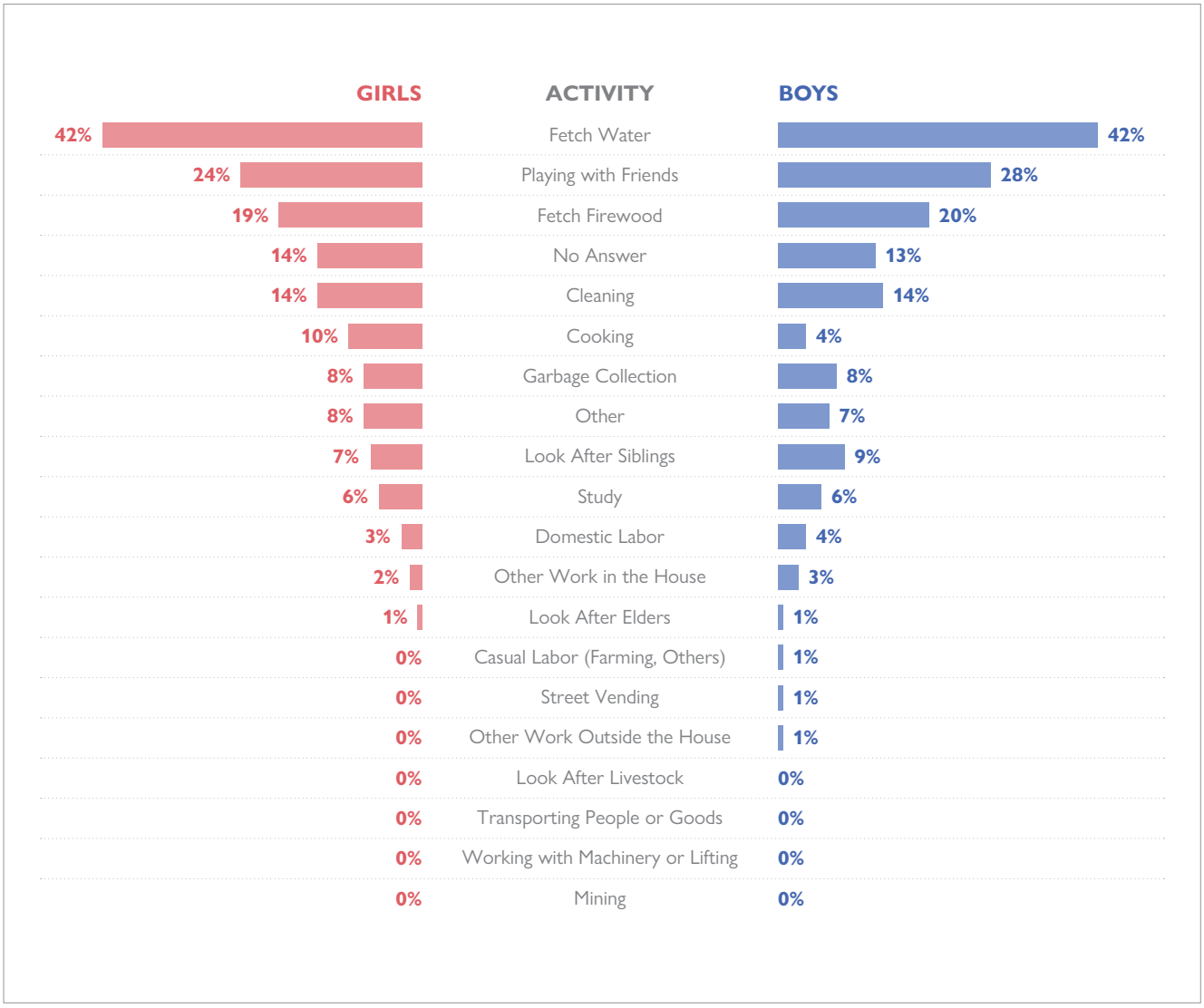
> *In Pemba there are many children wandering the streets. The number of children selling things on the streets has increased, difficult to say if they are mainly IDPs or if there are also cases of trafficking."*
> – CP Specialist, Pemba

When asked about the two top activities that children in the HH carry out, heads of HH reported mainly household chores and "playing". This is in contradiction to what CP Specialist relate, who ranked child labor as a high CP risk. Heads of HH responses may have been influenced responded this question, in full awareness that "playing" is the "acceptable", socially desirable response and knowing that child labor is illegal.

According to heads of HH, girls and boys carry out relatively similar activities. The main activity for girls and boys (42% each) is fetching water, followed by playing with friends (25% girls / 28% boys), fetching firewood (19% girls / 20% boys) and cleaning (14% each). Other activities include cooking (10% girls / 4% boys), garbage collection (8% each), looking after siblings (7% girls / 9% boys), study (6% each), domestic labor (3% girls / 4% boys) and other work in the house (2% girls / 3% boys). As mentioned above, studying was only mentioned as a main activity for 6% (for girls and boys) of the children, which is an especially low percentage that might be partially explained by the current closure of schools due to the pandemic and conflict.

In their responses to the question "Who normally fetches water", local KI somewhat contradict heads of HH, insofar as out of 180 responses, 29 stated that "all children" normally fetch water against 13 for "girls", and 2 for "boys".

Graph 5. The two (2) main activities of children in the household, according to heads of household



3.3.4 Child Trafficking

"Adolescents and parents can easily be deceived into accepting offers for children going to work in the city; traffickers target IDP parents, who will easily let their children go and lack awareness of the potential consequences."
– CP Specialist, Palma

There is a lack of data on child trafficking, but several CP Specialists concurred[16] that the risk of child trafficking has increased, especially for displaced, unaccompanied and separated children, teenage girls and children with albinism who can be kidnapped for body parts and murdered.[17] The dire situation, the lack of food and the scarcity of basic services as well insecurity may encourage parents or children to accept offers for children to work away from their homes.

CP Specialists have noted an increased number of children selling in the streets of Pemba, however, it is not known if these children were trafficked, are displaced, or if they decided on their own or with their families to come to Pemba to seek out income generating opportunities.

According to CP Specialists, awareness on trafficking is very low and;

"Parents may feel lucky when someone offers to take their children to the city."
– CP Specialist, Quissanga

"Parents are overwhelmed and willing to send children away to the city with strangers".
– CP Specialists, Metuge and Quissanga

"Strangers approach displaced parents to offer work/ study opportunities for children. Metuge reported that three (3) children went to Pemba with their parents' consent. The parents were told that the children would work in families as nannies but instead they were forced to work as street vendors. Parents allow their children to leave because they are convinced that children will have a better life; they don't believe that their children will be exploited; only later, when they don't know where their children are they become concerned."
– CP Expert, Pemba

Out of the key informants interviewed in 111 localities, only one (1) declared being aware of people offering children of the community the opportunity to travel to another location or outside the country for work since the beginning of displacement; according to the same KI, this opportunity was offered to girls. The remaining key informants stated that there was no instance of people offering such opportunities (103) or that they did not know about it (7).

The same KI were asked if anybody had offered the children of this community the opportunity to travel to another location or outside the country for education since the beginning of displacement. The great majority responded "no" (101) or that they did not know (5). However, five (5) key informants knew of cases where such an opportunity had been offered to children of the community; four (4) KI said the opportunities were offered to both girls and boys, while one KI stated that the opportunities were offered to boys only.

"Displaced children are at higher risks of being trafficked, during their movement to seek protection as well as in the sites. Due to the situation in Cabo Delgado, there is also a higher risk of trafficking for [forced recruitment by] armed groups."
– CP Specialist, Pemba

No data is available on the recruitment of children by Non-State Armed Groups, but CP Specialists for the Districts of Quissanga, Ibo and Mocimboa de Praia, mentioned this issue as a serious risk and provided anecdotal evidence:

- "Many UASC have been recruited or kidnapped. In Mocimboa da Praia, during attacks, many boys were taken; some could get free, others were shot. In June, the military identified a group of 17 children, 10 boys and 7 girls under 18 who were released/fled and were on their way to Pemba."
- "20 children were trafficked from Quissanga, most of them boys around 17 years old. They were recruited to go to Islamic schools but then exploited or trained to fight; some girls were kidnapped from Quissanga too."
- "Girls aged 16-17 are at high risk of being kidnapped. There are no cases actually identified but lots of anecdotal evidence that girls around 17 years were abducted as 'wives'."

16 As to table # 6 ten, 10 out of 24 CP Specialists mentioned trafficking as a risk for children.

17 The KI mentioned Cabo Delgado as one of the provinces with high number of trafficking of persons with albinism.

3.3.5 Sexual Exploitation and Sexual Abuse

"Sexual exploitation and abuse have increased during displacement. Due to the dire living conditions and fight for survival, parents accept or "turn a blind eye" to their children being sexually exploited in exchange for money or food. This can also include or lead to child marriage."
– CP Specialist, Ibo

CP Specialists in Pemba, Ancuabe, Quissanga, Montepuez, Muidumbe, Palma Ibo and Nangade mentioned the risk of sexual exploitation in the form of transactional sex for food and money as a coping mechanism for displaced families. One CP Specialist in Pemba raised the specific concern about transactional sex for humanitarian aid: *"New forms of exploitation emerging, such as sexual exploitation and abuse, transactional sex for food and humanitarian aid with girls offered by parents in exchange for food"*. According to the CP Specialists, adolescent displaced girls are especially vulnerable to sexual exploitation, as well as girls with intellectual and hearing disabilities.

Apart from adolescent girls, CP Specialist also showed their concern about the vulnerability of smaller children to sexual abuse, since caregivers often have to be absent for longer time periods whilst catering for the families' needs, looking for food and fetching water.

As to the results from HH interviews, fetching water is the main activity for girls and boys (42%) and fetching firewood is the third main activity for girls (19%) and boys (20%). Both activities lead children away from their families and pose risks for their safety. This is compounded by the fact that, of the 111 localities assessed, 43 have waterpoints further than 500 meters away from where the families live, posing a possible risk to women, girls and boys for sexual abuse as well as other CP violations, including abduction and trafficking. A total of 72.3% of children are involved in a chore or income generating activity that requires them to leave the house.

Sexual abuse can lead to early unions, where - as CP Specialists underlined - there is a tendency that families agree that the perpetrator marries the girl, if he pays a "fine" to the parents. This practice is also perceived to "save the honor" of the family. Several of the CP Specialists expressively mentioned this as a harmful "traditional practice" in communities.

"Instances of sexual violence are mainly resolved internally. The victims' family is paid off by the perpetrator, who then continues with abuses".
– CP Specialist, Metuge

"Due to the lack of services, the families sit together and make arrangements on their own, even if they have to make a union between the child and the one who has abused her."
– CP Specialist, Montepuez

3.3.6 Early Unions

"IDP parents may more easily consent to marriage of a girl in order to get some goods/ resources to sustain their other children. They may see the offer as "help" and see themselves forced to accept."
– CP Specialist, Pemba

Heads of HH declared that the vast majority of the children (98% of girls and 98% of boys) as being 'single'. This contradicts the 2011 DHS, which shows Mozambique as one of the countries with the highest rates of child marriage in the world, affecting almost one in every two girls, and with the second highest rate in the eastern and southern African sub-region. Some 48% of women in Mozambique aged 20 to 24 were first married or in a union before the age of 18, and 14% before the age of 15 (DHS, 2011).[18] Early union is also a widely spread practice in Cabo Delgado province. As to a publication by UNICEF, based on DHS data,[19] 17.6% of women married before reaching the age of 15 and 60.7% before the age of 18, while 5.2% of men married before reaching the age of 18. According to CP Specialists, early union has become an increased risk for IDPs, especially teenage girls. Head of HHs responses may have been influenced by what is socially desirable, and legally permissible.

CP Specialists in Pemba, Ancuabe, Chiure, Ibo, Mueda, Montepuez, Palma and Quissanga mentioned that early unions have increased due to the current emergency situation. They link this with an increase in sexual violence as well with scarcity of resources and increased economic vulnerability of the family.

"Child unions are a risk and have been increasing due to displacement, the lack of food, and all other basic needs. Parents marry their kids, in order to get something in return."
– CP Specialist, Mueda

"Families and children become more vulnerable; they may be approached by older men who offer to "marry" girls to give them a better life in exchange for a compensation; families hand girls over, unaware of law and risks."
– CP Specialist, Palma

18 Available at: https://www.unicef.org/mozambique/en/child-marriage-mozambique.

19 UNICEF, Prematuro e Gravidez na Adolescência em Moçambique: Causas e Impacto, 2015.

Beyond the loss in income and reduction in economic opportunities, other factors may lead to early marriage. These include the closure schools and scarce access to Sexual and Reproductive Health (SRH) services, which are now virtually non-existent and may also lead to an increase in early pregnancies.

The household level data found no correlation between food insecurity and child unions. This could be due to several reasons:

1. The proportion of food insecure households is very high.
2. The RCSI is a snapshot of food security levels of the past 7 days. A household's level of food insecurity today is not necessarily indicative of the level of food insecurity when the decision was made for a child to marry.

3.3.7 Physical Abuse, Violence and Neglect

CP Specialists raised concerns that displacement may exacerbate neglect and abuse. Small children may be left alone in shelters when parents are out to look for income generating activities, try to find food and fetch water and thus expose children to potential risks of violence from strangers.

Physical violence against children may also occur from the side of parents, due to their increased stress level and experienced trauma.

According to CP Specialists, children younger than 10 years, children with disabilities and children with albinism are most vulnerable to neglect and abuse.

In addition, host community children may be at a heightened risk due to the increase in population (with the influx of IDPs) or be neglected where scarce resources need to be shared.

> *"It is too early to link certain dynamics, like violence and neglect, back to displacement only. They may also be exacerbated by the COVID-19 pandemic, aggravated economic problems, and increased poverty. Parents have other priorities than childcare. The lack of food may lead to further neglect and malnutrition."*
>
> – CP Specialist

3.3.8 Children with Disabilities

> *"Children with disabilities tend to suffer from discrimination, neglect, abuse and sexual abuse when they are left without support."*
>
> – CP Specialist

Based on the interviews with displaced households, 721 cases of disability among children were reported. It is estimated that 428 (32%) households have a child living with at least one (1) disability[20], of which walking (14% of HH), hearing (12% of HH), learning (10% of HH), speaking (9% of HH), and seeing (6% of HH). In addition, it is estimated that 3% of households have a child living with albinism.

Table 7. Percentage of households with a child living with a disability by district

DISTRICT	TOTAL INTERVIEWED HH	NUMBER OF HH WITH AT LEAST ONE DISABILITY	% HH WITH DISABILITY
Ancuabe	105	37	35%
Balama	92	22	24%
Chiure	145	36	25%
Cidade De Pemba	175	57	33%
Ibo	150	39	26.0%
Mecufi	101	36	36%
Metuge	122	58	48%
Montepuez	112	41	37%
Mueda	148	54	37%
Namuno	77	17	22%
Nangade	110	31	28%
Grand Total	**1337**	**428**	**32%**

20 The number of cases of disabilities is higher than the number of households, as some households have more than one children with disability, or a child with more than one disability.

Among the total of child population[21], around 721 cases of disability were identified, which roughly corresponds to 10 - 12% of children. The distribution of 721 cases among disability type was the following: walking (26%), hearing (22%), learning (19%), speaking (16%), seeing (11%) and albinism[22] (6%).

According to most of the CP Specialists, children with disabilities are at special risk during displacement; due to physical, sensory or intellectual or psychosocial impairment they may not be able to move as fast or with clear sense of direction and may stay behind or be left behind in case of an attack.

Table 8. Number of cases of disability identified among children and frequency distribution of disability type*

DISABILITY	NUMBER (% OF HOUSEHOLDS)
Walking	186 (26%)
Hearing	156 (22%)
Learning	138 (19%)
Speaking	118 (16%)
Seeing	80 (11%)
Albinism	43 (6%)
Total	**721**

* Some households have several children with the same disability or one child with more than one disability.

Furthermore, according to the interviewed CP Specialists, children with disabilities are more vulnerable to neglect and abuse and are exposed to harm when left alone, since they may not be able to fully take care for themselves or defend themselves in case of attempted violence. Specifically, girls with intellectual and hearing disabilities were mentioned to be at an increased risk of sexual abuse. It might also be difficult or impossible for children with disabilities to access food, water and sanitation, health, education and other basic services, as well as the required assistive devices or rehabilitation services The lack of such services and the social deprivation and trauma may increase the prevalence of childhood disability, as developmental delays, especially among younger children, can turn into disabilities when no early intervention is performed.

Child labor and early marriage were not perceived as CP risk for children with disabilities[23], while trafficking was seen as a risk for children with albinism.

3.3.9 Mental Health and Psychological Distress

> *"There is an increase in people with the appearance of sadness and fear, or restraint due to armed attacks and stress."*
> – CP Specialist, Ancuabe

Mental health and psychological distress represent one of the main risks for all children, but this is especially the case for displaced children who suffer psychological trauma as they often witnessed violence, saw villages burn and sometimes saw their parents or other persons being killed.

> *"Many children have become aggressive due to the traumatic episodes they have witnessed. They don't laugh, don't play, are apathic. All support should be provided to those children, but there is a lack of access to mental health services after arrival in host communities."*
> – CP Specialist, Pemba

> *"Some children tend to isolate, others become violent, or are not talking. They are afraid of soldiers, of helicopters, of people - anyone, including those who try to help them. Most of the children are still hiding in the field, in distress, in pain, some have lost their parents, and some were even present when their parent got killed. They suffer psychological trauma, live in fear, and have no hope".*
> – CP Specialist, Montepuez

Respondents of the household-level survey were asked whether a child/children in their household were exhibiting any of 13 symptoms of trauma/stress. All interviewed households (100%) reported at least 1 symptom of child stress/trauma in their home, with headaches (41% of HH), social withdrawal (37% of HH), and excessive crying (28% of HH) being the three most commonly reported symptoms. Given that the interviewed population is predominantly comprised of conflict-affected IDPs, many of whom having been displaced more than once, this is unsurprising.

21 5,820 children, as to heads of HH information.

22 Albinism is not globally considered a type disability unless accompanied by visual impairment. However in many African countries, persons with albinism, due to social stigma and discrimination, face similar barriers to persons with disability.

23 While children with disabilities may not be at higher risk of involvement in most forms of child labour, they are at higher risk of being used for begging. Also, disability organizations in Mozambique have mentioned early marriage as a risk for women with hearing impairment.

Table 9. Have you seen signs of distress such as changes in behaviors in family members below the age of 18 since the conflict began?

CHANGES IN BEHAVIOR	% OF HH
Headaches	41%
Withdrawn from family and friends	37%
Excessive crying	28%
Startled easily	23%
Changes in appetite or eating habits	21%
Angry or aggressive outbursts	20%
New or recurring fears (fear of the dark, fear of being alone, fear of strangers)	16%
Upset stomach or vague stomach pain	15%
Nightmares or sleep disturbances	12%
Going back to behaviors present when a younger age	1%
New or recurrent bedwetting	1%
Clinging, unwilling to let you out of sight	1%
Substance use/abuse	0%

In addition, when asked about their main concerns for the health and safety of their children, 11% of heads of HH (555) mentioned "stress, nightmares, sadness, and similar signs" while 10% (95) mentioned "emotional harm".

Data on households were grouped according to the number of stress/trauma symptoms reported as an assumption/indication of the magnitude of child stress/trauma experienced in the household.[24]

MHPSS need per household has been calculated based on the following assumptions:

Table 10. MHPSS need calculation assumptions

MHPSS NEED	# OF CHILD STRESS/ TRAUMA SYMPTOMS PER HH	% OF HH PER CATEGORY	COMMENT
Low	1	24%	"Low, Medium, High" was used to simplify the explanation of the data analysis, however households with a symptom of child stress/trauma are in reality higher than a "low" level of need.
Medium	2	38%	
High	3 or more	38%	

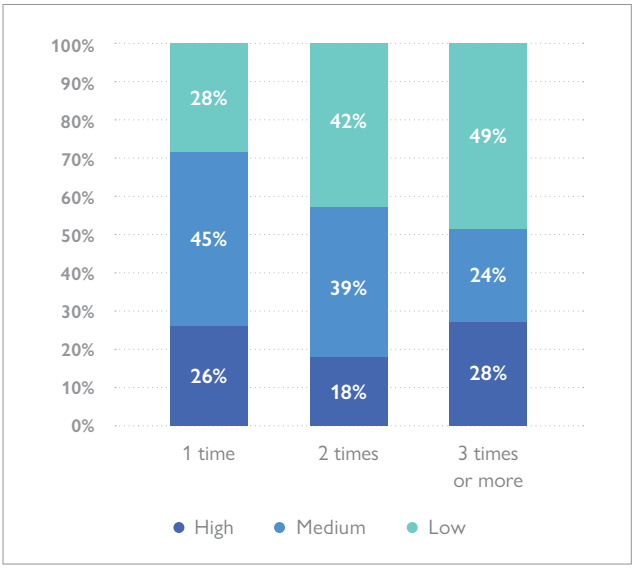
Data on household MHPSS need was then analyzed with other indicators to determine whether a correlation between situational factors could be inferred. It is not possible to correlate child stress/trauma with age group, as this data was not collected for each child.

Secondary Displacement may be a potential aggravating factor impacting on child stress/trauma.

24 Note: There are flaws with this assumption because it does not measure the number of symptoms experienced by each child, rather, it measures the variety of symptoms experienced amongst all children in a household, however can be indicative of MHPSS need per household.

Looking at the graph below, it appears that the **magnitude of MHPSS need increases with the number of secondary displacements.**[25] Only 28% of households that had been displaced once (before the current displacement) reported high MHPSS needs, rising to 42% of households twice displaced (before the current displacement), and 49% of households displaced 3 or more times (before the current displacement).

Graph 8. %HHs in Need of MHPSS by Secondary Displacement



Of all interviewed households, the most commonly reported parental concerns were access to appropriate food (88% of all households), access to education (42% of all households), and access to healthcare (33%).

The following table endeavors to obtain hints about aggravating factors that could increase child stress/trauma in a household. If we assume that "MHPSS Need" reflects the magnitude of child stress/trauma in a household, it is worth exploring whether parental concerns may reveal some of the sources of child stress (in addition to conflict and displacement).

The following list of parental concerns are comprised of those that may also increase the stress of a child (e.g. food, discrimination, education etc). The table looks at the proportion of households within the MHPSS Need group reported having each parental concern. For example, out of the 327 households that are within the MHPSS "Low" Need category, 39% of those households reported that education is a priority concern).

The magnitude of MHPSS need at household level was also analyzed with indicators related to disability and food insecurity, however no correlation was found.

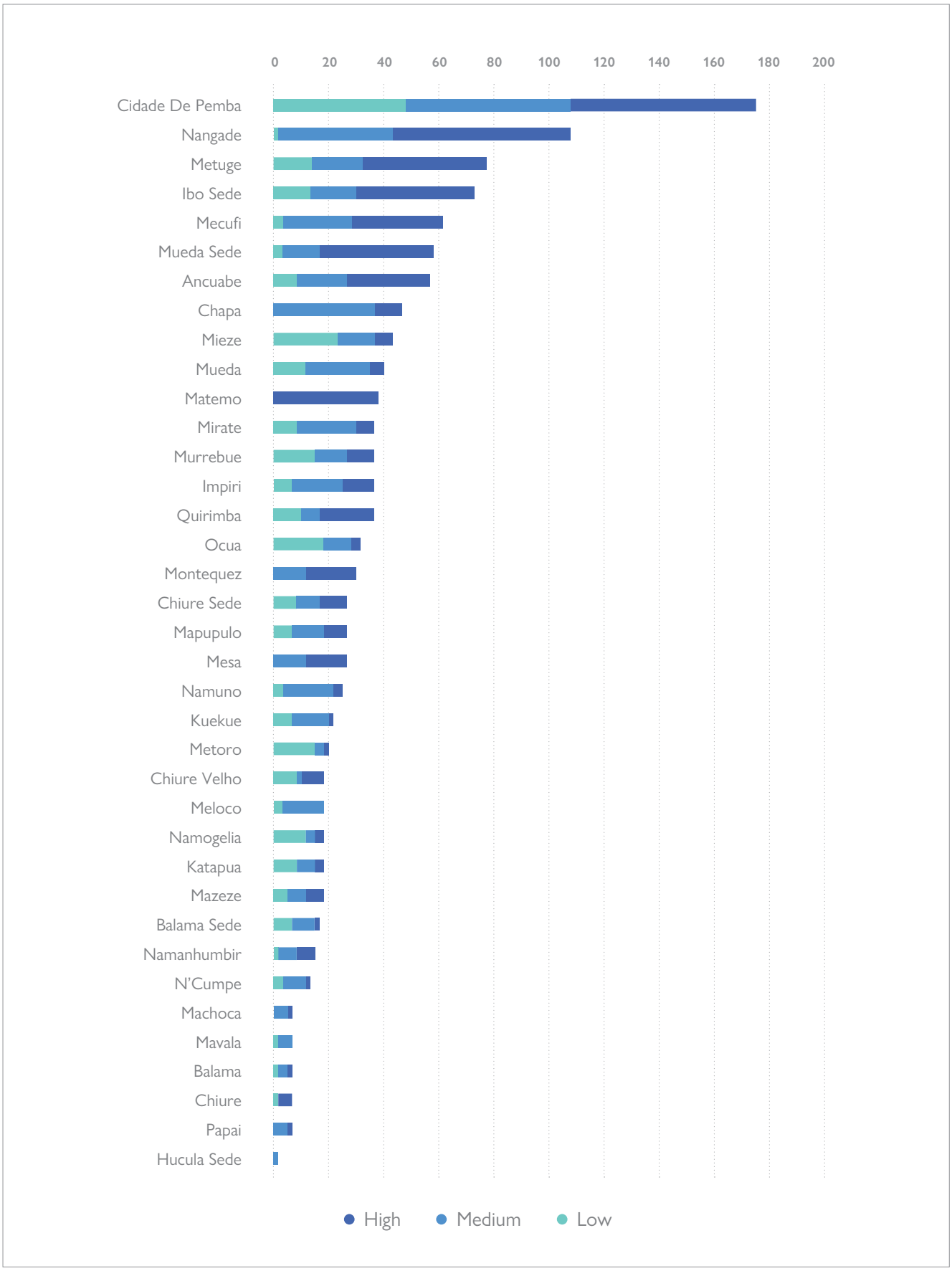
Table 11. The proportion of households within the MHPSS Need group

MHPSS NEED (MAGNITUDE OF CHILD STRESS PER HH)	PARENTAL CONCERNS								TOTAL HHS
	Missing Children	Dangerous Situation	Discrimi-nation	Emotional Harm	Food	Education	Physical Harm	Nightmares	
Low	2%	4%	2%	7%	89%	39%	8%	5%	327
Medium	1%	10%	2%	5%	88%	40%	7%	7%	507
High	3%	14%	2%	19%	87%	45%	7%	19%	503
Average of Total	**2%**	**10%**	**2%**	**10%**	**88%**	**42%**	**7%**	**11%**	**1337**

The following graph depicts the number of interviewed IDP households with low, medium and high MHPSS needs per location. Cidade de Pemba hosts the most IDP households, so it is not surprising that 125 households (71.4% of IDP HHs in the location) are reporting medium-high need of MHPSS. Although Nangade is hosting fewer IDPs, there are 108 households (98% of all IDP HHs in the location) that reported medium-high need, while most (93%) of households in Mecufi and Mueda Sede also reported medium-high need of MHPSS.

25 The number of households that did not face secondary displacement were not included in this analysis, as they represented too small of a sample (only 10 HH).

Graph 9. Admin Level 3: HHs per MHPSS Need



3.4 AVAILABILITY AND AWARENESS OF PROTECTION SERVICES AND PRIORITY LOCATIONS FOR RESPONSE

3.4.1 Availability and Awareness of Protection Services

When analyzing responses from local KI, it is clear that there exists a general lack of services, which has been exacerbated by the emergency. The limited presence of services or their current inactivity due to the crisis is likely to have led to significant gaps. The most severe gap is in the provision of mental health and psychosocial services, with only 11 localities (12%) having access to these services. Services for the identification of UASC are only available in 26 localities (23%) and family tracing and reunification is only available in 28 localities (25%). The provision of services for case management (42%), social workers (45%), legal support (47%), and healthcare (49%) is better but remains available in over half the localities assessed.

Table 12. Existing services in or near the community (according to local KI)

SERVICE	I DO NOT KNOW / NO ANSWER	NOT PRESENT	PRESENT BUT NOT CURRENTLY OPEN/ACTIVE	PRESENT AND CURRENTLY OPEN/ACTIVE
Identification of unaccompanied minors/separated children	2%	61%	14%	23%
Family tracing / reunification services	5%	59%	12%	25%
Services to help people mentally recover from stress and trauma	10%	69%	9%	12%
Case management for victims of violence (referral to health, mental health, legal, and other services)	5%	42%	10%	42%
Social workers	4%	42%	9%	45%
Legal support	4%	39%	11%	47%
Medical/Healthcare	4%	41%	6%	49%

Table 13. Head of households' awareness of availability of services

SERVICE	I DO NOT KNOW / NO ANSWER	NOT PRESENT	PRESENT BUT NOT CURRENTLY OPEN/ACTIVE	PRESENT AND CURRENTLY OPEN/ACTIVE
Identification of unaccompanied minors/separated children	14%	55%	7%	24%
Family tracing / reunification services	15%	50%	13%	22%
Services to help people mentally recover from stress and trauma	17%	55%	12%	17%
Case management for victims of violence (referral to health, mental health, legal, and other services)	15%	35%	13%	37%
Social workers	13%	38%	10%	39%
Legal support	16%	43%	8%	33%
Medical/Healthcare	7%	34%	8%	51%

Represented in the table below are the answers to the same question asked to interviewed displaced HH. Overall results are in line with the information shared by key informants. Respondents' awareness of services shows that there is a lack of mental health services as well as services for the identification of UASC and family tracing/reunification; legal support services, social workers, case management and healthcare are more widely available but remain insufficient. It is interesting to note that, while the overall results for households and key informants are in line, there seems to be a lower awareness of the presence of certain services from displaced households or a perceived higher presence from key informants.

Generally, the capacity of the government in child protection is limited, but, according to KIs, social services, police and health services are present in all locations (except Macomia, Quissanga and Mocimboa da Praia). A child protection INGO will discontinue operations in Macomia in March 2021, because no service providers are left; it is likely that the same is the case in other affected districts.

At community level, Child Community Committees (CCPC) are responsible for all CP concerns. They are entry points and refer the cases, usually to SDMAS ("Social Action").

As to CP Specialists, the following services and service providers exist for separated children: SDMAS, INAS, health services, education/schools; ICRC; Save the Children family tracing and reunification (FTR) services; IOM's MHPSS teams; INGO's PSS services.

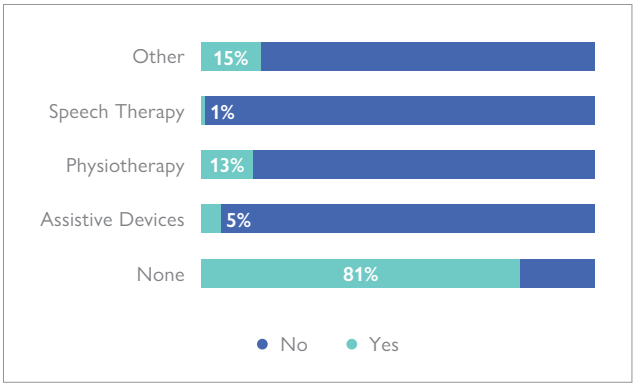
Services for children who are survivors of sexual abuse include social services; *Gabinete de Atendimento à família e vitimas de violência;* police stations, prosecutors office; *Instituto de Patrocínio e apoio Jurídico-IPAJ* (legal aid); Mulher, lei e desenvolvimento (MULEIDE); *Associação Moçambicana de Mulheres de Carreira Jurídica-(AMMCJ)*; IOM's MHPSS teams and INGOs. At community level, activists who do community outreach/HH visits.

However, CP experts agree that these services are insufficient, and all services are overstretched, Social and health services are not present everywhere. For instance, in Metuge, there are only two (2) social workers for an estimated 40,000 IDPs; and mobile health brigades do not serve all localities.

Specialized Services for Children with Disability

According to local KI, **specialized services for children with disabilities** are hardly available. 81% of KI state that there are no services for children with disabilities, 13% state that physiotherapy is available, 5% for assistive devices, and 1% for speech therapy.

Graph 10: Services available to children with disabilities (according to key informants)



CP Specialists related information that corroborates Ki's data; CP Specialists stated that there are few specialized services for children with disabilities and that, usually, children with disabilities use the same services as other children but face many challenges, including difficulties in accessing services and communicating their needs.

There is a general lack of training on working with children with disabilities. Some organizations and "Social Action" have personnel that have been trained to work with children with disabilities, however for specialized services such as physiotherapy, children need to go to Pemba. "Social Action" has also limitations in providing sufficient support, in terms of technical capacity and human resources, despite its activists carrying out outreach and household visits.

In addition, there is a lack of access to assistive devices from government sources/health services. Save the Children International offers some devices in the framework of case management as part of UNICEF and AVSI project. SCI's activists have basic training on disability care and what to consider in case management process.

Access of children with disabilities to regular services is not fully guaranteed; access to education will be especially difficult for displaced children with disabilities once schools reopen. Teachers will be overstretched to attend to the increased numbers of students and will not be able to pay special attention that children with disabilities may require. Schools also may not have the accessible physical infrastructures and conditions to facilitate the participation of children with disabilities, and teachers may lack training on how to assure that children with disabilities are being integrated and assisted.

59% of local KI stated that water points and sanitation infrastructures such as toilets are not accessible to people with disabilities (especially wheelchair users).

Obstacles to Access Services

According to CP Specialists, obstacles to access services included language barriers, distance to services, lack of knowledge about services and how to access them, and lack of resources to access services. Generally, services and local resources are limited and may not be able to cover the local population as well as all IDPs.

In addition, for unaccompanied and separated children, there is a lack of capacities among government and non-government staff and specialized services.

For cases of abuse and violence, one CP Specialist mentioned that the referral pathways were not fully functioning. There is also a lack of training on GBV and CP for police forces, resulting in a lack of trained police officers to attend to GBV and CP violations.

3.4.2 Priority Locations for Response

Priority Geographic Areas to Set Up Case Management

The following severity scale was developed for choosing priority geographic areas to set up case management. Please note that the % IDPs aware of services was not included, as most IDPs were either not aware or services, or the services did not exist in a location, which rendered the indicator ineffective for comparing geographic locations.

Table 14. Severity scale was developed for choosing priority geographic areas to set up case management

SEVERITY THRESHOLDS	THRESHOLDS				COMMENT
	Low (1)	Medium (2)	High (3)	Severe (4)	
% of all IDP children per location (KI data)	0-5%	6-10%	11-15%	Over 15%	Increases severity weighting in locations with more IDP children
Average Proxy Score: • % HH's with "Severe" RCSI • %HH in high risk shelters • %locations with water further than 500m • %locations with health further than 30min	0-15%	16-30%	31-45%	Over 45%	Increases severity in locations that have more HH's with 3 or more stress/trauma symptoms
Service Availability: Case Management (% localities with functioning services)	100-75%	75-50%	50-25%	25-0%	This one is not included in the average services so that it has more weight/influence on the final score
Service Availability: Average severity of all other CP & Medical services	1	2	3	4	

The following severity scale was produced, highlighting that Metuge is a location that should be considered for priority response. Note: the data used to calculate the severity scale was obtained from KI and HH data. Other qualitative data and expert key informant data could not be incorporated into the calculation. It is imperative that the Overall Severity result be adjusted if necessary based on expert judgement and other information sources. Prioritization should take humanitarian access and programmatic priorities into consideration.

Table 15: Severity scale was produced, highlighting that Metuge is a location that should be considered for priority response

DISTRICT	SEVERITY RANKING				
	% of All IDP Children	Case management Availability	Availability of Other CP & Medical Services	Average of Proxy Indicators	Overall Severity
Ancuabe	1	4	3	2	3
Balama	1	1	2	3	2
Chiure	2	3	2	2	2
Cidade de Pemba	4	4	3	3	3
Ibo	1	1	2	4	2
Mecufi	1	2	3	3	2
Metuge	4	4	4	3	4
Montepuez	3	2	4	4	3
Mueda	2	4	4	2	3
Namuno	1	4	3	3	3
Nangade	2	2	4	3	3

Priority Areas to Set up MHPSS

The following severity scale was developed for choosing priority geographic areas to set up MHPSS services.

Although "%" of IDPs not aware of services was initially selected as an indicator to help determine severity per location, it was removed from the scale because almost all IDPs are either not aware of MHPSS services, or they don't exist in their area (making the indicator ineffective for comparing severity between locations).

Table 16. Severity scale was developed for choosing priority geographic areas to set up MHPSS services

SEVERITY THRESHOLDS	THRESHOLDS				COMMENT
	Low (1)	Medium (2)	High (3)	Severe (4)	
% of all IDP children per location (KI data)	0-5%	6-10%	11-15%	Over 15%	Increases severity weighting in locations with more IDP children
% HH in MHPSS "HIGH" Need Category per location (HH data)	0-15%	16-30%	31-45%	Over 45%	Increases severity in locations that have more HH's with 3 or more stress/ trauma symptoms
Service Availability: MHPSS Services (% localities functioning) (KI Data)	100-75%	75-50%	50-25%	25-0%	Adjusts the severity based on the availability of MHPSS services in each location

The resulting severity scale was produced for areas in severe need of MHPSS services. The reported general absence of MHPSS services in all districts has pushed the severity scores per location up. Considering that the "available MHPSS services" is based on information from non-specialist KI's, it is recommended to review the overall severity score based on qualitative information and expert contextual knowledge.

Table 17: Severity scale was produced for areas in severe need of MHPSS services

DISTRICT	SEVERITY RANKING			
	% of All IDP Children	% HH's in High Need of MHPSS	Available MHPSS Services	Overall Severity (average of 3 columns)
Ancuabe	1	3	4	3
Balama	1	2	3	2
Chiure	2	2	4	3
Cidade de Pemba	4	3	4	4
Ibo	1	4	2	2
Mecufi	1	3	4	3
Metuge	4	2	4	3
Montepuez	3	3	4	3
Mueda	2	2	4	3
Namuno	1	1	4	2
Nangade	2	4	4	3

Photo: © IOM Mozambique

Priority Districts to Set Up Alternative Care for UASCs

The following severity scale was developed for choosing priority geographic areas to set up MHPSS services

Although key informant data on the number of UASC's are estimates by non-specialists, and therefore cannot be precise, the data can be used as a "red flag" to facilitate the prioritization of locations for follow up to verify needs.

The following severity scale was designed to highlight priority locations for follow up. Indicators were selected based on identification of information needs with UNICEF, and available data at admin level 3. Thresholds were selected based on the data to ensure that all locations are not categorized at the same severity.

Table 18: Severity scale was designed to highlight priority locations for follow up

SEVERITY THRESHOLDS	THRESHOLDS				COMMENT
	Low (1)	Medium (2)	High (3)	Severe (4)	
Unaccompanied # (KI Data)	0-50	51-200	201-800	800+	Separated children # not used, as reported to be grossly over-estimated by KIs. This will raise a "red flag" in locations with high reported numbers of unaccompanied minors.
Service Availability: UASC Identification (% localities functioning) (KI Data)	100-75%	75-50%	50-25%	25-0%	Adjusts severity based on availability of response services
Service Availability: Family Tracing (% localities functioning) (KI Data)	100-75%	75-50%	50-25%	25-0%	Adjusts severity based on availability of response services
Service Availability: Case Management (% localities functioning) (KI Data)	100-75%	75-50%	50-25%	25-0%	Adjusts severity based on availability of response services

Table 19: Severity scale was produced for priority areas to follow up on reported UASCs and their needs

DISTRICT	SEVERITY RANKING		
	Estimated # UASC	Service Availability	Overall Severity
Ancuabe	3	4	3
Balama	1	3	2
Chiure	1	1	1
Cidade de Pemba	4	2	3
Ibo	2	3	2
Mecufi	1	4	3
Metuge	2	4	3
Montepuez	4	4	4
Mueda	1	4	3
Namuno	1	3	2
Nangade	3	4	4

The overall severity score should be adjusted based on qualitative information and expert knowledge of the context in each district.

3.5 OTHER CHILD RIGHTS VIOLATIONS

An increase in the level of displaced and host community children without education can be expected, due to the lack of space and teachers; during displacement, different members of communities move to different locations, often resulting in teachers and the rest of the displaced community being separated in different locations. In addition, displaced children may face exclusion from education in host communities once schools reopen once COVID-19 restrictions are lifted.

Obstacles to access to education may be a problem once schools reopen, e.g.: Metuge has, due to displaced population, 20,000 additional school aged children. There will be a lack of teachers and school rooms since some schools were converted into accommodation centers.

There is an increase in malnutrition, especially amongst IDPs and children without caregivers, due to insufficient food support and stigma and discrimination that these children have suffered. Due to the COVID-19 pandemic and displacement, there is an increasing risk of malnutrition due to the loss of their machambas (fields).

3.6 PROXY INDICATORS OF CHILD PROTECTION RISKS[26]

Access to Health

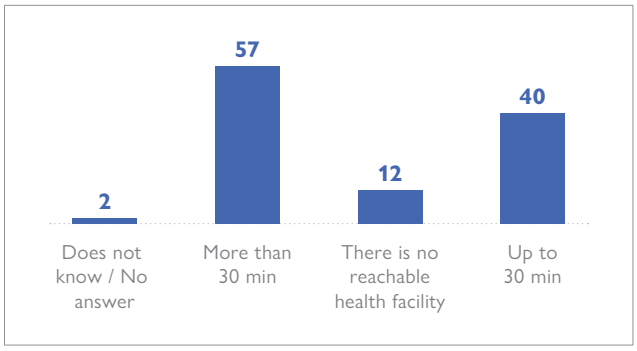
According to local KI, nothing prevents most people from accessing health care in 61 localities. Main obstacles to accessing healthcare in other localities include cost/money (19), lack of transportation (13), the lack of reachable health services (13), and the fear to get infected by COVID-19 (12). No key informants reported any of the following barriers: discrimination, damaged/destroyed health centres, health centres being used for other purposes, disabilities, or the road to health services is not safe.

Table 20. Obstacles to accessing healthcare services (number of localities)

OBSTACLES TO HEALTHCARE SERVICES	PERCENTAGE OF KEY INFORMANTS
Nothing is preventing people	61
Cost/money	19
Lack of transportation to healthcare services	13
There was never a reachable health service	13
Afraid of getting infected by COVID-19	12
People do not have the right documents	8
Other	8
No medicines available in healthcare centre	7
No healthcare personnel available in the healthcare centre	6
Do not know/ no answer	5
Health service are only accessible during part of the day or some days per week	3
Healthcare services are not working	2

When asked about the distance to the closest health facility, key informants responded more than 30 minutes (57 localities), up to 30 minutes (40), that there is no reachable health facility (12), and that they did not know (2).

Graph 11. Distance to the nearest health facility (walking – one way)



Shelter

According to local KI, none of the IDPs sleep outside in 62 localities while "a few" IDPs sleep outside in 22 localities, about half of the IDPs sleep outside in 18 localities, "most" in 8 localities, and everyone in one locality.

Table 21. IDP households in the location that sleep outdoors

% OF IDPS	# LOCATIONS WHERE IDPS SLEEP OUTDOORS	# LOCATIONS WHERE IDPS SLEEP IN EMERGENCY SHELTERS
A few (around 25%)	22	35
About half (around 50%)	18	14
Everyone (around 100%)	1	3
Most (around 75%)	8	18
Nobody (around 0%)	62	41
Grand Total	**111**	**111**

Comparing the key Informant's rough estimation of the proportion of IDPs sleeping outdoors and in emergency shelter per location, with the total estimated number of IDP children per location, reveals that up 86% of IDP children are living in shelters that expose them to greater risks of violence and GBV.

26 These proxy indicators for CP risk and response capacity were included in the severity scale analysis to determine priority geographic areas for response.

Access to Drinking Water

In most localities (67%), displaced households have to walk for 500 meters or less to reach a water point, while in 43 localities, households need to walk for more than 500 meters. In one location, the key informant could not provide this information.

Montepuez and Mueda had the highest proportion of localities with water sources over 500m away, meaning that the children in these locations are at particular risk while collecting water.

In 99 of the assessed localities, women are the primary group fetching water, while in 29 localities it is the responsibility of all children, and in 28 localities it is the responsibility of elder people. Girls fetch water in thirteen localities and boys in two (2) localities.

Table 22. Distance most families are living from the point where they get drinking water

DISTANCE TO WATER	NUMBER OF LOCALITIES
500 m or less	67
Does not know / no answer	1
More than 500 m	43
Grand Total	**111**

Table 23. Proportion of children fetching water per age group and location

% IDP CHILDREN COLLECTING WATER				
District	Age 3-9	Ages 10-14	Ages 15-17	All Age Groups Total
Ancuabe	56%	70%	76%	61%
Balama	32%	88%	74%	49%
Chiure	11%	43%	51%	24%
Cidade De Pemba	24%	68%	59%	39%
Ibo	26%	52%	43%	34%
Mecufi	40%	78%	76%	53%
Metuge	33%	72%	89%	48%
Montepuez	23%	60%	66%	41%
Mueda	15%	50%	53%	31%
Namuno	24%	76%	71%	40%
Nangade	32%	74%	86%	52%
Grand Total	28%	65%	65%	42%

The proportion of children fetching water per age group and location can be seen above, as per the demographic data collected in the household surveys.

According to Key Informants, about 27% of IDP children are living in locations where the water source is over 500m away.

Since children do play a significant role in the household with respect to collecting water, the children in these locations are at greater risk of exposure to violence and other forms of GBV while collecting water.

Table 24. % of IDP children are living in locations where the water source is over 500m away

DISTRICT	% IDP CHILDREN LIVING IN LOCATIONS WITH WATER SOURCE MORE THAN 500M
Ancuabe	68%
Balama	10%
Chiure	4%
Cidade de Pemba	27%
Ibo	78%
Mecufi	17%
Metuge	1%
Montepuez	52%
Mueda	37%
Namuno	76%
Nangade	52%
Grand Total	27%

3.7 TRADITIONAL AND COMMUNITY-BASED WAYS TO RESPOND TO CHILD PROTECTION VIOLATIONS

CP Specialists raised three traditional and community-based ways to respond to CP violations:

- **Separated children** are generally accommodated with host families from the community or with relatives while family tracing and reunification is carried out; whereas this is a positive aspect, CP Specialists showed concerns that this may lead to neglect and discrimination.
- **Sexual abuse and exploitation** are usually resolved within the family setting. Perpetrators are not referred to the legal justice system, but girls may be forced to marry the perpetrator. Families do not usually report cases of violence and early marriage.
- **Early unions** are a coping mechanism for some families. Initiation rites and religious practices continue to influence family behaviors; girls grow up wanting to get married as soon as possible; mothers also grew up like that and have difficulties understanding the negative impact on children.

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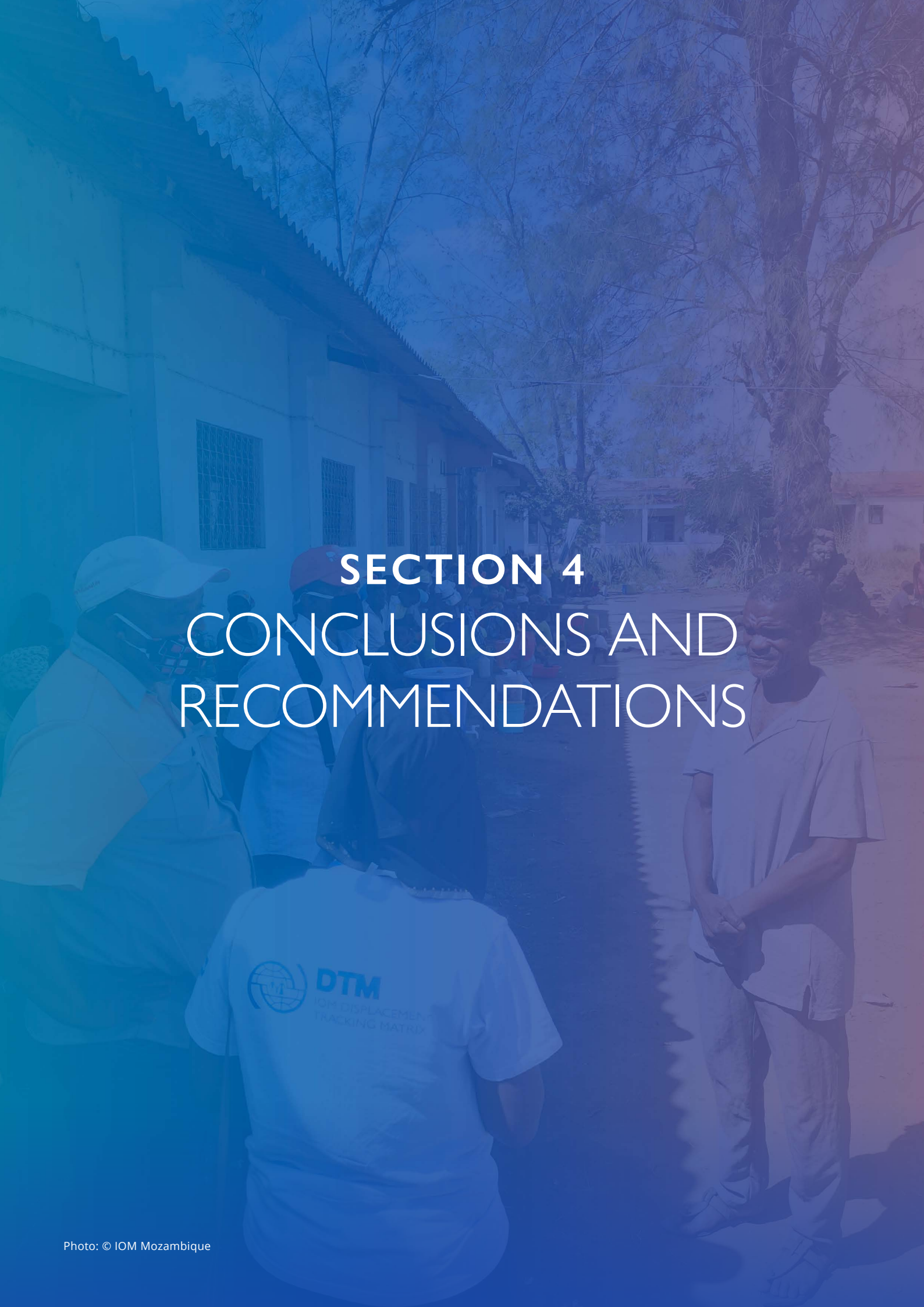

SECTION 4
CONCLUSIONS AND RECOMMENDATIONS

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4. CONCLUSIONS AND RECOMMENDATIONS

4.1 CONCLUSIONS

- Head of HH's immediate and priority concerns about children's health and safety as well as KI's top needs for their localities are mainly about survival – food, shelter, drinking water - and access to health services and education. CP risks and mental health issues were hardly or not at all raised. This is certainly a reflection of the current dire situation, but may also signal that there is a **lack of awareness about CP risks or that CP risks are being misjudged and underestimated compared to "immediate survival needs".**
- Interviewed CP Specialists mentioned separation, sexual abuse and violence, child trafficking, sexual exploitation, and child labor as the highest **child protection risks,** followed by physical abuse and violence, neglect, early unions and lack of documentation. These, already pre-existing CP violations have been exacerbated or are at risk of being exacerbated by displacement.
- Unaccompanied minors and separated children, adolescent girls and children with disabilities are most exposed to all risk for all CP violations.
- Separation has increased the risk of other CP violations, including child labor, trafficking and physical and sexual abuse and exploitation.
- **Teenage girls** are at heightened risk to **sexual abuse and exploitation** and to be forced into early unions. Poverty and desperation can lead parents to accept and/or encourage their daughter's transactional sexual relationships.
- **Sexual exploitation** in the form of transactional sex for food and money as a coping mechanism for displaced families Transactional sex for food was mentioned by various CP Specialist, and explicitly identified once as transactional sex for 'humanitarian aid'.
- Families have to also rely on their children to cover daily needs, which led to an increase in children's involvement in domestic work and in small informal business.
- Anecdotal evidence shows, that the risk of child trafficking has increased, especially for displaced, unaccompanied and separated children, teenage girls and children with albinism. The dire situation, the lack of food and the scarcity of basic services as well insecurity may encourage parents or children to accept offers for children to work away from their homes.
- Anecdotal evidence also indicates a risk of recruitment of children by Non-State Armed Groups.
- Fetching water is the top main activities of children during a weekday. Walking distances for displaced HH to get drinking water are longer than 500 meters in 43 localities. The long distances to fetch water pose a possible risk to women, girls and boys for sexual abuse as well as other CP violations, including abduction and trafficking.
- Heads of HH report a high number of children with disabilities. Whereas children with disabilities are especially vulnerable to various CP risks, specifically to separation, violence and sexual abuse, there are only few specialized services, that cater for their protection, health, mental health and education.
- Heads of HH confirm that **mental health issues** and stress are affecting children living in their households. Children suffering from headaches, are withdrawn from family and friends, cry excessively, are startled easily and show other symptoms of behaviour change and distress.
- The **limited presence of CP and social services** or their current inactivity due to the crisis led to significant gaps. The most severe gap is in the provision of mental health and psychosocial services and identification and FTR services for UASC. CP experts agree that CP services are insufficient, and that all services are currently overstretched. Generally, services and local resources are limited and may not be able to cover the local population as well as all IDPs.
- Most IDPs are provided with **shelter,** but gaps still remain. As to KI, a few" IDPs sleep outside in 22 localities, about half of the IDPs sleep outside in 18 localities, "most" in 8 localities, and everyone in one locality.
- Heads of HH and KI's responses regarding some key questions, specifically early unions and child labor may have been tweaked to reflect **"socially desirable"** and legally permissible behaviour.

4.2 KEY RECOMMENDATIONS

Immediate Response

Geographical Areas for Priority Response

- **Case management:** According to the severity scale, **Metuge** is the location that should be considered for priority response. for case management (**followed by** Montepuez, Mueda, Namuno, Nangade, Cidade de Pemba, Ancuabe)
- **MHPPS**: According to the severity scale Pemba is the location that should be considered for priority response (**followed by** Mecufi, Metuge, Montepuez, Mueda, Ancuabe, Chiure, Nagade)
- **Alternative care for UASC:** According to the severity scale Montepuez and Nangade should be considered for priority response for alternative care for UASC (followed by Cidade de Pemba, Ancuabe, Metuge, Mueda, Mecufi)

Other

Create awareness amongst IDP population and host communities on child protection issues as well as the availability of child protection services.

Educate parents on how to empower **children with disabilities** and improve their safety; do awareness and sensitization activities in the communities to reduce stigma, include children with disabilities in mainstream services through capacity building and support measures, increase specialized services and provision of assistive devices for children with disabilities and ensure physical access to waterpoints and sanitation/latrines.

Design focused protection prevention and response services for **adolescent girls.** These should include SRHS, awareness raising about the protection risks and SGBV and include practical measures, e.g.: minimized distance to water point and latrines; provision of whistles and torches.

Mid- and Long-term Response

Strengthen the child protection system, preventive and responsive services, including formal and informal, government and non- governmental structures that deliver the services, especially social workers and alternative care.

Strengthen psychosocial and mental health services of governmental and non-governmental services.

For Future Child Protection in Emergency Data Collection

Include children, including children with disabilities, through FGD.

Ensure the selection of KI who can provide adequate information on current data and who are provided with additional trainings on more in-depth child protection assessments.

Include organizations of persons with disabilities as key informants.

Adapt and design data collection tools to minimise the occurrence of "socially desirable" responses.

Plan for an additional assessment, since the number of IDPs has significantly changed since this assessment, and in order to include districts that could not be included in this assessment.

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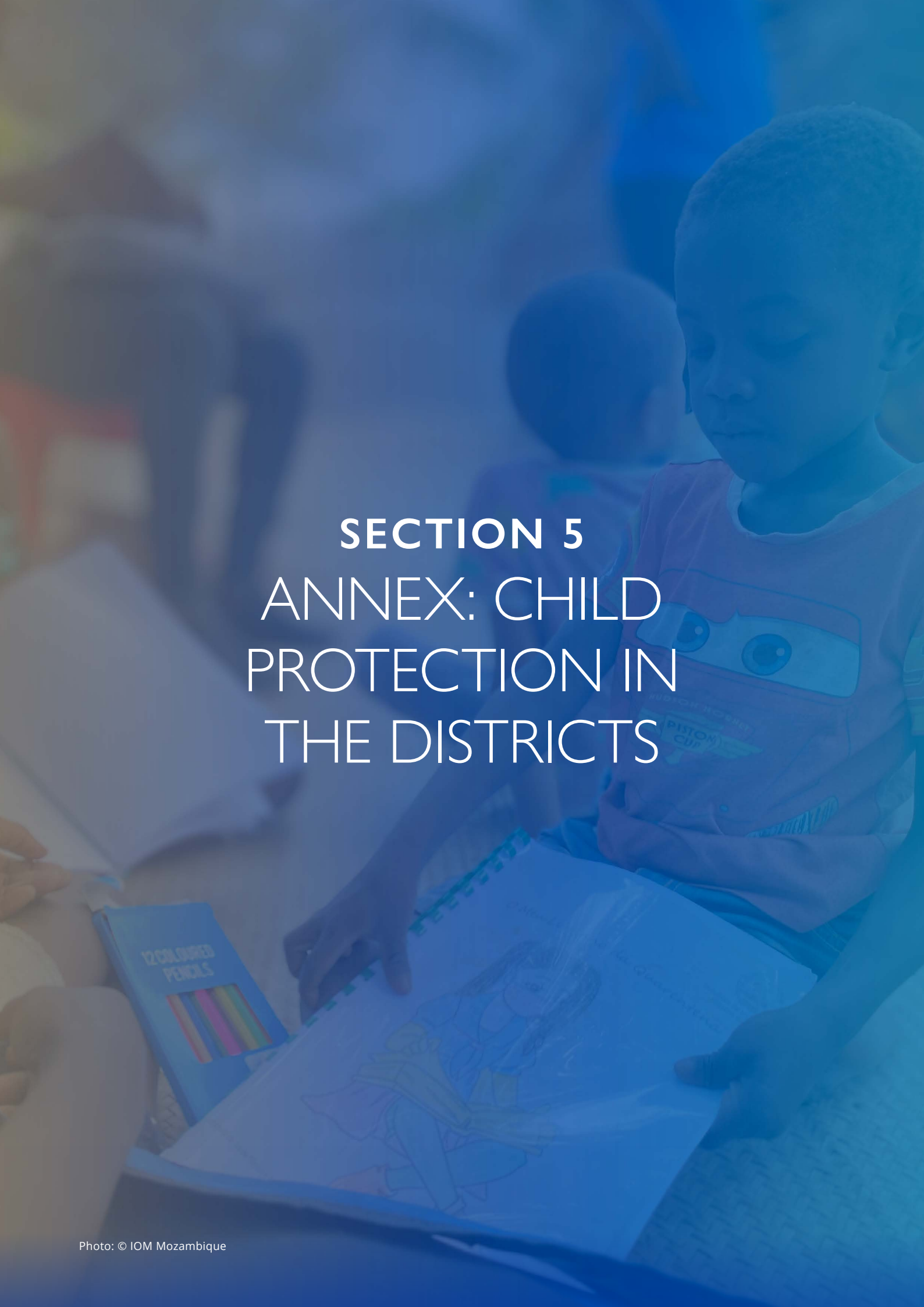

SECTION 5
ANNEX: CHILD PROTECTION IN THE DISTRICTS

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5. ANNEX: CHILD PROTECTION IN THE DISTRICTS

5.1 ANCUABE

- 56% of the IDP population is female and **43% are children.**
- According to KI, Ancuabe has **the third highest number of unaccompanied children of all assessed districts.** This number is not being published as it is a rough estimate made by a non-specialist, however the estimate has been taken into consideration for the severity scale on priority geographic areas for UASC follow-up.
- Ancuabe is the only of the eleven (11) districts where people were, next to conflict, also displaced by **food shortage.**
- According to local KI, **food** (78%), **shelter** (67%) and **drinking water** (44%) are the top three needs for their localities.
- Head of HH's main concerns about their children is access to **food** (63%), followed by access to **education** (42%), and **medicines** (24%).
- According to the CP Specialists, there is a high risk for children getting **separated from their parents** and many children arrive without their parents from neighbouring district. **IDP children and children without caregivers are most at risk.**
- Despite of the high number of separated children, only three (3) out of the nine (9) locations have identification and only one (1) FTR services.
- Distress and changes in behaviour of children were mentioned by all heads of HH, however only one (1) district has MHPSS services.
- In terms of prioritization of geographic locations to set up response, this district has initially been ranked at the following severity levels, however these severity scores need to be reviewed based on expert knowledge of the context:
  - Severity level 3 (out of 4) for case management
  - Severity 3 (out of 4) for UASC follow-up
  - Severity 3 (out of 4) for MHPSS response

Sample and Demographics

KI were interviewed in nine (9) locations, eight (8) rural and one (1) urban.

From the 11 districts, Ancuabe has, according to KI, the 8th largest IDP population. 56% of the IDP population is female and **43% are children:** 23% of IDPs are girls, 20% boys. 58% are adults: 33% women, including 3% elderly and 25% men, including 3% elderly.

Ancuabe is the only district where KI declared that IDPs were displaced due to a lack of food (in addition to conflict). **105 heads of HH** were interviewed, representing a total of 960 members of HH, with an average HH size of 9.1 persons. The **average age of head of household** is 39, the youngest is 18. An average of 4 children living in the household (46% female and 54% male), average age 7.1 for girls and 8.2 for boys.

Interviews conducted with **displaced** households show that 8% of IDP HH had been displaced already once before their current displacement (thus before having settled in their current location); 5% were displaced more than 2 times and 9% displaced more than 3 times (before they had been displaced and settled in their current location). 30% of respondents had not been displaced before this current displacement.

When asked about **children with disabilities,** heads of displaced households recounted hearing impairments (23); learning difficulties (21) and walking disabilities (20). 14 children have difficulties speaking, 8 are sight impaired. Eight (8) children are reported to be living with albinism. Some households have several children with the same or different disabilities.

Needs and Concerns

Needs as Expressed by Local Key Informants

Table 25. Top 3 needs of IDPs identified by key informants

NEEDS	KEY INFORMANTS
Food	78%
Shelter/housing	67%
Drinking water	44%
Health/Sanitation/Hygiene	33%
Civil documents	22%
Household Items (NFI)	22%
Access to income	11%
Cooking/Washing water	11%

According to KI, **food** (78%), **shelter** (67%) and **drinking water** (44%) are the top three needs for their localities.

Also raised were concerns regarding health and sanitation (33%); civil documents (22%), house hold items (22%) access to income (11%) and water for cooking.

CP services, psycho social support services, education and legal support were not perceived as top priorities by any of the local KI.

Table 26. Main concerns about health and safety of children

MAIN CONCERNS ABOUT HEALTH AND SAFETY OF CHILDREN	%
Lack of appropriate food	63%
Lack of education	42%
Lack of medicines	24%
Living in dangerous situation for a prolonged period of time	21%
Lack of healthcare	13%
Emotional harm	12%
Physical harm	4%
Stress/nightmares/sadness and other such signs	4%
Children going missing	4%
Interruption of rehabilitation services (replacement) in case of loss of assistive devices (for CWD)	1%

Displaced HH's predominate concerns regarding children's health and safety is access to **food** (63%), followed by access to **education** (42%), **medicines** (24%), living in dangerous situation for a prolonged period of time (21%), health care (13%) and emotional harm (12%).

CP violations were a lesser concern, with 4 (4%) of the heads of HH being concerned about physical harm, mental health issues and child separation (each).

Child Protection Risks

According to the two (2) CP Specialists, there is a high risk for children getting **separated from their parents.** Many children arrive without their parents from neighboring district. Children most at risk of separation or abandonment are children with physical and mental disabilities. Separation can increase the risk of **trafficking and exploitation, including sexual exploitation and child labor,** since, without parents who care and cater for their children's basic needs and protection, they rely fully on themselves and on strangers and could be easily lured into transactional sexual, abusive labor relationships or believe and follow false promises of work and/or education opportunities.

Due to the intensification of attacks in neighboring districts, displaced and children from host communities) are at risk of being recruited by armed groups.

Trafficking was not explicitly mentioned by CP Specialists. According to KI, one boy was offered the opportunity to travel to another location or outside the country for education.

Displaced children risk sexual violence due to lack of caregivers and their need for shelter and food. This risk is heightened for separated and mentally and physically disabled children.

Increased mental illness and psychosocial needs **are risks that exist for IDP children and children from host communities.** There is an increase in people with the appearance of sadness and fear, or restraint due to armed attacks and stress.

Generally, there is a risk of increased violence due to the lack of resources to accommodate the displaced.

Children with disabilities are specifically vulnerable to CP violations, discrimination and stigma. As to CP Specialists, children with physical disabilities that affect their mobility, may be abandoned by their family or left behind during displacement and are also at heightened risk to experience violence.

When asked about the **two top activities that children in the HH carry out,** heads of HH reported mainly fetching water (57% for girls; 64% for boys), fetching firewood (37% girls; 39% boys); followed by playing with friends (21% girls;

17% boys) and various domestic chores like looking after siblings, cooking and other domestic labor. There was no indication that children engage in child labor outside households, except of street vending (1% girls). **Studying** was only mentioned by 1% for girls and boys as a main activity.

Mental Health and Distress

Table 27. Have you seen signs of distress such as changes in behaviors in family members below the age of 18 since the conflict began?

CHANGES IN BEHAVIOR	% OF HH
Excessive crying	41%
Withdrawn from family and friends	36%
Angry or aggressive outbursts	33%
Headaches	26%
Startled easily	24%
Upset stomach or vague stomach pain	23%
New or recurring fears (fear of the dark, fear of being alone, fear of strangers)	9%
Changes in appetite or eating habits	7%
New or recurrent bedwetting	2%
Clinging, unwilling to let you out of sight	2%
Going back to behaviors present when a younger age	1%
Nightmares or sleep disturbances	0%
Substance use/abuse	0%

Interviews with heads of HH confirm that **mental health issues and distress** are affecting children living in their households. Heads of HH reported excessive crying (41%), withdrawal from family and friends (36%), angry or aggressive outbursts (33%), headaches (26%), being easily startled (24%) and upset stomachs (23%).

In addition, when asked about their main concerns for the health and safety of their children, 12% of heads of HH mentioned "emotional harm" and 4% "stress, nightmares, sadness, and similar signs".

Access to Child Protection Services

CP services have not been broadly available before the emergency and some of the previously existing services are currently not active. There is a serious lack in identification and FTR as well as, psycho social services.

Ancuabe has a high number of separated children, yet, out of the nine (9) locations, only three (3), 33%, that have identification and only one (1) 115 FTR services. Distress and changes in behavior of children were mentioned by many heads of HH, however only one (1) district (11%) has MHPSS services. Four (4) districts (44%) have case management services and five (5) districts (56%) social workers, legal support and health services available.

Represented in the table below are the answers to the same question asked to interviewed displaced households. Respondents' awareness of services shows a lack of legal support services, followed by a lack of social workers and mental health services. 35% said they know of identification services and 33% of FTR services.

Table 28. Existing services in or near the community (according to local KI)

SERVICE	I DO NOT KNOW/NO ANSWER	NOT PRESENT	PRESENT BUT NOT CURRENTLY OPEN/ACTIVE	PRESENT AND CURRENTLY OPEN/ACTIVE
Identification of unaccompanied minors/separated children	0%	67%	0%	33%
Family tracing/reunification services	0%	67%	22%	11%
Services to help people mentally recover from stress and trauma	0%	78%	11%	11%
Case management for victims of violence (referral to health, mental health, legal, and other services)	0%	56%	0%	44%
Social workers	0%	22%	22%	56%
Legal support	0%	22%	22%	56%
Medical/Healthcare	0%	44%	0%	56%

Table 29. Head of households' awareness of availability of services

SERVICES	PRESENT AND CURRENTLY OPEN/ACTIVE	PRESENT BUT NOT CURRENTLY OPEN/ACTIVE	NOT PRESENT	I DO NOT KNOW/NO ANSWER
Identification of unaccompanied minors/separated children	0%	67%	0%	33%
Family tracing/reunification services	0%	67%	22%	11%
Services to help people mentally recover from stress and trauma	0%	78%	11%	11%
Case management for victims of violence (referral to health, mental health, legal, and other services)	0%	56%	0%	44%
Social workers	0%	22%	22%	56%
Legal support	0%	22%	22%	56%
Medical/Healthcare	0%	44%	0%	56%

CP Specialist state that there are big gaps in service provision. SDSMAS, INGC; Save the Children and the Aga-Khan Foundation provide some support to UASC"; Attorney, Family Support Service and Women Victims of Violence, SERNIC, IPAJ provide support in cases of sexual abuse and violence and sexual exploitation and access to food is provided by PMA; SDSMAS. SDSMAS also provides MHPSS.

Children with disabilities have access to regular services, but there are no specialized services and no devices for children with disabilities. There are no organizations that work with children with mental disabilities or specialized schools or teachers.

Obstacles for separated children to accessing services are a lack of knowledge of the existence of service and the lack of defined physical spaces for the provision of services.

Proxy Indicators for CP Risk and Response

Access to Health Services

As to KI in six (6) locations, nothing prevents people from accessing health services. One (1) KI each mentioned unavailability of medicines; healthcare personnel and raised, that that there was never a reachable health service available in the locality.

When asked about the distance to the closest health facility, key informants responded more than 30 minutes (2 localities), up to 30 minutes (5) and one (1) locality never had a reachable health service. One KI did not know the answer.

Shelter

According to local KI, few ID HH (around 25%) sleep outdoors in three (3) localities; about half IDP HH sleep outside in three (3) localities and no HH in three (3) localities.

A few (25%) HH sleep in emergency shelters in five (5) locations; about half of HH in two (2) and nobody in two (2) locations.

Access to Drinking Water

In five (5) localities most families are living 500 meter or less from the point where they get drinking water; in four (4); more than 500 meters.

Women normally fetch water in nine (9) localities; all children in three (3); and girls in two (2).

Access to Water and Sanitation for Persons with Disabilities

22% of KI say that water points and sanitation facilities accessible to people with disabilities.

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5.2 BALAMA

- 59% of the IDP population is female and **51% are children.**
- According to local KI, food (100%), shelter (71%) and health and sanitation (43%) are the top three needs for their localities.
- HH expressed as main concern the lack of food, followed by lack of medicine (79, 86%) and health care (46, 50%)
- Protection concerns were not or hardly mentioned.
- No CP Specialist were interviewed in Balama.
- In terms of prioritization of geographic locations to set up response, this district has initially been ranked at the following severity levels, however these severity scores need to be reviewed based on expert knowledge of the context:
  - Severity level 2 (out of 4) for case management
  - Severity 2 (out of 4) for UASC follow-up
  - Severity 2 (out of 4) for MHPSS response

Sample and Demographics

Local KI were interviewed in **7 rural locations.** Of the 11 districts, Balama has the 9th largest IDP population. 59% of the IDP population is female and **51% are children:** 29% of IDPs are girls, 22% boys; 49% adults: 30% women (including 1% elderly women) and are 20% men. All IDPs are displaced due to conflict.

92 heads of HH were interviewed, comprising 583 household members with an average HH size of 6.3 persons. The average age of head of household is 40, the youngest was 19. An average of 4 children living in the household (47% female and 53% male), with the average age of 7.1 for girls and 7.4 for boys.

30% of respondents had not been **displaced** before this current displacement, 3% had been **displaced** more than 3 times, 5% more than 2 times and 8% once before having been displaced.

When asked about **children with disabilities,** heads of displaced households recounted that 14 children have walking disabilities; four (4) children (each) are hearing, speaking and learning impaired and one (1) child is vision impaired. Some households have several children with the same or different disabilities.

Needs and Concerns

KI identified the top three (3) needs for their districts as follows: **food (100%), shelter (71%) and health and sanitation (43%).** Further concerns are drinking water (14%); civil documents (14%), education for children (14%); financial support (14%) were mentioned.

CP services, psycho social support services and legal support were not perceived as top priorities by any of the local KI.

Table 30. Main concerns about health and safety of children

MAIN CONCERNS ABOUT HEALTH AND SAFETY OF CHILDREN	%
Lack of appropriate food	100%
Lack of medicines	86%
Lack of healthcare	50%
Lack of education	14%
Living in dangerous situation for a prolonged period of time	5%
Stress/nightmares/sadness and other such signs	3%
Interruption of rehab. services (replacement) in case of loss of assistive devices (for CWD)	1%
Physical harm	1%
Children going missing	1%
Discrimination from the rest of the community	1%
Emotional harm	0%
Stigma	0%

All 92 heads of HH expressed as main concern the lack of food, followed by lack of medicine (86%) and health care (50%) for their children. 14% also mentioned the lack of education as a concern. Protection concerns were hardly mentioned.

Child Protection Risks

No KI interviews were conducted with CP Specialists in Balama. The information reflected is only a reflection of the interviews with heads of HH and local KI interviews. These two

groups typically did not identify CP risks as priorities or needs in any of the districts. As table xx demonstrates that protection violations were hardly a concern for heads of HH. Only one head of HH expressed concerns over physical harm and one over children going missing. Trafficking: no opportunities. According to KI's knowledge, 12 children currently live separated from their parents or relatives and 7 are unaccompanied.

As to heads of HH, **the two main activities of children** are fetching water (49% for girls; 50% boys) and playing with friends (44% for girls and 35% for boys). According to the information, more boys than girls are involved in fetching waters and more girls than boys have time to play with friends. Other activities include mainly household chores and do not point to any child labor outside the households. No girl and only 1% of boys study as a main activity.

Table 31. Main child activities

MAIN CHILD ACTIVITIES	GIRLS	BOYS
Fetch water	49%	50%
Playing with friends	44%	35%
Cleaning	22%	30%
Fetch firewood	8%	12%
Look after siblings	5%	9%
Cooking	6%	4%
Domestic labor	9%	6%
Other work in the house	4%	7%
Casual labour (farming, others)	1%	1%
Look after livestock	1%	0%
Study	0%	1%

Mental Health and Distress

Table 32. Changes in behavior

CHANGES IN BEHAVIOR	% POSITIVE
Excessive crying	53%
Headaches	46%
Withdrawn from family and friends	32%
Startled easily	32%
Angry or aggressive outbursts	12%
Changes in appetite or eating habits	7%
Upset stomach or vague stomach pain	7%
New or recurring fears (fear of the dark, fear of being alone, fear of strangers)	2%

Interviews with heads of HH confirm that mental health issues and stress are affecting children living in their households. Heads of HH reported that 53% of children cry excessively; 46% suffer headaches; 32% are startled easily; 12% are aggressive; 7% show change sin appetite; and 7% have an upset stomach. 2% have new or reoccurring fears.

Access to Child Protection Services

Out of the seven localities, healthcare, legal support social workers and case management is available in four (4), 57% of localities; two localities (29%) have services to recover mentally from stress and trauma and one (1) locality (14%) has service for the identification of UASM. No FTR services are available.

Table 33. Existing services in or near the community (according to local KI)

SERVICE	NOT PRESENT	PRESENT BUT NOT CURRENTLY OPEN/ACTIVE	PRESENT AND CURRENTLY OPEN/ACTIVE
Identification of unaccompanied minors/separated children	86%	0%	14%
Family tracing/reunification services	100%	0%	0%
Services to help people mentally recover from stress and trauma	71%	0%	29%
Case management for victims of violence (referral to health, mental health, legal, and other services)	43%	0%	57%
Social workers	43%	0%	57%
Legal support	43%	0%	57%
Medical/Healthcare	43%	0%	57%

Awareness of the existence of services amongst heads of HH is low. In line with the information received form Ki, awareness of the existence of case management is relatively high, 38%; followed by health services and legal support. Awareness of the existence of identification services for UASC (5%), FTR (3%) and of services to help people mentally recover from stress and trauma is with 2% is very low.

Proxy Indicators for CP Risk and Response

Access to Health Services

As to six (6) of the local KI, nothing prevents people from accessing health services. (one local KI mentioned "other")

In four (4) localities it takes people less or up to 30 min to reach the closest health facility; in one (1) more than 30 minutes and two (2) localities have no reachable health facilities.

Shelter

A few (25%) IDP HH sleep outdoors in one (1) locality. A few (25%) IDP HH sleep in emergency shelters in 1 locality, about half of IDP HH in one (1) locality; most IDP HH in four (4) localities and none of the IDP HH in one (1) locality.

Access to Water and Sanitation for Persons with Disabilities

In none of the localities are waterpoints or sanitation/toilets accessible for wheelchair users.

Table 34. Head of households' awareness of availability of services

AWARENESS OF EXISTING CHILD PROTECTION SERVICES	PRESENT AND CURRENTLY OPEN/ACTIVE
Identification of unaccompanied minors/separated children	5%
Family tracing/reunification services	3%
Services to help people mentally recover from stress and trauma	2%
Case management for victims of violence (referral to health, mental health, legal, and other services)	38%
Social workers	14%
Legal support	22%
Medical/Healthcare	37%

Access to Drinking Water

In three (3) localities families live less than 500meters from drinking water. In three (3) localities more than 500meters. (one KI did not know the answer)

In four (4) localities women normally fetch water, in three (3) all children and in three (3) older people.

5.3 CHIURE

- 55% of the IDP population is female and **54% are children.**
- The multiple displacement rate is very high for IDPs in Chiure
- According to local KI, shelter (82%), food (76%) and access to income (53%) are the top three needs
- For heads of HH, food (88%), lack of education (62%); lack of healthcare (53%).
- CP Specialists identified child labor, separation and sexual abuse as the main child protection risks
- In crass contrast to the availability of FTR services and case management (in 96% of districts) only 9% of interviewed heads of HH are aware of these services and only 23% are aware of the availability of case management services.
- In terms of prioritization of geographic locations to set up response, this district has initially been ranked at the following severity levels, however these severity scores need to be reviewed based on expert knowledge of the context:
  - Severity level 2 (out of 4) for case management
  - Severity 1 (out of 4) for UASC follow-up
  - Severity 3 (out of 4) for MHPSS response

Sample and Demographics

KI were interviewed in **17 rural locations.** According to KI, out of the 11 districts, Chiure has the 7th largest IDP population. 55% of the IDP population is female and **54% are children:** 30% of IDPs are girls and 24% boys; 46% adults: 24% women, 22% men; including 2% elderly (>60 years) 1% elderly women and 1% elderly men. All IDPs were displaced by the conflict.

145 HH were interviewed, representing 1,043 of HH members, with an average size of 7.2 persons. The average age of the head of HH is 37, the youngest is 18. An average of 5 children are living in the household (51% female and 44% male), with the average age of 7.1 for girls and 7.9 for boys

The **multiple displacement rate** is very high, with 18% of the IDPs having been displaced more than 3 times, 8% more than 2 times and 9% once before. (0% had never been displaced before).

When asked about **children with disabilities,** heads of displaced households recounted that most of the disabilities are learning disabilities (27), and hearing impairments (18) followed by speaking disabilities (10) and vision impairment (2). Two children live with albinism (2). Some households have several children with the same or different disabilities.

Needs and Concerns

Table 35. Needs as expressed by local key informants

TOP NEEDS	%
Shelter/housing	82%
Food	76%
Access to income	53%
Health/Sanitation/Hygiene	35%
Other	24%
Drinking water	12%
Household Items (NFI)	12%
Civil documents	6%

According to local KI, shelter (82%), food (76%) and access to income (53%) are the top three needs in the district. Other needs included health and sanitation (35%); drinking water (12%) and civil documents (5%)

CP services, psycho social support services, education and legal support were not perceived as top priorities by any of the local KI.

For heads of HH, food (88%), lack of education (62%); lack of healthcare (53%) are the top priorities followed by the lack of medicines (43%), physical harm (23%); interruption of services for disabilities (12%).

Child Protection Risks

CP Specialists identified child labor, separation and sexual abuse as the main child protection risks in the district, which have also increased during displacement.[27] All IDP children are the at heightened risk for these CP violations.

Child Labor

> *The lack of food, housing, and other basic living conditions, force children to work even more than they used to. Children already worked before, but now it has increased, parents usually stay home while the children are selling some food to do other work to bring income and food home to the families.*

CP Specialist reported that,

> *Separation happened due to the surprise of the attacks. Children were hiding in the bushes; some children were sent away first. Some of the children could be reunited with their families by SDSMAS, others have lost their parents in the attacks, others have no news form their parents. There is a higher risk for children with disability, because of the lack of mobility in some, depending on the disability.'*

Children who are left alone at home when parents are gout to get food and water, or children who are the ones going by themselves, are in danger of **sexual abuse.**

> *Some children are taken advantage off because of their vulnerability, parents tend to offer them in exchange of food, sex exploitation unfortunately is becoming very common."*

CP Specialists also raised that early unions are a risk.

> *Older men with some financial status come and talk to children (with hunger), and take advantage of their dire situation. The family usually after the incident marry the girls are to their rapists. Some girls are forced to marry and end up abandoning school, most of these cases go unreported."*

27 The summaries of the two interviews were identical.

"Due to the lack of attention of the parents some kids are disappearing in camps, some are exchanged, they are told kids are going to a better place, and work, food and a home waits for them."
– CP Specialist, Chiure

Other forms of violence- physical and psychological abuse from the host community, xenophobia.

Other vulnerabilities include: Vulnerabilities: lack of food, services, health services and clothes.

Table 36. Top activities that children in the HH carryout

MAIN CHILD ACTIVITIES	% POSITIVE	
	Female	Male
Playing with friends	27%	46%
Fetch water	30%	18%
Cleaning	22%	22%
Garbage collection	17%	15%
Fetch firewood	12%	7%
Look after siblings	4%	5%
Cooking	8%	2%
Study	9%	11%
Casual labour (farming, others)	1%	3%
Domestic labor	2%	4%
Other work in the house	4%	5%
Other work outside the house	1%	1%
Other	15%	13%
No answer	24%	23%

When asked about the two **top activities that children in the HH carryout,** heads of HH reported mainly household chores and "playing". The two main children's activities are fetching water (30% for girls; 18% for boys), playing with friends (27% for girls, 46% for boys). This is followed by various household chores, including cleaning, cooking, fetching firewood and looking after siblings, cooking and other domestic labor.

There was little indication that children engage in child labor outside households, or in work apart from household chores, except of garbage collection (17% girls and 15% boys) and (undefined) "casual labor" (1% for girls; 3% for boys).

Studying was mentioned by 9% for girls and 11% for boys as a main activity, which is higher than in other districts.

Mental Health and Distress

Interviews with heads of HH confirm that mental health issues and stress are affecting children living in their households. Heads of HH reported that 53% of children suffer under headaches; 34% are withdrawn from their families; 28% have an upset stomach; 26% cry excessively; 16% are angry or aggressive; 12% how changes in appetite and 6% are startled easily.

Table 37. Mental health issues and stress affecting children

CHANGES	% POSITIVE
Headaches	53%
Withdrawn from family and friends	34%
Upset stomach or vague stomach pain	28%
Excessive crying	26%
Angry or aggressive outbursts	16%
Changes in appetite or eating habits	12%
Startled easily	6%

Access to Child Protection Services

Identification services are available in 24% of localities. 94% (16 localities) have FTR, case management and social workers available. Legal support and health care in 13 – 76% of localities. Services to help people mentally recover from stress and trauma only in 2 – 12% of localities.

Table 38. Existing services in or near the community (according to local KI)

SERVICE	NOT PRESENT	PRESENT BUT NOT CURRENTLY OPEN/ACTIVE	PRESENT AND CURRENTLY OPEN/ACTIVE
Identification of unaccompanied minors/separated children	71%	6%	24%
Family tracing/reunification services	6%	0%	94%
Services to help people mentally recover from stress and trauma	65%	24%	12%
Case management for victims of violence (referral to health, mental health, legal, and other services)	0%	6%	94%
Social workers	0%	6%	94%
Legal support	0%	24%	76%
Medical/Healthcare	6%	18%	76%

In crass contrast to the availability of FTR services, only 9% of interviewed heads of HH are aware of these services and only 23% are aware of the availability of case management services. 68% of heads of HH are aware of the presence of social workers and, 55% of legal support services and 36% of the presence of health services. Only 5% are aware of the existence of services to help people mentally recover from stress and trauma.

Table 39. Head of households' awareness of availability of services

SERVICES	PRESENT AND CURRENTLY OPEN/ACTIVE
Identification of unaccompanied minors/separated children	8%
Family tracing/reunification services	9%
Services to help people mentally recover from stress and trauma	5%
Case management for victims of violence (referral to health, mental health, legal, and other services)	23%
Social workers	68%
Legal support	55%
Medical/Healthcare	36%

According to CP Specialists, families and children, including children with disabilities can access and use various government services, including SDSMAS; the provincial and District Attorney General; CERNIC, the police, Mobile Brigades as well as community leader at local level.

Children with disabilities, especially with impaired mobility, can have difficulties accessing services, in which case they rely on the assistance of family members and/or activists. There are no specialized services and devices for children with disabilities. According to local KI, 15 localities (out of 17) have no services for children with disabilities. One locality provides assistive devices.

According to CP Specialists, obstacles in accessing services include the distance, fear, language.

Proxy Indicators for CP Risk and Response

Access to Health Services

The only obstacle KI (in six localities) mentioned was that a lack of transport prevents the population from accessing health services. It takes people more than 30 minutes in 6 localities and less or up to 30 min to reach the closest health facility (in 11 localities).

Shelter

A few (25%) IDP HH sleep outdoors in 2 localities; half in one (1) locality and no one in 14 localities. A few (25%) IDP HH sleep in emergency shelters in two (2) localities half of IDP HH in one (1) locality; and none of the IDP HH in 14 localities.

Access to Drinking Water

In 15 localities families live less than 500meters from drinking water. In 2 localities more than 500meters. In 17 localities women normally fetch water, in 1 all children and in 1 girls.

Access to Water and Sanitation for Persons with Disabilities

Only in 35% of localities are waterpoints accessible for wheelchair users. In 53% of localities sanitation/toilets are accessible for wheel chair users.

5.4 CITY OF PEMBA

- 56% of the IDP population is female and **41% are children.**
- IDPs in Pemba have a high multiple displacement level, with 17% having been displaced more than 3 times, 15% more than 2 times and 10% once before their current displacement.
- The City of Pemba has the the second largest UASC number of all districts. This number is not being published as it is a rough estimate made by a non-specialist, however the estimate has been taken into consideration for the severity scale on priority geographic areas for UASC follow-up.
- Shelter and food are the two is the top priority needs for all (100%) local KI
- Heads of HHs top main concern is about the lack of appropriate food (96%), followed by lack of medicine (38%) and lack of health care (31%).
- CP Specialists cited sexual exploitation and sexual abuse; trafficking; physical abuse and violence; neglect and maltreatment; child labour and separation as the main CP concerns.
- According to KI, Pemba has the second highest number of unaccompanied children of all district
- Pemba was, next to Ibo, the only district where KI expressed that CP services as a top need.
- In terms of prioritization of geographic locations to set up response, this district has initially been ranked at the following severity levels, however these severity scores need to be reviewed based on expert knowledge of the context:
  - Severity level 3(out of 4) for case management
  - Severity 3 (out of 4) for UASC follow-up
  - Severity 4 (out of 4) for MHPSS response

IDPs in Pemba have a **high multiple displacement rate,** with 17% having been displaced more than 3 times, 15% more than 2 times and 10% once before. (0% had never been displaced before).

When asked about children with disabilities, heads of displaced households recounted that most of the disabilities are hearing (32); learning (26) and walking (24) disabilities. Some households have several children with the same or different disabilities.

Needs and Concerns

Table 40. Top 3 needs of IDPs identified by key informants

TOP NEEDS	%
Shelter/housing	100%
Food	100%
Household Items (NFI)	46%
Child protection services	31%
Health/Sanitation/Hygiene	23%

Shelter and food are the two is the top priority needs for all (100%) local KI, followed by household items (46%), CP services (31%) and health/sanitation/hygiene services (23%). KI mentioned no other needs.

Heads of HHs top main concern is about the lack of appropriate food (96%), followed by lack of medicine (38%) and lack of health care (31%). Other concerns were about education (30%), emotional harm (11%), physical harm (10%) and mental health issues (6%).

Table 41. Main concerns about health and safety of children

CONCERN	%
Lack of appropriate food	96%
Lack of medicines	38%
Lack of healthcare	31%
Lack of education	30%
Emotional harm	11%
Physical harm	10%
Stress/nightmares/sadness and other such signs	6%
Interruption of rehabilitation services (replacement) in case of loss of assistive devices (for CWD)	3%
Living in dangerous situation for a prolonged period of time	3%
Discrimination from the rest of the community	2%
Children going missing	1%

Child Protection Risks

Seven CP Specialists were interviewed in Pemba. Most of them are responsible for the City of Pemba and also for other districts or at a provincial level. The CP Specialists cited the following CP main risks:

Sexual exploitation (5) and sexual abuse (1);

Trafficking (4); Physical abuse and violence (3); neglect and maltreatment (3 increased; 1 may increase); separation (2); child labour (4 has increased; 1 is at risk to increase); lack of documentation (3); "street children" (3); early unions (1increased; 1: difficult to say); mental health (1); early pregnancy (1); lack of access to education (1). One of the CP Specialists stated that "CP risk are the same for all districts, for IDPs in host families and accommodation sites". All except of one (1) CP Specialist affirmed that children with disabilities are at heightened risks for all CP violations.

According to KI, Pemba has **the second highest number of unaccompanied children of all district.** For most children, separations were not planned.

According to CP Specialists, IDP children are at risk of all forms of trafficking, sexual exploitation, forced early unions and forced labor: **Sexual exploitation** has emerged as a new CP violation, as it is accepted as a coping mechanism for the family. Parents may accept that girls have transactional sex in exchange for food and other humanitarian aid. Adolescent girls are most at risk for sexual exploitation.

Many children are disappearing during displacement. Many children which are separated from their parents can be identified in Pemba.

13 local KI affirmed that they know of cases where somebody had offered to children (directly or through their parents) in the community the opportunity to travel to another location or outside the country for work and 13 for educational purposes.

Children with albinism may be at higher risk of being trafficked for organs extraction and may also feel forced to change their routes while fleeing because they know they are at risk of being captured for organs extraction.

Heads of HH report that the two **main children's activities** are fetching water (45% for girls; 34% for boys), playing with friends (24% for girls, 39% for boys) and fetching firewood (12% for girls and 15% for boys), followed by cleaning, cooking, looking after siblings and other domestic labor. There was no indication that children engage in child labor outside households except of garbage collection (7% girls; 9% boys). According to CP Specialists, there is an increase of boys who are vending in the streets of Pemba. Studying was only mentioned by 2% for girls and 5% for boys as a main activity.

Mental Health and Distress

Table 42. Have you seen signs of distress such as changes in behaviors in family members below the age of 18 since the conflict began?

CHANGES	% POSITIVE
Withdrawn from family and friends	58%
Changes in appetite or eating habits	51%
Headaches	34%
Excessive crying	22%
Upset stomach or vague stomach pain	14%
Angry or aggressive outbursts	10%
Startled easily	10%
New or recurring fears (fear of the dark, fear of being alone, fear of strangers)	9%
Nightmares or sleep disturbances	4%
New or recurrent bedwetting	1%

Access to Child Protection Services

As to responses from KI, only 7 localities (54%) have UASC identification services and 4 localities (31%) services for FTR. Only 3 localities (23%) have services to help people mentally recover from stress and trauma, 10 localities (77%) have case management and legal support services and 12 localities (92%) social workers. 9 localities (69%) have health services.

Table 43. Existing services in or near the community (according to local KI)

SERVICE	NOT PRESENT	PRESENT BUT NOT CURRENTLY OPEN/ACTIVE	PRESENT AND CURRENTLY OPEN/ACTIVE	I DO NOT KNOW/NO ANSWER
Identification of unaccompanied minors/separated children	38%	8%	54%	0%
Family tracing/reunification services	54%	8%	31%	8%
Services to help people mentally recover from stress and trauma	46%	15%	23%	15%
Case management for victims of violence (referral to health, mental health, legal, and other services)	15%	8%	77%	0%
Social workers	8%	0%	92%	0%
Legal support	23%	0%	77%	0%
Medical/Healthcare	15%	8%	69%	8%

Local KI from the City of Pemba say there are no services for children with disabilities.

Represented in the table below are the answers to the same question asked to interviewed displaced households. Respondents' awareness of services shows that a high percentage (89%) knows about the existence of health services; followed by social workers (53%); case management (49%); legal support services (47%); identification for UASM (39%) and FTR services (35%). Few know about the existence of mental health services.

Table 44. Head of households' awareness of availability of services

HEADS OF HH AWARENESS OF SERVICES	NOT PRESENT	PRESENT BUT NOT CURRENTLY OPEN/ACTIVE	PRESENT AND CURRENTLY OPEN/ACTIVE	I DO NOT KNOW/NO ANSWER
Identification of unaccompanied minors/separated children	39%	4%	18%	38%
Family tracing/reunification services	35%	15%	11%	39%
Services to help people mentally recover from stress and trauma	13%	18%	19%	50%
Case management for victims of violence (referral to health, mental health, legal, and other services)	49%	8%	5%	38%
Social workers	53%	8%	4%	35%
Legal support	47%	12%	9%	32%
Medical/Healthcare	89%	5%	4%	2%

Proxy Indicators for CP Risk and Response

Access to Health Services

Asked what prevents people from accessing health services, 9 (69%) of local KI say that nothing prevents them, 2 (15%) that health services are not working; one (1) that people do not have the right documents and one (1) that no medicines are available in healthcare centers. As to KI, distance is not an obstacle. In four (4) localities it takes people less or up to 30 min to reach the closest health facility and in 9 localities more than 30 minutes.

Shelter

A few (25%) IDP HH sleep outdoors in 6 localities; half in 3 localities, most in one (1) and no one in 3 localities. A few (25%) IDP HH sleep in emergency shelters in 7 localities; half of IDP HH in 1 locality; most IDP HH in 3 localities and none of the IDP HH in two (2) localities.

Access to Drinking Water

In 10 localities families live less than 500 meters from drinking water. In 3 localities more than 500meters. In 13 localities women normally fetch water, in one (1) all children and in eight (8) girls and in one (1) boys.

Access to Water and Sanitation for Persons with Disabilities

In 31% of localities are waterpoints accessible for wheel-chair users.

In 23% of localities sanitation/toilets are accessible for wheel chair users.

5.5 IBO

- Ibo has the 2nd largest IDP population with a high multiple displacement rate.
- Local KI identify food, shelter and health and sanitation are with 75% each the top three needs for their localities
- Head of HH main concerns about their children is access to food (85%), followed by access to medicines (58%), emotional harm (46%)
- The CP Specialist in Ibo identified the main CP risk as separation, child labour, sexual exploitation and GBV. All these risks increased during displacements.
- Next to the City of Pemba, Ibo is the only district where KI identified that CP services are a top need.
- In terms of prioritization of geographic locations to set up response, this district has initially been ranked at the following severity levels, however these severity scores need to be reviewed based on expert knowledge of the context:
  - Severity level 2 (out of 4) for case management
  - Severity 2 (out of 4) for UASC follow-up
  - Severity 2 (out of 4) for MHPSS response

Sample and Demographics

Local KI were interviewed in **4 rural locations.** From the 11 districts, Ibo has, as to KI, the 2nd largest IDP population, concentrated in the smallest number of only four (4) localities. All IDPs were displaced by conflict.

150 heads of HH were interviewed, with an average size of 7 persons. Average age of head of household is 39, the youngest was 18. An average of 4 children are living in the household (53% female and 47% male), with the average age of 7.9 for girls as well as for boys.

Interviews conducted with displaced HHs show a **high rate of secondary or multiple displacement,** 20% of HH were displaced more than 3 times, 15% of HH two (2) times and 4% were displaced once before. There was no HH that had not been displaced before.

When asked about **children with disabilities,** heads of displaced households recounted that most of the disabilities are learning disabilities (26); followed by walking (22); hearing, speaking and vision impairment (14 children each). 16 children are living with albinism. Some households have several children with the same or different disabilities.

Needs and Concerns

Needs as Expressed by Local Key Informants

Table 45. Top 3 needs of IDPs identified by key informants

TOP NEEDS	#	%
Health/Sanitation/Hygiene	3	75%
Shelter/housing	3	75%
Food	3	75%
Drinking water	2	50%
Child protection services	1	25%

According to KI, food, shelter and health and sanitation are with 75% each the top three needs for their localities. Further, drinking water (50%) and CP services (25%) were mentioned. No other needs (e.g. education, psychosocial support, legal services) were raised.

Psycho social support services, education and legal support were not perceived as top priorities by any of the local KI.

Concerns about Health and Safety Expressed by Heads of Households

Table 46. Main concerns about health and safety of children

CONCERN	%
Lack of appropriate food	85%
Lack of medicines	58%
Emotional harm	46%
Lack of education	35%
Living in dangerous situation for a prolonged period of time	19%
Interruption of rehabilitation services (replacement) in case of loss of assistive devices	16%
Lack of healthcare	14%
Stress/nightmares/sadness and other such signs	9%
Physical harm	8%
Children going missing	1%
Discrimination from the rest of the community	1%
Stigma	1%

Head of HH main concerns about their children is access to food (85%), followed by access to medicines (58%), emotional harm (46%), lack of education (35%) and living in dangerous situation for a prolonged period of time (19%). There is also a concern regarding the Interruption of rehabilitation services (replacement) in case of loss of assistive devices (16%). Few express CP concerns. Only 1% expressed a concern regarding children going missing.

Child Protection Risks

The CP Specialist in Ibo[28] identified as the main CP risks for Ibo as separation, child labor, sexual exploitation and GBV. All these risks increased during displacements:

> *"During attacks children were separated from their parents and once the boats are full, they just leave, and sometimes leave the children behind, with neighbors. Many children could be reunited with their families, but some are still searching for their families. It's very common that IDP children arrive in the camp alone or with neighbors. Some of these kids don't have family members anymore."*

Children with mobility and other disabilities are more vulnerable to separation.

Child labor increased because parents need the help/work of children to buy basics for survival. Children are selling food in markets. Children are suffering from **sexual exploitation** during displacement. Parents are forced into a situation that they accept that their children gain money with sexual favors. This can also lead to parents marrying their children to abusers in exchange of money, food or items. Early unions are more common in IDPs because of the lack of food and resources, parents tend to arrange these unions to fix some of these issues. Parents' trauma can lead to physical and psychological abuse in their children. Children have suffered **trauma, as they had to** witness violence, seen villages burn and people be killed in front of them.

Children with disabilities tend to suffer from discrimination, neglect, abuse and GBV when they are left alone. IDPs children with disabilities also face more obstacles in access to services.

According to CP Specialists, no cases on child migration and trafficking have been reported. **None of the local KI reported offers to children for** opportunity to travel to another location or outside the country for work or education, since the beginning of displacement. Sensitization on trafficking is planned for activists, so that they, in turn, can sensitize people on this risk.

Table 47. Three main children's activities

MAIN CHILD ACTIVITIES	% POSITIVE	
	Female	Male
Fetch water	31%	37%
Playing with friends	30%	26%
Fetch firewood	20%	20%
Look after siblings	9%	12%
Cooking	9%	1%
Cleaning	3%	4%
Study	1%	2%
Garbage collection	7%	5%
Domestic labor	8%	6%
Other work in the house	1%	1%

28 The Coordinators of Refererence Group on Child Protection and Combating Trafficking, also responsible for Ibo also included CP concerns for Ibo.

Heads of HH report that the three main children's activities are fetching water (31% for girls; 37% for boys), playing with friends (30% for girls, 26% for boys) and fetching firewood (20% each), followed by looking after siblings, cooking and other domestic labor. There was no indication that children engage in child labor outside households, or in work apart from household chores, except of garbage collection (7% girls; 13% boys).

Studying was only mentioned by 1% for girls and 2% for boys as a main activity.

Mental Health and Distress

Table 48. Have you seen signs of distress such as changes in behaviors in family members below the age of 18 since the conflict began?

CHANGES	%
Withdrawn from family and friends	51%
Excessive crying	42%
Angry or aggressive outbursts	40%
Headaches	32%
Nightmares or sleep disturbances	27%
Startled easily	25%
Changes in appetite or eating habits	12%
New or recurring fears (fear of the dark, fear of being alone, fear of strangers)	12%

Interviews with heads of HH confirm that mental health issues and stress are affecting children living in their households. Heads of HH reported that children are withdrawn from family and friends (51%), cry excessively (42%), are angry or have aggressive outbursts (40%); suffer from headaches (32%); have nightmares or sleep disturbances (27%); are startled easily (25%); have changes in appetite or eating habits (12%), have new or reoccurring fears (12%) and other symptoms of distress.

Access to Child Protection Services

As to responses from KI, 2 localities (50%) have UASC identification services and 1 locality (25%) services for FTR. 2 localities (50%) have services to help people mentally recover from stress and trauma, case management and health services. 3 localities (75%) have legal support services.

Represented in the table below (Table 50) are the answers to the same question asked to interviewed displaced households. Respondents' awareness of services shows a high knowledge of health services (72%); followed by case management (63%); legal support (60%); and social workers (53%). There was less awareness about identification (31%) and FTR services (27%) for UASM and mental health services (24%).

As to the CP Specialist, SDSMAS provides services for separation, sexual exploitation and GBV cases.

Community structure- community leaders, community secretary and president, chief of homes; activists deal with child labor issues.

According to local KI, none of the four (4) locations has services for children with disabilities. However, SDSMAS, health services, Gabinetes de atendimento are also responsible for and attend to children with disabilities.

Table 49. Existing services in or near the community (according to local KI)

SERVICE	NOT PRESENT	PRESENT BUT NOT CURRENTLY OPEN/ACTIVE	PRESENT AND CURRENTLY OPEN/ACTIVE
Identification of unaccompanied minors/separated children	50%	0%	50%
Family tracing/reunification services	50%	25%	25%
Services to help people mentally recover from stress and trauma	50%	0%	50%
Case management for victims of violence (referral to health, mental health, legal, and other services)	25%	25%	50%
Social workers	50%	0%	50%
Legal support	25%	0%	75%
Medical/Healthcare	50%	0%	50%

Table 50. Head of households' awareness of availability of services

SERVICES	PRESENT AND CURRENTLY OPEN/ACTIVE	PRESENT BUT NOT CURRENTLY OPEN/ACTIVE	NOT PRESENT	I DO NOT KNOW/NO ANSWER	TOTAL
Identification of unaccompanied minors/separated children	31%	5%	58%	6%	100%
Family tracing/reunification services	27%	10%	56%	7%	100%
Services to help people mentally recover from stress and trauma	24%	7%	63%	7%	100%
Case management for victims of violence (referral to health, mental health, legal, and other services)	63%	5%	25%	7%	100%
Social workers	53%	15%	27%	6%	100%
Legal support	60%	5%	25%	9%	100%
Medical/Healthcare	72%	12%	11%	5%	100%

Proxy Indicators for CP Risk and Response

Accessing Health Services

As to KI, multiple obstacles prevent people from accessing health services, including Lack of transportation to health-care services (50%); unavailability of medicines (50%); lack of healthcare personnel (50%); limited accessible (25%). One KI (25%) said that nothing is prevents people from accessing health services.

In one (1) locality people have to walk longer than 30 minutes to reach a health facility, in one locality only up to 30 minutes' walk and in one locality there is no reachable health facility. One KI does not know the answer.

Shelter

In one locality about 25% (a few) IDP households sleep outdoors in two localities about half of IDP HH and in none locality no HH sleep outdoors

In one locality about 25% (a few) IDP HH sleep in emergency shelters; in one (1) locality about half and in two localities none sleep in emergency shelters.

Access to Drinking Water

In 2 localities the distance to drinking water was 500 meters or less; in 2 localities the distance to drinking water was more than 500 meters. Women normally fetch water in all four (4) localities. All children in three (3) localities. There are **no water points and sanitation facilities accessible to people with disabilities.**

Photo: © IOM Mozambique

5.6 MECUFI

- 53% of the IDP population is female and **63% are children.**
- From the 11 districts, Mecufi has the smallest IDP population, but a high number of IDP children
- Food, shelter and household items are the top three needs, as to local KI
- HH main concerns about their children is access to food (88%), followed by access to medicines (59%), lack of education (47%)
- In terms of prioritization of geographic locations to set up response, this district has initially been ranked at the following severity levels, however these severity scores need to be reviewed based on expert knowledge of the context:
  - Severity level 2 (out of 4) for case management
  - Severity 3 (out of 4) for UASC follow-up
  - Severity 3 (out of 4) for MHPSS response

Sample and Demographics

KI were interviewed in **five (5) locations,** four (4) rural and one (1) urban. From the 11 districts, Mecufi has the smallest IDP population. 53% of the IDP population is female and 63% are children: 32% of IDPs are girls, 31% boys; 37% adults: 21% women, including 1% of elderly women and 16% men, including 1% of elderly men. All IDPs are displaced due to conflict.

101 heads of HH were interviewed, with an average size of 9.6 persons. The average age of head of household is 36, the youngest 18. On average 5 children are living in the household (51% female and 49% male), with the average age of 7.3 for girls and 7.6 for boys.

Interviews conducted with heads of displaced HH show that 6% of the IDPs had already experienced **displacement** more than 3 times, 5% were displaced twice and 10% once before the current displacement. 10% of IDPs had not been displaced before.

When asked about **children with disabilities,** heads of displaced households recounted walking (disabilities 28); hearing (11), speaking (11) and vision 14 impairment. Six (6) children have learning disabilities. One child is living with albinism. Some households have several children with the same or different disabilities.

Needs and Concerns

According to KI, food, shelter and household items – 100% each – are the top three needs for their localities. No other needs were raised.

Heads of HH main concerns about their children is access to food (88%), followed by access to medicines (59%), lack of education (47%) and health care (38%). There is also a concern regarding emotional harm (17%) and nightmares/stress/sadness (7%) and physical harm (9%). Living in dangerous situations (5%), discrimination (5%), interruption of rehabilitation services (4%) and children going missing were mentioned (3%).

Table 51. Top 3 needs of IDPs identified by key informants

CONCERN	% POSITIVE
Lack of appropriate food	88%
Lack of medicines	59%
Lack of education	47%
Lack of healthcare	38%
Emotional harm	17%
Physical harm	9%
Stress/nightmares/sadness and other such signs	7%
Living in dangerous situation for a prolonged period of time	5%
Discrimination from the rest of the community	5%
Interruption of rehabilitation services (replacement) in case of loss of assistive devices (for CWD)	4%
Children going missing	3%
Stigma	0%

In one locality somebody offered a girl the **opportunity to travel** to another location or outside the country for work, and in one locality somebody offered boys and girls the opportunity to travel to another location or outside the country for education, since the displacement.

Heads of HH report that the **two main children's activities** are fetching water (54% for girls; 51% for boys) and fetching firewood (37% for girls, 32% for boys), followed by playing with friends (23% for girls, 26% for boys) cooking and other domestic labor. There was no indication that children engage in child labor outside households, or in work apart from household chores, except of garbage collection (6% girls; 8% boys). Studying was only mentioned by 4% for girls and 5% for boys as a main activity.

Mental Health and Distress

Interviews with heads of HH confirm that mental health issues and stress are affecting children living in their households. Heads of HH reported that children suffer from headaches (%), are withdrawn from family and friends (%), cry excessively (%), are startled easily (%), have changes in appetite or eating habits (%), new or reoccurring fears (%), an upset stomach (%), and nightmares or sleep disturbances (%).

Access to Child Protection Services

As to responses from KI, 2 localities (40%) have UASC identification services and 1 locality (20%) services for FTR, services to help people mentally recover from stress and trauma and case management. 3 localities (60%) have legal support services.

Table 52. Have you seen signs of distress such as changes in behaviors in family members below the age of 18 since the conflict began?

CHANGES	% POSITIVE
Headaches	45%
Withdrawn from family and friends	39%
Excessive crying	34%
Changes in appetite or eating habits	23%
Angry or aggressive outbursts	22%
Upset stomach or vague stomach pain	20%
New or recurring fears (fear of the dark, fear of being alone, fear of strangers)	19%
Nightmares or sleep disturbances	14%
Startled easily	11%
Clinging, unwilling to let you out of sight	2%
Going back to behaviors present when a younger age	2%
New or recurrent bedwetting	1%
Substance use/abuse	1%

Table 53. Head of households' awareness of availability of services

SERVICE	NOT PRESENT	PRESENT BUT NOT CURRENTLY OPEN/ACTIVE	PRESENT AND CURRENTLY OPEN/ACTIVE
Identification of unaccompanied minors/separated children	60%	0%	40%
Family tracing/reunification services	80%	0%	20%
Services to help people mentally recover from stress and trauma	80%	0%	20%
Case management for victims of violence (referral to health, mental health, legal, and other services)	80%	0%	20%
Social workers	40%	0%	60%
Legal Support	40%	0%	60%
Medical/Healthcare	40%	0%	60%

Represented in the table below are the answers to the same question asked to interviewed displaced households. Respondents' awareness of services shows a high knowledge of health services (71%); followed social workers (57%); case management (33%); mental health services (30%); identification (28%) and FTR services (28%) for UASM and legal support (27%).

Table 54. Head of households' awareness of availability of services

SERVICES	NOT PRESENT	PRESENT BUT NOT CURRENTLY OPEN/ACTIVE	PRESENT AND CURRENTLY OPEN/ACTIVE
Identification of unaccompanied minors/separated children	35%	28%	3%
Family tracing/reunification services	34%	28%	4%
Services to help people mentally recover from stress and trauma	34%	30%	5%
Case management for victims of violence (referral to health, mental health, legal, and other services)	26%	33%	5%
Social workers	13%	57%	12%
Legal support	30%	27%	7%
Medical/Healthcare	14%	71%	8%

Proxy Indicators for CP Risk and Response

Access to Health Services

Five (5) local KI said that nothing prevents people from accessing health care facilities; one (1) stated that not having the right documents is an obstacle.

In six (6) localities it takes people longer than 30 minutes to reach a health facility, in one locality only up to 30 minutes walk.

Shelter

In one locality about half the IDP HH sleep outdoors and in 4 localities no IDP HH sleeps outdoors. In one locality about 25% (a few) in one locality about half (in 3 none) of IDP HH sleep in **emergency shelters.**

Access to Drinking Water

In 4 localities 500 meters or less, in 1 locality more than 500 meters.

In 4 localities families live less than 500meters from drinking water. In 1 locality more than 500meters. Women normally fetch water in all five (5) localities. All children in 2.

Water points and sanitation facilities accessible to people with disabilities

40% of localities have waterpoints that are accessible for wheelchair users.

In 20% of localities sanitation/toilets are accessible for wheel chair users.

5.7 METUGE

- From the 11 districts, Metuge has, according to KI, the third largest IDP population with a high number of children.
- 54% of the IDP population is female and **60% are children.**
- HH report high incidences of children with disabilities.
- Local KI identified shelter and food as the top needs, (100% each).
- Heads of HH main concerns about their children is access to appropriate food (87%), followed by access to medicines (61%) and education (39%).
- In terms of prioritization of geographic locations to set up response, this district has initially been ranked at the following severity levels, however these severity scores need to be reviewed based on expert knowledge of the context:
  - Severity level 4(out of 4) for case management
  - Severity 3 (out of 4) for UASC follow-up
  - Severity 3 (out of 4) for MHPSS response

Sample and Demographics

KI were interviewed in five (5) locations, three (3) rural and two (2) urban. From the 11 districts, Metuge has the third largest IDP population. 54% of the IDP population is female and 60% are children: 30% of IDPs are girls, 30% boys; 40% adults: 22% women, 18% men; No elderly. All IDPs are displaced due to conflict.

122 heads of HH were interviewed, with an average size of 9.0 persons. The average age of the head of HH is 45, the youngest is 18. The average HH has 5 children are living in the household (46% female and 54% male), with the average age of 7.1 for girls and 7.5 for boys

7% of the households were displaced more than 3 times, 5% 2 times and 13% once before. 0% had never been displaced before.

When asked about children with disabilities, heads of displaced households recounted walking disabilities (33); learning disabilities (30), speaking (24), hearing (20) and vision (9) impairment. Six (6) children are living with albinism. Some households have several children with the same or different disabilities.

Needs and Concerns

Table 55. Top 3 needs of IDPs identified by key informants

TOP NEEDS	% POSITIVE
Shelter/housing	100%
Food	100%
Household Items	80%
Access to income	20%

Photo: © IOM Mozambique

Local KI identified shelter and food as the top needs, (100% each) followed by household items (80%) and access to income (20%). They mentioned no other needs.

Table 56. Main concerns about health and safety of children

CONCERNS	% POSITIVE
Lack of appropriate food	87%
Lack of medicines	61%
Lack of healthcare	46%
Lack of education	39%
Stress/nightmares/sadness and other such signs	17%
Physical harm	11%
Emotional harm	9%
Discrimination from the rest of the community	7%
Children going missing	5%
Living in dangerous situation for a prolonged period of time	5%
Interruption of rehabilitation services (replacement) in case of loss of assistive devices (for CWD)	3%
Stigma	2%

Heads of HH main concerns about their children is access to appropriate food (87%), followed by access to medicines (61%) and education 39%). Other concerns are lack of education (39%) nightmares/stress/sadness (17%) and physical harm (11%) and emotional harm (9%). Living in dangerous situations (5%), discrimination (7%), interruption of rehabilitation services (3%) and children going missing were also mentioned (5%).

Child Protection Risks

According to CP Specialist, **child trafficking, sexual violence, early unions and physical violence** are the main CP risks. CP Specialists stated that trafficking and sexual violence increased and that there is a possibility that early unions and physical violence may increase. There is an increased risk of sexual abuse for girls with mental disabilities.

Parents are overwhelmed and willing to send children away to the city with strangers; children living with host families are forced to work at home and machambas to “pay rent”.

Sexual violence: Very high risk in IDP centres when children go out at night, because parents may be absent and sites are not guarded; children living in host families are also at heightened risk for violence, there have already been such cases.

Parents are under a lot of stress can increase risk of violence and neglect.

Adolescent girls are most at risk for trafficking, sexual exploitation and physical violence.

According to KI, 103 children are unaccompanied and 103 children currently live separated from their parents or relatives. Separations were not planned.

> *"After attacks children get separated during the flight; they stay with others until they can reunite with parents and are generally treated well/the same as own children. However, they can suffer from fear, depression or feel alienated".*
> – CP Specialist

> *"Children are taken to Pemba. Strangers approach IDPs and offer work/study opportunities for children. There were reports of 3 cases of children that went to Pemba from Metuge. They left with their parents' consent. They were recruited to work in families as nannies but then were forced to work as street vendors. Their parents were convinced that their children will have a better life. Parents don't believe that children will be exploited; only later they become concerned when they don't know where their children are".*
> – CP Specialist

Local KI do not report of any offers were made for opportunity to travel to another location or outside the country for work or education since the beginning of displacement.

There have been reports of **sexual exploitation and abuse.**

Asked about the two main activities for children, heads of HH mentioned fetching water (46% for girls; 49% for boys) and fetching firewood (28% girls; 32% boys) followed by playing with friends (20% for girls, 21% for boys) There was no indication that children engage in child labor outside households, or in work apart from household chores, except of garbage collection (4% girls; 6% boys).

Studying was only mentioned by 6% for girls and 4% for boys as a main activity.

Mental Health and Distress

Interviews with heads of HH confirm that mental health issues and stress are affecting children living in their households. Heads of HH reported that children suffer from headaches (%), are withdrawn from family and friends (%), cry excessively (%), are startled easily (%), have changes in appetite or eating habits (%), new or reoccurring fears (%), an upset stomach (%), and nightmares or sleep disturbances (%).

Table 57. Have you seen signs of distress such as changes in behaviors in family members below the age of 18 since the conflict began?

CHANGES	% POSITIVE
Headaches	41%
Withdrawn from family and friends	34%
New or recurring fears (fear of the dark, fear of being alone, fear of strangers)	26%
Upset stomach or vague stomach pain	25%
Changes in appetite or eating habits	16%
Nightmares or sleep disturbances	16%
Angry or aggressive outbursts	16%
Excessive crying	16%
Startled easily	14%

Access to Child Protection Services

As to responses from KI, 1 locality (20%) has UASC identification services to help people mentally recover from stress and trauma, case management, social workers and legal support and 3 localities (60%) have health services. FTR services are not available in any of the localities.

Services for children with disabilities are, according to local KI available in one locality (assistive devices).

Table 58. Existing services in or near the community (according to local KI)

SERVICES	PRESENT AND CURRENTLY OPEN/ACTIVE	PRESENT BUT NOT CURRENTLY OPEN/ACTIVE	NOT PRESENT	I DO NOT KNOW/NO ANSWER
Identification of unaccompanied minors/separated children	20%	0%	80%	0%
Family tracing/reunification services	0%	0%	100%	0%
Services to help people mentally recover from stress and trauma	20%	0%	80%	0%
Case management for victims of violence (referral to health, mental health, legal, and other services)	20%	20%	60%	0%
Social workers	20%	20%	60%	0%
Legal support	20%	20%	60%	0%
Medical/Healthcare	60%	0%	40%	0%

Represented in the table below are the answers to the same question asked to interviewed displaced households. Respondents' awareness of services shows a high knowledge of health services (66%); followed social workers (57%); case management (31%); identification of UASM (30%); legal support (29%); mental health services (26%) and FTR (25%).

Table 59. Head of households' awareness of availability of services

SERVICES	PRESENT AND CURRENTLY OPEN/ACTIVE	PRESENT BUT NOT CURRENTLY OPEN/ACTIVE	NOT PRESENT	I DO NOT KNOW/NO ANSWER
Identification of unaccompanied minors/separated children	30%	6%	43%	21%
Family tracing/reunification services	25%	16%	33%	26%
Services to help people mentally recover from stress and trauma	26%	6%	39%	30%
Case management for victims of violence (referral to health, mental health, legal, and other services)	31%	8%	36%	25%
Social workers	57%	9%	13%	20%
Legal support	29%	5%	30%	36%
Medical/Healthcare	66%	8%	17%	8%

CP Specialists report that the social worker from Quissanga also covers Metuge and works with displaced communities. "SDSMAS works on FTR. Save the Children helps to identify UASCs and informs IDPs about FTR services; and SDSMAS does the tracing; assistance to reintegration of UASCs into families; coordination of UNHCR. AVSI is also present.

Proxy Indicators for CP Risk and Response

Access to Health Facilities

As to four (4)/80% of local KI, nothing prevents people from accessing health services.

One (25% stated that unavailability of medicines (50%); and one KI (25%) lack of documents prevents people from accessing health services.

In three (3) localities it takes less or up to 30 min to reach the closest health facility and in 2 localities more than 30 minutes.

Shelter

About half of IDPs sleep outdoors in 1 locality; most IDPs sleep outdoors in one locality and no IDPs sleep outdoors in three (3) localities and no one. A few (25%) IDP HH sleep in emergency shelters in one (1) locality; in one locality half; in two (2) localities more no IDPs sleep in emergency shelters.

Access to Drinking Water

In three (3) localities most families live less than 500meters from drinking water. In two (2) localities more than 500meters. In all five (5) localities women normally fetch water, in four (4) localities all children.

Water Points and Sanitation Facilities Accessible to People with Disabilities

In 60% of localities are waterpoints accessible for wheelchair users. In 80% of localities sanitation/toilets are accessible for wheel chair users.

5.8 MONTEPUEZ

- 64% of the IDP population is female; **45% are children.**
- The multiple displacement level is high.
- According to local KI, shelter and food (95% each) and drinking water (32%) are the top three needs for their localities.
- Heads of HH main concerns about their children is access to appropriate food (93%), followed by access to medicines (73%) and education (54%).
- Two (2) CP Specialist that were interviewed identified as the main CP risks sexual violence and abuse (2); child trafficking 1; separation (1). Access to health/ shelter (1); stigma (1); hunger (1); health (1) were other child rights concerns.
- In terms of prioritization of geographic locations to set up response, this district has initially been ranked at the following severity levels, however these severity scores need to be reviewed based on expert knowledge of the context:
  - Severity level 3 (out of 4) for case management
  - Severity 4 (out of 4) for UASC follow-up
  - Severity 3 (out of 4) for MHPSS response

Sample and Demographics

Local KI were interviewed in 19 rural locations. 64% of the IDP population is female and 45% are children: 29%of IDPs are girls, 16% boys; 57% adults: 35% women (including 1% elderly), 21% men including 1% elderly. All IDPs were displaced by conflict.

112 heads of HH were interviewed, with an average HH size of 8.5 persons. The average age of the head of household is 40, the youngest was 18. On average, five (5) children are living in the household (46% female and 54% male), with the average age of 7.1 for girls and 7.5 for boys.

Multiple displacement levels are high with 3% having been displaced more than 3 times, 6% 2 times and 13% once before. 0% had never been displaced before. All were displaced by conflict.

When asked about **children with disabilities,** heads of displaced households recounted hearing (29), walking (27), sight (9), speaking (8) and learning disabilities. One (1) child lives with albinism (1). Some households have several children with the same or different disabilities.

Needs and Concerns

Table 60. Top 3 needs of IDPs identified by key informants

TOP NEEDS	% TRUE
Shelter/housing	95%
Food	95%
Drinking water	32%
Access to income	21%
Household Items (NFI)	16%
Education for the children	11%
Health/Sanitation/Hygiene	5%
Civil documents	5%

According to local KI, shelter and food (95% each) and drinking water (32%) are the top three needs for their localities. Further, access to income (21%); house hold items (16%); education (11%); health sanitation hygiene (5%) and civil documents (5%) were mentioned.

Table 61. Main concerns about health and safety of children

CONCERN	%
Lack of appropriate food	93%
Lack of medicines	73%
Lack of education	54%
Lack of healthcare	34%
Children going missing	4%
Stress/nightmares/sadness and other such signs	2%
Discrimination from the rest of the community	2%
Emotional harm	1%

Heads of HH main concerns about their children is access to appropriate food (93%), followed by access to medicines (73%) and education (54%). Other concerns are lack of health care (34%); children going missing (4%); nightmares/stress/sadness (2%); discrimination (2%), and emotional harm (1%).

Child Protection Risks

According to KI, Montepuez hs by far the highest number of unaccompanied children of all districts, and a high number of children currently live separated from their parents or relatives.[29] These separations were not planned.

Two (2) CP Specialist that were interviewed identified as the main CP risks sexual violence and abuse (2); child trafficking 1; separation (1). Access to health/ shelter (1); stigma (1); hunger (1); health (1) were other child rights concerns.

Due to the situation, there has been an increase in **rape, sexual and physical abuse** of children as well as early unions. Most children are vulnerable to sexual exploitation in these situations of conflict, when they are alone, unprotected or reaching a service by itself. "Children may be asked for sexual favors in exchange of food, money or other needs. Some children don't get paid and when charging get beaten, a lot of these situations happen in these locations." Disabled children are more vulnerable since they cannot defend themselves.

Separation of children from their parents has increased. "Children run away in different direction, get separated from families, can't find their parents any more. It's difficult to know how many children lost their parents, some are looking for them, some are dead, it leads us to a situation where we can't say how many have died or survived. We do not have that data. But it's known that a lot of children have lost their parents or are still in search, most don't know were they are, others end up disappearing once they're in the camps. There are no numbers available for these situations, we don't have access to these numbers because people are still under attack and there is no contact with them."

It is more difficult for **children with disabilities** to run away, some can't see where they're going. All these risks are heightened for children between 1-10 years are the most vulnerable.

Early unions are the biggest risk, the numbers are growing every day due to the lack of basic needs, like food. Because of hunger some children are misled and raped, on the promise of an exchange for food, children from 2-10 years old are most in in danger because they don't think properly on do's and don'ts and end up abused.

Child Migration and Trafficking is the most dangerous risk. Children disappear because the situation is out of control.

IDPs also **suffer stigma** they are not always well received in all communities. Communities had been already deprived of resources and the arrival of IDPs aggravates their situation.

Due the number of people, there is **no shelter and a lack of food.** Assistance cannot be provided for all, leaving some in very desperate situations. Some of the health problems are related to the sleeping and living conditions. Particularly IDPs do not always receive health services.

With the **lack of food distribution** and the lack of access to the district, INGC can't give food and nor can any other humanitarian agency; it's a difficult time for children and elderly. Hunger has increased, with most of the kids remain in bushes, the situation is still dangerous; they can pass days without eating.

As to local KI: In one locality somebody offered girls, the opportunity to travel to another location or outside the country for work, and in one locality somebody offered children (boys and girls) the opportunity to travel to another location or outside the country for education, since the displacement.

Heads of HH report that the two **main children's activities** are fetching water (44% for girls; 38% for boys) and playing with friends (33% for girls, % for boys) followed by garbage collection (19% for girls and boys). Apart from garbage collection, and street vending (2% for girls and 4% for boys) there was no indication that children engage in child labor outside households. Studying was mentioned by 8% for girls and 7% for boys as a main activity.

29 This number is not being published as it is a rough estimate made by a non-specialist, however the estimate has been taken into consideration for the severity scale on priority geographic areas for UASC follow-up.

Mental Health and Distress

CP Specialists raised concerns about children's mental health and distress: Children tend to isolate, sometimes get violent, don't talk. They are afraid of soldiers, helicopters, of people and anyone who tries to get to them, trauma and psychological dysfunctional. Most of the children are still hiding in the field, in distress, in pain, some saw their parents getting killed. The suffer from trauma, fear, hunger and have no hope.

Interviews with heads of HH confirm that mental health issues and stress are affecting children living in their households. Heads of HH reported that children suffer from headaches (%), are withdrawn from family and friends (%), cry excessively (%), are startled easily (%), have changes in appetite or eating habits (%), new or reoccurring fears (%), an upset stomach (%), and nightmares or sleep disturbances (%).

Table 62. Have you seen signs of distress such as changes in behaviors in family members below the age of 18 since the conflict began?

CONCERN	%
Headaches	74%
Withdrawn from family and friends	38%
Excessive crying	27%
Upset stomach or vague stomach pain	25%
Angry or aggressive outbursts	24%
Changes in appetite or eating habits	13%
Nightmares or sleep disturbances	7%
Startled easily	6%
New or recurring fears (fear of the dark, fear of being alone, fear of strangers)	4%
New or recurrent bedwetting	0%
Clinging, unwilling to let you out of sight	0%
Going back to behaviors present when a younger age	0%
Substance use/abuse	0%

Access to (Child Protection) Services

As to responses from KI, 2 localities (11%) have UASC identification and FTR services, one (1) locality (5%) services to help people mentally recover from stress and trauma and case management; three (3) localities (16%) have social workers; six (6) localities (32%) legal support and 9 localities (47%) have health services.

Represented in the table below are the answers to the same question asked to interviewed displaced households. There is a relatively high awareness of the presence of services. Respondents' awareness of services shows a high knowledge of health services (61%); followed by services for the identification of UASC (60%); legal support and social workers (53%); case management (51%); FTR services ((50%) and mental health services (48%).

CP Specialist share that children, including children with disabilities and families can ask for help at governmental services including SDSMAS, the Attorney general, the police. There are also 20 (child protection) committees that exist in the district. UNHCR, UNICEF and CARE also offer CP services. **Obstacles assessing services include** language, distance and lack of communication and information on where can they go.

Photo: © IOM Mozambique

Table 63. Head of households' awareness of availability of services

SERVICES	PRESENT AND CURRENTLY OPEN/ACTIVE	PRESENT BUT NOT CURRENTLY OPEN/ACTIVE	NOT PRESENT	I DO NOT KNOW/NO ANSWER
Identification of unaccompanied minors/separated children	60%	3%	33%	4%
Family tracing/reunification services	50%	8%	32%	10%
Services to help people mentally recover from stress and trauma	48%	13%	28%	12%
Case management for victims of violence (referral to health, mental health, legal, and other services)	51%	9%	27%	13%
Social workers	53%	10%	22%	15%
Legal support	53%	10%	28%	10%
Medical/Healthcare	61%	7%	21%	12%

Proxy Indicators for CP Risk and Response

Access to Health Services

As to local KI, multiple obstacles prevent people from accessing health services, including cost (68%); afraid of getting infected by COVID-19 (63%); not having the right documents (21%); No healthcare personnel available in the healthcare centre (16%)

In 17 localities it takes people more than 30 min to reach the closest health facility. 2 localities do not have a health facility.

Shelter

A few (25%) IDP HH sleep outdoors in three (3) localities; half in four (4) localities and most in four (4) localities. In eight (8) localities no HH sleeps outdoors.

A few (25%) IDP HH sleep in emergency shelters in eight (8) localities; half of IDP HH in four (4); everyone in two (2) localities and most IDPs HH in two (2) localities and none of the IDP HH three (3) Localities.

Access to Drinking Water

In five (5) localities families live less than 500meters from drinking water. In 14 localities more than 500meters.

In 19 localities women normally fetch water, in 13 older people and in six (6) all children.

Access to Water and Sanitation for People with Disabilities

In 79% of localities waterpoints are accessible for wheelchair users. In 95% of localities sanitation/toilets are accessible for wheel chair users.

5.9 MUEDA

- 58% of the IDP population is female and **47% are children.**
- According to local KI shelter and food (94% each) and drinking water (56%) are the top three needs for their localities.
- According to CP Specialists, early unions, child trafficking; physical abuse; sexual abuse and early pregnancies as main CP risks.
- The availability of CP services is scarce.
- In terms of prioritization of geographic locations to set up response, this district has initially been ranked at the following severity levels, however these severity scores need to be reviewed based on expert knowledge of the context:
  - Severity level 3 (out of 4) for case management
  - Severity 3 (out of 4) for UASC follow-up
  - Severity 3 (out of 4) for MHPSS response

Sample and Demographics

Local KI were interviewed in **16 locations,** 11 rural and 5 urban. From the 11 districts, Mueda has the 5th largest IDP population. 58% of the IDP population is female 47% are children: 25% of IDPs are girls, 22% boys; 53% adults: 33% women, including 1% elderly women and 20% men including 1% elderly men. All IDPs were displaced by conflict.

148 heads of HH were interviewed, with an average HH size of 7 persons. The average age of the head of HH is 40, the youngest was 18. On average 3 children are living in the household (40% girls and 60% boys), with the average age of 8.2 for girls and 9 for boys.

7% of IDPs have been **displaced more than** 3 times, 22% 2 times and 7% once before. There was no HH that had not been displaced before.

When asked about **children with disabilities,** heads of displaced households recounted walking (30), hearing (16), vision (11) and speaking (5) impairments and learning disabilities (7). Four (4) children live with albinism. Some households have several children with the same or different disabilities.

Needs and Concerns

According to local KI shelter and food (94% each) and drinking water (56%) are the top three needs for their localities. Further, health and sanitation (6%); access to income (6%); household items (6%) and financial support (6%) were mentioned.

CP services, psycho social support services, education and legal support were not perceived as top priorities by any of the local KI.

Table 64. Top 3 needs of IDPs identified by key informants

TOP NEEDS	% TRUE
Shelter/housing	94%
Food	94%
Drinking water	56%
Education for the children	19%
Civil documents	13%
Health/Sanitation/Hygiene	6%
Access to income	6%
Household Items (NFI)	6%
Financial support	6%

Heads of HH main concerns about their children is access to appropriate food (84%), followed by education (38%) and Living in dangerous situation for a prolonged period of time (34%). Other concerns are lack of health care (30%); Stress/nightmares/sadness and other such signs (26%); Lack of medicines (11%); Children going missing (5%); Discrimination from the rest of the community (3%); physical harm (2%); interruption of rehabilitation services (replacement) in case of loss of assistive devices (for CWD) 1%; emotional harm 1%.

Table 65. Main concerns about health and safety of children

CONCERNS	% POSITIVE
Lack of appropriate food	84%
Lack of education	38%
Living in dangerous situation for a prolonged period of time	34%
Lack of healthcare	30%
Stress/nightmares/sadness and other such signs	26%
Lack of medicines	11%
Children going missing	5%
Discrimination from the rest of the community	3%
Physical harm	2%
Interruption of rehabilitation services (replacement) in case of loss of assistive devices (for CWD)	1%
Emotional harm	1%

Child Protection Risks

The two (2) CP Specialist identified early unions, child trafficking; physical abuse; sexual abuse and early pregnancies as main CP risks, all of which have increased during displacement.

Early unions increased because of vulnerability, especially the lack of food. Parents 'allow' sexual exploitation of children in exchange for food or other basic supplies. Girls, between 12-17 years old are most at risk. **Child trafficking** increased

> *"People come, saying they have good intentions and job offers and end up taking the kids, mostly to Tanzania. Children with albinism can't be left alone because they are in danger of being taken."*

Underaged children, mostly from 12-17 years old, sometimes from the age of 9 are most at risk for trafficking. *Child pregnancy* increased during displacement girls, mostly from 12-17 years old are most at risk. **Sexual abuse increased** due to children being left alone, when caregivers go to (food and basic utilities) distributions or to seek out job opportunities. Children with disabilities are more vulnerable for abuse and neglect and are more exposed to harm, whenever left alone by the caregivers. Displacement may exacerbate **neglect and abuse.** Some caregivers leave children alone in tents, or some children leave the tents to play with other children,

this is when abuse can occur and sometimes violence from host communities or other children who are host communities. Physical abuse increased as displacement exacerbates parents' and family members' distress and stress.

Child Unions are a risk and have been increasing due to displacement and lack of food, and all basic needs.

"Parents marry their kids, in order to 'get something in return'. Communities are aware that this is prohibited by law, but it still happens. Only some cases are being reported, the real numbers are hidden and must be bigger. Some children are married to their perpetrators (of sexual abuse)".

Separations of children from their parents can happen during all phases of the emergency.

"Sometimes parents send children away first, in an attempt to save them and sometimes parents die; but other times families could be reunited in the camps. There are UASC in the communities. The numbers are high, but are slowly decreasing since many children could be reunited with their families."

Child migration and trafficking are more bound to happen but there is no official data on missing and/or trafficked children.

"There was one case - children had gone to Tanzania, CERNIC, PRM and Procuradoria Geral and partners in Tanzania have brought the children back home".

Table 66. Main children's activities

MAIN CHILD ACTIVITIES	% POSITIVE	
	Female	Male
Fetch water	19%	39%
Cooking	32%	21%
Fetch firewood	23%	11%
Look after siblings	19%	21%
Garbage collection	18%	12%
Cleaning	17%	17%
Playing with friends	12%	12%
Domestic labor	2%	2%
Other work in the house	4%	5%
Study	0%	0%

Heads of HH report that the three main children's activities are fetching water (19% for girls; 39% for boys), cooking (32% girls; 21% boys); fetching firewood (23% girls; 11% boys), looking after siblings (19% girls; 21% boys) and other domestic work. Playing with friends was relatively low (12% each). There was no indication that children engage in child labor outside households, or in work apart from household chores, except of garbage collection (18% girls; 12% boys). Studying was not mentioned as a main activity.

Mental Health and Distress

Table 67. Have you seen signs of distress such as changes in behaviors in family members below the age of 18 since the conflict began?

CONCERN	% POSITIVE
Startled easily	59%
Changes in appetite or eating habits	49%
New or recurring fears (fear of the dark, fear of being alone, fear of strangers)	32%
Withdrawn from family and friends	25%
Angry or aggressive outbursts	24%
Headaches	18%
Nightmares or sleep disturbances	14%
Excessive crying	12%
New or recurrent bedwetting	1%
Upset stomach or vague stomach pain	1%
Going back to behaviors present when a younger age	1%

Interviews with heads of HH confirm that mental health issues and stress are affecting children living in their households. Heads of HH reported that children are startled easily (59%); have changes in appetite or eating habits (49%); show new or reoccurring fears (32%); are withdrawn from family and friends (25%); have angry outbursts (24%); headaches (18%); nightmares or sleep disturbances (14%) and cry excessively (12%).

Access to Child Protection Services

As to responses from KI, 2 localities (13%) have UASC identification and FTR services, social workers and legal services; one (1) locality (6%) has health services; three (3) localities (19%) have case management services and no locality has services to help people mentally recover from stress and trauma and case management.

Table 68. Head of households' awareness of availability of services

SERVICES	PRESENT AND CURRENTLY OPEN/ACTIVE	PRESENT BUT NOT CURRENTLY OPEN/ ACTIVE	NOT PRESENT	I DO NOT KNOW/NO ANSWER
Identification of unaccompanied minors/separated children	13%	0%	88%	0%
Family tracing/reunification services	13%	0%	88%	0%
Services to help people mentally recover from stress and trauma	0%	0%	100%	0%
Case management for victims of violence (referral to health, mental health, legal, and other services)	19%	0%	81%	0%
Social workers	13%	0%	81%	6%
Legal support	13%	6%	81%	0%
Medical/Healthcare	6%	0%	94%	0%

Represented in the table below are the answers to the same question asked to interviewed displaced households. There is a low awareness of services, which corresponds to KI information about existing services. Knowledge exists about the availability of case management (25%). For all other services, knowledge is extremely low: health services (2%); identification of UASC and social workers (3%); legal support and FTR services (2%). No one had any knowledge about mental health services.

Table 69. Head of households' awareness of availability of services

SERVICES	PRESENT AND CURRENTLY OPEN/ ACTIVE	PRESENT BUT NOT CURRENTLY OPEN/ACTIVE	NOT PRESENT	I DO NOT KNOW/NO ANSWER	TOTAL
Identification of unaccompanied minors/separated children	3%	4%	90%	3%	100%
Family tracing/reunification services	1%	7%	87%	4%	100%
Services to help people mentally recover from stress and trauma	0%	7%	91%	3%	100%
Case management for victims of violence (referral to health, mental health, legal, and other services)	25%	10%	61%	4%	100%
Social workers	3%	3%	89%	4%	100%
Legal support	1%	2%	87%	10%	100%
Medical/Healthcare	2%	1%	86%	10%	100%

According to CP Specialists, services for children, including CWD and families that are available and are used are: community leaders; police; SDSMAS; hospital and mobile brigades as well as to the Attorney General, CERNIC, and courts. Specialized services and devices for children with disabilities do not exist.

Obstacles Distance of the services available; the numerous people that need assistance; and language barrier.

Proxy Indicators for CP Risk and Response

Access to Health Services

As to KI in seven (7) locations there was never a reachable health services; in five (5) locations people are prevented to access health services, since there is a lack of transportation to healthcare services; and in three (3) location it is due to the costs. One KI each mentioned that people do not have

the right documents and that no medicines are available in healthcare centre. In three localities KI said that there were no obstacles to reach health services.

When asked about the distance to the closest health facility, key informants responded that the distance was more than 30 minutes in 12 localities, up to 30 minutes in one (1) locality and no reachable health service in one (1) community.

Shelter

According to local KI, few ID HH (around 25%) sleep outdoors in three (3) localities; about half IDP HH sleep outside in three (3) localities; all IDP HH sleepout doors in one (1) locality and no IDP HH in nine (9) localities. About half of HH sleep in emergency shelters in one (1) community, all IDP HH in one locality and no IDP HH sleeps in emergency shelter in 14 localities.

Access to Drinking Water

In nine (9) localities most families are living 500 meter or less from the point where they get drinking water; in seven (7); more than 500 meters. Women fetch water in 12 localities, next to men (in 8 localities); older people (in 5 localities) and boys (in 1 locality).

Access to Water and Sanitation for Persons with Disabilities

In 56% of localities wheelchair users have access to water points and sanitation facilities.

5.10 NAMUNO

- 59% of the IDP population is female and **55% are children.**
- According to KI, food (100%), shelter (78%) and drinking water (56%) are the top three needs for their localities.
- Displaced HH's predominate concerns regarding children's health and safety is access to food (100%), followed by access to medicines (84%), healthcare(60%).
- No interviews were held with CP Specialists in Namuno.
- Services for the identification of UASC (4%) and FTR services (3%) are hardly known/available.
- In terms of prioritization of geographic locations to set up response, this district has initially been ranked at the following severity levels, however these severity scores need to be reviewed based on expert knowledge of the context:
  - Severity level 3 (out of 4) for case management
  - Severity 4 (out of 4) for UASC follow-up
  - Severity 3 (out of 4) for MHPSS response

Sample and Demographics

Local KI were interviewed in **9 rural locations**. 59% of the IDP population is female and 55% are children: 34%of IDPs are girls, 21% are boys; 45% adults: 25% women, 20% men. All IDPs were displaced by conflict.

77 heads of HH were interviewed, with an average HH size of 5.1 persons. The average age of the head of household is 34, the youngest is 19 years. On average 3 children are living in the household (50% female and 50% male), having an average age of 7.1 for girls and 7.6 for boys.

2% of the displace HH had been displaced more than 3 times, 4% 2 times and 8% once before.

30% had never been displaced before their first displacement.

When asked about children with disabilities, heads of displaced HH recounted walking (3), hearing (7), vision (2) and speaking (5) impairments and learning disabilities (5). Some households have several children with the same or different disabilities.

Needs and Concerns

According to KI, **food** (100%), **shelter** (78%) and **drinking water** (56%) are the top three needs for their localities. Also raised were concerns regarding health and sanitation (11%) and household items (11%).

Displaced HH's predominate concerns regarding children's health and safety is access to **food** (100%), followed by **access to medicines** (84%), **healthcare** (60%), access to education (21%) and signs of stress (3%).

Table 70. Top 3 needs of IDPs identified by key informants

TOP NEEDS	% TRUE
Food	100%
Shelter/housing	78%
Drinking water	56%
Other	44%
Health/Sanitation/Hygiene	11%
Household Items (NFI)	11%

Table 71. Main concerns about health and safety of children

CONCERN	% POSITIVE
Lack of appropriate food	100%
Lack of medicines	84%
Lack of healthcare	60%
Lack of education	21%
Stress/nightmares/sadness and other such signs	3%

Child Protection Risks

CP services, psycho social support services, education and legal support were not perceived as top priorities by any of the local KI or heads of HH. No interviews could be held with CP Specialists.

Table 72. Main concerns about health and safety of children

MAIN CHILD ACTIVITIES	% POSITIVE	
	Girls	Boys
Playing with friends	50%	46%
Fetch water	33%	46%
Cleaning	29%	30%
Cooking	18%	3%
Fetch firewood	6%	10%
Look after siblings	2%	4%
Domestic labor	7%	7%
Study	0%	0%

When asked about the **two top activities that children in the HH carry out**, heads of HH reported playing with friends (50% for girls and 46% for boys); fetching water (33% for girls; 46% for boys), cleaning (29% for girls and 30% for boys), cooking (18% for girls; 35 for boys); fetching firewood (6% girls; 10% boys); **Studying** was not mentioned as a main activity.

Mental Health and Distress

Table 73. Main children's activities

CHANGES	% POSITIVE
Excessive crying	48%
Withdrawn from family and friends	42%
Headaches	38%
Startled easily	23%
Changes in appetite or eating habits	14%
New or recurring fears (fear of the dark, fear of being alone, fear of strangers)	10%
Angry or aggressive outbursts	9%
Going back to behaviors present when a younger age	6%
Upset stomach or vague stomach pain	4%

Interviews with heads of HH confirm that mental health issues and stress are affecting children living in their households. Heads of HH reported that children cry excessively (48%); are withdrawn from family and friends (42%): suffer from headaches (38%), are startled easily (23%), have changes in appetite or eating habits (14%); have new or reoccurring fears (10%), aggressive outbursts (9%); go back to behaviors present when a younger age (6%) and suffer under an upset stomachs (4%).

Access to Child Protection Services

As to responses from KI, 2 localities (22%) have UASC identification and social workers; four (4) localities (44%) have legal services; five (5) localities (56%) have health and case management services; and no locality has FTR services or services to help people mentally recover from stress and trauma and case management.

Table 74. Existing services in or near the community (according to local KI)

SERVICES	I DO NOT KNOW/NO ANSWER	NOT PRESENT	PRESENT BUT NOT CURRENTLY OPEN/ACTIVE	PRESENT AND CURRENTLY OPEN/ACTIVE
Identification of unaccompanied minors/separated children	0%	78%	0%	22%
Family tracing/reunification services	0%	100%	0%	0%
Services to help people mentally recover from stress and trauma	0%	100%	0%	0%
Case management for victims of violence (referral to health, mental health, legal, and other services)	0%	44%	0%	56%
Social workers	0%	78%	0%	22%
Legal support	0%	44%	11%	44%
Medical/Healthcare	0%	44%	0%	56%

Represented in the table below are the answers to the same question asked to interviewed displaced households. Respondents' awareness of services shows a relatively high awareness of the existence of case management (47%) and health services (39%); followed by legal support (21%); social workers and mental health services (10%). Services for the identification of UASC (4%) and FTR services (3%) are hardly known/available.

Table 75. Head of households' awareness of availability of services

SERVICES	PRESENT AND CURRENTLY OPEN/ ACTIVE	PRESENT BUT NOT CURRENTLY OPEN/ ACTIVE	NOT PRESENT	I DO NOT KNOW/NO ANSWER	TOTAL
Identification of unaccompanied minors/separated children	4%	9%	87%	0%	100%
Family tracing/reunification services	3%	16%	82%	0%	100%
Services to help people mentally recover from stress and trauma	10%	16%	74%	0%	100%
Case management for victims of violence (referral to health, mental health, legal, and other services)	47%	27%	26%	0%	100%
Social workers	10%	13%	77%	0%	100%
Legal support	21%	10%	69%	0%	100%
Medical/Healthcare	39%	17%	44%	0%	100%

Proxy Indicators for CP Risk and Response

Access to Health Services

As to KI in seven (7) locations, nothing prevents people from **accessing health services**. One (1) KI each mentioned unavailability of medicines; healthcare personnel and raised, that that there was never a reachable health service available in the locality.

When asked about the distance to the closest health facility, key informants responded more than 30 minutes (2 localities), up to 30 minutes (5) and one (1) locality never had a reachable health service. One KI did not know the answer.

Shelter

According to local KI, few ID HH (around 25%) sleep outdoors in three (3) localities; about half IDP HH sleep outside in three (3) localities and no HH in three (3) localities.

A few (25%) HH sleep in emergency shelters in five (5) locations; about half of HH in two (2) and nobody in two (2) locations.

Access to Drinking Water

In five (5) localities most families are living 500 meter or less from the point where they get drinking water; in four (4); more than 500 meters.

Access to Water and Sanitation for Persons with Disabilities

There are no waterpoints and sanitation facilities that are accessible for persons with disabilities.

5.11 NANGADE

- 48% of the IDP population is female and **49% are children.**
- All (100%) local KI mentioned food and shelter as the two top priorities, followed by drinking water (71%)
- Heads of HH main concerns about their children is access to appropriate food (82%), followed by access to medicines (73%) and education (70%).
- The CP Specialist raised malnutrition as a serious risk for childre.n
- The CP Specialist raised **separation, sexual exploitation and violence** as the main CP risks.
- According to local KI Nagade has a high number of UASC.
- Nangade is the only district, where heads of HH report that studying is one of the main activities; and the only district where heads of HH did not identify playing with friends (3% girls and 4% boys) as a main activity.
- In terms of prioritization of geographic locations to set up response, this district has initially been ranked at the following severity levels, however these severity scores need to be reviewed based on expert knowledge of the context:
  - Severity level 3 (out of 4) for case management
  - Severity 4 (out of 4) for UASC follow-up
  - Severity 3 (out of 4) for MHPSS response

Sample and Demographics

Local KI were interviewed in **7 rural locations**. 48% of the IDP population is female (including 3% elderly) and 49% are children, out of which 20% are girls and 19% boys; 60% adult: 28% women, including 3% elderly women and 32% men, including 4% elderly. All were displaced by conflict.

110 heads of HH were interviewed, with an average HH size of 8.1 persons. Ona average, the age of heads of HH is 40, the youngest is 19. An average of 5 children are living in the HHs (53% girls and 47% boys), with the average age of 7.9 for girls and 9.0 for boys.

All IDPs had been already **displaced** before the current displacement. 8% were displaced more than 3 times, 8% 2 times and 9% once before.

When asked about **children with disabilities**, heads of displaced households recounted walking (23), hearing (10), vision (14) and speaking (15) impairments and learning disabilities (15). Seven (7) children live with albinism. Some households have several children with the same or different disabilities.

Needs and Concerns

All (100%) local KI mentioned food and shelter as the two top priorities, followed by drinking water (71%), civil documents (14%) and house hold items (14%). No other needs were mentioned. access to income (11%) and water for cooking and washing were mentioned.

Heads of HH main concerns about their children is access to appropriate food (82%), followed by access to medicines (73%) and education (70%). Other concerns are lack of health care (2%); children going missing (2%); nightmares/ stress/sadness (43%) and Living in dangerous situation for a prolonged period of time (6%). No other concerns were raised.

The CP Specialist also raised the increase in malnutrition due to the lack of income and of continuous food support for IDPs.

Child Protection Risks

The CP Specialist raised **separation, sexual exploitation and violence** as the main CP risks as well as early unions, organized by the parents. Due to the intensification of attacks in neighboring districts, many children arrive without their parents and displaced and resident children are at risk of being recruited.

Separation can increase the risk of trafficking and child labor and exploitation and of sexual exploitation due to lack of caregivers.

> *"There are no official records of cases of violence, but there is a lot of sexual exploitation of minors due to unavailability of food and shelter."*
> – CP Specialist Nangade.

Heads of HH report that the two **main children's activities** are fetching water (50% for girls; 54% for boys), followed by looking after siblings, (24% for girls; 29% for boys); studying (23% for girls; 26% for boys) and fetching firewood (22% for girls; 15% for boys). There was no indication that children engage in child labor outside households, or in work apart from household chores, except of garbage collection (8% girls; 6% boys).

Nangade is the only district, where heads of HH report that studying is one of the main activities; and the only district where heads of HH did not identify playing with friends (3% girls and 4% boys) as a main activity.

Interviews with heads of HH confirm that mental health issues and stress are affecting children living in their households. Heads of HH reported that children suffer from headaches (61%); have new or reoccurring fears (52%); suffer under nightmares or sleep disturbances (44%); are startled easily (44%); have an upset stomach (25%), angry outbursts (14%) and show other symptoms of distress.

Mental Health and Distress

Table 76. Have you seen signs of distress such as changes in behaviors in family members below the age of 18 since the conflict began?

CHANGES	% POSITIVE
Headaches	61%
New or recurring fears (fear of the dark, fear of being alone, fear of strangers)	52%
Nightmares or sleep disturbances	44%
Startled easily	44%
Upset stomach or vague stomach pain	25%
Angry or aggressive outbursts	14%
Excessive crying	10%
Withdrawn from family and friends	9%
Changes in appetite or eating habits	1%
Going back to behaviors present when a younger age	1%
Substance use/abuse	1%

Access to Child Protection Services

As to responses from KI, one (1) locality has (14%) FTR services and one (1) locality has legal support services. No other services are available.

Table 77. Existing services in or near the community (according to local KI)

SERVICES	I DO NOT KNOW/NO ANSWER	NOT PRESENT	PRESENT BUT NOT CURRENTLY OPEN/ACTIVE	PRESENT AND CURRENTLY OPEN/ACTIVE
Identification of unaccompanied minors/ separated children	0%	43%	57%	0%
Family tracing/ reunification services	14%	57%	14%	14%
Services to help people mentally recover from stress and trauma	0%	100%	0%	0%
Case management for victims of violence (referral to health, mental health, legal, and other services)	29%	71%	0%	0%
Social workers	29%	71%	0%	0%
Legal support	29%	57%	0%	14%
Medical/Healthcare	0%	100%	0%	0%

Represented in the table below are the answers to the same question asked to interviewed displaced households. Corresponding to KI, there is a low awareness of services. Some Knowledge exists about the availability of FTR services (24%). Little knowledge exist about all other services: health, case management, social workers and mental health services (15%); legal support (12%) an identification services for UASC (11%).

Table 78. Head of households' awareness of availability of services

SERVICES	PRESENT AND CURRENTLY OPEN/ ACTIVE	PRESENT BUT NOT CURRENTLY OPEN/ ACTIVE	NOT PRESENT	I DO NOT KNOW/NO ANSWER	TOTAL
Identification of unaccompanied minors/ separated children	11%	22%	66%	1%	100%
Family tracing/reunification services	24%	23%	51%	3%	100%
Services to help people mentally recover from stress and trauma	15%	6%	78%	0%	100%
Case management for victims of violence (referral to health, mental health, legal, and other services)	15%	5%	81%	0%	100%
Social workers	15%	4%	76%	5%	100%
Legal support	12%	5%	83%	1%	100%
Medical/Healthcare	15%	2%	83%	1%	100%

As to CP Specialists, there are a lot of limitations when it comes to services for separated children. IOM has helped in locating children and referring them to SDSMAS.

Children with disabilities face several difficulties when in need of services. They can access existing services, however Specialized services for children with disabilities are not available in any of the seven (7) districts.

Lack of knowledge of the existence of services may be an obstacle to accessing them.

In case of sexual abuse and exploitation, children and families can seek assistance from Government services, including SDSMAS, Attorney general, Family Support Service and Women Victims of Violence, SERNIC, IPAJ. CWD have access to these same services.

In the case of malnutrition children and families can access SDSMAS, PMA. There is a lot of limitation since the support is not continuous. SDSMAS has limited funds and means, INGC. Access to services for children with disabilities is limited due to low coverage of organizations providing assistance.

In the case of trauma and mental distress, children and families can seek health from SDSMAS (psychiatric and mental health technician). There are no organizations that work directly with the mental health of people with disabilities.

Proxy Indicators for CP Risk and Response

Access to Health Services

As to 6 (84%) of the local KI, nothing is preventing people from accessing health services. Two (2) KI say that it is the costs that prevents people from accessing health services.

In three (3) localities it takes people less or up to 30 min to reach the closest health facility and in three (3) localities more than 30 minutes.

Shelter

A few (25%) IDP HH sleep outdoors in 2 localities; most in 1 locality and no one in 4 localities. A few (25%) IDP HH sleep in emergency shelters in six (6) localities; about half of IDP HH in one (1) localities.

Access to Drinking Water

In six (6) localities families live less than 500 meters from drinking water. In one (1) locality more than 500meters.

In five (5) localities older people normally fetch water; in two (2) localities women; in one (1) all children and in one (1) girls.

Access to Water and Sanitation for Persons with Disabilities

Only in 71% of localities are waterpoints accessible for wheelchair users.

No localities has sanitation/toilets that are accessible for wheel chair users.

5.12 Palma

- Information is available from interviews with CP Specialists. No HH or local KI interviews were conducted.
- Main protection risks identified for children in Palma are separation; neglect; physical and sexual violence risks that may increase are child trafficking and early unions.

No HH interviews and no local KI interviews were carried out in Palma. Information on CP is available only by interviews carried out with **two (2) CP Specialists.**

As to the CP Specialists, the main protection risks identified for children in Palma are separation; neglect; physical and sexual violence. Risks that may increase are child trafficking, early unions.

Separation increased due to the arrival of children from Mocimboa da Praia. Due to the intensification of attacks in neighboring districts, displaced and host communities' children are at risk of being recruited or/and abducted. **Neglect of and violence** against children increased, including for children with disabilities. **Sexual violence** increased due to lack of caregivers. According to the CP Specialist, it is difficult to address cases of sexual violence and exploitation, since family members prefer to solve it personally. There is a greater risk of sexual exploitation of displaced children, who are seen as a source of "income generation". Child sexual exploitation may result in unwanted early unions and unwanted pregnancies.

Child trafficking may increase. Adolescents and parents can easily be deceived and accept offers to leave and work in the city. Traffickers may target IDP parents, who will agree to let children go, in the believe that it enables children to have a better life. **Most at risk are** girls and boys, younger than 17 years.

Early unions: Families and children have become more vulnerable. They may be approached by older men who offer to "marry" girls to give them a better life in exchange for a compensation provided to the parents. Parents agree, as they are not aware of the law and the risks. Most at risk are 12-17 year old girls.

The CP Specialist had little information on **mental health and psychological distress**.

"There are people who show fear, sadness and various forms of psychological disorders."

CP Specialists raised the issue of a lack of specialized MHPSS.

CP Specialists also raised the increase in malnutrition due to the lack of food support, especially for children with disabilities, displaced children and children without caregivers.

"Overall, there is a lack of access to basic services, shelter, education and food. These risks are a result of displacement; children are hungry and have no access to education; parents lose the ability to care for their children. Children will feel pressured to contribute to income. All IDP children are equally at risk."

Availability of Child Protection Services

Even though certain government services, including SDSMAS, Police, Gabinetes de atendimento, Attorney general, health services; SENIC, IPAJ **are available, they are overburdened**.

In case of UASC, CP Specialists raised concerns that, despite the support from Save the Children and the Aga-Khan Foundation, severe limitations exist.

Children with disabilities face additional barriers in access to health care and increased risk of neglect. Due to their vulnerability, **children with disabilities** may face several difficulties when requesting support, and due to limitations, however, they have access to existing services. There are no organizations that work directly with the mental health of people with disabilities.

"Due to the security situation, including the lack of access to areas under the control of insurgents in Palma, many activities could not take place, such as awareness raising on trafficking. Child protection services do not know where IDP children are and what their conditions are, they are not registered; when the attacks happened, many services (incl. prosecutors) left. There is also a general lack of knowledge of the existence of services; stigma and discrimination, lack of coordination with parents in cases of abuse; low number of organizations providing assistance, as well as lack of means of subsistence."

IDP families in Metuge – Cabo Delgado. Photo: © IOM Mozambique

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