USAID
FROM THE AMERICAN PEOPLE

GROWING PAINS: ASSESSING CHILDHOOD ADVERSITY IN MOZAMBIQUE

Special Study Report

JUNE 2024

This publication was produced for review by the United States Agency for International Development. It was prepared by Management Systems International (MSI), A Tetra Tech Company.

(THIS PAGE INTENTIONALLY LEFT BLANK)

GROWING PAINS: ASSESSING CHILDHOOD ADVERSITY IN MOZAMBIQUE

Special Study Report

Commissioned under contract AID-656-C-17-00002

Mozambique Monitoring and Evaluation Mechanism and Services (MMEMS)

DISCLAIMER

The authors' views expressed in this report do not necessarily reflect the views of the United States Agency for International Development or the United States Government

(THIS PAGE INTENTIONALLY LEFT BLANK)

TABLE OF CONTENTS

ACRONYMS

ACE	Adverse Childhood Experience
CDC	Centers for Disease Control
CI	Confidence Interval
DEFF	Different Design Effect
DHS	Demographic and Health Surveys
EA	Enumeration Area
GRM	Government of the Republic of Mozambique
HH	Household
IMAGES	International Men and Gender Equality Survey
IPV	Intimate Partner Violence
OR	Odds Ratio
TB	Tuberculosis
WHO	World Health Organization

BACKGROUND

Adverse childhood experiences (ACEs) are potentially traumatic experiences that occur in children ages 0-17 years. They include events such as physical and sexual violence and neglect, the loss or separation from a caregiver, witnessing violence in the home or community, and events that threaten the safety of the home or community environment. ACEs are relatively common. For example, in the United States, 61 percent of adults reported experiencing at least one adverse experience in childhood, with 17 percent[1] stating they experienced four or more types of adversity in childhood. A study covering children in five African countries[2] found that 42 percent of the children had experienced physical violence within 12 months of the survey and 23 percent had experience sexual abuse in their lifetime. A study in nine countries in Eastern Europe[3] found that the prevalence of physical violence in children was as high as 83.2 percent in Greece.

ACEs are linked to poorer outcomes in adulthood, such as difficulty forming healthy and stable relationships and increased risk of health and mental health illnesses, such as depression, substance abuse, and chronic disease. Research has shown that experiencing four or more ACEs is associated with an increased risk for the leading adult causes of death, including heart disease, stroke, cancer, diabetes, Alzheimer's disease, and suicide.[4].

The link between ACEs and poor health outcomes in adulthood is complex. ACEs impact child development, cause physical disruption to the neurological and immune system, and cause disruption in social and economic development.[5]. Survivors of violence and abuse and people who live in unsafe environments suffer from a chronic arousal of the body's response to stress, releasing higher amounts of cortisol in the body. This phenomenon, also known as toxic stress, has been linked to chronic diseases, such as high blood pressure, stroke, and diabetes, among others.[6] ACEs can affect social functioning through the disruptions of trust in important relationships in childhood and through witnessing unhealthy relationships in their household (HH) and surrounding community. Adults who have experienced ACEs have been shown to have poorer decision-making, maladaptive coping, and less social capital than their peers who did not experience an adverse experience in childhood.[7]. Poor decision-making, maladaptive coping, and experiencing toxic stress can lead to unhealthy lifestyle choices, which have an effect on health outcomes. Harmful coping strategies, such as avoidance coping, often lead to high-risk and harmful behavior, such as alcohol and drug use, unsafe sexual behavior, over-eating, and smoking.[8]

---

[1] CDC website: https://www.cdc.gov/violenceprevention/aces/fastfact.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Facestudy%2Ffastfact.html

[2] David W Brown *et al*. Violence and adverse health behaviours in African children. Exposure to physical and sexual violence and adverse health behaviours in African children: results from the Global School based Student Health Survey. Bull World Health Organ 2009; 87:447–455 doi:10.2471/BLT.07.047423

[3] Nikolaidis *et al.* Child Adolesc Psychiatry Ment Health: Lifetime and past-year prevalence of children's exposure to violence in the countries of the study (2018) 12:1

[4] https://centerforyouthwellness.org/health-impacts/

[5] Monnat, Shannon M, and Raeven Faye Chandler. "Long Term Physical Health Consequences of Adverse Childhood Experiences." *The Sociological quarterly* vol. 56,4 (2015): 723-752. doi:10.1111/tsq.12107

[6] Franke, Hillary A. "Toxic Stress: Effects, Prevention and Treatment." *Children (Basel, Switzerland)* vol. 1,3 390-402. 3 Nov. 2014, doi:10.3390/children1030390

[7] Clausen John S. Adolescent Competence and the Shaping of the Life Course. *American Journal of Sociology.* 1991;96:805–42.

[8] Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study. *Dube SR, Felitti VJ, Dong M, Chapman DP, Giles WH, Anda RFPediatrics. 2003 Mar; 111(3):564-72.*

ACEs have also been shown to have an impact on economic status in adulthood. Adults who have experienced ACEs have been shown to have lower levels of education, poorer earnings, and fewer assets than adults who did not experience ACEs.[9]. Although the reasons for this decreased economic achievement are multiple, one phenomenon researchers have discovered is "ritualism and retreatism,"[10] which refers to the rejecting of conventional societal norms related to goal attainment, . by lowering expectations and aspirations. Adversity in childhood not only has an impact on economic achievement, but through this reduction in economic status, health is also affected. Low social and economic status have been linked to poor health outcomes due to poor access to a healthy lifestyle, poor health behavior, and less access to health services.[11]

The consequences of ACEs on individuals and societies cannot be underestimated. However, experiencing adversity in childhood does not automatically imply poor outcomes as an adult. Protective factors such as safe, stable, and nurturing relationships can mitigate some of the stress and maladaptive coping mechanisms that adults who experienced ACEs often use which can have an impact on health and economic outcomes in adulthood.[12]. One study showed that adults with four or more ACEs were 2.08 times more likely to report poorer health than adults with fewer than four ACEs. However, for adults with four or more ACEs and who grew up with at least one adult that made them feel safe at least some of the time were only 0.61 times more likely to report poorer health and 0.84 times more likely to report poorer health if they had an adult who tried to meet their basic needs. Therefore, the presence of a safe and stable relationship and having basic needs met can greatly mitigate the effects of ACEs on health in adulthood.

Therefore, understanding the frequency of adverse childhood experiences and providing a protective environment should be a crucial aspect of development programming. USAID Mozambique has commissioned a study to understand the frequency and type of adverse childhood experiences, understand how youths cope, and how adversity in childhood impacts outcomes, such as intimate partner violence, alcohol and drug use, and HIV risk in youth.

STUDY QUESTIONS

The study questions are as follows:

1. What are the types and frequency of childhood adverse events in the selected areas in Mozambique?
2. What is the relationship between childhood adversity and HIV risk behavior in youths aged 18-24 years?
3. What is the relationship between childhood adversity and intimate partner violence (victimhood and perpetuation) in youths aged 18-24 years?
4. What is the relationship between childhood adversity and substance use in youths ages 18-24 years?

[9] Macmillan Ross. Violence and the Life Course: The Consequences of Victimization for Personal and Social Development. *Annual Review of Sociology.* 2001;27:1–22

[10] Covey Herbert C, Menard Scott, Franzese Robert J. Effects of Adolescent Physical Abuse, Exposure to Neighborhood Violence, and Witnessing Parental Violence on Adult Socioeconomic Status. *Child Maltreatment.* 2013;18(2):85–97.

[11] Socioeconomic position and self-rated health: the contribution of childhood socioeconomic circumstances, adult socioeconomic status, and material resources. *Laaksonen M, Rahkonen O, Martikainen P, Lahelma E. Am J Public Health. 2005 Aug; 95(8):1403-9.*

[12] Crouch, Elizabeth et al. "Safe, Stable, and Nurtured: Protective Factors against Poor Physical and Mental Health Outcomes Following Exposure to Adverse Childhood Experiences (ACEs)." *Journal of child & adolescent trauma* vol. 12,2 165-173. 25 May. 2018, doi:10.1007/s40653-018-0217-9

5. What is the relationship between childhood adversity and educational attainment in youths ages 18-24 years?
6. What are the coping mechanisms of youths ages 18-24 years?

JUSTIFICATION FOR THE STUDY

Adversity in childhood is a global problem. Mozambique has additional historical and geographic risks that affect childhood adversity, such as past colonial rule; a 16-year civil war; propensity for natural disasters, such as floods, drought, and cyclones; and violent extremism in the north of the country.

Social practices, such as child marriage, compound existing historical and natural disaster adversity. Mozambique has the ninth highest child marriage rate in the world, with 25 percent of young women aged 20-25 years in northern provinces entering marriage before the age of 15.[13] Physical violence has also been reported as common. In the 2015 Mozambique Global School-based Student Health Survey, 36 percent of students aged 13-17 were seriously injured within the last 12 months of the survey.[14]. In the International Men and Gender Equality Survey (IMAGES) study on men aged 18-65 years in the cities of Maputo and Matola, 53 percent reported they had witnessed their siblings being beaten and 30 percent said they witnessed violence between their parents when they were children. Additionally, 49 percent of men stated they experienced situations of threat, intimidation, or harassment in their schools, and 42 percent reported these in their neighborhoods.[15]

Unfortunately, the link between witnessing or experience violence in childhood, particularly before the age of 10 and perpetuating violence in adolescence and adulthood is strong.[16] This link is also further exacerbated by personal and societal beliefs in strict gender roles, low education, low income, and unemployment,[17] which characterize much of Mozambique's rural population. According to the 2011 Demographic and Health Surveys (DHS), 33 percent of women reported being victims of physical violence and 12 percent reported being a victim of forced sex since the age of 15. In the 12 months before the survey, 25 percent had experienced physical violence and 7 percent experienced forced sex.[18]. Almost half of women surveyed in the DHS stated they were emotionally abused by their spouse.

Mozambique has the world's seventh highest HIV prevalence at 12.6 percent.[19] Adverse childhood experiences, depending on the type, are themselves risk factors for HIV exposure, since sexual assault and rape can expose the victims to HIV. Additionally, adverse experiences, regardless of the type, can lead to poor coping mechanisms, such as numbing through casual sexual encounters, poor self-esteem, and poor decision-making, which can also increase exposure to unsafe sexual encounters and decrease condom use. According to the IMAGES study, 42.5 percent of Mozambican students aged 13-15 years and 63.9 percent of students aged 16-17 years have had sexual intercourse and only 73.7 percent of these students reportedly used a condom at during their last sexual intercourse. Other poor coping

[13] ECPAT International and Rede da Criança. 2019. "Sexual Exploitation of Children in Mozambique" to the Committee on the Rights of the Child for the 82nd Pre-session. Bangkok, Thailand on 1st November 2018.
[14] Global School-based Student Health Survey, Mozambique 2015 Fact Sheet.
[15] Slegh, H., Mariano, E., Roque S., & Barker, G. (2017). *Being a Man in Maputo: Masculinities, Poverty and Violence in Mozambique: Results from the International Men and Gender Equality Survey (IMAGES)*. Washington, DC and Rio de Janeiro: Promundo.
[16] Weaver, Chelsea M et al. "Violence Breeds Violence: Childhood Exposure and Adolescent Conduct Problems." *Journal of community psychology* vol. 36,1 (2008): 96-112. doi:10.1002/jcop.20219
[17] https://www.cdc.gov/violenceprevention/intimatepartnerviolence/riskprotectivefactors.html
[18] Ministerio da Saude (MISAU), Instituto Nacional de Estatística (INE) e ICF International (ICFI). Moçambique Inquérito Demográfico e de Saúde 2011. Calverton, Maryland, USA: MISAU, INE e ICFI.
[19] http://unaids.mio.guru/en/regionscountries/countries/mozambique#:~:text=In%20Mozambique%20in%202018%3A,49%20years)%20was%2012.6%25.

mechanisms, such as alcohol, have also been shown to increase risky sexual behavior,[20] which puts youth at risk for HIV. Children and youths who have not received adequate protection from parents or a guardian are also at risk of exploitation, putting them at increased risk for HIV and violence, including being trafficked—a growing problem in Mozambique.[21]

Since ACEs affect young people's ability to achieve their life goals, development programming should be informed by evidence of which ACEs predominately affect the Mozambican population and how to diminish the possibility of ACEs, mitigate their effects, and help survivors develop positive coping mechanisms.

A significant gap exists in research focusing on the types of ACEs faced by children and adolescents in Mozambique, the mechanisms they use to cope, and the impact of ACEs—such as alcohol and substance use—on health outcomes and HIV risk. Coping mechanisms for youths have not been significantly studied, but growing concern exists among project implementers about the increase in negative coping strategies, such as alcohol abuse.

METHODOLOGY

DESIGN

This is a cross-sectional quantitative study with qualitative life stories. A cross-sectional study of youths and their current health outcomes and coping behaviors and a retrospective study of youths' ACEs were conducted. Additionally, life stories of youths were captured to demonstrate how childhood adversity impacts youths and how they cope with past and current adversity.

STUDY LOCATION

One province per region was selected based on USAID health and orphans and vulnerable children programming priorities. Districts were similarly selected, based on having a high level of USAID investment, geographic variety, and a variety of social characteristics. The capital cities of each province were included to ensure a diversity of urban and rural settings, since adverse experiences, resources, and coping and health behaviors may differ depending on the setting.

The study was conducted in the Provinces of Maputo, Nampula, and Sofala. In each province, the capital city and two other districts were included in the study. In Maputo Province: Matola City, and Maniça and Moamba Districts were included. In Nampula Province: Nampula City, and Memba and Mogovolas Districts were included. In Sofala Province: Beira City, and Gorongosa and Nhamatanda Districts were included.

PARTICIPANTS

Youths aged 18-24 who gave informed consent and who lived or were present in the geographical areas of the study were included. Several youths were selected by USAID implementing partners working in

[20] Kiene, S.M., Subramanian, S. Event-level association between alcohol use and unprotected sex during last sex: evidence from population-based surveys in sub-Saharan Africa. *BMC Public Health* **13,** 583 (2013). https://doi.org/10.1186/1471-2458-13-583
[21] ECPAT International and Rede da Criança. 2019**. "Sexual Exploitation of Children in Mozambique**" to the Committee on the Rights of the Child for the 82nd Pre-session. Bangkok, Thailand on 1st November 2018.

the selected districts to take part in the life story interviews. Participants in the life story interviews were male and female youths aged 18-24 who have experienced ACEs and consented to participate in the interview.

SAMPLING

The sampling framework for the quantitative survey with youths was based on the 2017 Population and Housing Census, which includes the list of enumeration areas (EAs) with basic information about HH and population targets. The population was estimated to be 883,428 boys and girls living in 1,015,002 HHs, divided into 310,719 EAs. The target population of the study HHs with at least one young male or female within the age range of 18-24 years old. The total sample size estimate of the study was 2,714 youths 18-24 years old.

The sample was disaggregated by six districts and three capital cities. In each district a representative sample of 254 youths was interviewed, while in the capital cities the sample size was 399 youths. The estimation of the sample size was based on the following assumptions:

a) The target population variance is more pronounced in the cities than in rural districts. Consequently, the sample size of the capital cities should be much larger than the sample of districts. For districts, a sampling error of about 6.5 percent was considered, while for capital cities, a sampling error of 5.6 percent was the base for sample size estimation.

b) Cluster sampling with different design effect (DEFF) between capital cities and districts was taken into consideration. A DEFF of 1.12 was the base for district sample size estimation while for capital cities a DEFF of 1.30 was used. The DEFF of 1.30 means the variance is 1.3 times as large would be expected with Simple Random Sample (SRS) in the capital cities.

c) Power=0.8, with a confidence interval of 95 percent.

TABLE 1: SAMPLE SIZE DISTRIBUTION

Place	Population size (15 - 24 years old)	Sample size	Margin of error	Design Effect	Number of HHs per Enumeration area	Number of Enumeration areas
Memba	50,958	254	6.5%	1.12	12	22
Mogovolas	62,668	254	6.5%	1.12	12	22
Cidade de Nampula	252,431	399	5.6%	1.30	20	20
Total of the sample for the 3 places in Nampula	**366,057**	**907**	**3.58%**	**1.2**		

Place	Population size (15 - 24 years old)	Sample size	Margin of error	Design Effect	Number of HHs per Enumeration area	Number of Enumeration areas
Gorongosa	35,854	254	6.5%	1.12	12	22
Nhamantanda	59,371	254	6.5%	1.12	12	22
Beira	143,975	399	5.6%	1.30	20	20
Total of the sample for the 3 places in Sofala	**239,200**	**907**	**3.58%**	**1.2**		
Moamba	16,884	247	6.5%	1.12	12	22
Maniça	50,131	254	6.5%	1.12	12	22
Matola	374,546	399	5.6%	1.30	20	20
Total of the sample for the 3 places in Maputo	**452,742**	**900**	**3.58%**			
Total sample	**1,432,600**	**2,714**	**2.06%**	**1.2**		

A probabilistic, multistage, and stratified sampling approach was used to ensure that every HH had an equal chance of being selected for the study:

1. Multistage cluster sample: In each place, a three-stage sample cluster was conducted. First, the primary sampling unit/EA was randomly selected by Instituto Nacional de Estatística from the sampling frame using the probability proportional to size method (PPS). Second, a random selection

of HHs with at least one youth with age between 18-24 was applied, and finally (third), a random selection of HH members in cases where there is more than one eligible member in the HH to be interviewed was applied.

2. Stratified sample: The primary sampling unit, the EA, was classified or grouped according to the following criterion: urban/rural, socioeconomic level, and agriculture-climate characteristics. In the capital cities, EA belonging to the neighborhood of the industrial hub were included.
3. PPS is a sampling procedure that was used to select the EAs. The probability of an EA being selected was proportional to size of the EA (number of HHs), giving larger EA a greater probability of selection and smaller EA a lower probability.
4. A substitute EA was selected from the neighboring EA that required substitution.

HOUSEHOLD AND PARTICIPANT SELECTION

Cartographic maps in which the boundaries of the selected EAs are clearly defined were installed in the data collection application to ensure all data was collected within the selected EAs.

HH listing was used to identify eligible HHs and to coordinate with youths to participate in the questionnaire. Simple Random Sampling (SRS) was used to select 12 HHs in each district EA, or 20 HHs in each capital city EA. Within each eligible HH, a Kish grid[22] was used to select study participants in each target study group for which there was more than one eligible member. If the selected participant was not available, the interviewer came back one more time. If in the second round the participant was not available, he/she was replaced by another eligible member of the HH of the same gender when possible. Four additional HHs were included in the list in the event that an HH needed to be substituted (replaced).

LIFE STORIES

Four youths, 2 male and 2 female, were selected for the life stories interviews. These youths were purposively selected through current development projects working with youths using the following criteria: all must have undergone at least one significant ACE and several should also be HIV positive.

QUESTIONNAIRE DEVELOPMENT

Youths were asked about their ACEs using the World Health Organization (WHO) International ACE Questionnaire.[23]. This questionnaire has been adapted slightly to the Mozambican context. Additionally, the BRIEF COPE[24] questionnaire was used to assess current coping mechanisms of the youths who participated in the study. The BRIEF COPE questionnaire assesses a person's coping style based on 14 types of coping. Youths were also asked questions about HIV risk behavior from the INSIDA 2009[25] questionnaire. Intimate partner violence (IPV) questions were developed using definitions from the U.S.

[22] The Kish grid or Kish selection grip is a method for selecting members within a householdHH to be interviewed. It uses a pre-assigned table of random numbers to find the person to be interviewed.
[23] https://www.who.int/docs/default-source/documents/child-maltreatment/ace-questionnaire.pdf?sfvrsn=baed215c_2
[24] https://scienceofbehaviorchange.org/measures/brief-cope/
[25] https://dhsprogram.com/pubs/pdf/ais8/ais8.pdf

Centers for Disease Control (CDC)[26] and WHO[27]. Alcohol and substance use questions are taken from the AUDIT Alcohol Screening Questionnaire[28] and DAST Drug Screening Questionnaire[29].

DATA ANALYSIS

Data was analyzed using SPSS statistical software. Frequencies were conducted and selected demographic disaggregation were calculated on all questions in the questionnaire. A logistic regression analysis was conducted on the association between having four or more ACEs and specific health risk behaviors as well as educational attainment.

DATA COLLECTION TEAMS

Enumerators were psychology students or recent graduates and received a five-day training, including a one-day pilot testing. There were three groups of enumerators, one for each province and a cascade training was applied to ensure the same trainers trained all enumerators for standardization purposes. All enumerators were proficient in the local languages in the areas where they worked.

ETHICAL CONSIDERATIONS

The study was approved by the bioethical committee at UniLurio in Nampula Province. Youth participants gave their informed consent and were told about the nature of the questionnaire. None of the participants stopped the interview after it started, although 10 youths refused to participate citing a lack of time or interest as they stated they have participated in several questionnaires without seeing any benefits. At the end of the questionnaires, enumerators led the participants in a short debrief session which included information on common symptoms of trauma, helpful coping behaviors, information on how to access mental health services and a progressive muscle relaxation exercise.

COVID-19 PREVENTION

The Mozambique Monitoring and Evaluation Mechanism and Services (MMEMS) abided by all Government of the Republic of Mozambique (GRM) COVID-19 protocols. In addition, prior to starting field work and prior to traveling, all MMEMS staff and consultants answered a COVID-19 risk screening and got a COVID-19 test if deemed necessary. Daily health checks were conducted for all team members, including temperature and symptom checks. No member of the field teams was allowed to work if they had a fever or a cough, and any member of the team who had symptoms was sent to the nearest health facility and only allowed to work if cleared by a health professional. Face masks were worn at all times in public and during the data collection. Alcohol gel was made available for intermittent use throughout the day. Appropriate distance was observed during training and fieldwork.

LIMITATIONS

There are a few limitations to the study. The questionnaire relies on self-reporting and recall bias for the questions relating to childhood. This is likely to cause under-reporting of highly sensitive questions. Additionally, during the interviews, the data collection team witnessed the normalization of violence and abuse among the study participants. Enumerators were trained to prompt and rephrase questions to

[26] https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html
[27] https://apps.who.int/iris/bitstream/handle/10665/77432/WHO_RHR_12.36_eng.pdf
[28] https://www.drugabuse.gov/sites/default/files/audit.pdf
[29] http://www.sbirtoregon.org/wp-content/uploads/DAST-English-pdf.pdf

avoid this bias, however, there could have been under-reporting due to the normalization of many of the ACEs.

The fieldwork team encountered extreme weather conditions including heavy rain and flooding of rivers in Nhamatanda District and, consequently, could not collect the desired sample.

RESULTS

Overall, the sample size was met, except in Nhamatanda District. Due to inclement weather during the data collection period, 45 percent of the sample was collected in Nhamatanda District. The data collection had a very low no-response rate, with just 10 youths refusing to participate in the study. No participant stopped the questionnaire once it was started.

TABLE 2: CUMULATIVE RESULTS OF DATA COLLECTION

Province	District	# EA covered	# of youths covered				Sample	# youths who refused to be interviewed
			M	F	Total	%		
Nampula	Nampula	20	169	217	**386**	102.4	377	0
	Memba	22	98	166	**264**	100.0	264	0
	Mogovolas	22	116	144	**260**	98.5	264	0
	Sub-total Nampula	**64**	**383**	**527**	**910**	**100.6**	**905**	**0**
Sofala	Beira	20	179	208	387	102.9	376	0
	Gorongosa	21	114	138	252	95.5	264	0
	Nhamatanda	10	47	72	119	45.1	264	0
	Sub-total Sofala	**51**	**340**	**418**	**758**	**83.8**	**904**	**0**
Maputo	Matola	20	176	202	378	100.3	377	7
	Manhiça	22	92	151	243	92.0	264	0
	Moamba	22	92	163	255	96.6	264	3
	Sub-total Maputo	**64**	**360**	**516**	**876**	**96.8**	**905**	**10**
Total 3 provinces		**179**	**1083**	**1461**	**2,544**	**93.7**	**2,714**	**10**

In the study sample there was a slightly higher percentage of females surveyed at 57 percent compared to males. This is due to two factors: 1) there were fewer males registered in the rural districts during the HH listing because the families stated the males had left the district in search of schooling or employment opportunities and 2) it was more difficult reach males in the cities because they tended to stay outside of the home for longer periods, only to return late at night. Additionally, most of the youths who refused to participate in the study were males.

A small percentage of youths in the sample had never attended school, at 7.9, while 35.4 percent had completed secondary school or higher. Forty percent of youths were unemployed at the time of the study and 25.6 percent were in school.

TABLE 3 SAMPLE DEMOGRAPHIC CHARACTERISTICS

		N	%
Total		**2544**	**100**
Urban (cities)	Nampula	386	15.2
	Beira	387	15.2
	Matola	378	14.9
Rural	Memba	264	10.4
	Mogovolas	260	10.2
	Gorongosa	252	9.9
	Nhamatanda	119	4.7
	Moamba	255	10.0
	Manhiça	243	9.6
Total sample		**2544**	**100.0**
Province	Nampula	910	35.8
	Sofala	758	29.8
	Maputo	876	34.4
Gender	Male	1083	42.6
	Female	1461	57.4
Education	Did not attend	200	7.9
	Did not complete primary	769	30.3
	Completed primary	673	26.5
	Completed secondary or above	900	35.4
Employment status	Unemployed	1010	40.6
	Self-employed	639	25.7

		N	%
Total		**2544**	**100**
	Formal employment	204	8.2
	Student	636	25.6

ADVERSE CHILDHOOD EXPERIENCES

Youths were asked a series of questions to determine if they had undergone physical, emotional, and/or sexual abuse. Physical abuse was classified by the frequency and intensity of the physical encounter, which had to have occurred when the youth was under 18. For instance, if the intensity was very light, meaning it did not leave any kind of mark (bruise, cut, and so on), but frequent, then it was considered abuse. If the physical encounter occurred, even only once, and left a mark, it was also considered abuse. In total, 35.9 percent of the youths surveyed met the criteria of physical abuse in childhood. There was a statistically significant difference between physical abuse by province, with Nampula at 43.2 percent compared to Sofala at 27.4 percent.

There was no significant difference of percentage of physical abuse by gender or urban/rural area, but there was a difference by educational status. Forty-eight percent of youths who never attended school were physically abused as children by a caregiver compared to 31.5 percent of youths who completed secondary school or above.

Emotional abuse was the most common form of abuse at 65 percent. Emotional abuse was characterized as having someone in the HH yell, insult, or humiliate the youth or having a parent, caregiver, or someone living in the home threaten or abandon the youth or kick them out of the house. There was no significant difference in prevalence of emotional abuse by province, urban or rural area, gender, or education. However, it is important to note that emotional abuse was very high in Memba District at 78.4 percent.

Sexual abuse was classified as any unwanted attempt or occurrence of someone touching or caressing in a sexual manner or any attempt or occurrence of unwanted oral, vaginal, or anal sex. Overall, 37.4 percent of youths stated they were sexually abused during childhood. Sexual abuse was significantly different by province, with Nampula Province having the highest percentage of sexual abuse at 49.6 percent, compared to 27.4 percent in Maputo Province. This means that half of the youths involved in the study in Nampula Province stated they were sexually abused in childhood. In one district (Memba in Nampula), 59.5 percent of youths reported that they were sexually abused. Although there was also a significant difference between gender and sexual abuse, there was a high percentage of males who reported that they were sexually abused at 30.4 percent. Sexual abuse was also more common in urban areas at 40.2 percent.

TABLE 4-ACE- PHYSICAL, EMOTIONAL AND SEXUAL ABUSE

		Physical Abuse			Emotional Abuse			Sexual Abuse		
		N	%	P	N	%	P	N	%	P
Total		**913**	**35.9**		**1653**	**65.0**		**952**	**37.4**	
Urban areas	Nampula	159	41.2	0.014	226	58.5	0.001	178	46.1	0.013
	Beira	121	31.3		270	69.8		148	38.2	
	Matola	132	34.9		265	70.1		137	36.2	
Rural areas	Memba	162	61.4	<0.001	207	78.4	<0.001	157	59.5	<0.001
	Mogovolas	72	27.7		141	54.2		116	44.6	
	Gorongosa	62	24.6		157	62.3		81	32.1	
	Nhamatanda	25	21.0		79	66.4		32	26.9	
	Moamba	98	38.4		167	65.5		47	18.4	
	Manhiça	82	33.7		141	58.0		56	23.0	
Region	Nampula	393	43.2	<0.001	574	63.1	0.277	451	49.6	<0.001
	Sofala	208	27.4		506	66.8		261	34.4	
	Maputo	312	35.6		573	65.4		240	27.4	
Location	Urban	412	35.8	0.929	761	66.1	0.273	463	40.2	0.008
	rural	501	36.0		892	64.0		489	35.1	
Gender	Male	366	33.8	0.058	682	63.0	0.068	329	30.4	<0.001
	Female	547	37.4		971	66.5		623	42.6	
Education	Did not attend	94	47.5%	<0.001	132	66.0%	0.296	106	53.3%	<0.001
	Did not complete primary	310	40.4%		504	65.7%		300	39.3%	
	Completed primary	225	33.5%		416	62.0%		228	34.1%	

		Physical Abuse			Emotional Abuse			Sexual Abuse		
		N	%	P	N	%	P	N	%	P
	Completed secondary or above	283	31.5%		597	66.4%		308	34.6%	

The questions making up the sexual abuse criteria are shown in Table 5. A staggering 14.2 percent of youths stated they had been raped (vaginal, anal, or oral intercourse), 27.7 percent experienced unwanted touching of a sexual nature, 22.3 percent stated someone made them touch them, and 21.7 percent had the experience of an attempted rape. Thirty-six percent of youths in Memba stated they had been raped before the age of 18, with 19 percent of female youths and 8.1 percent of male youths stating they had been raped. In Nampula Province, 27.7 percent of youths stated they had been raped before the age of 18.

TABLE 5: PREVALENCE OF THE FORMS OF SEXUAL ABUSE

		Someone touched or caressed you in a sexual way		Someone made you touch their body in a sexual way		Has anyone tried oral, anal or vaginal sex with you without your consent?		Has anyone ever had oral, anal, or vaginal sex with you without your consent?	
		N	%	N	%	N	%	N	%
		703	27.7	565	22.3	551	21.7	360	14.2
Urban areas	Nampula	133	34.5	131	33.9	135	35.1	110	28.5
	Beira	97	25.1	77	19.9	82	21.2	37	9.6
	Matola	90	23.9	66	17.6	58	15.4	30	8.0
Rural areas	Memba	127	48.5	113	43.0	118	44.9	94	35.9
	Mogovolas	96	37.1	75	28.8	69	26.5	47	18.1
	Gorongosa	58	23.0	41	16.3	33	13.1	16	6.3

	Nhamatanda	21	17.6	14	11.8	13	10.9	7	5.9
	Moamba	42	16.5	18	7.1	15	5.9	10	4.0
	Manhiça	39	16.1	30	12.4	28	11.6	9	3.7
Region	Nampula	356	39.3	319	35.1	322	35.5	251	27.7
	Sofala	176	23.2	132	17.4	128	16.9	60	7.9
	Maputo	171	19.6	114	13.1	101	11.6	49	5.6
Location	Urban	320	27.9	274	23.9	275	24.0	177	15.4
	Rural	383	27.6	291	20.9	276	19.9	183	13.2
Gender	Male	220	20.4	192	17.7	141	13.1	88	8.1
	Female	483	33.2	373	25.6	410	28.1	272	18.7
Education	Did not attend	91	45.5	67	33.7	72	36.0	45	22.5
	Did not complete primary	237	30.9	197	25.6	198	25.7	147	19.2
	Completed primary	160	23.8	137	20.4	126	18.8	85	12.7
	Completed secondary and above	215	24.0	164	18.3	155	17.3	83	9.3

Marriage, or premature union, before the age of 18 is unfortunately known to be common in Mozambique[30] and in this sample, just over half of females (54.1 percent) reported that they were subjected to premature unions. The percentage was higher in rural areas and highest in the province of Nampula at 61.1. Typically, premature union is usually only calculated for females, but males were included in this question as well and 35.5 percent of male youths stated they were in a domestic union before the age of 18. When considering only females, the premature union percentage was 60.1 percent. Premature unions were highest among youths who never attended school at 72.9 percent, compared to 20.8 percent of those who had completed secondary school or higher.

Youths were asked if they lived with someone who had a problem with alcohol or was an alcoholic, or who used illegal drugs. Twenty-eight percent of youth respondents stated they had lived with someone who abused alcohol or drugs. The percentage was significantly higher in Nampula Province at 33 percent, compared to 23.2 percent in Maputo Province. Urban/rural location and education were also significantly different. Youths in urban areas (30.4 percent) and youths who had never attended school

[30] https://www.unicef.org/mozambique/en/child-marriage-mozambique

(31 percent) had the highest prevalence of living with someone during childhood who had a substance abuse problem.

Respondents were asked if they lived with someone when they were under 18 years of age who has ever been taken to jail or sent to prison, and 17.5 percent reported that they had. There was no significant difference by province in the percentage of youths who lived with someone who was incarcerated, but there was a significant difference by location, with a 21.5 percent prevalence of incarceration of a relative in urban areas.

TABLE 6 -ACE-PREMATURE MARRIAGE, SUBSTANCE ABUSE IN HH, AND INCARCERATION OF RELATIVE

		Premature marriage			**Substance use in the household**			**Incarceration of relative**		
		N	%	P	N	%	P	N	%	P
Total		**209**	**54.1**		**713**	**28.0**		**444**	**17.5**	
Urban areas	Nampula	29	46.0	0.961	139	36.0	0.004	95	24.6	0.169
	Beira	17	44.7		117	30.2		79	20.4	
	Matola	5	41.7		94	24.9		73	19.3	
Rural areas	Memba	65	67.0	0.004	70	26.5	0.004	35	13.3	<0.001
	Mogovolas	44	66.7		91	35.0		41	15.8	
	Gorongosa	23	46.9		65	25.8		24	9.5	
	Nhamatanda	3	23.1		28	23.5		11	9.2	
	Moamba	13	43.3		62	24.3		61	23.9	
	Manhiça	10	55.6		47	19.3		25	10.3	
Region	Nampula	138	61.1	0.005	300	33.0	<0.001	171	18.8	0.106
	Sofala	43	43.0		210	27.7		114	15.0	
	Maputo	28	46.7		203	23.2		159	18.2	
Location	Urban	51	45.1	0.022	350	30.4	0.015	247	21.5	<0.001
	Rural	158	57.9		363	26.1		197	14.1	
Gender	Male	33	35.5	<0.001	312	28.8	0.45	187	17.3	0.832

	Female	176	60.1		401	27.4		257	17.6	
Education	Did not attend	43	72.9	<0.001	62	31.0	<0.001	22	11.0	0.013
	Did not complete primary	109	63.7		249	32.4		121	15.8	
	Completed primary	46	44.7		197	29.3		134	19.9	
	Completed secondary or above	11	20.8		205	22.8		167	18.6	

Youth respondents were asked about neglect in childhood and these questions made up two categories: emotional and physical neglect. Emotional neglect was characterized by the respondents' statements about whether parents/caregivers understood their problems and concerns. Physical neglect was characterized by caregivers' inattention and lack of supervision as measured by the knowledge of where the child was when not at school/during free time, if caregivers withheld food from the child when it was available, if a caregiver was under the influence of alcohol or drugs and could not properly care for the child, if a caregiver did not send their child to school when they were able to (or if the child was in school and they would inhibit or prohibit the child from attending).

Emotional neglect was less common at 14.5 percent, compared to 55.8 percent for physical neglect. There was no significant difference by gender for either type of neglect. There was a significant difference in percentage of physical neglect with educational status, as would be expected since lack of attending school is one of the definitions of physical neglect and the other criteria could inhibit school attendance. Eighty-two percent of youths who experienced physical neglect never attended school, compared to 41.9 percent that completed secondary school or above. Education was also significantly associated with emotional neglect, with 29.1 percent of youths who never attended school reporting emotional neglect, compared to just 10.8 percent of youths who completed secondary school or higher. The prevalence of both emotional and physical neglect was significantly higher in rural areas.

Respondents were asked if, before the age of 18, they ever lived with someone who was depressed, had a mental illness, or had suicidal intent. Sixteen percent of respondents stated that in childhood they had lived with someone with a mental illness. This percentage was significantly higher in Nampula Province at 19.3 percent, compared to 12.7 percent in Maputo Province. There were no significant differences by sex, urban/rural areas, or educational attainment.

TABLE 7-ACE-EMOTIONAL NEGLECT, PHYSICAL NEGLECT, AND MENTAL ILLNESS

		Emotional neglect			Physical neglect			Family member with Mental illness		
		N	%	P	N	%	P	N	%	P
Total		**368**	**14.5**		**1419**	**55.8**		**404**	**15.9**	
Urban areas	Nampula	60	15.5		270	69.9		61	15.8	
	Beira	39	10.1	0.073	220	56.8	<0.001	78	20.2	0.064
	Matola	47	12.4		126	33.3		53	14.0	
Rural areas	Memba	49	18.6		199	75.4		54	20.5	
	Mogovolas	56	21.5		200	76.9		61	23.5	
	Gorongosa	45	17.9	<0.001	168	66.7	<0.001	30	11.9	<0.001
	Nhamatanda	11	9.2		60	50.4		9	7.6	
	Moamba	41	16.1		97	38.0		37	14.5	
	Manhiça	20	8.2		79	32.5		21	8.6	
Region	Nampula	165	18.1		669	73.5		176	19.3	
	Sofala	95	12.5	<0.001	448	59.1	<0.001	117	15.4	0.001
	Maputo	108	12.3		302	34.5		111	12.7	
Location	Urban	146	12.7	0.020	616	53.5	0.037	192	16.7	0.315
	Rural	222	15.9		803	57.6		212	15.2	
Gender	Male	141	13.0	0.074	620	57.2	0.199	165	15.2	0.444
	Female	227	15.5		799	54.7		239	16.4	
Education	Did not attend	57	29.1	<0.001	154	81.9	<0.001	40	20.0	0.168
	Did not complete primary	119	15.6		521	69.0		131	17.1	

	Completed primary	95	14.1		352	52.6		104	15.5	
	Completed secondary or above	97	10.8		376	41.9		129	14.3	

As mentioned previously, 55.8 percent of respondents met the criteria for physical neglect. The four questions that made up the criteria had the same relative frequency among the respondents, so there was not one main contributing factor that led to physical neglect. Twenty-four percent of respondents reported that they were not given enough food when food was available, 29.5 percent stated that their caregiver was under the influence of alcohol or drugs and could not effectively care for them, 25 percent stated that they were not sent to school even when the family had the conditions to do so, and 25.4 percent stated that their caregiver did not know where they were during their free time.

There were differences by province. In Nampula, the most frequent form of physical neglect was not sending the child to school, when possible, at 43 percent. In Sofala, it was that the caregiver was under the influence of alcohol or drugs at 32.8 percent and in Maputo Province, it was a lack of caregiver supervision at 20.1 percent. There were no large differences in these forms of physical neglect by gender. Physical neglect had an impact on educational attainment with all forms of neglect showing big differences in percentages between youths who had never been to school and those who completed secondary school or higher.

TABLE 8 DESCRIPTION OF NEGLECT

		Caregiver not providing food		**Alcoholic caregiver**		**Caregiver not sending the kid to school**		**Lack of caregiver attention**	
		N	%	N	%	N	%	N	%
Total		**608**	**23.9**	**751**	**29.5**	**636**	**25.0**	**645**	**25.4**
Urban areas	Nampula	134	34.7	149	38.6	143	37.0	119	30.8
	Beira	93	24.0	131	33.9	60	15.5	100	25.8
	Matola	47	12.4	72	19.0	20	5.3	79	20.9
Rural areas	Memba	109	41.3	90	34.1	123	46.6	77	29.2
	Mogovolas	99	38.1	100	38.5	125	48.1	86	33.1
	Gorongosa	68	27.0	83	32.9	93	36.9	61	24.2

	Nhamatanda	17	14.3	35	29.4	22	18.5	26	21.8
	Moamba	27	10.6	46	18.0	29	11.4	58	22.7
	Manhiça	14	5.8	45	18.5	21	8.6	39	16.0
Region	Nampula	342	37.6	339	37.3	391	43.0	282	31.0
	Sofala	178	23.5	249	32.8	175	23.1	187	24.7
	Maputo	88	10.0	163	18.6	70	8.0	176	20.1
Location	Urban	274	23.8	352	30.6	223	19.4	298	25.9
	Rural	334	24.0	399	28.6	413	29.6	347	24.9
Gender	Male	258	23.8	345	31.9	258	23.8	287	26.5
	Female	350	24.0	406	27.8	378	25.9	358	24.5
Education	Did not attend	84	42.4	73	36.5	99	51.6	81	41.1
	Did not complete primary	231	30.4	263	34.3	320	41.8	199	25.9
	Completed primary	158	23.5	196	29.3	136	20.2	180	26.7
	Completed secondary or above	135	15.0	219	24.4	81	9.0	185	20.6

Respondents were asked if their parents were divorced/separated or if a parent died before the respondent turned 18. Thirty-five percent of youths stated that their parents separated or divorced, and 32.5 percent stated that a parent died during the respondent's childhood. Note that this ACE includes youths who experienced the death of at least one parent, but some of the youths may have had both parents pass away. There was a significant difference in youths whose parents divorced during their childhood by province, but there was no meaningful difference between province and the prevalence of the death of a caregiver. The prevalence of divorce was higher in Nampula at 43.5 percent, compared to Sofala at 24.7 percent. There was a significant difference between divorce and educational attainment, but there was not a difference between death of a parent and education.

Respondents were asked if they saw or heard someone who lived in their house being yelled at, being insulted or humiliated, or being physically assaulted. If the respondent affirmed that they witnessed even one of these types of abuse, they were considered to have witnessed family abuse. Witnessing family abuse was high at 67.6 percent. There was no statistical difference between witnessing family abuse and province, gender, or educational attainment.

TABLE 9-ACE DIVORCE AND DEATH OF CAREGIVER, WITNESSING FAMILY ABUSE

		Divorce			Death of caregiver			Witnessing family abuse		
		N	%	P	N	%	P	N	%	P
Total		**885**	**35.0**		**827**	**32.5**		**1712**	**67.6**	
Urban areas	Nampula	168	43.5	<0.001	121	31.4	0.001	258	67.2	0.947
	Beira	114	29.5		158	40.8		262	67.9	
	Matola	131	35.1		106	28.0		249	66.8	
Rural areas	Memba	113	42.8	<0.001	83	31.6	0.012	223	84.8	<0.001
	Mogovolas	114	44.0		68	26.2		150	57.9	
	Gorongosa	42	16.7		68	27.0		170	67.7	
	Nhamatanda	31	26.1		38	31.9		76	63.9	
	Moamba	97	38.5		101	39.6		165	65.0	
	Manhiça	75	31.4		84	34.6		159	65.7	
Region	Nampula	395	43.5	<0.001	272	30.0	0.093	631	69.6	0.236
	Sofala	187	24.7		264	34.8		508	67.2	
	Maputo	303	35.1		291	33.2		573	65.9	
Location	Urban	413	36.1	0.296	385	33.5	0.356	769	67.3	0.724
	Rural	472	34.1		442	31.8		943	67.9	
Gender	Male	350	32.4	0.021	322	29.8	0.010	726	67.5	0.922
	Female	535	36.9		505	34.6		986	67.7	
Education	Did not attend	71	35.9	0.004	61	30.5	0.056	145	72.9	0.122
	Did not complete primary	305	39.8		272	35.5		530	69.2	
	Completed primary	225	33.7		228	33.9		433	64.8	

	Completed secondary or above	282	31.5		266	29.6		603	67.3	

Bullying, as characterized by a peer saying or doing mean or unpleasant things to the youth, was common among the respondents at 42.7. percent. There was a significant difference between the percentage of bullying by province, with Nampula at 50.3 percent, compared to Maputo at 37.45 percent. There was no difference in the prevalence of bullying by gender. Physical fighting was infrequent, with 8.4 percent of the respondents stating they fought often. Male respondents had a higher frequency at 11 percent than female respondents at 6.5 percent. A fifth (20.1 percent) of respondents had witnessed community violence. Community violence was defined by witnessing someone being threatened with a knife or gun, being beaten, or being stabbed or shot. There was a significant difference between province and witnessing community violence with Maputo Province at 25.5 percent compared to Sofala at 19.3 percent.

TABLE 10-ACE BULLYING, FIGHTING AND COMMUNITY VIOLENCE

		Bullying			**Fighting**			**Community violence**		
		N	%	P	N	%	P	N	%	P
Total		**1085**	**42.7**		**214**	**8.4**		**546**	**21.5**	
Urban areas	Nampula	204	52.8	0.02	40	10.4	0.758	86	22.3	0.012
	Beira	174	45.0		34	8.8		98	25.3	
	Matola	163	43.2		36	9.5		119	31.6	
Rural areas	Memba	135	51.1	<0.001	34	12.9	<0.001	51	19.3	0.008
	Mogovolas	117	45.7		17	6.6		40	15.5	
	Gorongosa	74	29.4		4	1.6		25	10.0	
	Nhamatanda	54	45.4		11	9.2		23	19.3	
	Moamba	100	39.2		17	6.7		54	21.2	
	Manhiça	64	26.3		21	8.6		50	20.6	
Region	Nampula	456	50.3	<0.001	91	10.0	0.033	177	19.5	0.002
	Sofala	302	39.8		49	6.5		146	19.3	

	Maputo	327	37.4		74	8.5		223	25.5	
Location	Urban	541	47.0	<0.001	110	9.6	0.060	303	26.4	<0.001
	Rural	544	39.2		104	7.5		243	17.5	
Gender	Male	484	44.8	0.07	119	11.0	<0.001	258	23.9	0.013
	Female	601	41.2		95	6.5		288	19.8	
Education	Did not attend	71	35.9	0.004	61	30.5	0.056	145	72.9	<0.001
	Did not complete primary	305	39.8		272	35.5		530	69.2	
	Completed primary	225	33.7		228	33.9		433	64.8	
	Completed secondary or above	282	31.5		266	29.6		603	67.3	

Collective violence was classified as including wars or shootings, terrorism, political or ethnic conflicts, genocide, repression or curfews, disappearances, torture, and violent organized crime, such as banditry, drug trafficking, and gang warfare. Respondents were asked if they were ever forced to live elsewhere because of any of these events; if they experienced the willful destruction of their home due to any of these events; if they were ever beaten by soldiers, police, militia, or gangs; or if a family member or friend had been killed or beaten by soldiers, police, militia, or gangs. If the respondent responded yes to any of these four questions, then they were considered to have experienced community violence. Almost a fourth of the respondents had been affected by community violence during childhood, at 23.6 percent. Collective violence was experienced the most in Sofala Province (32.6 percent), with Gorongosa District as high as 49 percent. In contrast, only 10.1 percent of respondents in Maputo Province were affected by collective violence.

Goronogosa (in Sofala Province) and Memba District (in Nampula Province) were the districts with the highest prevalence of collective violence. These two districts have historically been areas where there is more instability due to political reasons. While not a large difference, there was a statistically significant difference in collective violence by gender, with 26.7 percent of males reporting collective violence, compared to 21.3 percent of females. Collective violence reports were also significantly different in terms of educational attainment. Thirty-three percent of youths who experienced collective violence never attended school, compared to 18.2 percent who completed secondary school or higher.

Respondents who had ever attended school were asked if they had ever felt unsafe at school. Forty percent of youths who attended school stated they had felt unsafe. Feeling unsafe at school was significantly higher in Sofala Province at 45 percent, compared to Maputo Province at 33.6 percent, and was higher in youths living in urban areas (48.3 percent). There was no significant difference between gender and feeling unsafe in school.

Respondents were asked if they were forced to work when they were under 18. This does not include children who were asked to work on a family farm or help with a small business. This also does not include children who wanted to work. One youth stated that as a child she was sent to work and live with a different family, and that she is currently still working for them. She says she was not forced, and her life is much better than it was when she was with her family. While she does not receive any renumeration, works full time, and therefore has not attended school, this respondent was adamant that she was not forced to work by her family and that she is much better off because of her work situation. She was, therefore, not counted as experiencing child labor.

Twenty-nine percent of youths stated that they were forced to work when they were children or adolescents. Child labor was much higher in Nampula Province at 47.6 percent than in Maputo Province at 9.5 percent. Respondents in Memba reported a very high prevalence of child labor with 65.2 percent of youths forced to work as children. There was a statistically significant difference by gender and child labor, with males having a higher percentage (31.5 percent) of child labor than females (26.5. percent). Educational attainment was also significantly different with 53 percent of youths who were forced to work in their childhood never attending school, compared to 12.9 percent who completed secondary school or higher. In the overall sample, only 25.2 percent of youths never attended school, so forced work in childhood has an impact on educational attainment.

TABLE 11-ACE COLLECTIVE VIOLENCE, SCHOOL INSECURITY, CHILD LABOR

		Collective violence			**School insecurity**			**Child labor**		
		N	%	P	N	%	P	N	%	P
Total		**598**	**23.6**		**1015**	**40.1**		**728**	**28.6**	
Urban areas	Nampula	102	26.6	<0.001	181	46.9	0.209	140	36.3	<0.001
	Beira	87	22.5		201	51.9		78	20.2	
	Matola	46	12.2		174	46.0		25	6.6	
Rural areas	Memba	96	36.4	<0.001	116	43.9	<0.001	172	65.2	<0.001
	Mogovolas	65	25.2		84	33.6		121	46.5	
	Gorongosa	123	49.0		78	31.0		105	41.7	
	Nhamatanda	37	31.1		62	52.1		29	24.4	
	Moamba	20	7.9		58	22.8		39	15.3	
	Manhiça	22	9.1		61	25.3		19	7.8	

Region	Nampula	263	29.1	<0.001	381	42.3	<0.001	433	47.6	<0.001
	Sofala	247	32.6		341	45.0		212	28.0	
	Maputo	88	10.1		293	33.6		83	9.5	
Location	Urban	235	20.5	0.001	556	48.3	<0.001	243	21.1	<0.001
	Rural	363	26.2		459	33.3		485	34.8	
Gender	Male	288	26.7	0.001	452	41.9	0.114	341	31.5	0.006
	Female	310	21.3		563	38.8		387	26.5	
Education	Did not attend	66	33.3	<0.001	-	-	0.027	106	53.0	<0.001
	Did not complete primary	236	30.8		313	40.7		342	44.5	
	Completed primary	133	19.8		272	40.4		164	24.4	
	Completed secondary or above	163	18.2		416	46.2		116	12.9	

Respondents who were forced to work during their childhood were asked if their work was dangerous, if they missed school because of this work, and if they personally received any renumeration (aside from being given food or shelter in exchange for work). For these three questions, the results were poor: 60.9 percent of youths reported that their work was dangerous, 66.9 percent said they missed school because of their work, and only 30.8 percent stated that they received renumeration for their work. For all three of these questions, Nampula Province, the rural districts, and female respondents had the worst prevalence.

TABLE 12 CHILD LABOR CHARACTERISTICS

		Dangerous work for your health		**Missing school due to child labor**		**Receiving salary**	
		N	%	N	%	N	%
Total		**443**	**60.9**	**487**	**66.9**	**224**	**30.8**
Urban areas	Nampula	93	66.4	96	68.6	39	27.9

	Beira	29	37.2	39	50.0	37	47.4
	Matola	10	40.0	12	48.0	15	60.0
Rural areas	Memba	133	77.3	123	71.5	29	16.9
	Mogovolas	90	74.4	104	86.0	17	14.0
	Gorongosa	44	41.9	68	64.8	39	37.1
	Nhamatanda	16	55.2	16	55.2	9	31.0
	Moamba	19	48.7	18	46.2	29	74.4
	Manhiça	9	47.4	11	57.9	10	52.6
Region	Nampula	316	73.0	323	74.6	85	19.6
	Sofala	89	42.0	123	58.0	85	40.1
	Maputo	38	45.8	41	49.4	54	65.1
Location	Urban	132	54.3	147	60.5	91	37.4
	Rural	311	64.1	340	70.1	133	27.4
Gender	Male	199	58.4	215	63.0	121	35.5
	Female	244	63.0	272	70.3	103	26.6
Education	Did not attend	81	76.4	81	76.4	23	21.7
	Did not complete primary	221	64.6	262	76.6	103	30.1
	Completed primary	84	51.2	97	59.1	63	38.4
	Completed secondary and above	57	49.1	47	40.5	35	30.2

The four most common reasons for feeling insecure or unsafe at school were due to physical violence or verbal abuse from either teachers or peers. Twenty-five percent of youths who felt unsafe at school stated it was because they received harsh physical punishment or received other forms of physical violence from their teacher, 20.2 percent reported that they were yelled at by their teacher, and 8 percent stated that they were sexually harassed by a teacher (14.1 percent for females). Physical and verbal abuse from peers was also common among the youths who reported that they felt unsafe at school during their childhood (33.8 percent and 20.8 percent, respectively).

TABLE 13 REASONS FOR SCHOOL INSECURITY

		Physical violence or physical punishment from the teacher		Verbal abuse (teacher yells or gets angry)		Peer bullying or physical violence between peers		Verbal violence between colleagues		Sexual harassment by teachers	
		N	%	N	%	N	%	N	%	N	%
		247	24.7	202	20.2	338	33.8	208	20.8	80	8.0
Urban areas	Nampula	32	17.9	45	25.1	80	44.7	44	24.6	24	13.4
	Beira	63	31.3	48	23.9	63	31.3	50	24.9	15	7.5
	Matola	34	19.5	14	8.0	54	31.0	21	12.1	19	10.9
Rural areas	Memba	43	38.7	28	25.2	42	37.8	24	21.6	11	9.9
	Mogovolas	11	13.4	25	30.5	30	36.6	23	28.0	4	4.9
	Gorongosa	22	29.3	12	16.0	22	29.3	14	18.7	1	1.3
	Nhamatanda	14	22.6	10	16.1	14	22.6	18	29.0	1	1.6
	Moamba	20	34.5	12	20.7	18	31.0	5	8.6	2	3.4
	Manhiça	8	13.6	8	13.6	15	25.4	9	15.3	3	5.1
Region	Nampula	86	23.1	98	26.3	152	40.9	91	24.5	39	10.5
	Sofala	99	29.3	70	20.7	99	29.3	82	24.3	17	5.0
	Maputo	62	21.3	34	11.7	87	29.9	35	12.0	24	8.2
Location	Urban	129	23.3	107	19.3	197	35.6	115	20.8	58	10.5

	Rural	118	26.4	95	21.3	141	31.5	93	20.8	22	4.9
Gender	Male	115	25.7	91	20.4	161	36.0	94	21.0	2	0.4
	Female	132	23.8	111	20.0	177	31.9	114	20.6	78	14.1
Education	Did not complete primary	98	31.3	76	24.3	110	35.1	79	25.2	24	7.7
	Completed primary	58	21.3	54	19.9	93	34.2	57	21.0	16	5.9
	Completed secondary and above	91	21.9	72	17.3	135	32.5	72	17.3	40	9.6
Employment status	Unemployed	76	22.6	82	24.3	105	31.2	80	23.7	34	10.1
	Self employed	84	31.7	54	20.4	103	38.9	59	22.3	21	7.9
	Formal employment	25	32.5	16	20.8	26	33.8	15	19.5	4	5.2
	Student	59	19.8	47	15.8	100	33.6	50	16.8	21	7.0

Analysis was conducted to understand how many ACEs youths experienced during their childhood. According to the literature,[31] the threshold for the number of ACEs experienced, and the significant impact on a person's life is four or more ACEs. In this sample of youths from the three regions of Mozambique, 75.3 percent of youths had experienced four or more ACEs during childhood. This is an incredibly high percentage. Only 6 percent of the sample had experienced just one ACE. There was a significant difference by region, with respondents from Nampula Province reporting the highest percentage of four or more ACEs at 83.2 percent, compared to Maputo Province at 67 percent. Even though Maputo Province had the lowest percentage of youths who experienced four or more ACEs, this is still very high.

[31] https://centerforyouthwellness.org/health-impacts/

There was no significant difference by gender, with males and females experiencing four or more ACEs at relatively the same prevalence (75.3 percent and 75.4 percent, respectively). There was a significant difference in experiencing four or more ACEs and educational attainment with 85.5 percent of youths who experienced four or more ACEs having never attended school, compared to 70.6 percent of youths who completed secondary school or more. It is important to note that although youths who never attended school had the highest prevalence of experiencing four or more ACEs in the sample, still 70.6 percent of youths with the highest educational achievement experienced four or more ACEs and therefore were excelling in an extremely challenging environment.

TABLE 14-ACE DISTRIBUTION

		0-1 ACE			**2 ACE**			**3 ACE**			**4 or more ACE**		
		N	%	P	N	%	P	N	%	P	N	%	P
Total		**153**	**6.0**		**197**	**7.7**		**278**	**10.9**		**1916**	**75.3**	
Urban areas	Nampula	23	6.0	0.197	28	7.3	0.822	31	8.0	0.161	304	78.8	0.067
	Beira	16	4.1		31	8.0		38	9.8		302	78.0	
	Matola	27	7.1		32	8.5		46	12.2		273	72.2	
Rural areas	Memba	4	1.5	<0.001	4	1.5	<0.001	20	7.6	0.002	236	89.4	<0.001
	Mogovolas	12	4.6		13	5.0		18	6.9		217	83.5	
	Gorongosa	10	4.0		26	10.3		33	13.1		183	72.6	
	Nhamatanda	9	7.6		9	7.6		14	11.8		87	73.1	
	Moamba	20	7.8		26	10.2		36	14.1		173	67.8	
	Manhiça	32	13.2		28	11.5		42	17.3		141	58.0	
Region	Nampula	39	4.3	<0.001	45	4.9	<0.001	69	7.6	<0.001	757	83.2	<0.001
	Sofala	35	4.6		66	8.7		85	11.2		572	75.5	
	Maputo	79	9.0		86	9.8		124	14.2		587	67.0	

Location	Urban	66	5.7	0.589	91	7.9	0.871	115	10.0	0.169	879	76.4	0.263
	Rural	87	6.2		106	7.6		163	11.7		1037	74.4	
Gender	Male	69	6.4	0.514	85	7.8	0.865	114	10.5	0.577	815	75.3	0.951
	Female	84	5.7		112	7.7		164	11.2		1101	75.4	
Education	Did not attend	5	2.5	<0.001	11	5.5	0.013	13	6.5	0.116	171	85.5	<0.001
	Did not complete primary	27	3.5		43	5.6		85	11.1		614	79.8	
	Completed primary	51	7.6		60	8.9		71	10.5		491	73.0	
	Completed secondary or above	70	7.8		84	9.3		111	12.3		635	70.6	

CURRENT YOUTH COPING BEHAVIORS

The questionnaire included 32 questions regarding coping behaviors to assess how youths ***currently*** cope with life stressors. The questionnaire measures the types of coping behaviors and has them divided into 14 different domains that represent avoidant and approach coping. Avoidant coping behaviors are maladaptive when used frequently and approach coping behaviors are the most helpful types of coping. For each question, respondents rated how often they use each coping behavior on a 4-point scale from "I haven't been doing this at all" to "I've been doing this a lot" and then scored (1 point for not doing the behavior at all and 4 points for doing it a lot). Each respondent's score for avoidant behaviors and approach behaviors were added, and the respondent was considered to have avoidant coping if his/her total score for avoidant behaviors was higher than for approach behaviors.

Among the respondents, 24.5 percent of them had predominately avoidant coping behaviors. There was no difference in coping type by gender, but there was a significant difference by province and educational attainment. Respondents in Nampula Province had a higher prevalence of avoidance coping at 30.9 percent, compared to 20.3 percent of respondents in Maputo. Thirty-seven percent of respondents who never attended school had avoidant coping compared to 22.4 percent of youths who completed secondary school or higher.

TABLE 15-ACE – YOUTH CURRENT COPING BEHAVIORS

		Avoidance			Approach		
		N	%	P	N	%	P
Total		**624**	**24.5**		**1872**	**73.6**	
Urban areas	Nampula	132	34.2	<0.001	245	63.5	<0.001
	Beira	83	21.4		303	78.3	
	Matola	89	23.5		288	76.2	
Rural areas	Memba	84	31.8	<0.001	180	68.2	<0.001
	Mogovolas	65	25.0		178	68.5	
	Gorongosa	52	20.6		190	75.4	
	Nhamatanda	30	25.2		85	71.4	
	Moamba	39	15.3		212	83.1	
	Manhiça	50	20.6		191	78.6	
Region	Nampula	281	30.9	<0.001	603	66.3	<0.001
	Sofala	165	21.8		578	76.3	
	Maputo	178	20.3		691	78.9	
Location	urban	304	26.4	0.045	836	72.6	0.322
	Rural	320	23.0		1036	74.4	
Gender	Male	270	24.9	0.685	797	73.6	0.995
	Female	354	24.2		1075	73.6	
Education	Did not attend	73	36.5	<0.001	121	60.5	<0.001
	Did not complete primary	205	26.7		543	70.6	
	Completed primary	144	21.4		517	76.8	
	Completed secondary or above	202	22.4		689	76.6	

Several of the coping questions asked if the respondent reaches out to someone to assist them, such as discussing their feelings or seeking advice. For these questions, a follow-up question was asked to understand who the respondents most frequently turned to for help. The most common people were friends and family members (99 percent), and the next most common type of people were religious leaders/traditional healers/or other informal supportive people in the community at 29.9 percent. Only 1.9 percent of the youths stated that they reached out to teachers or healthcare workers for support to cope with stress or difficulties in their lives.

TABLE 16- SOURCE OF SUPPORT

		Parents/family/friends			**Teachers/ health workers (formal supports)**			**Traditional Healers/ religious leaders/Other informal supports**		
		N	%	P	N	%	P	N	%	P
Total		**2358**	**99.0**		**46**	**1.9**		**713**	**29.9**	
Urban areas	Nampula	366	99.5	0.213	9	2.4	0.536	131	35.6	<0.001
	Beira	364	98.9		6	1.6		96	26.1	
	Matola	353	98.1		5	1.4		58	16.1	
Rural areas	Memba	260	100.0	0.171	8	3.1	0.068	145	55.8	<0.001
	Mogovolas	224	98.7		9	4.0		86	37.9	
	Gorongosa	234	98.7		4	1.7		62	26.2	
	Nhamatanda	110	98.2		2	1.8		38	33.9	
	Moamba	224	98.2		1	0.4		56	24.6	
	Manhiça	223	100.0		2	0.9		41	18.4	
Region	Nampula	850	99.4	0.246	26	3.0	0.008	362	42.3	<0.001
	Sofala	708	98.7		12	1.7		196	27.3	
	Maputo	800	98.6		8	1.0		155	19.1	

Location	Urban	1083	98.8	0.545	20	1.8	0.730	285	26.0	<0.001
	Rural	1275	99.1		26	2.0		428	33.3	
Gender	Male	1001	99.1	0.516	22	2.2	0.451	281	27.8	0.055
	Female	1357	98.8		24	1.7		432	31.5	
Education	Did not attend	179	98.9	0.883	2	1.1	0.357	74	40.9	<0.001
	Did not complete primary	715	99.2		10	1.4		285	39.5	
	Completed primary	616	98.7		16	2.6		168	26.9	
	Completed secondary or above	846	98.9		18	2.1		186	21.8	

HEALTH RISK BEHAVIORS

Youths were asked if they currently drink alcohol. For youths who do drink alcohol, they were asked how much they drink on a typical occasion when they drink. Responses were classified by alcohol type (beer/cider/cooler, wine, hard liquor/spirits) and then converted into units of alcohol (a 12-ounce bottle of beer is equivalent of one unit, one shot of hard liquor is equivalent of 1 unit, and so on). Consuming four of more units of alcohol a day for women and six or more units of alcohol a day for men was considered alcohol abuse. According to this definition, 29.9 percent of the respondents are abusing alcohol. Drug use was considered if they had used at least one drug one time. Five percent of youths have ever used drugs. Alcohol abuse and drug use were higher in urban areas and among males. There was a significant difference by province as well, but for alcohol abuse, Maputo Province had the highest prevalence at 38.7 percent compared to 20.6 percent in Nampula Province. While Nampula Province had the lowest percentage of alcohol abuse, it had the highest prevalence of drug use at 6.2 percent, compared to 3.2 percent in Sofala. Alcohol abuse was higher in youths who had completed secondary school or higher (35.4 percent) than those who never attended school (10.3 percent).

TABLE 17-CURRENT- ALCOHOL ABUSE AND DRUG USE

		Alcohol abuse			Drug use		
		N	%	P	N	%	P
Total		**223**	**29.9%**		**131**	**5.1%**	
Urban areas	Nampula	29	27.4	0.001	30	7.8	0.003
	Beira	32	22.7		16	4.1	
	Matola	74	41.3		40	10.6	
Rural areas	Memba	8	17.8	0.001	11	4.2	0.015
	Mogovolas	6	10.3		15	5.8	
	Gorongosa	6	25.0		5	2.0	
	Nhamatanda	5	26.3		3	2.5	
	Moamba	41	40.2		10	3.9	
	Manhiça	22	30.1		1	0.4	
Region	Nampula	43	20.6	0.000	56	6.2	0.012
	Sofala	43	23.4		24	3.2	
	Maputo	137	38.7		51	5.8	
Location	Urban	135	31.7	0.207	86	7.5	<0.001
	Rural	88	27.4		45	3.2	
Gender	Male	149	35.6	<0.001	100	9.2	<0.001
	Female	74	22.5		31	2.1	
Education	Did not attend	4	10.3	0.001	11	5.5	0.124
	Did not complete primary	35	21.7		36	4.7	
	Completed primary	61	30.5		26	3.9	

	Completed secondary or above	122	35.4		58	6.4	

There were just 131 youths who stated they had ever used a drug other than prescription drugs that were prescribed to them and 106 of them had used cannabis (80.9 percent). The next most commonly used drug was cocaine at 8.4 percent (11 youths). Seven youths (23.3 percent) in Nampula City stated that they used cocaine, which was the highest of any city or district. Cocaine was used almost exclusively in urban areas, with just one youth in a rural area reporting cocaine use. The use of other types of drugs was very limited, with just three youths reporting using narcotics, four reporting the use of mandrax (a highly addictive sedative drug), seven reporting the use of inhalants, and five reporting the use of prescription drugs that were not prescribed to them.

TABLE 18- TYPE OF DRUGS CONSUMED

		Narcoticos		**.Mandrax**		**Methamphetamine**		**Cocaine**		**Inalantes**		**Calmantes**		**Cannabis**		**hallucinogens**		**Prescription drugs**	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total		3	2.3	4	3.1	4	3.1	11	8.4	7	5.3	5	3.8	106	80.9	0	0.0	5	3.8
Urban areas	Nampula	1	3.3	1	3.3	2	6.7	7	23.3	1	3.3	2	6.7	20	66.7	0	0.0	2	6.7
	Beira	1	6.3	1	6.3	0	0.0	1	6.3	0	0.0	0	0.0	13	81.3	0	0.0	1	6.3
	Matola	1	2.5	0	0.0	1	2.5	2	5.0	4	10.0	2	5.0	36	90.0	0	0.0	1	2.5
Rural	Memba	0	0.0	2	18.2	0	0.0	0	0.0	2	18.2	0	0.0	10	90.9	0	0.0	0	0.0

areas	Mogovolas	0	0.0	0	0.0	1	6.7	0	0.0	0	0.0	1	6.7	11	73.3	0	0.0	1	6.7
	Gorongosa	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	4	80.0	0	0.0	0	0.0
	Nhamatanda	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	33.3	0	0.0	0	0.0
	Moamba	0	0.0	0	0.0	0	0.0	1	10.0	0	0.0	0	0.0	10	100.0	0	0.0	0	0.0
	Manhiça	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	100.0	0	0.0	0	0.0
Region	North	1	1.8	3	5.4	3	5.4	7	12.5	3	5.4	3	5.4	41	73.2	0	0.0	3	5.4
	Center	1	4.2	1	4.2	0	0.0	1	4.2	0	0.0	0	0.0	18	75.0	0	0.0	1	4.2
	South	1	2.0	0	0.0	1	2.0	3	5.9	4	7.8	2	3.9	47	92.2	0	0.0	1	2.0
Location	Urban	3	3.5	2	2.3	3	3.5	10	11.6	5	5.8	4	4.7	69	80.2	0	0.0	4	4.7
	Rural	0	0.0	2	4.4	1	2.2	1	2.2	2	4.4	1	2.2	37	82.2	0	0.0	1	2.2
Gender	Male	2	2.0	4	4.0	3	3.0	8	8.0	5	5.0	4	4.0	83	83.0	0	0.0	3	3.0

	Female	1	3.2	0	0.0	1	3.2	3	9.7	2	6.5	1	3.2	23	74.2	0	0.0	2	6.5
Education	Did not attend	0	0.0	0	0.0	1	9.1	0	0.0	1	9.1	0	0.0	7	63.6	0	0.0	0	0.0
	Did not complete primary	1	2.8	2	5.6	1	2.8	1	2.8	2	5.6	2	5.6	27	75.0	0	0.0	1	2.8
	Completed primary	0	0.0	1	3.8	1	3.8	4	15.4	0	0.0	1	3.8	22	84.6	0	0.0	0	0.0
	Completed secondary and above	2	3.4	1	1.7	1	1.7	6	10.3	4	6.9	2	3.4	50	86.2	0	0.0	4	6.9

In the sample, 43.9 percent of female youths stated they were a victim of IPV and 36. 1 percent of male youths reported they had perpetrated intimate partner violence in the last 12 months. Intimate partner violence was defined as any physical, sexual, or emotional violence toward a significant other. IPV victimization was more common on Nampula Province at 53.7 percent, compared to 20.4 percent in Maputo Province, but self-reported IPV perpetration among male youths was highest in Sofala Province at 44.15 percent, compared to 25.3 percent in Maputo Province. There was no significant difference between IPV victimization or perpetration by urban or rural area, but there was a difference by education. Female youths with low or no education (52.9 percent for both categories) had a higher prevalence of IPV victimization than those who graduated from secondary school or higher. However, having a higher education did not make female youths immune to violence as 34.3 percent of them still suffered IVP within the last year. This trend in education and violence was also significant for male

TABLE 19-CURRENT- INTIMATE PARTNER VIOLENCE, AND INTIMATE PARTNER PERPETRATION AND VICTIMIZATION

youths reporting IVP perpetuation, with the least educated males having the highest prevalence of IPV perpetuation.

		Intimate partner violence victimhood			Intimate violence perpetration		
		N	%	P	N	%	P
Total		**641**	**43.9**		**391**	**36.1**	
Urban areas	Nampula	112	51.6	<0.001	59	34.9	<0.001
	Beira	101	48.6		87	48.6	
	Matola	58	28.7		50	28.4	
Rural areas	Memba	115	69.3	<0.001	51	52.0	<0.001
	Mogovolas	56	38.9		40	34.5	
	Gorongosa	73	52.9		44	38.6	
	Nhamatanda	27	37.5		19	40.4	
	Moamba	61	37.4		19	20.7	
	Manhiça	38	25.2		22	23.9	
Region	Nampula	283	53.7	<0.001	150	39.2	<0.001
	Sofala	201	48.1		150	44.1	
	Maputo	157	30.4		91	25.3	
Location	Urban	271	43.2	0.663	196	37.4	0.389
	Rural	370	44.4		195	34.9	
Gender	Male	0	0.0	-	391	36.1	-
	Female	641	43.9		0	0.0	
Education	Did not attend	73	52.9	<0.001	28	45.2	0.267
	Did not complete primary	246	52.9		117	38.5	
	Completed primary	161	41.0		96	34.3	

	Completed secondary or above	159	34.3		150	34.3	

Female youths were asked if their partner (boyfriend, girlfriend, spouse, or anyone they had been intimate with) in the last year had ever hurt or tried to hurt them by hitting or using other forms of physical violence. Forty-eight percent of female youths reported physical violence by an intimate partner in the last 12 months. Physical violence was more common in Nampula Province (61.8 percent), among female youths in rural areas (52.4 percent), and among female youths who either never attended school (57.5 percent) or did not finish primary school (62.2 percent).

Female youths were asked if they had suffered sexual violence, meaning being forced or a forced attempt to engage in sexual activities without their consent by an intimate partner in the last 12 months. Thirty-six percent of female youths affirmed they had suffered sexual violence, which was highest in Nampula Province (49.1 percent), and slightly higher in rural areas (38.4 percent) and among female youths who had never attended school (52.1 percent) or did not complete primary school (43.9 percent).

Emotional violence, which was defined as an intimate partner ever insulting or disrespecting respondents using ugly words or gestures, was high at 85.2 percent. Emotional violence was pervasive across provinces, urban/rural areas, and educational attainment, and there were no significant differences among these various demographic and geographic groups.

TABLE 20: FEMALE INTIMATE VIOLENCE VICTIMIZATION

		Physical Violence		**Sexual Violence**		**Emotional Violence**		**Intimate partner violence**	
		N	%	N	%	N	%	N	%
Total		**311**	**48.5**	**233**	**36.3**	**546**	**85.2**	**641**	**43.9**
Urban areas	Nampula	64	57.1	56	50.0	98	87.5	112	51.6
	Beira	41	40.6	22	21.8	85	84.2	101	48.6
	Matola	12	20.7	13	22.4	52	89.7	58	28.7
Rural areas	Memba	79	68.7	57	49.6	98	85.2	115	69.3
	Mogovolas	32	57.1	26	46.4	45	80.4	56	38.9
	Gorongosa	32	43.8	32	43.8	62	84.9	73	52.9
	Nhamatanda	9	33.3	7	25.9	25	92.6	27	37.5
	Moamba	27	44.3	13	21.3	48	78.7	61	37.4

	Manhiça	15	39.5	7	18.4	33	86.8	38	25.2
Region	North	175	61.8	139	49.1	241	85.2	283	53.7
	Center	82	40.8	61	30.3	172	85.6	201	48.1
	South	54	34.4	33	21.0	133	84.7	157	30.4
Location	Urban	117	43.2	91	33.6	235	86.7	271	43.2
	Rural	194	52.4	142	38.4	311	84.1	370	44.4
Gender	Male								
	Female	311	48.5	233	36.3	546	85.2	641	43.9
Education	Did not attend	42	57.5	38	52.1	58	79.5	73	52.9
	Did not complete primary	153	62.2	108	43.9	203	82.5	246	52.9
	Completed primary	68	42.2	46	28.6	144	89.4	161	41.0
	Completed secondary and above	48	30.2	40	25.2	139	87.4	159	34.3

The 641 female youths who reported they had suffered IPV in the last 12 months were asked if they sought any form of help for the violence. Forty-two percent reported that they sought some form of help, with 7.8 percent going to the hospital, 28.4 percent seeking help from a religious institution, and 95.1 percent seeking help from family or a friend. Pursuing support at the hospital was most common in Maputo Province (11.9 percent) and was relatively the same in urban and rural areas. Not one female youth who never attended school sought help at a hospital. Seeking help from a religious institution was most common in Nampula Province (34.7 percent), among rural populations (34.8 percent), and among female youths who never attended school (42.3 percent). Respondents were able to add other sources of support, and no one mentioned going to the police for IPV.

TABLE 21-CURRENTLY- INTIMATE PARTNER VIOLENCE AND SOURCE OF HELP

	Sought help		**Type of Help: Hospital**		**Type of Help: Religious Institution**		**Type of Help: Family and friends**	
	N	%	N	%	N	%	N	%
Total	**268**	**41.8**	**21**	**7.8**	**76**	**28.4**	**255**	**95.1**

Urban areas	Nampula	48	42.9	3	6.3	9	18.8	46	95.8
	Beira	46	45.5	3	6.5	7	15.2	41	89.1
	Matola	19	32.8	2	10.5	6	31.6	19	100.0
Rural areas	Memba	59	51.3	5	8.5	26	44.1	59	100.0
	Mogovolas	17	30.4	1	5.9	8	47.1	16	94.1
	Gorongosa	26	35.6	1	3.8	7	26.9	25	96.2
	Nhamatanda	13	48.1	1	7.7	3	23.1	10	76.9
	Moamba	26	42.6	4	15.4	6	23.1	25	96.2
	Manhiça	14	36.8	1	7.1	4	28.6	14	100.0
Region	Nampula	124	43.8	9	7.3	43	34.7	121	97.6
	Sofala	85	42.3	5	5.9	17	20.0	76	89.4
	Maputo	59	37.6	7	11.9	16	27.1	58	98.3
Location	Urban	113	41.7	8	7.1	22	19.5	106	93.8
	Rural	155	41.9	13	8.4	54	34.8	149	96.1
Gender	Male								
	Female	268	41.8	21	7.8	76	28.4	255	95.1
Education	Did not attend	26	35.6	0	0.0	11	42.3	26	100.0
	Did not complete primary	113	45.9	8	7.1	35	31.0	107	94.7
	Completed primary	69	42.9	7	10.1	21	30.4	64	92.8
	Completed secondary and above	59	37.1	6	10.2	9	15.3	57	96.6

Similarly to the female youth IPV victimization profile, emotional violence was the most common form of violence that male youth reported they perpetuated at 84.1. percent. However, sexual violence was the next most common form of violence at 32.5 percent, and then physical violence at 28.6 percent. Physical violence was more common among male youths in Nampula Province (41.3 percent), compared

to just 16.5 percent in Maputo Province, and those who never attended school (32.1 percent) or never completed primary school (41.9. percent). Similarly to female youths, there was no large difference between prevalence of male youths' perpetuation of physical violence and urban/rural areas. Sexual violence was also higher among male youths in Nampula Province, in rural areas, and among male youths who had never attended or who never completed primary school. It is important to note that 70 percent of male youths in the Mogovolas District in Nampula Province stated that they had attempted or had forced their partner to engage in sexual activities without their consent in the last 12 months. This prevalence of sexual violence is incredibly high and shows that there are some problematic social norms specifically in this district.

Emotional violence perpetuation was most common in Maputo Province, in urban areas, and among male youths who had completed secondary school (92.7 percent).

TABLE 22: MALE INTIMATE VIOLENCE PERPETUATION

		Physical Violence		**Sexual Violence**		**Emotional Violence**		**Intimate partner violence**	
		N	%	N	%	N	%	N	%
Total		**112**	**28.6**	**127**	**32.5**	**329**	**84.1**	**391**	**36.1**
Urban areas	Nampula	24	40.7	26	44.1	50	84.7	59	34.9
	Beira	21	24.1	17	19.5	77	88.5	87	48.6
	Matola	9	18.0	5	10.0	47	94.0	50	28.4
Rural areas	Memba	27	52.9	27	52.9	42	82.4	51	52.0
	Mogovolas	11	27.5	28	70.0	27	67.5	40	34.5
	Gorongosa	13	29.5	12	27.3	34	77.3	44	38.6
	Nhamatanda	1	5.3	4	21.1	18	94.7	19	40.4
	Moamba	4	21.1	3	15.8	16	84.2	19	20.7
	Manhiça	2	9.1	5	22.7	18	81.8	22	23.9
Region	North	62	41.3	81	54.0	119	79.3	150	39.2
	Center	35	23.3	33	22.0	129	86.0	150	44.1
	South	15	16.5	13	14.3	81	89.0	91	25.3

Location	Urban	54	27.6	48	24.5	174	88.8	196	37.4
	Rural	58	29.7	79	40.5	155	79.5	195	34.9
Gender	Male	112	28.6	127	32.5	329	84.1	391	36.1
	Female	--	--	--	--	--	--	--	--
Education	Did not attend	9	32.1	14	50.0	20	71.4	28	45.2
	Did not complete primary	49	41.9	59	50.4	89	76.1	117	38.5
	Completed primary	28	29.2	23	24.0	81	84.4	96	34.3
	Completed secondary and above	26	17.3	31	20.7	139	92.7	150	34.3

HIV risk behavior, including either having multiple sexual partners or not using a condom in the last 12 months was high at 79.3 percent. Not using a condom was the most common risk behavior at 66.7 percent, and 41.4 percent of youths in the sample stated they had more than one partner in the last year. Not using a condom was higher among respondents in Nampula Province, among youths in rural areas, female youths, and youths who never attended school. Not using a condom was very high among youths who never attended school at 92.2 percent.

The percentage of youths having multiple partners in the last year had a different profile than the youths that had the higher prevalence of not using a condom. Multiple partnerships was higher among youths in Nampula Province, male youths, and those in urban areas. There was no significant difference between having multiple partners and education.

TABLE 23: HIV RISK BEHAVIOR

		Not using condom			**Having multiple patterns**			**HIV risk**		
		N	%	P	N	%	P	N	%	P
Total		**1521**	**66.7**		**944**	**41.4**		**1810**	**79.3**	
	Nampula	278	75.7	<0.001	204	55.6	<0.001	321	87.5	<0.001

Urban areas	Beira	170	48.9		126	36.2		234	67.2	
	Matola	128	39.8		140	43.5		206	64.0	
Rural areas	Memba	227	89.0	<0.001	130	51.0	<0.001	244	95.7	<0.001
	Mogovolas	218	89.3		120	49.2		224	91.8	
	Gorongosa	172	86.9		41	20.7		180	90.9	
	Nhamatanda	61	61.6		24	24.2		73	73.7	
	Moamba	131	57.0		66	28.7		160	69.6	
	Manhiça	136	62.1		93	42.5		168	76.7	
Region	Nampula	723	83.5	<0.001	454	52.4	<0.001	789	91.1	<0.001
	Sofala	403	62.5		191	29.6		487	75.5	
	Maputo	395	51.2		299	38.8		534	69.3	
Location	Urban	576	55.5	<0.001	470	45.3	<0.001	761	73.4	<0.001
	Rural	945	75.9		474	38.1		1049	84.3	
Gender	Male	564	60.3	<0.001	583	62.3	<0.001	766	81.8	0.013
	Female	957	71.1		361	26.8		1044	77.6	
Education	Did not attend	177	92.2	<0.001	79	41.1	0.553	180	93.8	<0.001
	Did not complete primary	603	85.0		297	41.9		648	91.4	
	Completed primary	381	64.9		229	39.0		463	78.9	
	Completed secondary and above	359	45.3		339	42.8		518	65.4	

ASSOCIATION ANALYSIS WITH ACE AND NEGATIVE HEALTH OUTCOMES AND EDUCATION

After the bivariate analysis, statistically significant variables in the previous stage were included in the multivariate analysis. Unconditional logistic regression analysis was conducted after adjusting for age, gender, urban/rural location, and education level of the primary caregiver to obtain adjusted odds ratios (ORs) and 95 percent confidence intervals (CIs). ORs test for associations between adverse experiences in childhood (four or more ACEs) and negative health behaviors. This analysis examines the role of ACEs as predictors of alcohol abuse, drug use, IPV (victimization and perpetuation), HIV risk behavior, and educational attainment.

In all five logistic regression analyses, having four or more ACEs was statistically significantly associated with poor health behavior and low educational attainment. Four or more ACEs made youths 2.8 times more likely to use drugs, 68 percent more likely to abuse alcohol, and 52 percent more likely to engage in an HIV risk behavior (having multiple partners within a year or not using a condom). The predictive factor for intimate partner violence was also strong. Female youths with four or more ACEs were three times more likely to have suffered from IPV in the last year, and male youths were 2.8 times more likely to be violent toward their partner in the last year. Additionally, youths with four or more ACEs were 39 percent less likely to have completed primary school or higher.

TABLE 24- LOGISTIC REGRESSION ANALYSIS: ASSOCIATION BETWEEN 4+ ACES AND HEALTH BEHAVIORS

		Model 1		**Model 2**		**Model 3**		**Model 4**		**Model 5**	
		Drug use		**Alcohol abuse**		**IPV Victimization**		**IPV Perpetration**		**HIV risk**	
		OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
ACE	Less than 3										
	4 or more	2.822*	1.514 - 5.261	1.688*	1.032 - 2.763	3.152**	2.314 - 4.292	2.853**	1.97-4.132	1.518*	1.169 - 1.972
Teste de Hosmer e Lemeshow (p-value)		7.896 (0.444)		5.069 (0.750)		14.023 (0.081)		6.211 (0.624)		10.934 (0.205)	
Classification table		94.9%		71.4%		65.6%		66.6%		79.8%	

Nagelkerke R square	0.139	0.130	0.176	0.122	0.201
*Significant at the 0.05 level (2-tailed).					
**Significant at the 0.01 level (2-tailed).					

TABLE 25: LOGISTIC REGRESSION ANALYSIS: ASSOCIATION BETWEEN 4+ ACE AND EDUCATIONAL ATTAINMENT

		Model I	
		Educational Attainment	
		OR	95% CI
ACE	Less than 3		
	4 or more	0.590*	0.486-0.717
Teste de Hosmer e Lemeshow (p-value)		0.000 (-)	
Classification table		61.9	
Nagelkerke R square		0.016	

LIFE STORIES

Four youths who had experienced at least one adverse experience were interviewed to understand what happened to them, how it impacted their life, how they tried to cope with the adversity, what they think could have helped them, and the reaction from the community. Two of the youths were HIV-positive and were asked additional questions to understand how they became HIV-positive, how they are coping with HIV, what has helped them, and how their childhood adversity impacted their HIV status and ability to stay on treatment. The HIV-positive youths' interviews focused more on understanding the interaction between their HIV status and childhood adversity and not specifically on the management of their HIV.

The names of the four youths were changed to protect their confidentiality.

LIFE STORY 1: FILIPA, 22 YEARS OLD FROM NAMPULA CITY

Background Information on family and the ACE

Filipa[32] is 22, single, and currently not working. She lives in Nampula City, has completed 12th grade, and has a 2-year-old son.

[32] Name has been changed for confidentiality.

Filipa grew up in a home with both parents and five siblings (one of which has passed away). She is the only girl child and the oldest. When she was 1 or 2 years old, Filipa was hospitalized for six months in critical condition. Filipa reflected on her childhood and said it was not easy. "I can say that I felt bad when I lived with my parents. My parents at that time they were very violent, they always beat me, whatever I did, their solution was to beat, until I got sick because of this type of violence, being beaten all the time…." She also recounts not being given clothes or shoes even though her parents had the ability to provide for her, (both parents are government employees). She was not given necessities.

Filipa's siblings were also repeatedly beaten by both parents and because of this, she grew up thinking this treatment was normal. As an adult, she recognizes that is not normal, partly because she had a cousin who lived with her family run away (80 kilometers on foot) to another family member because the situation was so bad. Filipa can also recognize that because this was the only example she had growing up, she reacts with violence when she feels she must defend herself and that she started to display the same behavior toward her own child.

Filipa said that throughout her childhood when she was physically abused, she never received any kind of outside help or support. She acknowledges that this is partly because she never asked for help because she thought her situation was normal and she and her siblings had learned to live with the abuse. She says now she does talk to close friends, and she even went to the hospital to ask for help because she saw herself doing many of the things her parents did, and she wanted help managing certain situations.

Filipa was asked if she could think of anything positive from her childhood and she said "no, the only positive aspects of my childhood I remember are sometimes with my friends." During the interview, Filipa reported she had attempted suicide once by consuming insecticide when she was 15 years old after a brutal beating from her mother. Filipa reported she thought, "I better just finish it off.".

What were other people's reaction to the ACE?

Filipa reports that neighbors and other people in the community knew she was abused and did nothing. "People knew. But as they say here in Mozambique, especially us Macuas,[33] they say, 'you can do whatever you want, because in fact, it's your child.' They do not feel they are responsible for this, because they saw someone beating their child, they do not go there to help, they let them."

Filipa stated she believes that her parents think what they did was "normal" and not abusive, "because they express what they feel, right. If they are angry, they hit. For them, when it comes to abuse, they think that everything that is abuse, is sexual abuse. And sexual abuse can only be of a child. They consider someone with 12 years old is already big."

What did she do to overcome the ACE?

Filipa did not have many coping mechanisms to deal with the abuse. She tries to "come to terms with it and move on." She tries to focus on what she can do and when she cannot do anything, "I just leave it."

As Filipa reflected on this question she said, "When I sit down and start to analyze, I see that everything… of all the things I went through, what I learned…I learned that I have to know how to manage on my own…in fact, I need to know how to manage on my own and learn not to worry,

[33] Macuas are the ethnic majority in Nampula Province.

especially now that I'm a mother. I know I don't have a job; I can't do much, but I can do something to give my son … ." Filipa also attends church and finds this to be helpful. Although no one knows about her situation at church, it gives her a place to be away from her family and be at peace.

Filipa also reported that she copes by going on the offensive and "attacking" when she feels threatened. She also tries to distract herself and says that sitting down and talking with someone about the situation is difficult because she has a hard time forming and maintaining relationships. However, she reports that she does go to the hospital to talk to a nurse there occasionally and has found that to be helpful.

How has the ACE affected her life today?

Filipa says she has difficulty trusting and opening up to people and trouble having trust and confidence in herself. She says she has learned to "defend myself. But I can say that because of what I've been through, now when I see someone who wants to do something to me, I try to attack them." Filipa states she has "nerve problems" which we understand to be anxiety and panic feelings and flashbacks of abuse "sometimes." Filipa says she considers herself "problematic."

If they could look back, what would have helped them overcome the ACE?

Filipa mentioned three things she thought might have helped her when she was a child suffering from physical and emotional abuse: 1) If neighbors tried to help, 2) if there was a supportive service where abused children could talk to someone, and 3) if her parents had more information on child rearing.

Community's reaction

Hitting children is normal in Filipa's community. She said people did not think anything different about her situation. She states that things are changing slowly now, however. Some people now say, " 'if the child doesn't listen, let it go. The child will learn later.' There are mothers who speak [and do not hit]."

How she become HIV-positive

Filipa did not give details about how she became HIV-positive. She said when she was 15 years old, she was visiting an aunt in another district, and she encouraged her to take a test. The result was negative. A year later, she took another test when she was 16 years old and it was positive, but she did not believe the result. Only when she retook the test again when she was 17 years old did she believe the result and started on treatment.

Coping with diagnosis/illness

She says that her life is "normal" and that her child is HIV-negative. She accepts her diagnosis, has been on treatment for five years, and reports no difficulties or complications. She says what makes it easier for her to cope with having HIV is having treatment.

What relation, if any, with the adverse experience and becoming HIV-positive

Filipa says that things got so bad at home that she left. "At that time there, because I was beaten frequently, I had already gotten used to it, but I didn't completely get used to it (sigh). With everything I went through there, I was already afraid, sometimes I ran away. I didn't go home for a week. I looked for a place to sleep at an aunt's house, or in the tent, or in the neighborhood. I had a boyfriend when I was

14 and he found out [about the violence in my home] and that's when I moved there [to his house]." It seems that it is from this relationship that she contracted HIV.

Filipa says that she also had a lack of sexual health and HIV information when she was a teenager, which also contributed to her vulnerability to HIV.

What could have helped you avoid HIV or better accept your situation?

Filipa stated she thought that the specialized, youth-friendly health services that focus on sexual and reproductive health, called SAAJ, could have helped her. "That time was before it existed. The SAAJ service has just appeared… most of the teenagers are there. They can talk to those nurses, get advice…yes, that would have helped me."

LIFE STORY 2: ATALIA, 24 YEARS OLD FROM MAPUTO CITY

Background Information on family and the ACE

Atalia[34] is 24 and lives in a neighborhood outside of Maputo City. She studied until 9th grade and has a small business selling food and household goods from her house.

Atalia's mother died when she was very young. She lived with her father and two younger siblings until she was 17, when her father died. This is when she reports that her life became very difficult. When her father was alive, he worked, and her family had enough money to survive. Until she was 17 years old, Atalia reports her childhood was "tranquil." However, when her father died, she was responsible for caring for her two younger siblings and life became difficult.

When her father passed away, Atalia was working and was able to take care of her siblings. However, she, too, became sick and had to stop working. When she became sick, she took an HIV test, and it was positive. She said she became depressed but started treatment. She was on treatment for a year when she was also diagnosed with tuberculosis (TB) and started on treatment. It was during her TB treatment that she came across the community-based organization, Kindlimuka, and someone came to her house to give her counseling about HIV and TB.

Affect of the ACE on her life

Atalia stated, "I had depression when my father died and when I came home, I could not sleep. I had headaches. I was isolated, alone in my corner. I didn't want to do anyth.ng, I just wanted to stay in bed." She also reports having high blood pressure from "thinking too much" both about caring for her siblings and about how neighbors were talking negatively about her.

What did she do to overcome the ACE?

Atalia received support from her church and a local association. She is also on treatment. She states, "Now I'm confident. I don't listen to people much anymore. I don't depend too much on other people's opinions. I got through this with support from the church and Kindlimuka."

[34] Name has been changed for confidentiality.

The savings group has been instrumental for Atalia as it gave her a livelihood that she could do from her home, and it was also made up of other HIV-positive youths.

If she could look back, what would have helped her overcome the ACE?

Atalia believes that if she had the support of her extended family, that things would have been better and would have been easier. She and her siblings would not have been alone. She also stated that if she had been able to stay in school, that it would have helped her feel that she had a future. "Maybe if I hadn't dropped out of school, maybe a lot would change. Because before I got sick, I had dreams. I wanted to do many things. When I got sick, I had nothing to do with it."

Community's reaction

Atalia reported stigma from the community regarding her HIV-positive status. She reported that if her parents had been alive, she would not have suffered as much from stigma. She stated, "when I got sick, a lot of people moved away—friends, neighbors, moved away. A lot of people [told others my status]. They pointed at me on the street. Even for me dating at that time was difficult. Because for me to have a boyfriend approaching me, soon people would talk about my condition before I spoke." Atalia also stated that community members called her a prostitute and stated that is why she has HIV.

"I felt bad. That's why I closed myself. I stayed at home a lot. I didn't like to go out. My life was just house-church, house-church. I wouldn't even go to family members' houses."

Atalia also stated that once her father died, her father's side of the family did not contact her or support her and her siblings. She says, "What was left that I still keep in my heart was the lack of support from my family. Especially on my father's side. On my mother's side, they always supported me a lot until now. Even though I'm far away, they call me to see how I'm doing. Now, my father's family, they don't do that." She reports that her father's side of the family started to distance themselves from her when she had TB and now, they have rejected her.

How she became HIV-positive

Atalia had a boyfriend when she was a teenager, and they did not use condoms. She says she did not hear much about condoms and she did not know much about HIV. Even though her father also had HIV and died of TB, she says they never talked about it. She only heard about HIV from school.

Atalia was living with her boyfriend when she started to feel sick and lose weight. When she went to the health facility to get an HIV test, she had trouble getting one because her partner refused to come, and they tried to insist that she come with her partner for testing. She found out later that her boyfriend already knew he had HIV and had stopped treatment when he met her. He has since died.

How she copes with her diagnosis/illness

Atalia stated, "When I found out I was HIV positive, there was a church that came to give me advice. They came to visit me so I wouldn't be alone, thinking it's the end of the world. They even supported me in food, these things, school, they supported me. Then I met the Kindlimika Association, which started to support me and my sisters. There was a time when they helped with a little money for me to

open my savings and I could save. Because at that time I didn't have a boyfriend, I didn't have anyone to support me financially so I could save. They put me in a savings group, so I afford [food for myself and my sisters]."

What relation, if any, with the ACE and becoming HIV-positive

Atalia mentioned repeatedly that she lacked information about her sexual health and about HIV. She thinks that if her mother had been alive, she would have talked to Atalia about her sexuality in a way that her father never did. She also feels that if her father had been alive, his side of the family would not have rejected her. It is this rejection that has made coping with her diagnosis even more difficult.

Did the ACE make it more difficult to live with HIV?

Atalia reported that it did make her life more difficult to cope with HIV because she did not have a caring family to take care of her when she was sick with TB. She reports that her extended family treated her badly, not giving her blankets and giving her a cup to drink out of that was used to feed chickens.

What could have helped?

Atalia stated that having more knowledge of HIV and condoms, and the education and protection of her parents would have helped her.

LIFE STORY 3: PABLO, 24 YEARS OLD FROM MOAMBA DISTRICT IN MAPUTO PROVINCE

Background Information on family and the ACE

Pablo[35] is 24, formally employed, and works for a company that does electric sealing.

Pablo has three living siblings, and one has passed away. His mother died when he was 10 years old. He is not clear if his father died or left the family because he has never seen his father.

His mother died a month after giving birth, but she had been sick for a while before this. Pablo reports that he was responsible for the baby after his mother's death. Pablo's stepfather lived in South Africa, and he supported Pablo and his siblings for two years after Pablo's mother's death, but then he died. When Pablo's stepfather died, he and his two younger brothers moved in with their grandparents. Pablo's older brother went to South Africa and is no longer connected to the family. When Pablo was 10 years old, he says he became the father of his family, looking after a 6-year-old brother and an infant. He sold water on the street to earn money to care for his infant brother.

When he was 13, he became involved Geração Biz, a program for adolescents about puberty and sexual and reproductive health. Pablo would sell drinks on the street after school into the evening and some days he would miss school to sell if the family needed more money.

[35] Name has been changed for confidentiality.

During this difficult time, Pablo said, "I felt bad, desperate. I did not know what to do. But ideas always came up."

Community's reaction

Neighbors who knew about his situation helped when they could. A missionary group in the community that supports orphans also found out about Pablo and gave clothes and items that his baby brother needed and some school supplies. Pablo states that he does have other family besides his grandparents, but they never helped him or his brothers. He states it is because of a "lack of will, of interest. Lack of charity." There was a time when Pablo tried to have a relationship with his surviving family, but they did not take an interest in him. He stated, "I just wanted to have a relationship as a family … ."

Affect of the ACE on his life

When asked how his mother's death has impacted his life, the interview became emotionally heavy. Pablo stated, "First, I got over the pain, although not completely, but I got over the pain. I believe that if my mother had been alive, I would have done something, I would have graduated, and I would not have had many expenses. I would have been using my salary for other purposes." He added, "It affects me in the sense of help because it is not easy to manage the family situation. I'm working but it doesn't happen 100 percent of what I wanted, right? I wanted to graduate but it hasn't been easy. What scares me is seeing my brothers without any training—finish the 12th grade and stop there. This is too heavy for me."

Pablo continues to care for his two younger brothers. His youngest brother who is now 14 is still in school, but his other brother stopped school because Pablo was able to find him a job at the same company where he works. He started to study to become a priest, but the situation at home deteriorated when he was not there and so he left his studies and came home to help his brothers. Becoming a priest was, "my biggest dream. I tried, but it didn't work," he recounted. He also stated that he does not have a girlfriend or a wife, "I haven't thought about it yet because life is not easy now."

Pablo states that he spends a significant amount of time thinking about how to care for his grandparents and his brothers and that he became sick because of all the worrying. This also made him closed off to other people. He is trying to reach out to friends more and not isolate himself." I always thought what to do to make them happy. And I thought what to do in my future? What will the future of my brothers be like? That's what worries me the most, what made me a little closed off," he explained.

What did he do to overcome the ACE?

He said, "I feel good when I'm at home and when I'm alone. Being at home, I try to distract myself through the phone, watch some sermon videos, watch some music. I have a lot of books too that I usually read." Church has also been a source of support and hope for him and finding work has been essential to helping him overcome the burden of caring for his family.

LIFE STORY 4: DERCIO, 23 YEARS OLD FROM MOAMBA DISTRICT IN MAPUTO PROVINCE

Background Information on the ACE(s)

Dercio[36] is 23 and works as an activist. He has never been married and his highest educational level is 12th grade.

Dercio lived with his mother while his father lived and worked in Maputo (roughly two hours away) and visited the family occasionally. His mother died when he was 8 years old. The year before she died, she became very sick, and his family was kicked out of their house. They came to live with a "grandmother" who was not a relative, who Dercio continued to live with after his mother's death.

Dercio reports that his father left when his mother died and that his other siblings also passed away. Before his mother died, he reports that life was "tight" but with his mother things were good.

For some time Dercio thought his father was dead, but he had been living in Maputo and had a new family. His father came back into his life when Dercio was 13 years old and that is when he realized his father had been alive. When his father came back into his life, he came to live with Dercio, but this lasted only three months and then he, too, died.

When his mother was alive, the family had a small piece of land with a house. When she passed away, her brothers, Dercio's uncles, took over the house. According to Dercio his uncles had mental health problems and never treated him like family. Dercio never lived in his family's house after his mom's death. One uncle has since died when Dercio was 18 years old. The remaining uncle is the only family that Dercio mentioned, and he said that he does not treat him like family and does not acknowledge him.

Dercio did odd jobs like fetching water to earn enough money to go to school. He paid for school all by himself—he even admits to stealing other students' notebooks because he did not have money to buy his own. Dercio reports that his grandmother died when he was 16 years old, and this is when his life became very difficult. He was able to stay at the grandmother's house and continued to do odd jobs to buy food and go to school, but there was no other family for him to live with, so he lived by himself.

He recounts crossing the border to sell goods on the South African side in the evening and returning home at 5 a.m. to go to school. He studied in the morning, came home to cook and do his homework, and then went back across the border to work in the evening. He reported that from grade 10, he did this almost every day. One of his teachers repeatedly caught him sleeping in her class and finally he told her about his life, and she occasionally helped him.

Community's reaction

Neighbors and friends were supportive and tried to help him. They gave him food when they could, and his friends talked to him and supported him. When his grandmother died, Dercio reported that he felt very bad and extremely alone, but, he stated, "little by little, with the friends and neighbors I have, I got over it. I got over it." Dercio also received support from a missionary group in his community and from the Red Cross.

Dercio was asked how the community in general treated him and other orphaned children like him. He said, "many times instead of someone trying to help, they just stand aside and laugh, instead of helping

[36] Name has been changed for confidentiality.

that person who needs to be helped. Helping is not [only about] giving him something, but helping, even with words, is help. Words help, a lot even."

Affect of the ACE on his life

Dercio stated that when his grandmother was very sick, he became afraid. He became worried, thinking "Who is going to stay with me? That was the first thing that came to my mind: 'who will stay with me?' I sometimes cried while my grandmother was already sleeping, but I saw that crying is not a solution either…I can say that it affected me a lot."

What did he do to overcome the ACE?

Dercio had the occasional help of neighbors and friends, and he did odd jobs to sustain himself. To cope with the constant fear of being alone, Dercio says he prayed, and that even today he still prays, goes to church, and sings in the church choir.

Impact of the ACE on his life

Dercio says that he still has the bad memories of when his mother and grandmother were sick and died, but he no longer lives in fear of being alone. Life is still difficult as he is still supporting himself and living alone.

What could have helped him overcome the ACE?

Dercio stated that having consistent work would have helped him overcome the adversity he felt when his grandmother passed away. He thinks that job training like computer courses or carpentry would also help other orphans like himself have more skills to be able to take care of themselves, and this would alleviate a lot of worry and stress. He also says that having friends that he could talk with and distract him was helpful. It was difficult to stay at home alone, so friends that kept him company and got him out of the house were helpful. Dercio also reiterated several times how important church activities and praying has helped him with his emotions, particularly the fear of being alone.

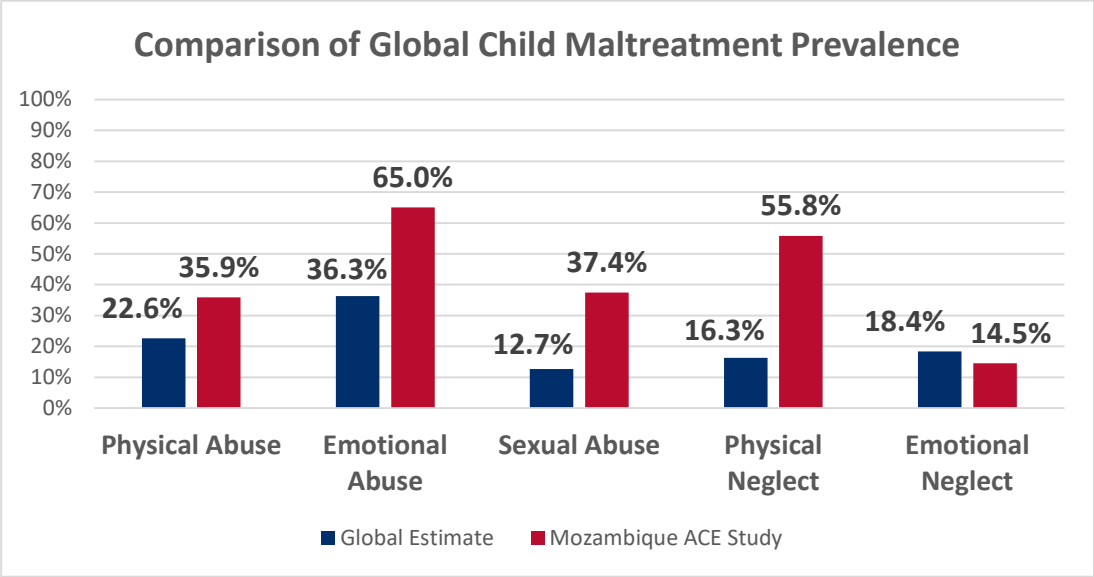
DISCUSSION

ACES IN COMPARISON

Comparing ACEs across populations and countries can be difficult due to differing definitions and age groups. However, a meta-analysis[37] conducted in 2015 on 244 publications of child maltreatment across the globe calculated the prevalence of physical, sexual, and emotional abuse, and physical and emotional neglect in children under 18 years old. According to this study, there was a 22.6 percent global prevalence of physical abuse, a 12.7 percent prevalence of sexual abuse, a 36.3 percent prevalence of emotional abuse, a 16.3 percent prevalence of physical neglect, and an 18.4 percent prevalence of emotional neglect. This study found the prevalence of maltreatment in every category but one to be well above this global average. Only emotional neglect (14.5 percent in this study compared to 18.4 percent in the global estimate) was slightly lower than the global estimate.

[37] Stoltenborgh, M., Bakermans-Kranenburg, M. J., Alink, L. R. A., & van IJzendoorn, M. H. (2015). The prevalence of child maltreatment across the globe: Review of a series of meta-analyses. *Child Abuse Review*, *2015*(24), 37-50. https://doi.org/10.1002/car.2353

FIGURE 1: COMPARISON OF GLOBAL CHILD MALTREATMENT PREVALENCE



Although the prevalence of child maltreatment was high compared to the global estimates, this study's findings were more in line with the regional physical and sexual abuse findings of the Brown et al. study[38] of four African countries that found that 42 percent of children were physically abused (compared to 35.9 percent in this study) and 23 percent were sexually abused (compared to 37.4 percent in this study). However, the percentage of sexual abuse in this study is high even in comparison to surrounding African countries.

Emotional abuse was very high in this study, at 65 percent compared to 36.3 percent in the global estimate and 35.5 percent in a 2016 nationally representative study in South Africa among 10- to 17-year-olds. The main difference in the definition of emotional abuse was that in this study, yelling was included along with insulting and humiliating. The age range starting at 10 years in the South African study meant that there was a large percentage of the respondents that were only roughly halfway through their childhoods, compared to the sample in this study that included only respondents 18 years and over, and this could potentially signify an underreporting in the South African study.

Sexual abuse was also higher in this study compared to a 2019 Mozambican study, which was nationally representative of youths aged 13-24[39] and which found sexual violence for females at 14.3 percent and 8.4 percent for males. According to the WHO, globally, 8 percent of men and 20 percent of women report being sexually abused as a child. This study found that 30.4 percent of male youths and 42.6 percent of female youths reported being sexually abused as a child. If we consider both Mozambican studies to be accurate, the difference in sexual abuse prevalence could be due to the age range in the 2019 sample, which included respondents as young as 13, who still have five years left in their

[38] David W Brown *et al*. Violence and adverse health behaviours in African children. Exposure to physical and sexual violence and adverse health behaviours in African children: results from the Global School based Student Health Survey. Bull World Health Organ 2009; 87:447–455 doi:10.2471/BLT.07.047423

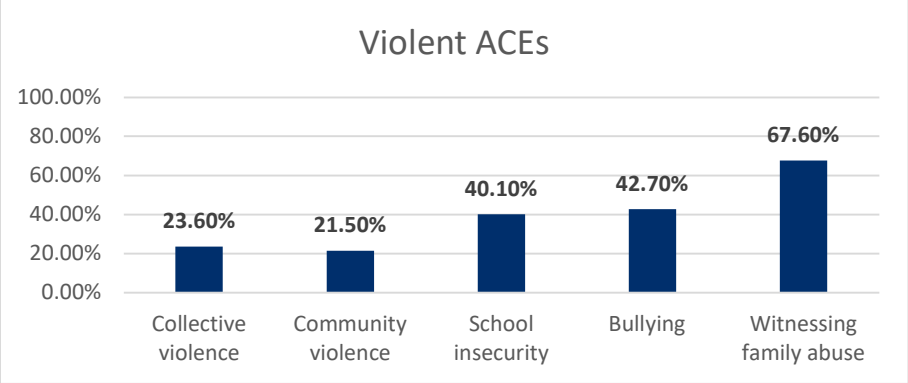
[39] Instituto Nacional de Saúde (INS), Ministério da Saúde (MISAU), Ministério do Género, Criança e Acção Social(MGCAS), Instituto Nacional de Estatística (INE) e Centros de Controlo e Prevenção de Doenças (CDC). 2020.Inquérito sobre Violência contra as Crianças em Moçambique, 2019 (InVIC, 2019): Relatório de IndicadoresBásicos. Maputo, Moçambique.

childhoods. If both studies are accurate, it can be assumed that a considerable amount of sexual abuse occurs in the teenage years, which would account for these differences.

Physical neglect, which stood out at 55.8 percent, was another form of child maltreatment that was much higher than the global estimate of 16.3 percent. Half of the youths who report being physically neglected in childhood potentially shows the low standing that children have in families in addition to serious family stress and vulnerability, which can cause neglect.

Another noteworthy aspect of the ACE profile of youths is the high prevalence on ACEs containing violence. Besides the ACE related to peer fighting, which was just 8 percent overall, there was not another violent ACE below 20. percent. Witnessing and being impacted personally by violence were both widespread, as was community and family violence. Males had the highest prevalence of experiencing violent ACEs.

FIGURE 2: PREVALENCE OF VIOLENT ACES



It is important to recognize that male children and adolescents are exposed to violence within their community, among their peers, and in their families at a high prevalence. Many of the youths spoke about how normalized physical and emotional violence are in their societies. When asked the question about physical abuse from a caregiver, youth respondents would try to clarify, "if I was beaten for a reason or without a reason?" Many acts of violence are normalized if there is a "good" reason for the violence. This is true for "discipline" of children as well as with intimate partners, who feel justified both to inflict or to receive violence if the reason for the violence is believed to be justified. Due to this, physical abuse prevalence may have been underreported.

Additionally, physical violence is so common in some communities and families that it has become normal. Filipa from the life story, is a good example of this as she describes not understanding that the frequent beatings she and her siblings received were not normal and should have never happened to them. Youth respondents when asked if they had ever been hit, slapped, cut, stabbed, and so on, would reply that their experience was nothing above "normal." Enumerators had to rephrase and ask if these events had ever, for whatever reason, happened to them. This normalization of violence, coupled with the violent history of colonial rule, the 16-year civil war, continued violent clashes between political groups, and the violent insurgency in the north of the country characterizes Mozambique as a violent country that has a clear impact on its children and youths and will take time to change.

Finally, three-fourths of all youth in the sample have four or more ACEs. This is incredibly high. Four ACEs is what has been shown in the literature to be the threshold whereby the likelihood for long-term health and economic consequences significantly increases. Mozambicans already face health and economic challenges, such as high unemployment and a high burden of communicable and infectious diseases, along with poor access and low-quality health services, thus compounding the effect of ACEs on the population. In comparison to 75.3% percent of this sample with four or more ACEs, the U.S. population has roughly 17 percent of its adult population reporting four or more ACEs. Therefore, adversity in childhood should receive urgent attention from the GRM as well as the donor and development community.

The majority of ACEs are issues of ***protection*** of children—they are not uncontrollable events like natural disasters. Instead, most of the ACEs are the result of lack of protection by adults, who should be the ones safeguarding and caring for children. This shows that societal beliefs and norms, such as the role of children in families and beliefs around when a child becomes an adult (for example the belief that a girl becomes an adult when she starts menstruating), factor into the high prevalence of child maltreatment. More needs to be understood about the societal norms that allow for high rates of abuse to flourish.

While the high prevalence of four or more ACEs in the youth sample is alarming, it is important to remember the protective factors that can help mitigate the effect of ACEs. Safe, stable, and nurturing relationships, characterized by the presence of a safe and stable parental relationship and having basic needs met are two ways that the impact of an ACE can be mitigated. Youth groups that have caring facilitators who model healthy and stable communication and relationships with youths and groups that provide school support or create savings groups are some of the ways in which projects can increase protective factors for young people and their impact should not be underestimated.

For example, in the life stories, all four of the youths interviewed were engaged in a supportive group and reported that these groups played important roles in their coping ability. The two male youths were health activists at their secondary school and were helped by a missionary organization. The two female youths were part of a youth HIV-positive support group that provided peer and financial support. In all life stories, church or a religious institution was a cornerstone of their positive coping behavior and provided hope and a relief from their struggles. Supporting children, adolescents, and youths with supportive groups and livelihood interventions are important ways that projects can mitigate the effects of adversity in childhood.

ACES AND DEMOGRAPHIC CHARACTERISTICS

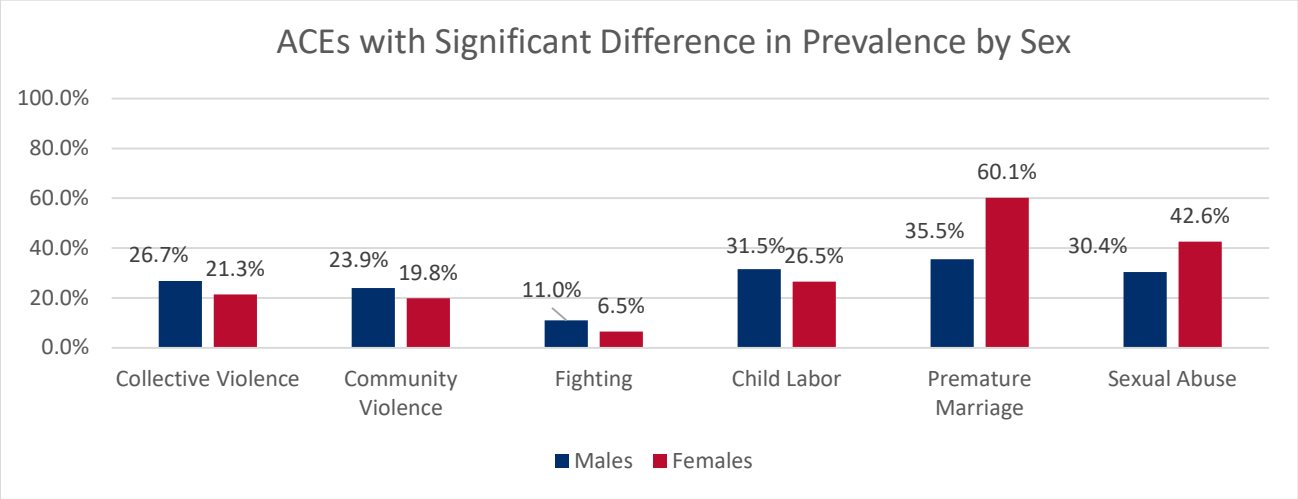
The data show an overwhelming vulnerability for children and adolescents in Nampula province. There are 16 total ACEs and 14 of the ACEs were statistically significant by province. Eleven of the 14 that were significantly different were higher in Nampula Province. Only community and collective violence and school insecurity were higher in other provinces. Nampula Province also had a significantly higher percentage of youths with four or more ACEs.

While the number of youths with four or more ACEs was not significantly different by sex or urban/rural area, there were some distinctive characteristics of the experiences of youths by gender and location. For example, youths in urban areas had a significantly higher prevalence of sexual abuse, the incarceration of someone living in their HH, bullying, community violence, and school insecurity. Youths

in rural areas had higher percentages of premature marriage, emotional and physical neglect, collective violence, and child labor.

Only six ACEs were significantly different by gender. This is partly due to many ACEs affecting families, such as death and divorce of a caregiver and incarceration of a family member in the HH, which would affect both male and female children in the family. However, it is surprising that of the six ACEs that were significantly different by sex, four of them were higher in males. The ACEs that were highest in males were fighting, community and collective violence, and child labor. Sexual abuse and premature marriage were higher in females. While not as high as for females, sexual abuse and premature marriage were both high in males in the sample.

FIGURE 3: ACES WITH SIGNIFICANT DIFFERENCE IN PREVALENCE BY SEX



The data highlight the vulnerability of boys and male adolescents, which is extremely important to note as it is often overlooked. The vulnerability of girls has been highlighted and documented, particularly in the context of premature marriage and sexual exploitation in Mozambique. Development agencies and the GRM had been attempting to respond to the vulnerabilities of girls through programming specifically for girls.

However, gender programs often attempt to uplift women and encourage men to support women. Very few of these programs look at the unique needs of men and boys or attempt to help men overcome their challenges or acknowledge the vulnerability and exploitation of boys in Mozambican society. Patriarchy and male privilege may be hiding the struggles of men and boys. While men tend to have more privilege, it does not mean that they have not been abused or exploited and ignoring the abuse of male children can have dire consequences when these boys reach adulthood.

Educational attainment was significantly different in 10 of the 14 ACEs, with increased prevalence of the respective ACE for youths who never attended school or never completed primary school. The relationship between educational attainment and ACEs is complex. Some ACEs, such as physical neglect, can be the cause of the low educational attainment, while low education can create additional vulnerabilities to ACEs. With such a high correlation between childhood adversity and educational attainment, it is even more discouraging to see that for 40 percent of youths, school is not a place of refuge from adversity, but a cause. It is also important to note that educating a traumatized child has

additional challenges. Trauma interrupts normal brain function, causing disruption to attention and memory. If coming to school itself is also a trauma trigger, it will be difficult for child survivors of abuse and maltreatment to learn effectively.

One of the limitations of the study is that it did not accurately assess the economic status of the youths in the sample, making it difficult to understand the association between childhood adversity and economic attainment. However, from the life stories, it is evident that childhood adversity, particularly the loss of a parent or caregiver, has devastating consequences on economic attainment. Pablo and Atalia in particular are examples of how their futures were limited because of the pressure to provide for their families when their parents became sick and died. Despite the immense challenges, these youths are still trying to succeed in any way they can. Pablo's confession, "I felt bad, desperate. I did not know what to do. But ideas always came up," is testament to the immense potential that these youths have to be successful, even in impossible situations. If these youths are surviving with no resources against all odds, imagine how impactful support, training, and opportunities could be for them.

HEALTH RISK BEHAVIORS AND THE CORRELATION WITH ACES

Perhaps the most compelling data among the health risk behaviors was the high prevalence of IPV victimization and self-reported perpetuation in the last 12 months. The high prevalence of self-reported perpetuation, particularly for sexual violence, is particularly worrisome. Since male youths frequently reported forcing an intimate partner to conduct sex acts against their will, it points toward the acceptability of intimate partner violence in society. For example, in the 2011 DHS,[40] women and men were asked if there were justifiable reasons for a husband to assault his wife and 23 percent of women and 19 percent of men came up with at least one reason to justify physical violence. Justifiable reasons ranged from burning food, leaving the house without informing the husband, refusing sex, and discussing/arguing with her husband.

Among the health risk behaviors, IPV victimization and perpetuation were the most highly correlated with suffering four or more ACEs. Youth females who experienced four or more ACEs are three times more likely to suffer IPV than youths who have fewer or no ACEs. For male youths, those with four of more ACEs were 2.8 times more likely to perpetuate IPV than those with fewer or no ACEs. There is a wealth of literature describing the link between the increased probability of victimization and perpetration for adults who experienced maltreatment as children.

Surviving trauma, if untreated, increases the body's arousal response making a person hyper vigilant. Since this high alert state is uncomfortable and unsustainable for the body and the emotional state of a person, people who have experienced trauma tend to try to diminish or ignore the body's response to danger. This actually makes people more susceptible to becoming revictimized because the body's danger and stress response is no longer trusted or is not working properly. Additionally, people who have been abused often lack models of healthy relationships and healthy communication and are more likely to accept unhealthy relationship behaviors. Other factors, such as low self-esteem and economic vulnerability, can also be factors in the increased likelihood of suffering IPV in adulthood among survivors of childhood maltreatment.

[40] Ministerio da Saude (MISAU), Instituto Nacional de Estatística (INE) e ICF International (ICFI). Moçambique Inquérito Demográfico e de Saúde 2011. Calverton, Maryland, USA: MISAU, INE e ICFI.

It is important to remember that males in this sample had a high prevalence of experiencing and witnessing violence. Repeated exposure to violence normalizes abuse and conditions people to respond to threats, however small, with violence. Additionally, the painful memories of child abuse often lead to intense emotions, such as anger and shame, and many people in abusive environments as children have not had an opportunity to learn how to cope with these feelings. Insecurity and anger, therefore, can spark hostility and violence for because of a lack of other ways to cope.

While males still need to be held accountable for their actions, many of them are victims as well. Treating all men as perpetuators, without offering support for past abuse will not change the multigenerational nature of IPV. *It is crucial to address the root causes of IPV in gender-based violence programming.* Childhood trauma for both perpetrators and survivors needs to be addressed to decrease the incidences and mitigate the effects of IPV.

The logistic regression data, which showed a significant likelihood of all of the health risk behaviors studied, is compelling. It is extremely important for development organizations and the GRM to address childhood adversity in all forms of development programming as the link is strong between childhood adversity and poorer health outcomes and poor educational attainment.

It is surprising that while ACEs significantly increased the likelihood of HIV risk behaviors, the impact of ACEs on HIV risk was not as strong as for the other health behaviors. This is surprising because childhood adversity is shown to have a negative impact on the ability to form healthy relationships and impulse control, which are associated with some HIV risk behaviors. However, the HIV risk behaviors were very common across all youth and demographic characteristics, which may have diminished the impact of childhood adversity in the logistic model.

COPING BEHAVIORS

A fourth of youths are consistently using avoidant coping, which is maladaptive. However, most of the youths are using approach coping, which means that they are prime recipients of projects that have psycho-social supportive components to them, as these youths are already seeking out help from supportive people in the community. This also means that it may be more challenging to recruit youths who are not naturally seeking out approach coping behaviors. These are the youths that could most benefit from supportive psycho-social services to help them regain trust in others and hope that could help them stop avoiding their problems and turn toward more productive ways of coping. Recruitment of youths in development projects should take this into account and try to develop strategies to encourage youths with avoidant coping behaviors to join youth clubs or other supportive services.

YOUTH LIFE STORIES

There are many takeaways from the life stories. These stories highlight the profound loss and trauma youths have encountered in just the first 17 years of life. In all the life stories, youths reported how their life prospects and opportunities are hindered due to ACEs. With the limitations placed on them, it seems that many of these youths are losing hope, stating, "I used to have dreams …," and are now more focused on survival. Even in the face of these problems, the youths demonstrate incredible strength, will, and ingenuity to keep going and provide for themselves. Training programs and savings groups were identified as resources that would have been useful to them or that were useful to help them take care

of themselves and their siblings. These services should not be underestimated in the design of development programs.

Filipa and Atalia's experiences in particular highlight the difficult dynamics and social norms that prevent community members from intervening in cases of abuse. In Atalia's case, when she lost both parents and became sick, her neighbors taunted and ridiculed her and made her life more difficult. Filipa talked at great length in her interview about the strong belief that what happens inside the home is no one else's business and that it would be difficult for a neighbor to try to help an abused child if the abuse was happening in the home. She also highlights the social beliefs around what is considered abuse and at what age, culturally, a child becomes an adult. More research will need to be done to further understand these beliefs so appropriate awareness and education campaigns can be conducted in communities to increase the protection of children. Furthermore, more research is needed to understand the many complex dynamics in Nampula Province that are driving the high prevalence of childhood adversity.

Finally, it is important to highlight the importance of church and religious institutions as well as youth support clubs. All the youths mentioned going to church as an important coping mechanism for them. Church is a haven where there are supportive people, where they can alleviate some of the negative emotions, and where they can feel hope. Religious institutions, therefore, are natural partners for youth programming. Youth support clubs are also incredibly important because they provide needed life skills as well as a community for youths in similar situations. For youths who suffered adverse experiences in childhood, they may have difficulty forming healthy relationships, so the supportive clubs are an important way that youths have access to healthy relationship models and supportive relationships.

RECOMMENDATIONS

ADDRESS CHILDHOOD ADVERSITY AND THE LACK OF PROTECTION OF CHILDREN

1. **Conduct focused research to better understand the social norms that contribute to child maltreatment and the lack of protection of children, particularly in Nampula Province.**

2. **There is an urgent need to address the mental health of survivors of abuse, neglect, violence, and exploitation.** Psychologists are becoming more common staples in health programming, particularly in HIV programs, where the GRM and donors have realized the connection between mental health and successful HIV treatment. Training the existing psychologists in trauma treatment and connecting them to projects and community initiatives is needed.

3. **Community-based psychoeducation to teach positive coping skills is needed.** In addition to facility-based mental health care, psychoeducation at the community level can help community members learn about basic mental health and self-care, positive coping mechanisms, and how to cope with common mental health problems, such as depression and anxiety. Positive coping can help reduce avoidant coping behaviors, which can lead to substance abuse and other unhealthy behaviors. Psychoeducation should be community-wide, encompassing youths and their supportive family members, and key people in communities such as community and religious leaders, teachers, and community health workers.

   a. **Expand HIV-supportive psychoeducation to youths' existing social support network.** Education on HIV as well as on coping mechanisms and how to support people living with HIV should be integrated into HIV programming and target youths' existing support circles (which include family, friends, and religious leaders).

4. **Training for community leaders in the signs of abuse/maltreatment and the establishment/strengthening of community referral systems.** In combination with a deeper understanding of the social norms surrounding the lack of protection of children in communities and appropriate awareness-raising campaigns to change social norms, community leaders and other people of influence, such as religious leaders and community health workers, should be trained in identifying the signs of abuse. A referral system for children who are maltreated should also be established or strengthened.

5. **Training of teachers and school counselors on the signs of abuse/maltreatment of children.** This is an effort to reduce violence within school with more sensitization of teachers and accountability from school counselors. Additionally, it will support teachers to talk with students, much like Dercio's teacher, from the life story, did when she noticed he frequently slept in her class. Talking with students who show warning signs instead of punishing students for misbehavior or missed assignments can help support and protect vulnerable children.
6. **Continue to work on making school safe for children.** Teachers can be trained in non-violent discipline and classroom management. Schools and communities can work together to reduce bullying among students and peers through campaigns and after-school clubs.

7. **Parent education.** Parenting education, such as teaching non-violent discipline, educating about developmental abilities at different ages and what to expect of children, and positive communication can equip parents to provide safe and healthy family environments for their children.

8. **Youth-focused programming.** Youths in the life stories felt that when they were in school, they were focused and had something to strive for. When they graduated or left school, there was often no institution for them to go to or a place where they could receive more training. Saving groups, skills training, or supportive groups can be useful for youths to bridge the gap between childhood and adult responsibilities. These groups can also provide needed protection for youths and reach youths in and out of school.

9. **Expand sexual health education for adolescents.** Prevalence of the two HIV risk behaviors surveyed was very high. Additionally, the two youths who were HIV-positive in the life stories both stated they had little sexual education or knowledge of HIV and how to prevent sexually transmitted infections and HIV. This points to a need to increase sexual education and make it more personalized. While both girls in the life stories stated they had "heard" about HIV from school, they said they lacked conversations from their parents and other adults to help them apply the information to their lives. Interactive sexual health education that teaches adolescents how to apply the knowledge to their lives is needed.

10. **Train the new USAID Youth Focal Point in integrating mental health and gender into programming.**

INCLUDE TRAUMA-SENSITIVE COMPONENTS INTO EXISTING PROJECTS

1. **Have a mental health specialist review new project designs** to best integrate mental health into all projects.

2. **Supportive groups**: any type of group that is formed, whether it be a behavior change group, a mothers' group, or a savings group has an opportunity to give space to participants, particularly youth participants to encourage and empower them. These groups may be the only source of support a person has and the role of these groups to improve in the emotional wellbeing of participants should not be underestimated. Recruitment should factor in ways to engage participants who may not typically join a supportive group. Recruitment of young people should focus on attracting youths both in and out of school.

3. **Train facilitators of groups in psychological first aid and crisis management.** Any type of group, particularly those with youth participants, may have members that reach out to facilitators to speak personally about challenges they are going through. For example, one of the projects that the study team connected with to recruit the youths for the life stories, had staff that were involved in helping some of the youths exit abusive relationships and were relied on to help in many crisis management situations. These staff were instrumental to helping these youths navigate ongoing adverse experiences, but it is unclear if they had been trained for this since it was not a component of the project. Training all facilitators in basic crisis management and talking to a distressed participant is important.

4. **Link with health facilities to refer cases.** Similar to the reasoning behind the above recommendation, since participants may go to facilitators to help navigate difficult situations, it is important to recognize that these facilitators are not mental health professionals and should not be required to handle these situations on their own. Connecting with health facilities at the start of the project to inform them of the groups and the potential for referrals will help facilitate the process when a referral for mental health needs to be given to group participants.

5. **Focus on teaching interpersonal skills, because many people did not have models of healthy relationships, and this can affect group dynamics.** For projects that have training or supportive groups, it can be advantageous to spend some time teaching interpersonal skills, as a high percentage of youths have experienced significant amounts of adversity that may affect their ability to form and maintain healthy relationships and work as a team. This would be especially important for savings groups or agricultural groups that need to work together and be accountable to group members.

6. **Sensitivity to historical challenges.** Projects should be sensitive to historical challenges in specific communities and geographic areas. For example, in Gorongosa and Memba Districts, which had a high prevalence of collective violence that displaced populations, residents in these areas may be hesitant to engage in some forms of income generating or agricultural activities such as animal husbandry, for example, that require them to be attached to the land and will find it difficult to continue if they have to move locations due to insecurity. In some areas, attacks on public infrastructure, such as health facilities were common, and may be a reason residents resist going to these institutions. Programming should be sensitive to these challenges and work with community members to design interventions suitable to their needs.

7. **Integrate mental health and youth needs into existing USAID platforms, such as the Gender Work Group.** The Gender Work Group is a network of implementing partners that meet monthly to discuss various topics related to gender integration. This could be an

important platform to discuss the needs of youth and how to incorporate mental health into programming. Similarly, the USAID Gender Advisor could receive more training in mental health integration and expand their role to include mental health.

RETHINK GENDER PROGRAMMING

1. **Programs need to uplift all children—girls *and* boys.** Focus should be on supporting and empowering all people with an emphasis on healthy relationships and positive gender dynamics. Gender programming aimed at males should not only focus on how males can empower the females in their lives, but on how to address the needs of males themselves.

2. **Need for holistic gender programming, not just for specific indicators relevant to each project.** Gender is becoming more integrated into project interventions, but gender is largely focused on achieving specific behaviors that support the project's overall mission. For example, in health programming, gender initiatives are often focused on helping women make decisions on their children's and their own healthcare, and men engaging more and accompanying their partners to the health facility for HIV testing or prenatal care. While these initiatives are important and are helping to change gender dynamics, they 1) often do not focus on addressing the specific needs of men, 2) they create a false sense of gender empowerment if gains in these few select behaviors are made, and 3) they often do not address the ingrained and persistent negative beliefs that hinder gender equality.

3. **Men need to be active recipients of interventions aimed at reducing gender-based violence and IPV.** They need treatment for past trauma, education on positive coping to learn how to handle negative emotions, and more examples of healthy relationship communication. Additionally, the harmful stereotypes and expectations of boys and men to be tough/emotionless, providers, and healthy/strong need to be challenged.

ANNEX

ANNEX I: QUANTITATIVE QUESTIONNAIRE

Questionário Internacional de Experiências Adversas na Infância (EAI-QI)

Adverse Childhood Experiences – International Questionnaire (ACE-IQ)

Organização Mundial da Saúde (OMS) Adaptação para o uso em Moçambique pela MMEMS, Novembro de 2021

COORDENADAS DO GPS	**LATITUDE**	GRAU	MIN.	SEG	**LONGITUDE**	GRAU	MIN.	SEG
0	**INFORMAÇÕES DEMOGRÁFICAS**							
0.1 [C1]	Sexo (Marque de acordo com o observado) [ ] Masculino [ ] Feminino							
0.2 [C2]	Qual é a sua data do seu nascimento? Dia [ ] mês [ ] ano [ ][ ][ ][ ] Não sabe (não sei) /não informou (não quero informar) [ ] ***(Vá para Q.C3)***							
0.3 [C3]	Qual é a sua idade? [ ] [ ]							

0.4 [C5]	Qual é o seu nível de escolaridade mais alto? [ ] Nunca frequentou a escola formal [ ] Frequentou a escola mas não completou o ensino primário [ ] Completou ensino primário [ ] Completou ensino médio (10 classe) [ ] Completou ensino secundário (12a classe) [ ] Completou ensino técnico [ ] Completou ensino superior [ ] Não quis responder/ Não sabe?
0.5	Qual é o nível de escolaridade mais alto da sua cuidadora/ cuidador principal? [ ] Nunca frequentou a escola formal [ ] Frequentou a escola mas não completou o ensino primário [ ] Completou ensino primário [ ] Completou ensino médio (10 classe) [ ] Completou ensino secundário (12a classe) [ ] Completou ensino técnico [ ] Completou ensino superior [ ] Não quis responder/ Não sabe?
0.6 [C6]	Quais das seguintes opções melhor descrevem a sua principal situação de trabalho nos últimos 12 meses? (*resposta única*) [ ] Funcionário público/ Vínculo com o setor público [ ] Empregado do setor privado [ ] Trabalhador autónomo/trabalha por conta própria/Empregador [ ] Trabalho não remunerado/trabalho voluntário [ ] Estudante [ ] Dona de casa/Trabalho doméstico não remunerado [ ] Aposentado(a)/ Reformado [ ] Desempregado(a) – com capacidade de trabalhar [ ] Desempregado(a) – sem capacidade de trabalhar [ ] Outros:_____ [ ] Não quis responder/ Não quero responder

0.7 [C7]	Qual é o seu estado civil? [ ] Casado(a) ***(Vá para Q.M2)*** [ ] Vive em união marital [ ] Divorciado(a) / separado(a) [ ] Solteiro(a) [ ] Viúvo(a) ***(Vá para Q.M2)*** [ ] Outro: _____ [ ] Não quis responder/ Não quero responder

1	**CASAMENTO**
1.1 [M1]	Já foi casado(a) ou viveu maritalmente? [ ] Sim [ ] Não ***(Vá para Q.M5)*** [ ] Não quis responder/ Não quero responder
1.2 [M2]	Com que idade se casou pela primeira vez? Idade [ ] [ ] (anos) [ ] Não quis responder/ Não quero responder
1.3 [M3]	Quando se casou pela primeira vez, foi o/a senhor/a mesmo(a) quem escolheu seu marido/esposa? [ ] Sim ***(Vá para Q.M5)*** [ ] Não [ ] Não sabe (Não sei)/ Não tem certeza (Não tenho certeza) [ ] Não quis responder/ Não quero responder
1.4 [M4]	Quando se casou pela primeira vez, se não foi você quem escolheu seu marido/esposa, você concordou com a escolha? [ ] Sim [ ] Não [ ] Não quis responder/ Não quero responder
1.5 [M5]	Se já teve filhos(as), qual era sua idade quando nasceu seu(sua) primeiro(a) filho(a)? Idade [ ] [ ] (anos) [ ] Não se aplica/ nunca teve filhos(as) [ ] Não quis responder/ Não quero responder
2	**RELACIONAMENTO COM OS PAIS OU CUIDADORES** A partir de agora, todas as perguntas estão relacionadas ao período de sua infância e adolescência, desde que era criança até os seus 18 anos.

2.1 [P1]	Seus pais/cuidadores compreendiam seus problemas e preocupações? [ ] Sempre [ ] Na maioria das vezes [ ] Às vezes [ ] Raramente [ ] Nunca [ ] Não quis responder/ Não quero responder
2.2 [P2]	Seus pais/ cuidadores **realmente** sabiam o que você estava fazendo no seu tempo livre, quando você não estava na escola ou no trabalho? [ ] Sempre [ ] Na maioria das vezes [ ] Às vezes [ ] Raramente [ ] Nunca [ ] Não quis responder/ Não quero responder
3	
3.1 [P3]	Quantas vezes seus pais/ cuidadores **não** lhe davam comida suficiente, mesmo que pudessem facilmente oferecer um alimento para você? *Entrevistador: perceba com que frequência esta situação aconteceu.* [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder
3.2 [P4]	Quantas vezes seus pais/ cuidadores ficavam muito embriagados ou sob o efeito de drogas quando cuidavam de você? *Entrevistador: perceba com que frequência esta situação aconteceu.* [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder

3.3 [P5]	Quantas vezes os seus pais/ cuidadores **não** lhe mandavam para a escola, mesmo que tivessem a obrigação de fazer isso? *Entrevistador: perceba com que frequência esta situação aconteceu.* [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder
4	**AMBIENTE FAMILIAR** Nos primeiros 18 anos da sua vida...
4.1 [F1]	Morou com alguém que tinha problemas com álcool ou era alcoólatra, ou que abusava de drogas ilícitas? [ ] Sim [ ] Não [ ] Não quis responder/ Não quero responder
4.2 [F2]	Morou com alguém que estava deprimido, ou tinha alguma doença mental ou intenção suicida? [ ] Sim [ ] Não [ ] Não quis responder/ Não quero responder
4.3 [F3]	Morou com alguém que alguma vez tenha sido levado para cadeia ou mandado para prisão? [ ] Sim [ ] Não [ ] Não quis responder/ Não quero responder
4.4 [F4]	Nesse período (até os seus 18 anos) seus pais alguma vez se separaram ou se divorciaram? [ ] Sim [ ] Não [ ] Não quis responder/ Não quero responder
4.5 [F5]	Sua mãe, ou seu pai ou seu cuidador/ cuidadora faleceram (nesse período)? [ ] Sim, a minha mãe [ ] Sim, o meu pai [ ] Sim, o meu cuidador/ cuidadora [ ] Sim, o meu pai e a minha mãe [ ] Não [ ] Não sabe/Não tem certeza

	[ ] Não quis responder/ Não quero responder
	As próximas perguntas estão relacionadas a algumas situações que você pode ter ouvido ou visto **EM SUA CASA**. São situações que podem ter acontecido **COM OUTRAS PESSOAS QUE MORAVAM NA SUA CASA.** Nos primeiros 18 anos da sua vida...
4.6 [F6]	Viu ou ouviu alguém que morava na sua casa recebendo gritos ou berros, ou sendo insultado ou humilhado? [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder
4.7 [F7]	Viu ou ouviu alguém que morava na sua casa sendo agredido fisicamente, esbofeteado, ou chutado? [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder
4.8 [F8]	Viu ou ouviu alguém que morava na sua casa ser agredido ou cortado com algum objeto, como uma vara (ou bengala), garrafa, cinto, faca, chicote, ou algum outro objeto? [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder

5	As próximas perguntas estão relacionadas a algumas situações que **VOCÊ** pode ter vivenciado. Nos primeiros 18 anos da sua vida...

5.1 [A1]	Algum de seus pais, cuidador/ cuidadora ou alguém que morava na sua casa gritou consigo, berrou, insultou ou humilhou-lhe? [ ] Sim, Muitas vezes [ ] Sim, Poucas vezes [ ] Sim, Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder
5.2 [A2]	Algum de seus pais, cuidador/ cuidadora ou alguém que morava na sua casa **ameaçou** abandonar-lhe ou expulsar-lhe de casa, **ou de fato fez isso**? [ ] Sim, Muitas vezes [ ] Sim, Poucas vezes [ ] Sim, Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder
5.3 [A3]	Algum de seus pais, cuidador/ cuidadora ou alguém que morava na sua casa lhe agrediu fisicamente: bateu, chutou, deu socos em si? [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder
5.3.2.	Qual foi a intensidade dessas agressões? [ ] Leve [ ] Moderada [ ] Intensa [ ] Muito intensa [ ] Não quis responder/ Não quero responder
5.4 [A4]	Algum de seus pais, cuidador/ cuidadora ou alguém que morava na sua casa lhe agrediu ou lhe cortou usando algum objeto, como uma vara (ou bengala), garrafa, cinto, faca, chicote, ou algum outro objeto? [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder
	As próximas perguntas são sobre situações de assédio ou abuso sexual que **VOCÊ** pode ter vivenciado antes dos 18 anos, e que podem ter sido cometidas por qualquer pessoa. Antes de você ter 18 anos...

5.5 [A5]	Alguém **<u>tocou ou acariciou</u>** você de uma forma sexual, sem que você quisesse? [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder ***Vá para 5.7***
5.6 [A6]	Alguém **<u>fez com que lhe tocasse</u>** o corpo dele(a) de uma forma sexual, sem que você quisesse fazer isso? [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder
5.7 [A7]	Alguém **<u>tentou fazer</u>** sexo oral, anal ou vaginal consigo, sem que você quisesse? [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder
5.8 [A8]	Alguém **<u>já fez</u>** sexo oral, anal ou vaginal com você, sem que você quisesse? [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca ***Vá para 6.1*** [ ] Não quis responder/ Não quero responder
5.9	Foi alguém que morava na sua casa? [ ]Sim [ ]Não

	[ ]Não quis responder/ Não quero responder
6	**VIOLÊNCIA DE PARES** As próximas perguntas estão relacionadas ao **BULLYING**. O bullying ocorre quando um jovem ou um grupo de jovens fala ou faz coisas más ou desagradáveis para outro jovem. Também é bullying quando uma pessoa jovem é provocada de forma desagradável ou quando é deixada de fora das atividades de propósito. Não é bullying quando dois jovens com a mesma força ou poder discutem ou brigam, ou, ainda, quando a provocação ocorre de forma amistosa e divertida. Nos primeiros 18 anos da sua vida...
6.1 [V1]	Com que frequência sofreu bullying? [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca *(**Vá para Q.V3**)* [ ] Não quis responder/ Não quero responder
6.2 [V2]	Qual era a forma **mais frequente** de bullying que sofreu? **(Assinalar apenas uma opção)** [ ] Me batiam, esbarravam em mim, era chutado(a), empurrado(a), ou trancado(a) em lugares fechados [ ] Gozavam de mim por causa da minha raça, nacionalidade ou cor da pele [ ] Gozavam de mim por causa da minha religião [ ] Gozavam de mim por meio de brincadeiras ou comentários de cunho sexual, ou gestos obcenos [ ] Era excluído(a) de atividades de propósito ou completamente ignorado(a) [ ] Gozavam de mim por causa da aparência do meu corpo ou do meu rosto [ ] Eu sofria alguma outra forma de bullying (especificar) _____ [ ] Não quis responder/ Não quero responder
	A próxima pergunta é sobre **LUTAS FÍSICAS**. Uma luta ou briga física ocorre quando dois jovens com aproximadamente a mesma força ou poder escolhem brigar um contra o outro. Durante o período de crescimento, nos primeiros 18 anos da sua vida...
6.3 [V3]	Com que frequência você se envolvia numa luta física? [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca

	[ ] Não quis responder/ Não quero responder
7	**VIOLÊNCIA NA COMUNIDADE** As próximas perguntas são sobre a frequência com que **VOCÊ_** viu ou ouviu certas coisas **NO SEU BAIRRO OU COMUNIDADE** (não na sua casa ou na TV, rádio ou em filmes). Nos primeiros 18 anos da sua vida...
7.1 [V4]	Viu ou ouviu alguém sendo espancado no seu bairro ou comunidade (não na sua casa ou na TV, rádio ou em filmes)? [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder
7.2 [V5]	Viu ou ouviu alguém sendo esfaqueado ou levando um tiro no seu bairro ou comunidade (não na sua casa ou na TV, rádio ou em filmes)? [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder

7.3 [V6]	Viu ou ouviu alguém ser ameaçado(a) com uma faca ou arma de fogo no seu bairro ou comunidade (não na sua casa ou na TV, rádio ou em filmes)? [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder
8	**VIOLÊNCIA COLETIVA**

	As próximas perguntas são sobre se **VOCÊ**_vivenciou, ou não, algum dos seguintes acontecimentos quando era criança. Todos eles estão relacionados com violência coletiva, incluindo guerras ou tiroteios, terrorismo, conflitos políticos ou étnicos, genocídio, repressão ou recolher obrigatório, desaparecimentos, tortura e crime organizado violento, como bandidagem, tráfico de drogas e guerra de gangues. Nos primeiros 18 anos da sua vida...
8.1 [V7]	Foi forçado a ir viver em outro lugar devido a algum desses acontecimentos? [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder
8.2 [V8]	Vivenciou a destruição propositada da sua casa devido a algum desses eventos? [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder
8.3 [V9]	Foi espancado por soldados, policiais, milicianos ou gangues? [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder
8.4 [V10]	Algum familiar ou amigo(a) foi morto ou espancado por soldados, policiais, milicianos ou gangues? [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca [ ] Não quis responder/ Não quero responder
9	**INSEGURANÇA NA ESCOLA**
	As próximas perguntas referem-se a experiências, que VOCÊ , quando era criança possa ter testemunhado ou sofrido na escola.

	Antes de você completar 18 anos de idade…
9.1	Alguma vez se sentiu inseguro na escola? [ ] Sim [ ] Não [ ] Nunca [ ] Não quis responder/ Não quero responder ***Vá para 9.1.1***
9.1.1.	O que lhe fazia sentir inseguro na escola? ***Permite múltiplas respostas*** 1. Violência física ou castigo físico do/a professor/a 2. Abuso verbal (o professor grita ou zanga) 3. *Bullying* dos/as colegas ou violência física entre colegas 4. Violência verbal entre colegas 5. Assédio sexual pelos/as professores/as 6. Assédio sexual pelos/as colegas 7. Falta de privacidade ou cobertura sanitária 8. Distância da escola para casa 9. Falta de iluminação nas escolas ou nas ruas 10. Factores climaticos (cheias, chuvas fortes, vento forte, etc.) 11. Outro, especificar
10	**TRABALHO INFANTIL. Agora gostaríamos de fazer algumas perguntas sobre trabalho infantil. Trabalho infantil ocorre quando uma criança – pessoa com menos de 18 anos – é forçada a fazer trabalho que mental, física, social e moralmente é perigoso e faz mal às crianças.**
10.1	Quando era criança foi forçado/a a trabalhar? [ ] Sim [ ] Não – ***Vá para 11***
10.2	O trabalho era perigoso e/ou fazia mal a si [ ] Muitas vezes [ ] Poucas vezes [ ] Uma vez [ ] Nunca

	[ ] Não quis responder/ Não quero responder?
10.3	Este trabalho afectou sua actividade escolar? [ ] Sim, nunca pude ir à escola porque tinha de trabalhar [ ] Sim, tive que abandonar a escola para poder ir trabalhar [ ] Sim, tinha que combinar a escola com longas horas de trabalho e isso dificultava os meus estudo [ ] Não, o trabalho não afectou os meus estudos
10.4	Recebia pagamento pelo trabalho que fazia? [ ] Sim [ ] Não
10.5	O trabalho infantil lhe afectou de alguma outra forma diferente das mencionadas acima? [ ] Sim [ ] Não ***Vá para 11***
10.6	Como? ***Permite múltiplas respostas*** [ ] Eu tinha muita responsabilidade no meu trabalho [ ] O trabalho era muito stressante para mim [ ] Eu me sentia inseguro/a e/ou desconfortável no trabalho [ ] O trabalho me separou da minha família [ ] As pessoas me desprezavam por causa do tipo de trabalho que eu fazia [ ] Não tenho poder de tomar decisões sobre a minha própria vida [ ] Não tenho tempo para descansar [ ] Não tenho tempo para brincar/ me divertir com amigos [ ] Não tenho tempo para participar em outras actividades sociais, como ir à igreja, jogar futebol, eventos da comunidade [ ] Outro, especificar _____

	_____

11. LIDAR COM DIFICULDADES – Versão reduzida

As questões abaixo são sobre como é que VOCÊ lida com o stress, problemas ou desafios na sua vida agora. Existem várias formas de lidar com dificuldades. Nós gostaríamos de saber o que é faz quando tem alguma dificuldade, problema ou stress e se isso acontece muitas ou poucas vezes.

Escolha uma resposta para cada questão. Avalie e responda na sua mente cada questão separadamente. Tente que suas respostas sejam o MAIS VERDADEIRAS possível.

1- Você não fazia isso de forma nenhuma

2- Você fazia isso um pouco

3- Você fazia isso por volta de 50% (metade) das vezes

4- Você fazia isso muito

11.1	Você refugiava-se no trabalho ou em outras actividades (domésticas, ocupações de tempo livre) para não pensar naquele problema.	1	2	3	4
11.2	Você fazia o que deveria ser feito para resolver o problema. Um passo de cada vez.	1	2	3	4
11.3	Você dizia a si mesmo "não, isto não pode estar mesmo a acontecer comigo"	1	2	3	4
11.4	Você usava bebidas alcólicas e outras drogas para se fazer sentir melhor	1	2	3	4
11.5	Você buscava conselhos de alguém sobre o que fazer por causa daquele problema.	1	2	3	4
	11.5.1Caso tenha respondido 2, 3 ou 4: A quem procurava para se aconselhar? (***Permite múltiplas respostas)*** [ ] Pais ou encarregados de educação [ ] Outros familiares (não os pais ou encarregados de educação) [ ] Professores				

	[ ] Trabalhadores de saúde [ ] Amigos [ ] Vizinhos [ ] Praticantes de Medicina Tradicional [ ] Padre/Pastor/ Xê [ ] Outro.Quem?_____				
11.6	Você desistia de lidar com o assunto.	1	2	3	4
11.7	Você tentava agir para melhorar a situação	1	2	3	4
11.8	Você se recusava a acreditar que aquilo estivesse a acontecer	1	2	3	4
11.9	Você sentia-se emocionalmente mal, aflito, e exprimia/mostrava muito os seus sentimentos	1	2	3	4
11.10	Você recebia ajuda e conselhos de outras pessoas	1	2	3	4
	11.10.1Caso tenha respondido 2, 3 ou 4: A quem procurava para se aconselhar? (***Permite múltiplas respostas)*** [ ] Pais ou encarregados de educação [ ] Outros familiares (não os pais ou encarregados de educação) [ ] Professores [ ] Trabalhadores de saúde [ ] Amigos [ ] Vizinhos [ ] Praticantes de Medicina Tradicional				

	[ ] Padre/Pastor/ Xê [ ] Outro.Quem?_____ _____				
11.12	Você aprendia a partir daquela experiência	1	2	3	4
11.13	Você criticava-se a mim próprio	1	2	3	4
11.14	Você tentava arranjar uma estratégia sobre o que fazer.	1	2	3	4
11.15	Você recebia conforto e compreensão de alguém/ de uma outra pessoa	1	2	3	4
	11.15.1Caso tenha respondido 2, 3 ou 4: De quem recebia conforto e compreensão? (***Permite múltiplas respostas)*** [ ] Pais ou encarregados de educação [ ] Outros familiares (não os pais ou encarregados de educação) [ ] Professores [ ] Trabalhadores de saúde [ ] Amigos [ ] Vizinhos [ ] Praticantes de Medicina Tradicional [ ] Padre/Pastor/ Xê [ ] Outro.Quem?_____ _____				
11.16	Você fazia pouco esforço para resolver o problema	1	2	3	4

11.17	Você tentava encontrar o lado positivo do problema	1	2	3	4
11.18	Você fazia piadas sobre isso.	1	2	3	4
11.19	Você fazia outras coisas, para adiar ter de resolver o problema, tal como sair ou conversar com amigos, ver filmes, dormir, trabalhar na machamba, fazer desporto, etc	1	2	3	4
11.20	Você aceitava a realidade: que de facto aquilo havia acontecido	1	2	3	4
11.21	Você ficava zangado, frustrado e exprimia as suas emoções	1	2	3	4
11.22	Você buscava conforto na sua religião ou crenças espirituais, ia à igreja/ mesquita, lia a Bíblia/ Alcorão, cantava músicas da sua religião.	1	2	3	4
11.23	Você perguntava a pessoas que tiveram experiências similares, o que elas fizeram.	1	2	3	4
11.24	Você aprendia a viver com o problema.	1	2	3	4
11.25	Você reflectia/ pensava a sério sobre os passos a dar dali para frente.	1	2	3	4
11.26	Você culpava-se a si a próprio/a pelo acontecido.	1	2	3	4
11.27	Você rezava ou meditava.	1	2	3	4
11.28	Você invocava os antepassados	1	2	3	4
11.29	Você discutia seus sentimentos com alguém.	1	2	3	4

11.29.1 Caso tenha respondido 2, 3 ou 4:

A quem procurava para discutir os seus sentimentos? (***Permite múltiplas respostas)***

[ ] Pais ou encarregados de educação

[ ] Outros familiares (não os pais ou encarregados de educação)

[ ] Professores

[ ] Trabalhadores de saúde

[ ] Amigos

	[ ] Vizinhos [ ] Praticantes de Medicina Tradicional [ ] Padre/ Pastor/ Xê [ ] Outro.Quem?_____ _____				
11.30	Você forçava-se a esperar pelo momento certo, antes de fazer algo.	1	2	3	4
11.31	Você procurava apoio emocional de amigos ou familiares	1	2	3	4
	11.31.1Caso tenha respondido 2, 3 ou 4: A quem procurava para ter apoio emocional? (***Permite múltiplas respostas)*** [ ] Pais ou encarregados de educação [ ] Outros familiares (não os pais ou encarregados de educação) [ ] Amigos [ ] Outro.Quem?_____ _____				
11.32	Você dormia mais do que o normal.	1	2	3	4

12. CONSUMO DE ÁLCOOL

O consumo de álcool pode afectar a sua saúde. Responda por favor as perguntas que se seguem.

12.1	Quantas vezes você toma uma bebida contendo álcool	Nunca ***Vá para 13.01***	Raramente	Algumas vezes por mês	Algumas vezes por semana	Todos os dias/ Pelo menos uma vez por dia
12.2	Quando está a consumir álcool, quanto é que bebe num dia? ***Instruções para o entrevistador: i) a <u>quantidade</u> de álcool que o respondente consome num dia. Seleccione a resposta mais aproximada.*** ***ii) Permite múltiplas respostas***	Bebida: [ ] garrafa (340ml) de cerveja/ cidra/ Cabanga/ Otheka/ Ossura/ Muthekele [ ] shot (copo pequeno) de bebidas secas: gin, uísque, vodka, Tentação, Royal, Game, Supremo, Lorde, Tontonto, Nipa, Vinho Makwa [ ] copo de vinho			Quantidade (quantas unidades): [___]___] [___]___] [___]___]	
12.3	Durante o ano passado, quantas vezes sentiu dificuldades em parar de beber, após ter iniciado o consumo de álcool?	Nunca	Raramente	Algumas vezes por mês	Algumas vezes por semana	Todos os dias/ Pelo menos uma vez por dia
12.4	Durante o ano passado, quantas vezes não conseguiu fazer o que devia fazer porque estava embriagado?	Nunca	Raramente	Algumas vezes por mês	Algumas vezes por semana	Todos os dias/ Pelo menos uma vez por dia

13. USO DE DROGAS

O uso de drogas pode afectar a sua saúde.

13.01. Alguma vez usou drogas?

[ ] Sim ***Vá para 13.02***

[ ] Não ***Vá para 14***	
13.02 Quais das drogas abaixo usou?	
13.02.01.Metaamfetamina (speed, crystal)	[ ] Sim [ ] Não ***Passe à droga seguinte*** Com que regularidade usava? [ ] Mensalmente ou menos [ ] Semanalmente [ ] Diariamente ou quase diariamente
13.02.02.Cocaina	[ ] Sim [ ] Não ***Passe à droga seguinte*** Com que regularidade usava? [ ] Mensalmente ou menos [ ] Semanalmente [ ] Diariamente ou quase diariamente
13.02.03. Cannabis (suruma)	[ ] Sim [ ] Não ***Passe à droga seguinte*** Com que regularidade usava? [ ] Mensalmente ou menos [ ] Semanalmente [ ] Diariamente ou quase diariamente

13.02.04. Narcóticos (heroína, metadona,	[ ] Sim [ ] Não ***Passe à droga seguinte*** Com que regularidade usava? [ ] Mensalmente ou menos [ ] Semanalmente [ ] Diariamente ou quase diariamente
13.02.05 Mandrax	[ ] Sim [ ] Não ***Passe à droga seguinte*** Com que regularidade usava? [ ] Mensalmente ou menos [ ] Semanalmente [ ] Diariamente ou quase diariamente
13.02.06 Medicamentos de receita médica (benzodiapinas, diazepan, morfina, codeína)	[ ] Sim [ ] Não ***Passe à droga seguinte*** Com que regularidade usava? [ ] Mensalmente ou menos [ ] Semanalmente [ ] Diariamente ou quase diariamente
13.02.07 Inalantes (tinner de pintura, aerosol, cola)	[ ] Sim

	[ ] Não ***Passe à droga seguinte*** Com que regularidade usava? [ ] Mensalmente ou menos [ ] Semanalmente [ ] Diariamente ou quase diariamente
13.02.08 Alucinogéneos (LSD, cogumelos)	[ ] Sim [ ] Não ***Passe à droga seguinte*** Com que regularidade usava? [ ] Mensalmente ou menos [ ] Semanalmente [ ] Diariamente ou quase diariamente
13.02.09 Calmantes (valium)	[ ] Sim [ ] Não ***Passe à droga seguinte*** Com que regularidade usava? [ ] Mensalmente ou menos [ ] Semanalmente [ ] Diariamente ou quase diariamente
13.02.10 Outros. Quais:_____ _____	[ ] Sim [ ] Não

	Com que regularidade usava? [ ] Mensalmente ou menos [ ] Semanalmente [ ] Diariamente ou quase diariamente	
13.03 Sente-se incapaz de parar o consumo de drogas, mesmo quando quer parar?	[ ] Não	[ ] Sim
13.04 Já se sentiu doente (enjoado, mãos a tremer, suores, etc) quando tentou parar de tomar drogas?	[ ] Não	[ ] Sim

14. Violência entre parceiros íntimos (Violência doméstica) - vitimização *Se o respondente é feminino, as perguntas sobre vitimização devem aparecer.	
14.01a Nos últimos 12 meses, o/a seu/sua parceiro feriu-lhe ou tentou ferir-lhe, batendo-lhe ou usando outra forma de violência física? [ ] Sim [ ] Não ***Salte para 14.02a*** ***Caso a resposta seja Sim:*** Procurou ajuda? [ ] Sim [ ] Não ***Salte para 14.02a[a]*** ***Caso a resposta seja Sim:***	

Que tipo de ajuda? Assistência médica [ ] Sim [ ] Não (Se Sim): Onde:_____ Aconselhamento psicológico [ ] Sim [ ] Não (Se Sim): Onde:_____ Aconselhamento religioso/ espiritual [ ] Sim [ ] Não (Se Sim): Onde:_____ Apoio moral de um familiar [ ] Sim [ ] Não (Se Sim): Onde:_____ Apoio moral de um amigo [ ] Sim [ ] Não (Se Sim): Onde:_____ Outro; [ ] Sim [ ] Não (Se Sim): Onde:_____	
14.02a Nos últimos 12 meses o/a seu/sua parceiro/parceira forçou-lhe ou tentou forçar-lhe praticar actividades sexuais, sem o seu consentimento? [ ] Sim [ ] Não ***Salte para 14.03a*** ***Caso a resposta seja Sim:*** Procurou ajuda? [ ] Sim [ ] Não ***Salte para 14.03a*** ***Caso a resposta seja Sim:*** Que tipo de ajuda?	

Assistência médica [ ] Sim [ ] Não (Se Sim): Onde:_____ Aconselhamento psicológico [ ] Sim [ ] Não (Se Sim): Onde:_____ Aconselhamento religioso/ espiritual [ ] Sim [ ] Não (Se Sim): Onde:_____ Apoio moral de um familiar [ ] Sim [ ] Não (Se Sim): Onde:_____ Apoio moral de um amigo [ ] Sim [ ] Não (Se Sim): Onde:_____ Outro; [ ] Sim [ ] Não (Se Sim): Onde:_____	
14.03a. Nos últimos 12 meses o/a seu/sua parceiro/a alguma vez já lhe insultou ou lhe faltou respeito usando palavras ou gestos feios?? [ ] Sim [ ] Não ***Salte para Secção 15*** ***Caso a resposta seja Sim:*** Procurou ajuda? [ ] Sim [ ] Não ***Caso a resposta seja Sim:*** Que tipo de ajuda? Assistência médica [ ] Sim [ ] Não (Se Sim): Onde:_____	

Aconselhamento psicológico [ ] Sim [ ] Não (Se Sim): Onde:_____ Aconselhamento religioso/ espiritual [ ] Sim [ ] Não (Se Sim): Onde:_____ Apoio moral de um familiar [ ] Sim [ ] Não (Se Sim): Onde:_____ Apoio moral de um amigo [ ] Sim [ ] Não (Se Sim): Onde:_____ Outro; [ ] Sim [ ] Não (Se Sim): Onde:_____	

14.1 Violência entre parceiros íntimos (Violência doméstica) - Perpetuando *Se o respondente é masculino, as perguntas relacionadas sobre perpetuar a violência devem aparecer.	
14.1a Nos últimos 12 meses você feriu ou tentou ferir o seu parceiro/a, batendo-lhe ou usando outra forma de violência física?	[ ] Sim [ ] Não
14.1b Nos últimos 12 meses você forçou ou tentou forçar o seu parceiro/a praticar actividades sexuais, sem o consentimento dele/a?	[ ] Sim [ ] Não
14.1c Nos últimos 12 meses você insultou ou faltou respeito ao seu/sua parceiro/a usando palavras ou gestos feios??	[ ] Sim [ ] Não

15	**VIDA SEXUAL** Agora, eu gostaria de fazer algumas perguntas sobre a sua vida sexual, para entender alguns temas importantes da sua vida.	
15.1	Alguma vez já teve relações sexuais?	Sim □ Nunca teve □

				(fim da entrevista)
15.2	Qual era a sua idade quando teve pela primeira vez relações sexuais?		Idade em anos ☐☐	
15.3	Com quantas pessoas teve relações sexuais nos últimos 12 meses?		Nr de pessoas ☐☐	***Se 0, fim da entrevista.***
15.4	Usou preservativo na última vez que teve relações sexuais com o seu/sua primeiro/a parceiro/a – nos últimos 12 meses? *Repetir a pergunta até um máximo de 3 vezes, para um total de 3 parceiros (os 3 mais recentes):* *Primeiro parceiro* *Segundo parceiro* *Terceiro parceiro*	Sim ☐ Não ☐	Sim ☐ Não ☐	Sim ☐ Não ☐

ANNEX II: ADDITIONAL ANALYSIS ON REASON ON AFFECTS OF CHILD LABOR

Table 17: Other affects of child labor

	I had a lot of responsibility in my work	Work was too stressful for me	I felt insecure and/or uncomfortable at work	Work separated me from my family	People looked down on me because of the kind of work I did

		N	%	N	%	N	%	N	%	N	%
		40	22.0	42	23.1	32	17.6	25	13.7	23	12.6
Urban areas	Nampula	6	13.3	11	24.4	9	20.0	7	15.6	8	17.8
	Beira	5	25.0	2	10.0	3	15.0	5	25.0	4	20.0
	Matola	1	16.7	2	33.3	3	50.0	2	33.3	2	33.3
Rural areas	Memba	13	26.5	13	26.5	11	22.4	7	14.3	5	10.2
	Mogovolas	8	24.2	9	27.3	4	12.1	1	3.0	3	9.1
	Gorongosa	3	15.8	3	15.8	1	5.3	1	5.3	0	0.0
	Nhamatanda	1	50.0	1	50.0	0	0.0	1	50.0	1	50.0
	Moamba	1	33.3	0	0.0	0	0.0	0	0.0	0	0.0
	Manhiça	2	40.0	1	20.0	1	20.0	1	20.0	0	0.0
Region	Nampula	27	21.3	33	26.0	24	18.9	15	11.8	16	12.6
	Sofala	9	22.0	6	14.6	4	9.8	7	17.1	5	12.2
	Maputo	4	28.6	3	21.4	4	28.6	3	21.4	2	14.3
Location	Urban	12	16.9	15	21.1	15	21.1	14	19.7	14	19.7
	Rural	28	25.2	27	24.3	17	15.3	11	9.9	9	8.1
Sex	Male	14	19.4	18	25.0	10	13.9	10	13.9	12	16.7
	Female	26	23.6	24	21.8	22	20.0	15	13.6	11	10.0
Education	Did not attend	9	24.3	12	32.4	6	16.2	2	5.4	3	8.1
	Did not complete primary	20	22.0	21	23.1	18	19.8	14	15.4	9	9.9
	Completed primary	9	24.3	6	16.2	7	18.9	8	21.6	7	18.9
	Completed secondary and above	2	11.8	3	17.6	1	5.9	1	5.9	4	23.5
Employment status	Unemployed	17	27.4	13	21.0	6	9.7	10	16.1	6	9.7
	Self employed	17	19.3	22	25.0	20	22.7	10	11.4	13	14.8

	Formal employment	2	20.0	1	10.0	2	20.0	3	30.0	3	30.0
	Student	4	23.5	5	29.4	3	17.6	2	11.8	1	5.9