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UNICEF MOZAMBIQUE

Gender Brief

July 2025

9

The ninth in a sequence of 11 Thematic Briefs presenting analysis from Mozambique's 2022 Demographic and Health Survey (DHS)

Background

The release of the 2022-23 Demographic and Health Survey (DHS 2022) provides an opportunity to review the situation of children in Mozambique. To this end, UNICEF has produced a series of thematic briefs that present key child-related information from this survey with a view to strengthening evidence-based policy making.

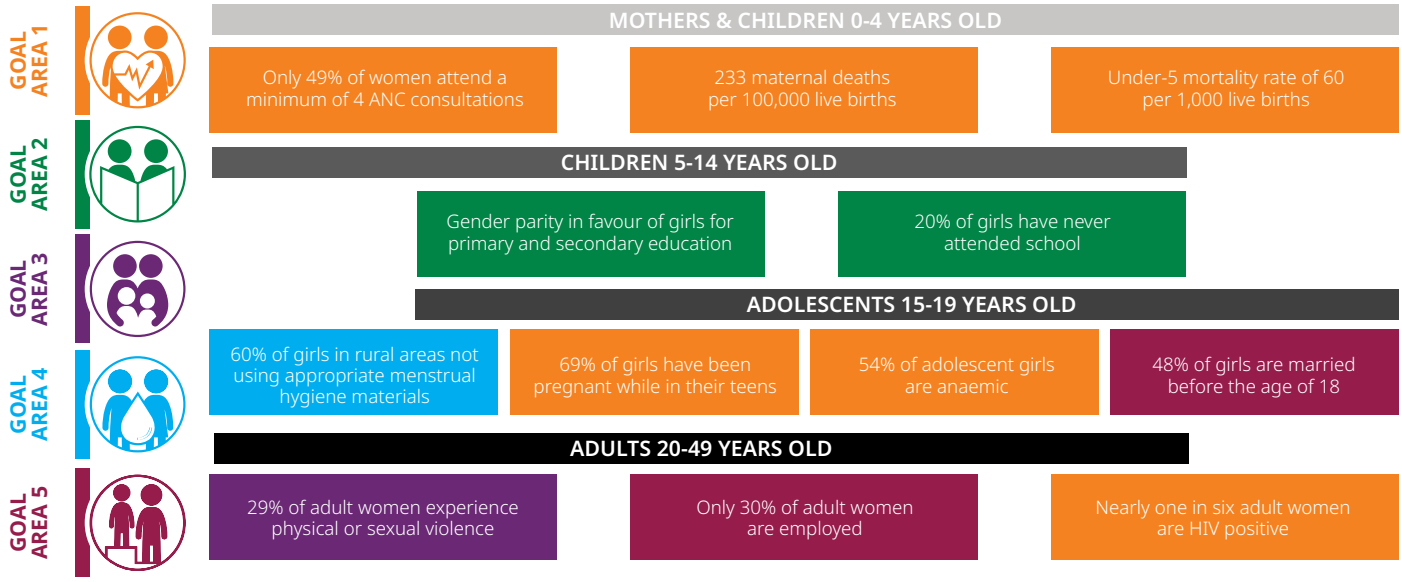
SDG Goal 5
Achieve gender equality and empower all women and girls

In recent years, Mozambique has made significant progress in advancing gender equality and improving the lives of girls and women in the country. The government's Five-Year Programme 2020–2024[1] committed it to the promotion of gender equality as a strategic objective within the Human Capital Development Pillar. This objective was supported by the National Plan to Prevent and Combat Gender-Based Violence 2018–2021, the Education Sector Gender Strategy 2018–2022, the Health Sector Gender Inclusion Strategy 2018–2023, and the National Action Plan for the Advancement of Women 2018–2024. However, significant gender gaps persist across several domains, including health, education, and the protection of girls and women from violence and harmful practices. Also, the overlapping impacts of climate disasters, conflict and political instability are jeopardizing the advances achieved in recent years. It is, therefore, critical that Mozambique continues to address gender issues.

UNICEF's Gender Action Plan 2022–2025 (GAP) outlines the priority areas to promote gender equality across the five Goal Areas of the UNICEF Strategic Plan 2022–2025, both through mainstreaming approaches and through targeted action on adolescent girls' outcomes: Goal Area 1 on health and nutrition; Goal Area 2 on education; Goal Area 3 on protection from violence, abuse and neglect; Goal Area 4 on water, sanitation and hygiene; and Goal Area 5 on social protection and poverty alleviation.

Data from the DHS 2022 were analysed to highlight gender-related patterns across these areas. Figure 1 presents an overview of the key gender indicators across these goal areas, adopting a life-course approach.

Figure 1: Measures of gender equality and empowerment within the Five Goal Areas across the life-course (2022)



[1] https://faolex.fao.org/docs/pdf/moz196768.pdf.

1 Maternal, neonatal and infant gender issues

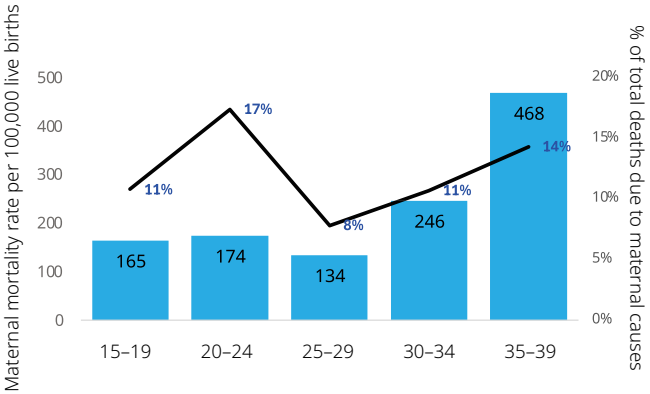
Key fact: According to the DHS 2022, 43 per cent of women aged 20–24 years had a live birth prior to the age of 18 years.

The first key gender priority within Goal Area 1 of the GAP is to ensure access to quality maternal health care and nutrition. This is also the aim of SDG target 3.1, which seeks to reduce the maternal mortality ratio to under 70 per 100 000 live births.

Maternal mortality

Figure 2 shows the maternal mortality rates disaggregated by age, and the proportion of all deaths that are maternal-related. This shows that, on average, 12 per cent, or around one in eight, of all deaths among women aged 15–39 years were due to maternal causes, with the proportion a staggering one in six among women aged 20–24 years. According to the DHS 2022, the maternal mortality rate is 233 per 100 000 live births, or more than three times the SDG target. All told, the lifetime risk of maternal death is estimated at 0.012, meaning that slightly over one per cent of all women in Mozambique will die due to maternal causes.

Figure 2: Maternal mortality rates and proportions by age cohort (2022)



Antenatal care and skilled assistance during birth

A key contributor to the increased risk of maternal death is a lack of sufficient antenatal and post-natal care. Figure 3 shows that only 49 per cent of all women with a live birth attended at least the recommended minimum of four antenatal care visits, and 13 per cent of women attended no antenatal care visits whatsoever. This lack of sufficient antenatal care coverage places both mothers and their unborn children at significantly increased risk of negative birth outcomes, including pregnancy complications, low birthweight, and maternal and perinatal death. Figure 4 shows that one third of births were not attended by skilled health personnel, which further increases the risk of maternal and neonatal mortality.

Figure 3: Proportion of pregnant women attending antenatal care visits (2022)

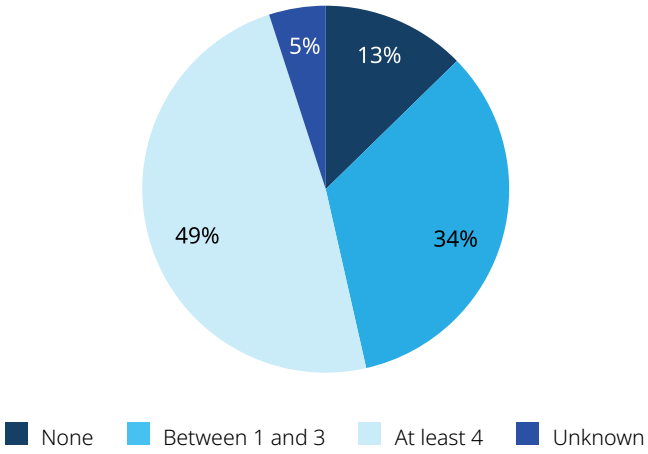
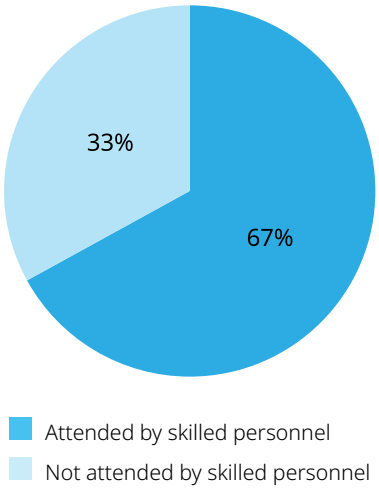


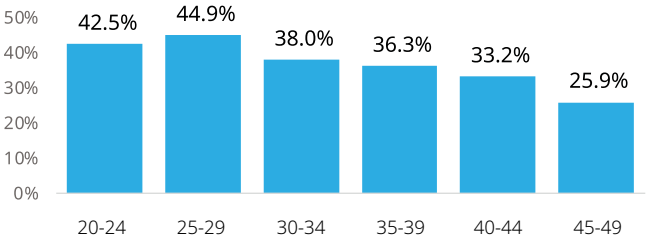
Figure 4: Rate of skilled attendance at birth (2022)



Early child bearing

Avoiding adolescent pregnancy is a further key priority in the GAP, given the established relationship between teenage pregnancy and poor maternal and neonatal health outcomes (Goal Area 1), increased rates of school dropout and reduced educational attainment (Goal Area 2), and increased risks of poverty and unemployment (Goal Area 5). Figure 5 highlights the significant progress that still needs to be made in this area. Forty-three per cent of women aged 20–24 years had a live birth prior to the age of 18 years. Of significant concern is the fact that rates of early childbearing have increased over time, from 26 per cent among women who are now 45–49 years to a high of 45 per cent among women who are now 25–29 years. This places young girls at increased risk of negative health, education and economic outcomes, and could serve to widen existing gender gaps among younger generations.

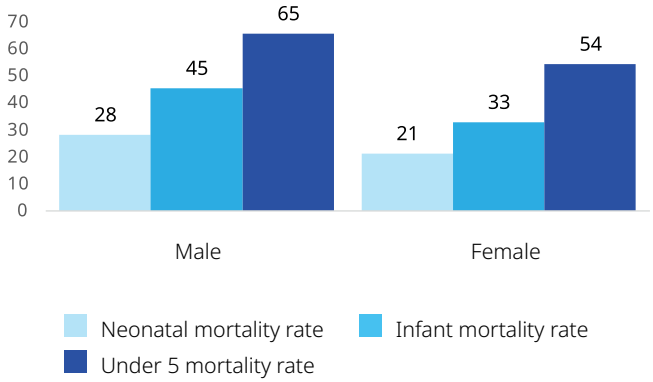
Figure 5: Proportion of women with a live birth prior to 18 years of age, by age group (2022)



Under-5 mortality rates

Child health outcomes are key to Goal Area 1 of the GAP and also SDG 3.2, which seeks to reduce neonatal mortality to under 12 per 1 000 live births, and under-5 mortality to under 25 per 1 000 live births. Figure 6 shows that Mozambique remains well short of achieving these targets. The neonatal mortality rate is 24 per 1 000 live births – double the SDG target – and the under-5 mortality rate is 60 per 1 000 – also more than double the SDG target. The rates of neonatal, infant and under-5 mortality are all significantly higher among boys than girls, irrespective of their income level. This is driven primarily by biological factors, and is a generally observed pattern across most countries. The fact that these mortality rates reflect a normal bias favouring females is an indicator that young girls in Mozambique do not face specific gender-based neglect, poor access to care or infanticide, which would tend to reverse the usual biological pattern.

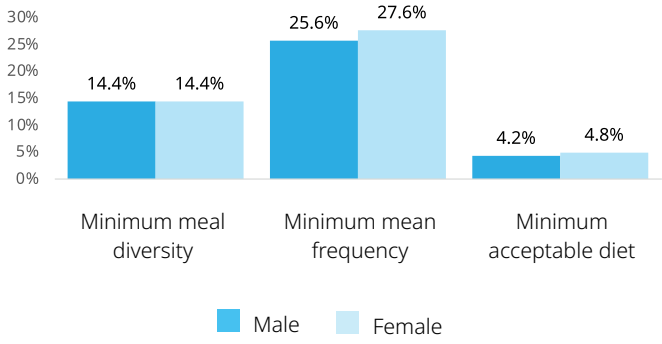
Figure 6: Child mortality rates by type and gender (2022)



Feeding practices for young children

A key determinant of child health outcomes is adequate nutrition, key to Goal Area 1 of the GAP and SDG 2.1, which seeks to ensure that all people, including infants, have access to sufficient, safe and nutritious food. According to Figure 7, a mere five per cent of children aged 6–23 months received a minimum acceptable diet. The data indicates that young girls are marginally more likely to receive a minimum acceptable diet, but rates remain concerningly low for both boys and girls. This lack of adequate nutrition places all young children in Mozambique at increased risk of stunting and wasting, which, in turn, results in increased health and developmental risks.

Figure 7: Rates of feeding practices among children 6–23 months by gender (2022)



2 Gender issues impacting children aged 5–14

Key fact: According to the DHS 2022, one in five girls and women aged 6–24 years have not attended school.

Equitable access to education

Beyond early childhood, a core focus of Goal Area 2 of the GAP is to ensure equitable access to education among children and young adolescents aged 5–14 years. This is also the aim of SDG 4.1, which seeks to ensure that all boys and girls complete free, equitable and quality primary and secondary education.

Figure 8 shows that there are still significant gaps in access to education in Mozambique, with 18 per cent of males and 20 per cent of females aged 6–24 years having had no education, and only four per cent of males and females within this age group having completed secondary education or higher. While a significant proportion of these respondents are still of school-going age and may yet progress to complete primary and secondary education, the fact that rates of secondary education completion remain so low – only 14 per cent of women aged 20–24 years have completed secondary education – is a cause for concern.

While a lack of access to education and low rates of educational attainment overall are a great concern, Figure 9 does suggest that Mozambique has made significant strides in achieving a degree of gender parity in education among children and adolescents specifically. The Gender Parity Index, which compares the ratio of female to male values for education enrolment, shows a slight favouring of boys in enrolment in primary education, and a slight favouring of girls in the rates of enrolment in secondary education, while higher education continues to strongly favour boys.

The fact that girls are increasingly enrolling in school and progressing through to secondary education is a very encouraging development.

Figure 8: Rates of educational attainment among 6–24 year-olds by gender (2022)

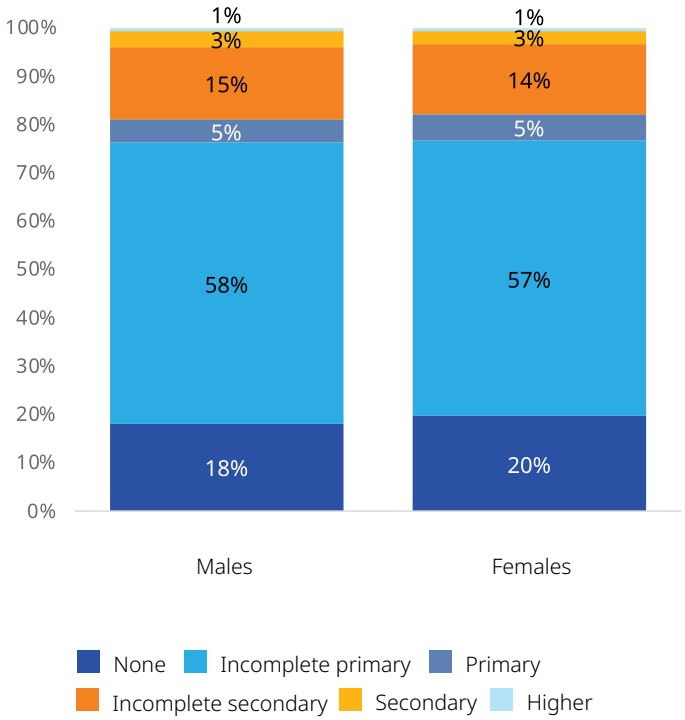
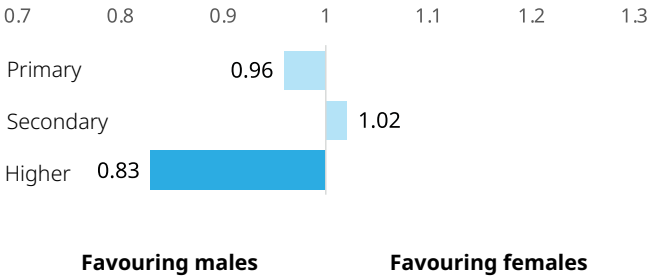


Figure 9: Education gender parity index



3 Issues facing adolescent girls (15–19 years)

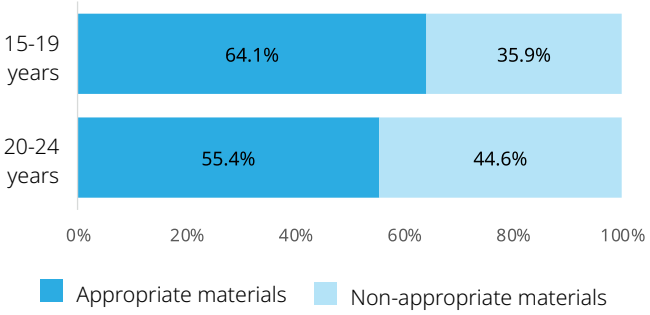
Key fact: According to the DHS 2022, 48 per cent of women aged 20–24 years were married prior to the ageof 18 years.

For adolescent girls important issues are their access to dignified menstrual health and hygiene, their health and nutrition status, exposure to violence, and eliminating child marriage.

Access to appropriate menstrual materials

Ensuring access to dignified menstrual health and hygiene is critical to ensuring girls' wellbeing. It is also a strong enabling factor for keeping girls in school. Figure 10 shows that more adolescent girls (at 64 per cent) have access to appropriate menstrual materials compared to women 20–24 years (55 per cent). Appropriate materials include reusable and disposable sanitary pads and tampons. It remains a concern that 36 per cent of adolescent girls and nearly 45 per cent of women aged 20–24 years still use non-appropriate materials such as cloth, toilet paper, cotton wool or underwear only. The DHS 2022 highlights that only 40 per cent of women in rural areas are using appropriate menstrual materials due to the non-availability of these materials, or due to their unaffordability in the context of widespread poverty.

Figure 10: Access to appropriate menstrual materials by age (2022)



Prevalence of anaemia

Anaemia is a key indicator of adolescent girls' nutritional status. Figure 11 shows that more than half of all girls aged 15–19 years in Mozambique suffer from anaemia, with serious repercussions for their physical health and cognitive development. The increased risk of pregnancy complications that anaemia induces represents a serious threat, especially given that 48 per cent of girls go through pregnancy before the age of 18. The persistence of the very high rates of anaemia among women places their wellbeing at risk, as well as that of their newborn babies. This points to a clear need for targeted nutrition programmes and iron supplementation for adolescent girls and women.

Adolescent mental health

Figure 12 illustrates the gendered nature of poor mental health among adolescents in Mozambique. Rates of anxiety are more than three times higher among girls than boys, at 22 per cent and 7 per cent respectively. Similarly, rates of depression are more than four times higher among girls than among boys. These findings highlight an urgent need for gender-responsive mental health interventions that address the specific challenges and psychosocial stressors experienced by adolescent

Figure 11: Rates of anaemia among girls (aged 15–19 years) and women (aged 20–49 years)

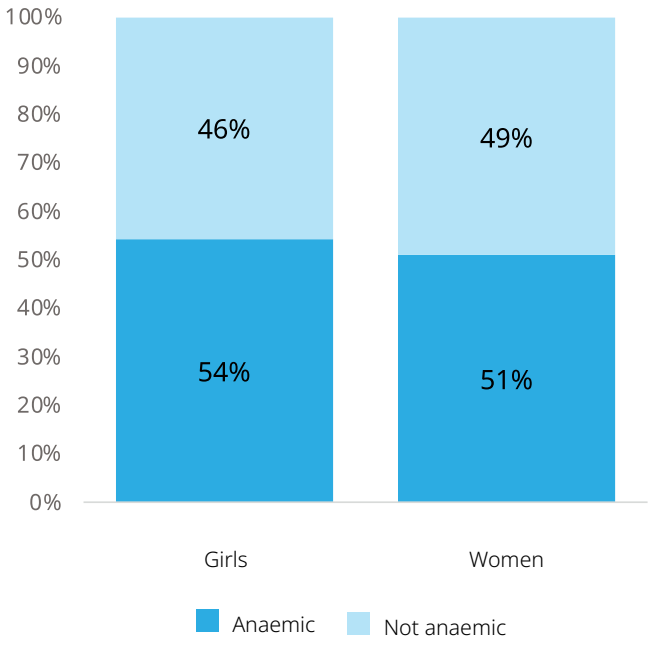
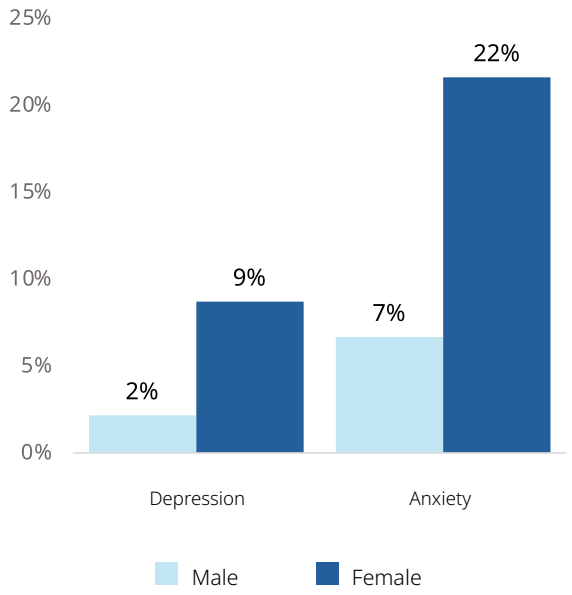


Figure 12: Rates of mental health issues among 15–19-year-olds by gender (2022)



Exposure of adolescents to violence

Goal Area 3 of the GAP, along with SDG 5.2, highlights the importance of addressing violence against adolescent girls. Figure 13 shows the worrying levels of intimate partner violence experienced by adolescents aged 15–19 years. The data shows that adolescent girls face higher levels of sexual, physical and emotional violence, which highlights the gendered nature of abuse within intimate relationships. The reality is that girls are exposed to higher levels of intimate partner violence due to the very high rates of child marriage. This emphasizes the need for gender-responsive interventions that prioritize the protection, empowerment and rights of girls, particularly those in vulnerable situations such as child marriages.

Prevalence of child marriage

Figure 14 shows that child marriage remains a significant issue in Mozambique and an inherently gendered one too. Nearly half of all women aged 20–24 years were married before 18 years of age, whereas only 13 per cent of boys married before 18 years of age. The very high prevalence of child marriage not only poses a risk to adolescent girls' safety and autonomy, but also undermines their access to education, increases their likelihood of facing mental and maternal health issues, and increases the likelihood of early childbearing. This series of briefs includes a dedicated brief titled Ending Child Marriage, which elaborates on these risks and shares key recommendations and policy priorities for eliminating child marriage.

Figure 13: Rates of intimate partner violence among 15–19-year-olds by gender (2022)

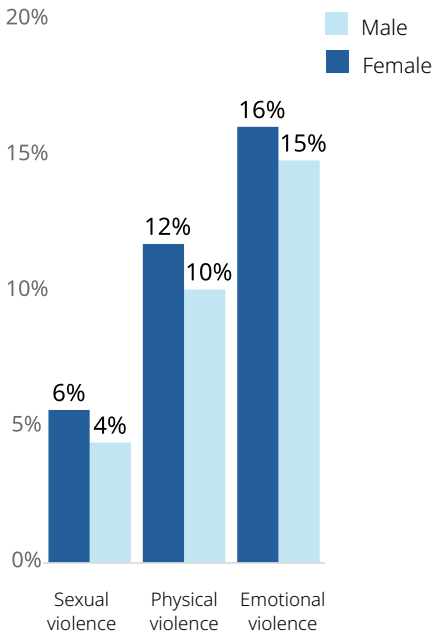
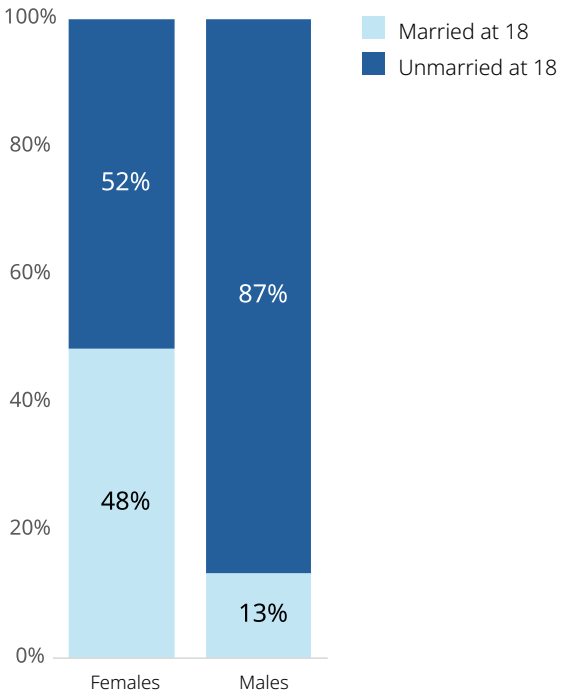


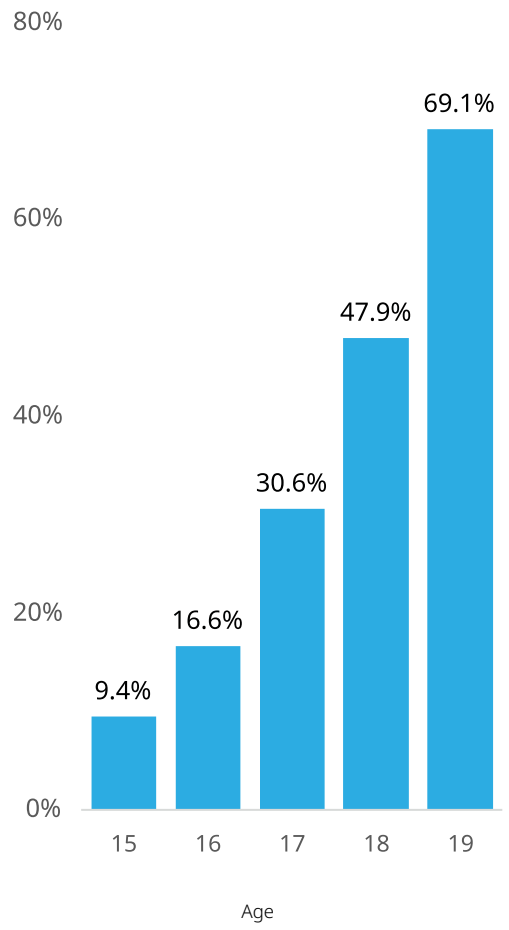
Figure 14: Rates of child marriage among 20–24-year-olds by gender (2022)



Teenage pregnancy

Closely related to child marriage, a further burden facing adolescent girls in Mozambique is early pregnancy. Figure 15 shows that nearly one in ten girls (9 per cent) have been pregnant by 15 years of age, and nearly half (48 per cent) have been pregnant by 18 years of age. Like child marriage, teenage pregnancy severely limits girls' opportunities to stay in school and exercise autonomy, while also posing significant maternal and neonatal health risks. Ending child marriage, and expanding access to adolescent-friendly sexual and reproductive health services, are essential steps to ensuring girls can avoid early and unwanted pregnancies, and instead realize their full potential.

Figure 15: Girls who have ever been pregnant by age (2022)



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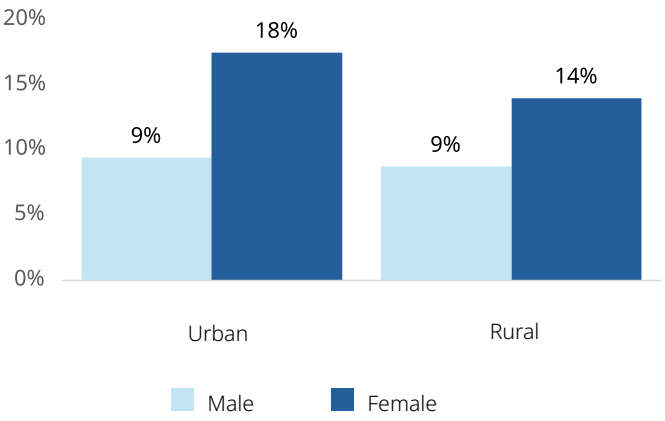
4 Gender issues across the adult life-course

Key fact: According to the DHS 2022, only 3 in 10 adult females were employed in the 12 months preceding the survey.

Prevalence of HIV

A key focus of Goal Area 1 of the GAP is ensuring access to interventions that fast-track the elimination of HIV/AIDS. This is particularly pertinent in Mozambique, which has the sixth-highest HIV prevalence rate globally, at 12 per cent, and the third largest adult population living with HIV. Data from INSIDA highlights a significant gender disparity in HIV prevalence among adults in both rural and urban settings. These high prevalence rates among women are partly a reflection of women's greater biological vulnerability to HIV infection, but, more significantly, are the result of a range of social factors such as the prevalence of child marriage; and a lack of autonomy over sexual and reproductive decisions due to power imbalances, which limits women's ability to negotiate condom use; and the prevalence of transactional or survival sex due to very high rates of poverty. These factors are further aggravated by geographic and rural-urban disparities in health care access.

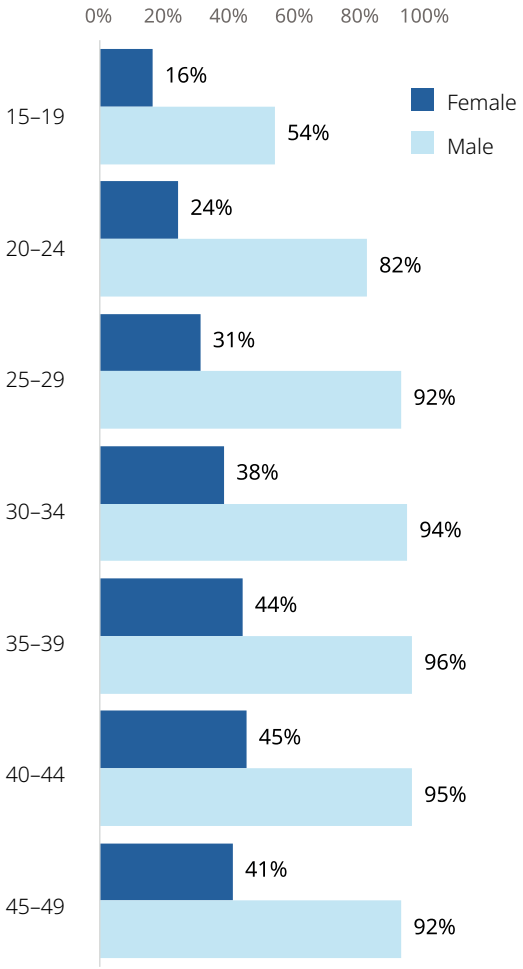
Figure 16: HIV-positive status among adults (aged 15–49 years) by gender and geographical location (INSIDA 2022)



Participation in labour markets

Participation in the labour market is another key area in which there are clear gender inequities among the adult population in Mozambique. Data from the DHS 2022 show that only 30 per cent of adult women were employed in the year preceding the survey, while 81 per cent of adult men were employed during this time. Figure 17 shows that these enormous gender disparities in rates of employment persist across all age groups. The particularly low rates of employment among younger women – only 24 per cent of women aged 20–24 years were employed – is concerning and further limits the autonomy of young women. These data illustrate the persistent role that gendered barriers to labour market participation, including caregiving responsibilities and limited access to education and skills training, continue to play in undermining the achievement of gender equity in Mozambique.

Figure 17: Rates of employment in the year prior to the survey, by gender and by age group (2022)

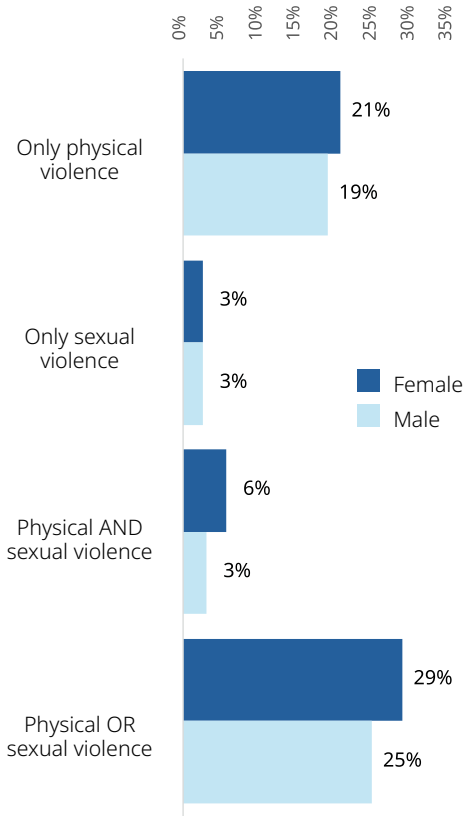


Violence against women

Figure 18 shows that the experience of violence among adults aged 15–49 years remains a gendered issue. Nearly one in three women (29 per cent) have experienced some form of physical or sexural violence compared to 25 per cent of men. Women are more likely than men to experience either physical or sexual violence, and are twice as likely men to have experienced both in their lifetime.

However, violence affects more than just the direct victims. Very often, children and adolescents are witnesses of violence between parents, at school, or due to community crime or insurgent attacks. Being witnesses to violence can deeply affect their emotional development and sense of safety. The prevalence of gender inequalities, poverty and weak justice systems means that victims of violence are rarely protected or able to find redress. This highlights the need for a holistic approach to addressing violence that tackles not just individual acts of violence, but the harmful gender norms and practices that allow violence to persist, and the environments that normalize and enable it.

Figure 18: Experience of violence by type and gender (2022)



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Proposed Policy Priorities

To improve outcomes for girls and women, the Government of Mozambique should consider the following:

1. Promote interventions to improve girls' nutritional status:
Improving girls' and women's access to adequate nutrition, including folic acid, iron and Vitamin A supplements, is key to securing their health and wellbeing. These interventions can help reduce the risk of nutrition-related morbidities, and also significantly reduce the risks of maternal and neonatal mortality.

2. Develop a new national gender policy and action plan to reflect priorities across sectors:
The National Plan to Prevent and Combat Gender-Based Violence 2018–2021, the Education Sector Gender Strategy 2018–2022, the Health Sector Gender Inclusion Strategy 2018–2023, and the National Action Plan for the Advancement of Women 2018–2024 have all expired. The government needs to develop a new comprehensive national, multi-sector gender policy and action plan to chart how to improve gender-related outcomes in Mozambique going forward.

3. Remove barriers to enable girls to remain at school:
The policies to allow girls to stay at school are in place. However, implementation and adherence to them remain a challenge. The government needs to ensure teachers are trained to support girls in marriages, going through pregnancy or with young children to remain at school. The government needs to ensure schools have acceptable WASH facilities. The government needs to prioritize equity in education access, especially for girls from poorer households and rural areas. Special focus needs to be given to interventions that seek to eliminate child marriage and early childbearing, two factors that specifically contribute to reduced rates of educational attainment among girls.

4. Improve provision of adolescent sexual and reproductive health services:
Provision of accessible and gender-sensitive adolescent sexual and reproductive health services represents a key protective intervention for adolescents girls and young women, and must be prioritized.

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Wherever he lives.

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A future.

A fair chance.

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The furthest from help.

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And never give up.

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Adolescents Brief

July 2025

10

The tenth in a sequence of 11 Thematic Briefs presenting analysis from Mozambique's 2022 Demographic and Health Survey (DHS)

Background

The release of the 2022–23 Demographic and Health Survey (DHS 2022) provides an opportunity to review the situation of children in Mozambique. To this end, UNICEF has produced a series of thematic briefs that present key child-related information from this survey with a view to strengthening evidence-based policy making.

Adolescence is a critical period of growth and opportunity, and the Government of Mozambique, with the support of international partners, is taking important steps to ensure that every adolescent has the chance to thrive. A range of national policies and programmes are being implemented to promote adolescent health and wellbeing, addressing essential issues such as sexual and reproductive health, nutrition and mental health.

These initiatives typically adopt a multi-sectoral approach, engaging the health, education and social welfare sectors. Adolescent health has been mainstreamed into the National Health Sector Strategic Plan (Plano Estratégico do Sector da Saúde – PESS, 2014–2019), which prioritizes equitable access to quality health services for all, with a specific focus on young people.

To address the high rates of teenage pregnancy and promote sexual and reproductive health, the government has introduced strategies that include: school-based education on sexual and reproductive health, expanded access to contraceptives, and community and legal efforts to prevent child marriage and gender-based violence. These initiatives are supported by key partners such as UNICEF and the United Nations Population Fund (UNFPA), who work to strengthen systems and empower adolescents. They support initiatives that train peer educators and healthcare providers, disseminate accurate health information, and create safe spaces where adolescents can access confidential sexual and reproductive health services and counselling.

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Malnutrition remains a serious challenge, especially among adolescent girls. In response, the Government of Mozambique, together with partners such as UNICEF and the World Food Programme (WFP), are implementing nutrition programmes aimed at reducing food insecurity and dietary deficiencies. One of the primary strategies is the School Feeding Programme, which provides take-home food baskets to students and their families, improving students' nutrition and encouraging school attendance. Another innovative solution is the e-vouchers programme, which enables vulnerable households, including adolescents, to access nutritious food and make healthy dietary choices.

1 Nutritional status[1]

SDG Target 2.2
End all forms of malnutrition… and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons

Key fact: According to the DHS 2022, more than 2 in every 10 female adolescents living in rural areas are stunted.

The DHS 2022 reveals a deeply concerning picture of adolescent nutrition in Mozambique. Adolescent girls aged 10–19 years are experiencing significantly higher levels of malnutrition than adult women aged 20–49 years. This nutrition crisis is threatening the health, wellbeing and future potential of millions of girls.

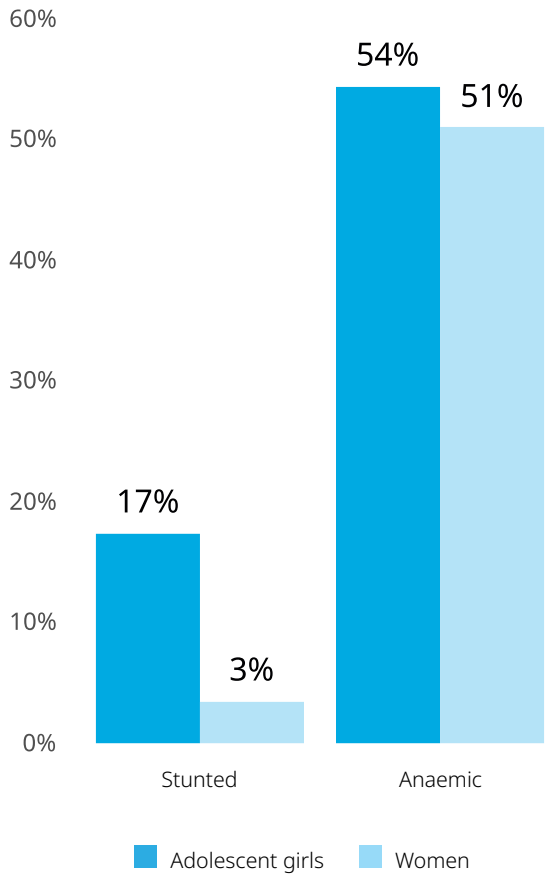
Stunting – a sign of chronic malnutrition and impaired growth – affects 17 per cent of adolescent girls compared to just three per cent of adult women. This stark difference signals increasing food insecurity over the past two decades, and highlights the urgent need for targeted nutritional interventions for adolescents.

Anaemia is also widespread, affecting both adolescent girls and women, and placing them at increased risk during pregnancy. Anaemia can lead to serious complications, including premature birth, low birthweight and birth complications – putting both mothers and babies in danger.

Rural adolescent girls are bearing the brunt of this crisis. More than one in five are stunted – almost double the rate seen in their urban counterparts. They also suffer from higher rates of anaemia, underscoring the inequities in access to nutrition, healthcare and basic services.

The DHS 2022 data also show that levels of stunting among adolescent girls vary significantly across the provinces. It is highest in Cabo Delgado (32 per cent), Nampula (26 per cent) and Niassa (23 per cent). In contrast, the lowest rates of stunting are found in Inhambane (7 per cent) and Cidade de Maputo (3 per cent). Urgent action is needed to bridge these gaps to ensure every girl, regardless of where she lives, has access to the nutrition she needs to thrive.

Figure 1: Nutritional status of adolescent girls (aged 10 –19) and women (aged 20–49), 2022



[1] Note that all reported nutritional information is only available for females in the DHS 2022.

Figure 2: Nutritional status of adolescent girls (aged 10–19) and women (aged 20–49) by location, 2022

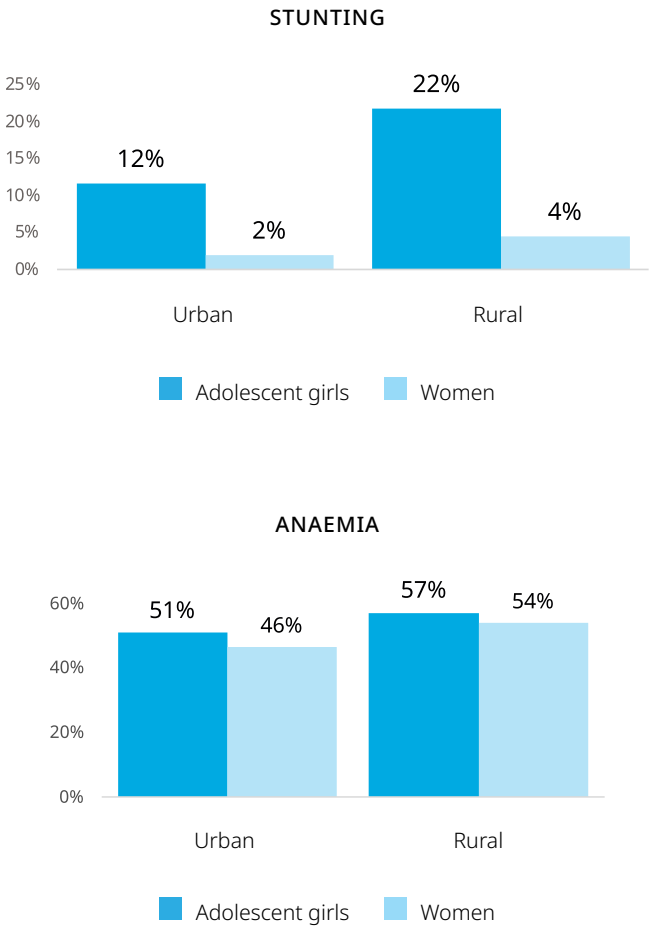
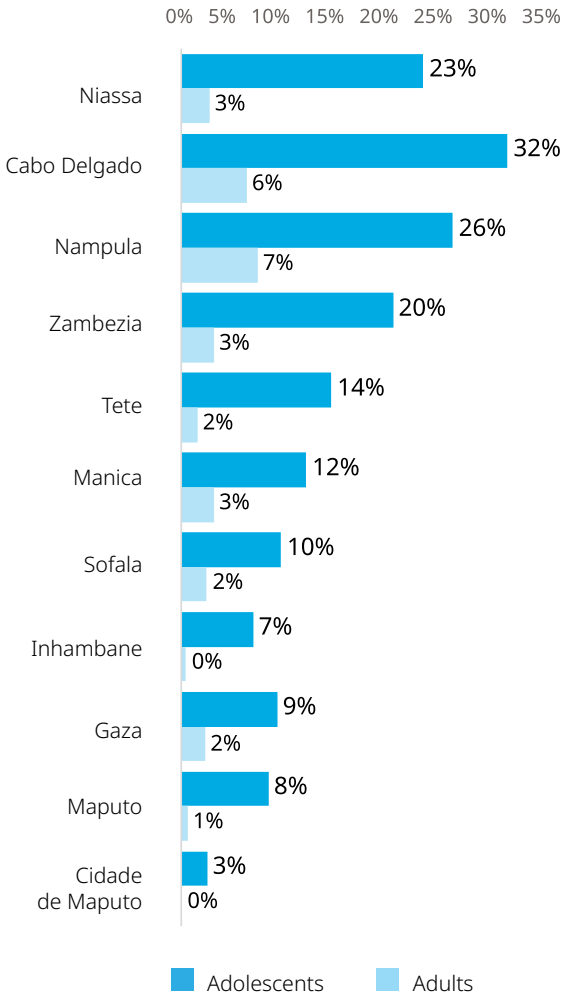


Figure 3: Nutritional status of adolescent girls (10-19) and women (20-49) by province, 2022



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2 Adolescent sexual and reproductive health

SDG Target 3.7
Ensure universal access to sexual and reproductive health care services, including for family planning, information and education

Key fact: According to the DHS 2022, 36 per cent of adolescent girls aged 10–19 years have been pregnant at least once.

In Mozambique, more than one in three girls aged 10–19 (36 per cent) have already experienced pregnancy. Thirty-six per cent have been pregnant at least once, 29 per cent have had at least one live birth and three per cent have suffered a pregnancy loss. These early pregnancies often occur in settings where girls have limited access to adolescent-friendly health services, and where social and gender norms restrict their autonomy.

Early pregnancy can lead to dangerous health complications for both mothers and their babies. For many girls, pregnancy is closely tied to child marriage. The Ending Child Marriage Brief reveals strong links between a girl's sexual debut and early marriage, as well as between first childbirth and marriage. Also, in a significant proportion of instances, it is possible that norms around couples "having" to marry if a man gets a girl pregnant may be one of the factors driving child marriages. The DHS 2022 shows that 18 per cent and 25 per cent of girls who married before the ages of 15 and 18 years, respectively, were pregnant when the marriage took place.

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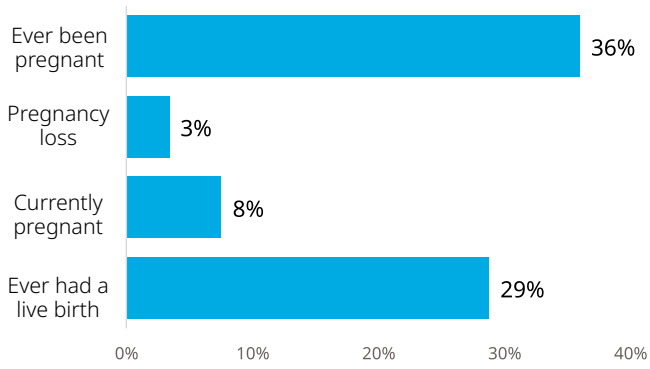
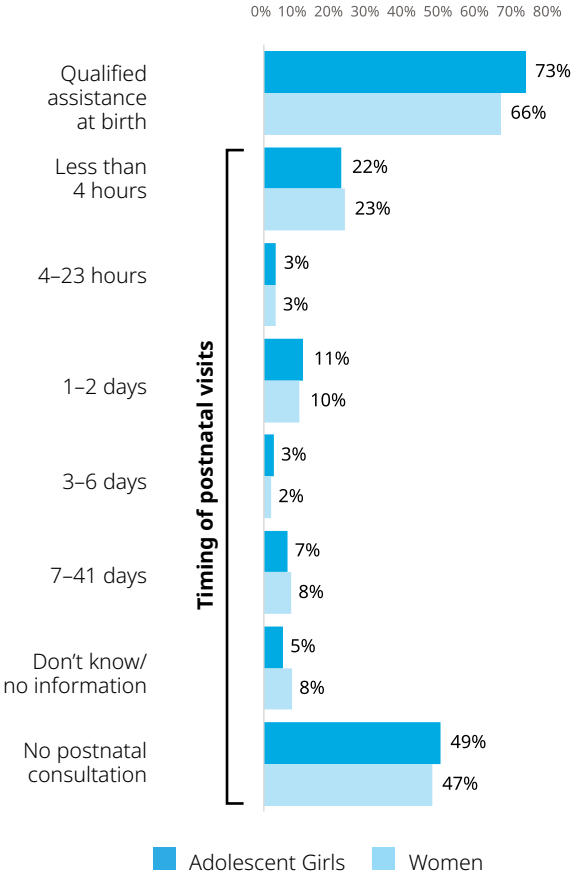
The DHS 2022 data show that 73 per cent of adolescent girls receive qualified assistance during birth, compared to 66 per cent of women. However, gaps remain in postnatal care, a critical time for both mothers and newborns. Nearly half (49 per cent) of adolescent mothers do not attend postnatal consultations, and only 22 per cent receive such care within four hours following a birth. This lack of immediate postnatal care is associated with particular adverse maternal and neonatal health outcomes among adolescent mothers and their neonates, as observed in the Neonatal and Child Mortality Brief[2].

Figure 4: Pregnancies and live births among adolescent girls (aged 10–19), 2022



[2] See Brief 11 in this series

Figure 5: Qualified assistance at birth and timing of postnatal visits among adolescent girls (aged 10–19), 2022



Adolescents are aware of contraception. Ninety-three per cent of girls and 98 per cent of boys aged 15–19 years know about modern contraception methods, according to DHS 2022. These rates are only slightly lower than comparable rates for adult women and men, at 96 per cent and 99 per cent respectively.

However, knowledge does not always translate into use. Only 26 per cent of sexually active adolescent girls use modern contraceptives compared to 33 per cent of adult women. It is notable that 47 per cent of sexually active adolescent boys claim to use modern contraceptives compared to 38 per cent of adult men. This discrepancy between knowledge and utilization suggests that, while information is widely available, barriers to access, social and gender norms (such as initiation rites promoting early sexual debut), the lack of adolescent sexual and reproductive services in remote rural areas, or personal circumstances may prevent adolescents, and adolescent girls in particular, from effectively using modern methods of contraception.

Adolescent girls continue to face limited autonomy in reproductive health decisions. Just 55 per cent of adolescent girls are involved in decisions around family planning within their marriage or partnership, whereas 68 per cent of adult women report participation in such decisions. This indicates that younger women have less autonomy in reproductive health matters, which could contribute to lower contraceptive use and higher rates of unplanned pregnancies. Furthermore, the data highlight concerning trends regarding adolescent girls' ability to negotiate sexual health decisions.

Figure 6: Knowledge and use of modern methods of contraception, 2022

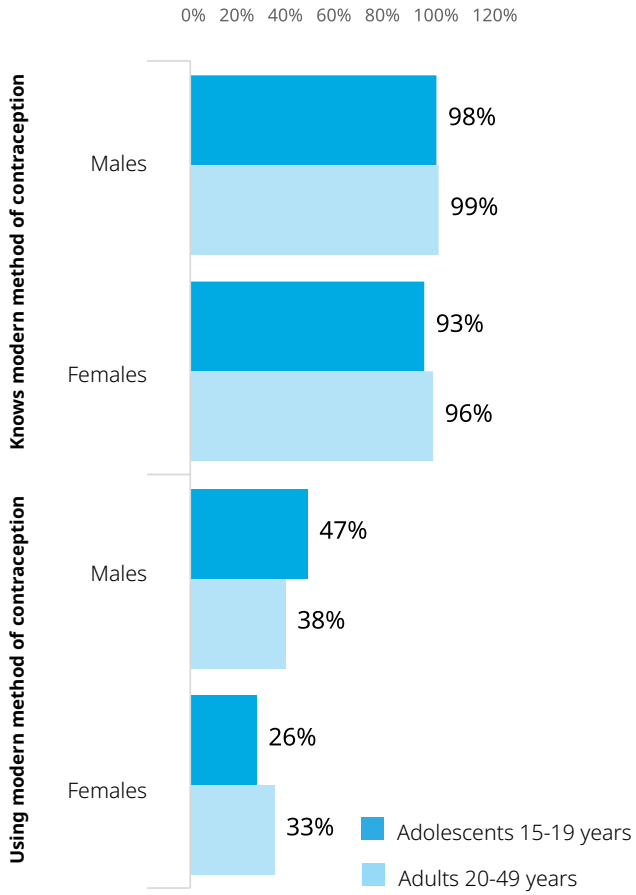
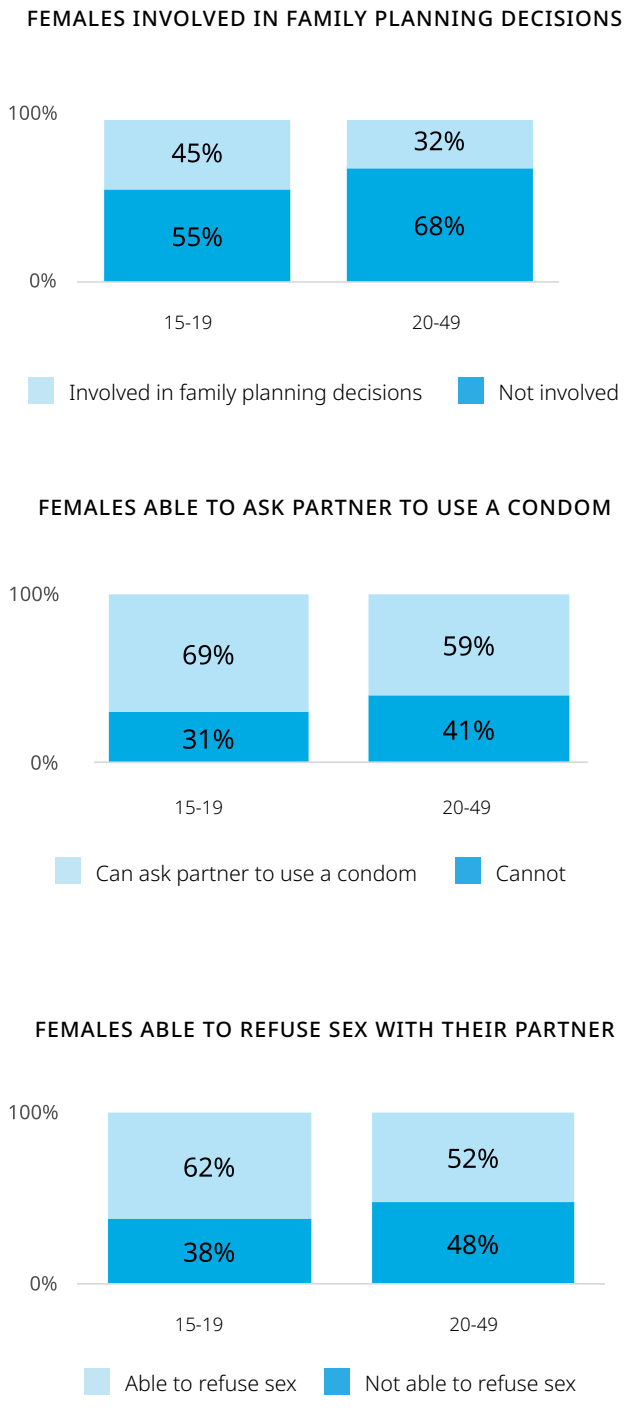


Figure 7: The role of girls and women in family planning and sexual relations, 2022

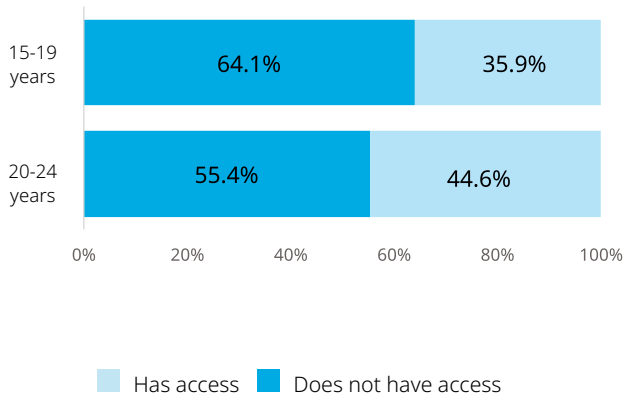


Only 38 per cent of adolescent girls report being able to refuse sex with their partners, compared to 48 per cent of adult women. Similarly, just 31 per cent of adolescent girls state that they can ask their partner to use a condom, whereas 41 per cent of adult women feel empowered to do so. These findings suggest that adolescent girls face significant power imbalances in their relationships, limiting their ability to make autonomous decisions about their sexual and reproductive health.

The Ending Child Marriage Brief[3] highlights that many child marriages involve age-disparate relationships, with men often being significantly older than the girls they marry. Men marrying girls below the age of 15 years are on average seven years older. However, 26 per cent are at least 10 years older, and 10 per cent are at least 15 years older. These large age gaps raise serious questions regarding the possible exploitative nature of these marriages, which impacts on the ability of the girls to make decisions about their sexual and reproductive health.

Ensuring dignified menstrual health means having access to safe and appropriate materials for managing menstrual blood, as well as private spaces to wash and change. Findings from the DHS 2022 indicate that adolescent girls are slightly better off when it comes to accessing these essential resources compared to women aged 20–24 years. However, nearly 35 per cent still do not have access to appropriate arrangements. Addressing this gap is crucial to supporting their health, wellbeing and full participation in daily life.

Figure 8: Adolescent girls' access to menstrual arrangements, 2022



[3] See Brief 1 in this series.

3 Protection and safety

SDG Target 16.2
End abuse, exploitation, trafficking and all forms of violence against and torture of children

Key fact: According to the DHS 2022, 49 per cent of adolescent girls experience control issues in the context of the intimate relationships.

Violence continues to threaten the safety and wellbeing of adolescents, with nearly one in five experiencing physical violence and 5.4 per cent facing sexual violence. However, experiences of violence vary by gender. Adolescent boys (20.8 per cent) are more likely to experience physical violence than adolescent girls (16.7 per cent). In contrast, among adults, women (28.9 per cent) face higher rates of physical violence than men (22.7 per cent). When it comes to sexual violence, adolescent girls (6.2 per cent) are more affected than boys (4.5 per cent). Urgent action is needed to protect children and adolescents from all forms of violence, and ensure their right to safety and dignity.

Many adolescents continue to experience violence in their intimate relationships, with concerning gender differences. Among adolescent girls, 6.2 per cent have faced sexual violence from a partner, slightly lower than the 6.7 per cent reported by adult women. Similarly, adolescent girls report lower rates of physical violence (13.7 per cent) compared to women (22.5 per cent). While intimate partner violence is less common among males, it still affects 4.9 per cent of adolescent boys through sexual violence, and 12.1 per cent through physical violence.

The most widespread form of intimate partner violence across all groups is controlling behavior, affecting nearly half of adolescent girls (49.3 per cent) and women (49.6 per cent), and even higher rates among adolescent boys (68.9 per cent) and adult men (68.5 per cent).

Emotional violence is also common, affecting 17.5 per cent of adolescent girls, 23.2 per cent of women, 16.5 per cent of adolescent boys, and 21.2 per cent of adult males.

The Ending Child Marriage Brief highlights that adolescent girls in child marriages are particularly vulnerable to intimate partner violence at 39 per cent compared to 26 per cent among women who married after 18 years of age. By contrast, women aged 20–24 years who married before 18 years of age are almost twice as likely (7 per cent) to experience sexual violence compared to women who married after 18 years of age (4 per cent). Also, 53 per cent of women aged 20–24 years who married before 18 years of age report being afraid of their husbands, compared to 37 per cent of women aged 20–24 years who married after 18 years of age. In addition, 24 per cent of women aged 20–24 years who married before 18 years of age thought wife beating could be justified, compared to 18 per cent among women aged 20–24 years who married after 18 years of age.

When looking at intimate partner violence in the last 12 months, controlling behaviour remains the most frequently reported form of violence, affecting 46.9 per cent of adolescent girls, 44.1 per cent of women, 64.3 per cent of adolescent boys and 60.4 per cent of adult males. Emotional violence is also prevalent, affecting 16 per cent of adolescent girls and 18.9 per cent of women. These findings suggest that violence within intimate relationships is not only widespread, but also persists over time. Tackling these harmful dynamics is essential to ensuring that all young people can build safe, respectful and supportive relationships.

Figure 9: Adolescents' experience of physical and sexual violence, 2022

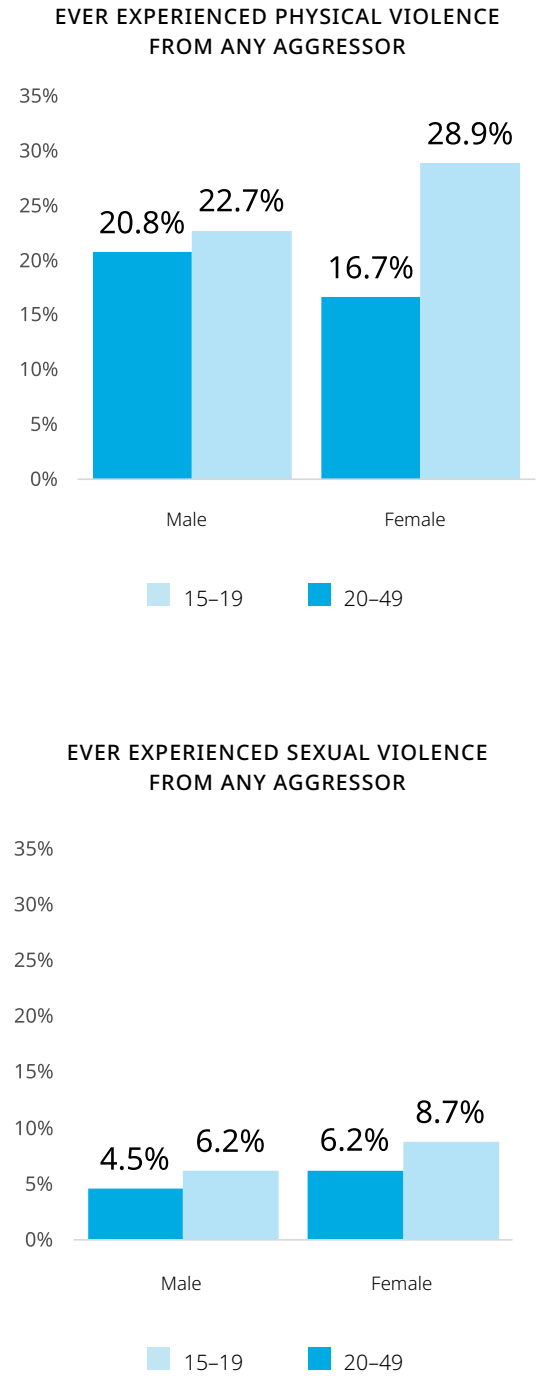
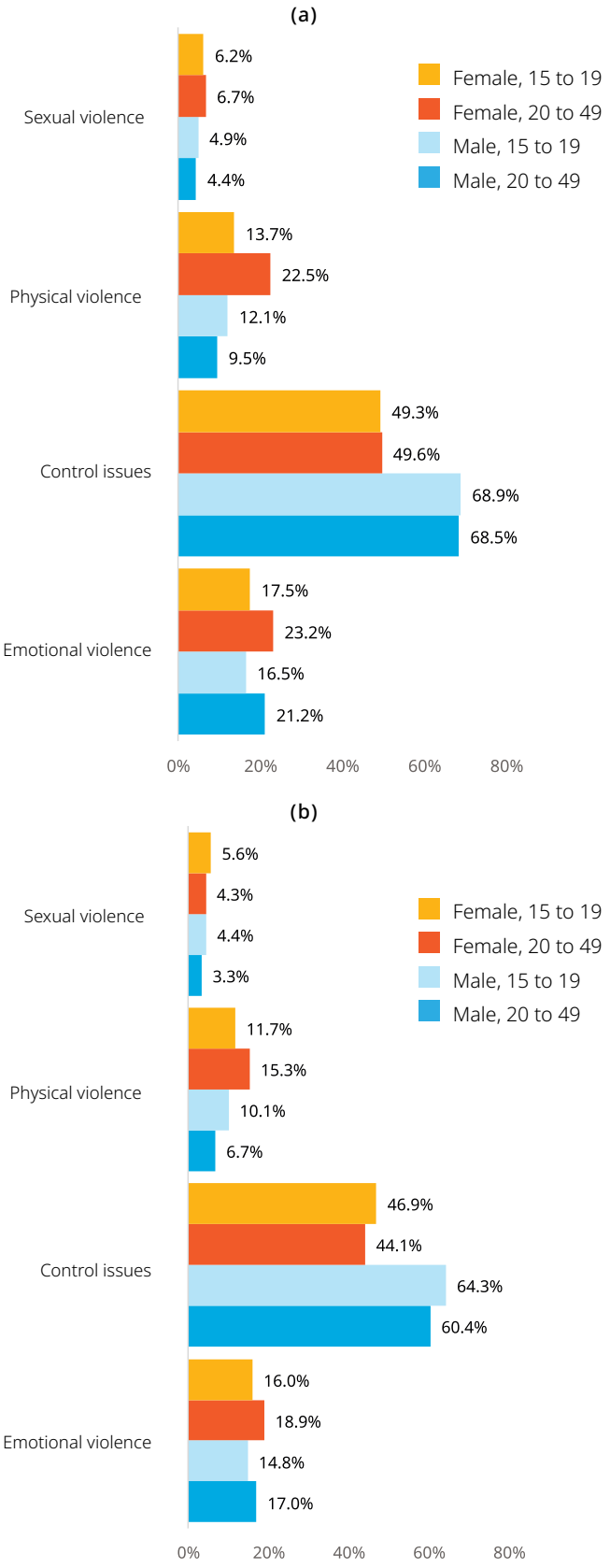


Figure 10: Prevalence of intimate partner violence among adolescents – (a) lifetime experience and (b) experience within the past 12 months, 2022



4 Mental health and wellbeing[5]

SDG Target 3.4
Reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

Key fact: According to the DHS 2022, one in five adolescent girls suffers from anxiety, and nearly 1 in 12 suffers from depression.

Mental health is a vital aspect of every child's and adolescent's wellbeing. Yet, across Mozambique, too many young people are living with untreated mental health challenges such as anxiety and depression, conditions that often begin early and worsen over time without proper support.

Adolescents are particularly vulnerable, and the data shows a troubling trend: one in five adolescent girls (21.6 per cent) experiences anxiety compared to just 6.6 per cent of boys. Similarly, 8.6 per cent of girls report symptoms of depression while only 2.1 per cent of boys do. These stark gender disparities underscore the urgent need for gender-sensitive mental health support tailored to the unique experiences of adolescent girls.

Early identification, access to quality care, and supportive environments in families, schools and communities can make a profound difference in helping adolescents build resilience, restore hope and reach their full potential.

Figure 11: Mental health of adolescents (aged 15–19 years) and adults (aged 20–49 years), 2022

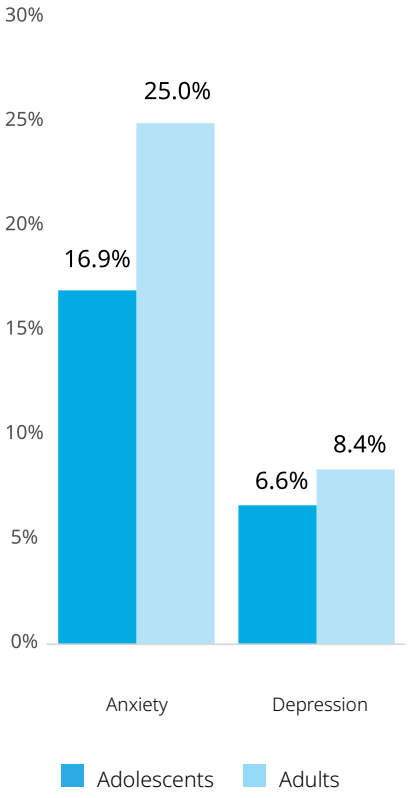
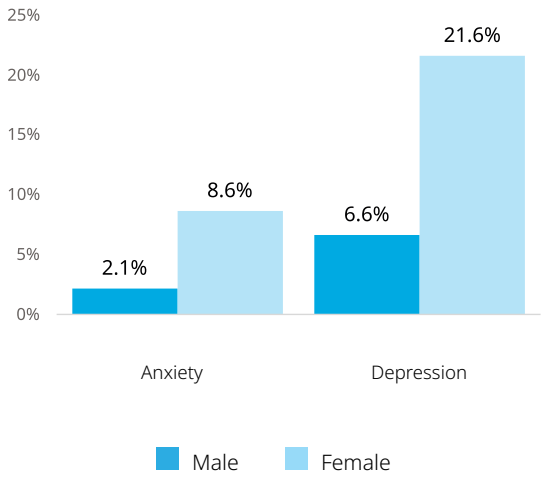


Figure 12: Mental health of adolescents (aged 15–19 years), by gender, 2022



[5] This only covers adolescents aged 15-19 years because this is the age range for which the detailed depression and anxiety data is collected.

Proposed Policy Priorities

As noted, Mozambique's adolescents, especially girls, face multiple and overlapping vulnerabilities that threaten their health, education and future opportunities. Ensuring that they not only survive, but thrive, requires a cross-sectoral approach.

1. Strengthen nutrition of adolescent girls

Adolescent girls, especially those of reproductive age, must have the nutritional foundation to grow, develop, and enter adulthood healthy and strong. Improving adolescent nutrition is not only critical for their wellbeing today, but also for the health of the next generation. To strengthen the nutrition of adolescent girls requires targeted interventions such as iron, vitamin A and folic acid supplementation, as well as fortification of staple foods to combat micronutrient deficiencies that jeopardize girls' health, learning and future pregnancies.

2. Expand access to adolescent-friendly sexual and reproductive health services

Every adolescent deserves access to comprehensive sexual and reproductive health information and care. Too many girls still lack the support they need to make informed decisions about their bodies and futures. Expanding access to adolescent sexual and reproductive health services should therefore be a key priority for the Government of Mozambique and its supporting partners. This includes implementing interventions to delay sexual debut and prevent teenage pregnancy, ensuring the provision of comprehensive antenatal and postnatal care, and improving knowledge, access and provision of modern contraceptive methods. Furthermore, ensuring that adolescent girls have access to menstrual hygiene materials is critical for their dignity, health and continued engagement in education.

3. Protect adolescents from violence and harm

Violence, especially within intimate relationships, remains a devastating reality for too many adolescent girls. Changing social norms about the acceptability of the use of violence generally, but particularly within intimate relationships, is vital in reducing exposure to violence.

4. Prioritize adolescent mental health and wellbeing

Mental health is central to adolescent wellbeing but is too often overlooked. It is important to reduce the stigma around mental health issues. This can be achieved through mass communication campaigns. The aim would be to build resilience among young people. The government needs to expand adolescents' access to psychosocial support and mental health services.

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