



# **A SITUATIONAL ANALYSIS OF THE WELL-BEING OF ADOLESCENTS BENEFICIARIES OF THE COVida PROJECT IN MOZAMBIQUE**

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# **A SITUATIONAL ANALYSIS OF THE WELL-BEING OF ADOLESCENT BENEFICIARIES OF THE COVida PROJECT IN MOZAMBIQUE**

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## **DISCLAIMER**

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States government.

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## Acronyms

ARV	Anti-retroviral
CBO	Community-based Organization
DHS	Demographic and Health Survey
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (Initiative)
FGD	Focus Group Discussion
HIV and AIDS	Human Immuno-deficiency virus and Acquired Immuno-deficiency Syndrome
IMASIDA	Inquérito de Indicadores de Imunização, Malária e HIV/SIDA
INE	Instituto Nacional de Estatística
MISAU	Ministério da Saúde (Ministry of Health)
OVC	Orphans and Vulnerable Children
PEN IV	Plano Estratégico Nacional de Resposta ao HIV e SIDA IV
PEPFAR	President's Emergency Plan for AIDS Relief
Project FCC	Project Força à Comunidade e às Crianças
USAID	United States Agency for International Development

# Executive Summary

## Study Background and Purpose

COVida is a five-year (2016-2021) USAID-funded project implemented by FHI360 in partnership with Palladium, CARE and Path. The goal of COVida is to improve the health, nutritional status, and well-being of OVC living in PEPFAR-defined priority districts for epidemic control. The project will support 300,000 OVC and their caregivers annually to access high-quality, comprehensive, compassionate services across all of Mozambique's provinces.

## Study Design

This is a mixed methods study involving a survey of adolescents in households served by the COVida project and focus group discussions with adolescents served by the COVida project.

With caregiver consent and adolescents' assent, we interviewed all adolescents aged 12-17 years who were residing in selected households at the time of survey, using a standardized, structured data collection instrument. Of the randomly sampled 1440 households, we were able to establish contact with 1250 households (87% of the sample). Within the 1250 households with which we established contact, 817 had at least one adolescent between the ages of 12-17 years according to the caregiver surveyed as part of the wider baseline study. Within those 817 households, caregivers provided information on a total of 1375 adolescents aged 12-17 years.

We conducted nine focus groups with adolescents aged 15-17 years with caregiver informed consent and the children's assent, in three districts: Matola (Maputo), Buzi (Sofala), and Mocuba (Zambezia).

Palladium conducted a household survey using a two-stage cluster sample design among active COVida beneficiaries enrolled in project year 1 (2016-2017). Forty-eight clusters were randomly selected and 30 households were randomly selected from within each cluster to yield a sample size of 1,440 households. A standardized questionnaire was used to interview OVC caregivers about services received and the well-being of the children in the household.

## Key Findings

### Respondent characteristics

We conducted interviews with 1115 adolescents aged 12-17 years from 716 households. Of the 1115 adolescents surveyed, 679 were aged 12-14 years, 436 were aged 15-17 years. Half (n=536, 48%) of adolescents surveyed were female and half (n=579, 52%) were male.

A total of 91 adolescents aged 15-17 years participated in the nine FGDs that took place in the three study locations (from North to South: Mocuba, Buzi and Matola), of which 34 were boys (37%) and 57 were girls (63%).

## **Adolescents' wellbeing**

**Education.** Both quantitative and qualitative findings demonstrate that adolescents value schooling. School enrollment was 81 percent among children aged 12-14 years (66% of which were regularly attending) and 62% percent among children aged 15-17 years (51% of which were regularly attending). Poverty was cited as the main reason for non-enrolment; whereas poor health was cited as the main reason for missing school days among those enrolled. Focus group respondents also cited pregnancy and sexual assault in schools as key reasons why female adolescents drop out of school.

**Hope.** Adolescents reported high levels of hopefulness, scoring on average 3 out of 4 on a validated scale.

**Support.** A majority of adolescents reported that they felt supported by their guardians. When asked specifically who they talked to in reference to a recent problem at school or home, or a question about their future or sex, most respondents noted that they talked with their guardians. However, between 28-40% said they had no one to talk to about these specific issues. Focus group participants noted interest in participating in youth groups as another avenue of support and information.

**Perceived Safety.** Four-fifths (83%) of adolescents feel comfortable walking alone in their community during the day, and one-third (32%) feel safe walking in the community at night. Most adolescents feel safe at school and at home; however, 10 percent and 5 percent do not feel safe at school or at home, respectively.

**Sexual Behavior.** Almost half (49%) of adolescents aged 15-17 years reported ever having sex and 12% of 12-14-year-olds reported the same. The median age of sexual debut was 13 among male adolescents, and 14 for female adolescents. Sexually active adolescents most commonly reported 1-2 sexual partners in the last 12 months. Reported condom use both at first and last sex was low. Less than one third (30%) of sexually active adolescents reported using a condom during the first sexual encounter, with 38 percent reporting condom use at last sex.

## **Attitudes Toward Early Marriage**

Both qualitative and quantitative data demonstrate that adolescents are not supportive of early marriage (prior to age 18 years).

## **HIV Knowledge and Practices**

**HIV Prevention Knowledge.** Eighty-five percent of all adolescents reported that they had heard of an illness called AIDS. Of these, 17 percent of adolescents aged 12-14 years and 31 percent of adolescents aged 15-17 years had comprehensive knowledge of HIV (knowledge of prevention strategies and rejection of major misconceptions around transmission of HIV).

**HIV Testing Knowledge and Practices.** A majority (72%) of adolescents have knowledge about where to get tested for HIV, with most naming the hospital. However, only 30 percent of adolescents aged 12-14 years, and 47 percent of adolescents aged 15-17 years reported previously testing for HIV and receiving their results. Shame, fear, stigma and the social exclusion that would result if they tested HIV positive were cited as barriers to testing by focus group respondents.

**Information Channels.** Radio (53%), friends and siblings (37%), television (35%) and teachers (32%) were the information channels most commonly cited about HIV.

## **Family Planning**

**Attitudes about Pregnancy in Childhood.** Two-thirds of female adolescents reported that it was important for them to avoid pregnancy prior to marriage and before completing secondary school (67% and 69%, respectively).

**Information Channels.** Survey respondents most commonly reported the following information sources for family planning: radio (24%), friends and siblings (19%) and television (18%).

**Access to commodities.** Fifty-nine percent of 15-17 year old females and 23 percent of 12-14 year old females know where they could obtain a modern method of family planning, with health facilities most commonly mentioned. Forty-six percent of female adolescents knew where to find a male condom, compared with nearly two-thirds (63%) of male adolescents. When asked whether they could acquire a male condom, 82 percent of boys and 55 percent of girls responded positively.

Only 41 percent of female survey respondents reported that they have the skills to prevent unplanned / early pregnancy (54% of 15-17 year olds compared to 34% of 12-14 year olds). When asked if they could begin a family planning regimen if they wanted to, almost half (47%) of girls aged 15-17 years responded positively compared to only 15% of girls aged 12-14 years.

**Uptake of services.** Thirty percent of sexually debuted females ages 15-17 years said that they were using a modern method of family planning, compared to seven percent of those aged 12-14 years.

## **Preparation for the Financial Demands of Adulthood**

Two-thirds (65%) of adolescents responded that it was hard for young people to find work – a finding echoed by focus group respondents. Eleven percent of survey respondents aged 12-14 years and 20 percent of those aged 15-17 years reported recent work outside the household. Male adolescents were much more likely to report recent work (21% vs. 8%, respectively). Household and farm chores for other families was the type of work most commonly cited, although focus group respondents also talked about self-employment on the street (hawking goods, running errands). Work was reported to be ad hoc. A majority of working adolescents (93%) are paid for the work they do, with 27 percent of those reporting some savings. Focus group participants noted interest in participating in savings groups for adolescents.

## **Civic Engagement**

Data suggest low levels of adolescent civic engagement in decision making about their community or schooling (6% and 23%, respectively). That said, the majority of adolescents (66%) feel they can make a difference in their community and 86% agree that is important for them to contribute to their community and society.

## Conclusion

This study provides a situation analysis of nearly 1500 adolescents aged 12-17 years served by the COVida project in 2017. This is the largest repository of information on adolescents aged 12-14 years that we know of in Mozambique and complements available data on 15-17 year old adolescents collected during the 2015 Demographic and Health Survey. The findings illuminate beneficiary population needs and will be used to inform program management decisions.

# 1. Introduction and Background

## 1.1. Study rationale

Adolescence is a particularly critical time in a child's social and biological development, and the outcomes of the adolescent period impact the individual's future, the next generation, and the economic development of a country. A recent Lancet commission on adolescent health and well-being has argued that an investment in adolescents is one of the most clear-cut development policies, leading to substantial economic and social returns (Sheehan, et al., 2017). During adolescence, children face a number of transitions – from, in most cases, leading a relatively insular life, with survival needs being met by others, to becoming sexually active adults with new financial, civic (and often care) responsibilities and surrounded by a complex set of influencers, opportunities and constraints. Further, adolescence marks not just a period of transition but one of increasing vulnerability to accidents as well as illnesses such as HIV and AIDS, to early pregnancy and early marriage, and school drop-out.

Globally, there is a renewed focus on the importance of adolescents and youth more generally<sup>1</sup> in development. The DREAMS Initiative<sup>2</sup> (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe), one of several global programs supporting adolescents and youth, focuses particularly on HIV prevention among adolescent girls. PEPFAR-funded programs in a number of countries are receiving additional funding through the DREAMS Initiative to support interventions to address structural drivers that directly and indirectly increase girls' HIV risk, including poverty, gender inequality, sexual violence, and a lack of education.

The PEPFAR-funded COVida project in Mozambique – a national orphan and vulnerable children project – provides HIV prevention services to adolescent girls in select DREAMS districts. Additionally, the project is supporting the needs of 43,167 adolescent girls and boys aged 12-17 years living in households affected by HIV through case management programming. During start-up, COVida determined that to achieve the greatest impact among adolescents with scarce resources, more information was needed about adolescents' needs and the information channels and interventions through which support may be offered.

During the first year of the project, COVida carried out a baseline assessment of a sample of enrolled beneficiaries (Chapman et al., 2018a). Information collection about adolescents aged 12-17 years was integrated into this baseline assessment. This report describes the methods and results of the embedded study among adolescents.

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<sup>1</sup> In this report we define adolescents as ages 12-17 years and youth ages 15-24 years.

<sup>2</sup> The DREAMS Initiative, a partnership among the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the Bill & Melinda Gates Foundation, Girl Effect, Johnson & Johnson, Gilead Sciences, and ViiV Healthcare, focuses on HIV prevention among adolescent girls and young women.

## 1.2. Country context

### 1.2.1. Adolescents in Mozambique

Mozambique ranks 159 out of 170 countries on the Youth Development Index – a composite index of five domains including education, health and well-being, employment and opportunities, political participation, and civic participation developed by the Commonwealth Secretariat for Youth aged 15-24 years (The Commonwealth, 2016). Data from the most recent Demographic and Health Survey (IMASIDA - Inquérito de Indicadores de Imunização, Malária e HIV/SIDA) help explain this low ranking, reporting that 44 percent of females and 42 percent of males aged 15-19 years have not completed primary education (MISAU, INE, & ICF International, 2015). Failure to complete school is linked with poverty and a high prevalence of early pregnancy and early childhood marriage: in Mozambique, about 15 percent of girls are married by age 15, and half (49%) are married by age 18 (MISAU, INE, & ICF International, 2015). Forty-six percent of adolescents aged 15-19 years have been pregnant at least once (14% of 15-year-olds, 29% of 16-year-olds, 44% of 17-year-olds, 57% of 18-year-olds, and 76% of 19-year-olds) (MISAU, INE, & ICF International, 2015). Further, youth unemployment is high. The same survey found that 74 percent of females and 52 percent of males aged 15-19 years have not worked in the 12 months prior to survey (MISAU, INE, & ICF International, 2015).

Young people are at high risk of acquiring HIV, with girls disproportionately affected. There is a lack of data on children under 15 years, but 6.5 percent of females and 1.5 percent of males aged 15-19 years are HIV-positive (MISAU, INE, & ICF International, 2015). Sexual debut occurs early, with one-quarter of 15-19-year-olds reporting sex prior to age 15 (MISAU, INE, & ICF International, 2015). Only 44 percent of sexually active, unmarried females aged 15-19 years report using a modern contraceptive method, and only half of unmarried females report condom use at last sex (MISAU, INE, & ICF International, 2015). Having multiple sexual partners is common especially among 20-39-year-old men (approximately one-quarter of whom report multiple sex partners in the last 12 months) even within marriage (Chapman et al, 2018b), as is polygamy: 9 percent of females report that their spouses have more than one wife (MISAU, INE, & ICF International, 2015).

### 1.2.2. National policy

Mozambique has a number of policies and authorities in place to support youth development, including a National Youth Policy, focused on:

- Technical and vocational education;
- Labor/employment and entrepreneurship;
- Housing for young people;
- Sport, arts, and culture including the development of cultural and sporting infrastructure;
- Awareness about sexual and reproductive health and combating HIV/AIDS; and
- Strengthening moral and civic education.

Mozambique also has a National Strategic Plan Against HIV/AIDS (PEN IV) and a National Education Strategic Plan, which both specifically address youth, and a National Action Plan for Children II (PNAC 2013-

2019), which provides guidance on strengthening social services for continued improvements in family welfare.

Resources to support youth include the Ministry of Gender, Children and Social Action's National Institute of Social Action social grants and financial support; Ministry of Education funds for school fee exemption and provision of school materials; and Ministry of Health (MISAU) facility- and community-based free health services (including expansion into adolescent-friendly services).

### 1.3. COVida Project Description

COVida is a five-year (2016-2021) USAID-funded project implemented by FHI360 in partnership with Palladium, World Vision, CARE, Path and N'weti. The goal of COVida is to improve the health, nutritional status, and well-being of orphans and vulnerable children (OVC) living in PEPFAR-defined priority districts for epidemic control. The project has four key objectives:

- Increase the utilization of quality social, health, and nutritional services among the children and caregivers within the target OVC households;
- Reduce the economic vulnerability of OVC households so that they can better provide and plan for the essential needs of the children in their care;
- Increase the capacity of families and communities to better provide early childhood development services that promote healthy, nurturing, engaging, and safe environments for vulnerable children under the age of 5;
- Increase the capacity of district government and communities to provide essential preventive and protective services to vulnerable families and children.

To meet these objectives, the project is supporting approximately 300,000 OVC and their caregivers annually to access high quality, comprehensive, compassionate services in 71 districts across all of Mozambique's provinces. Project activities include strengthening the capacity of community-focused providers to initiate and retain clients in HIV and other care and refer them for onward services, rolling out community dialogues to tackle barriers to service access, supporting village savings and loan groups to improve households' access to financial products, and implementing early childhood stimulation and nutrition-focused activities.

### 1.4. Research Questions

Adolescent-focused research questions were:

1. What are the attitudes of adolescents aged 15-17 years about education, early marriage, pregnancy, and HIV?
2. What do adolescents aged 15-17 years know about preventing HIV and the related services available?
3. To what extent are adolescents aged 15-17 years accessing HIV prevention services, and what are the barriers to accessing services?
4. Where and from whom do adolescents aged 15-17 years seek help, support, and information?
5. How and to what extent are adolescents aged 15-17 years preparing for the financial demands of adulthood?

6. How and to what extent are adolescents aged 15-17 years civically engaged?
7. How can COVida interventions be best designed to meet adolescents' needs and support them to engage in their communities and become productive adults?

The study to which this report pertains was embedded in a wider baseline evaluation of the COVida project. The objective of the wider evaluation was to assess the well-being of children and their households who are active beneficiaries of COVida over time. This broader study was conducted in part to fulfil PEPFAR global reporting requirements that aim to measure and track progress of PEPFAR-supported OVC programs. The primary research question, on which the wider evaluation, and hence this sub-study, was statistically powered, is: *What is the status of COVida beneficiaries, with respect to various measures of well-being, including the PEPFAR Monitoring, Evaluation, and Reporting (MER) essential survey indicators?*

## 2. Methods

### 2.1. Study design

This is a mixed methods study involving a survey of adolescents in households served by the COVida project and focus group discussions with adolescents served by the COVida project.

### 2.2. Sampling

#### 2.2.1. Household Survey

We surveyed adolescents residing within a cross-sectional sample of COVida project beneficiary households using a two-stage cluster sampling design. The sampling frame for the household survey included all households registered to receive services from the project between July 1, 2016 and June 30, 2017. Forty-eight clusters of households were randomly selected using probability proportionate to size methodology and 30 households were then randomly selected from within each cluster. The process for random sampling households within clusters was based on a beneficiary listing exercise conducted by the data collection teams as they arrived in new clusters. Data collection teams worked with local COVida staff (*activistas*) to list all active beneficiary households. A total of 17,279 project beneficiary households were listed with the COVida local implementing partners in the 32 survey clusters. From this list, the data collection team randomly sampled 30 households for the survey. This sampling process yielded a sample size of 1,440 households.

#### 2.2.2. Focus Group Discussions

We conducted nine focus groups with adolescents aged 15-17 years with caregiver-informed consent and the children's assent<sup>3</sup> in three districts: Matola (Maputo), Buzi (Sofala), and Mocuba (Zambezia). Districts were chosen purposively to ensure diversity in responses. Other factors that were considered in sampling include: the number of project beneficiaries (districts with more project beneficiaries were prioritized), the presence of a strong community-based organization (CBO) to support the focus groups, accessibility, and security.

Given the sensitive nature of some of the topics discussed, particularly marriage, pregnancy, and school drop-out, separate group discussions were held with boys and girls, and these groups were further segmented by marital/child-bearing status (see Table 1 below).

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<sup>3</sup> In cases where the child was married and emancipated, we obtained informed consent from the child directly if he/she was at least 16 years old.

**Table 1. Focus group sample**

	Matola (urban, south)		Buzi (rural, central)		Mocuba (rural, north-central)	
	Girls	Boys	Girls	Boys	Girls	Boys
Married and/or with children	1	0	1	0	1	0
Single and no children	1	1	1	1	1	1

## 2.3. Recruitment and Data Collection

Data collection was conducted by a trained team. Quantitative data were collected by a team comprised of seven field supervisors, and forty-five interviewers set up in seven field teams that worked simultaneously in various regions of the country. Qualitative data were collected by three regional teams, each including one facilitator, one assistant and one translator. A field manager who was present for the whole data collection process in the field led the data collection team. Data collection took place from August – October 2017.

### 2.3.1. Household Survey

At the cluster level, the data collection team worked with COVida local implementing partners to locate the selected households. In most instances, the *activista* or other member of the local implementing partner organization accompanied the data collectors to the selected households and left prior to the consent process.

With caregiver consent and adolescents’ assent, we interviewed all adolescents aged 12-17 years who were residing in selected households at the time of survey, using a standardized, structured data collection instrument. The tool was developed in English and later translated into Portuguese. It included the following sections: demographic questions; attitudes on education and school enrollment and attendance status; finances and work; community participation and civic engagement; hope<sup>4</sup> and social support; information channels; HIV and family planning knowledge and use of/access to services; sexual behavior; attitudes on early marriage and pregnancy; and questions regarding sense of safety in various settings.

Field interviewers captured responses electronically on password-protected Android tablets that had been pre-programmed with the questionnaire using Kobo Toolbox. The electronic data capture tool presented one question per screen. Instructions were included in the tool to guide data collectors and facilitate interview flow. Skip logic was built in and error messages and caution notices were triggered when faulty data were entered to alert interviewers to correct problems. Adolescents were interviewed in a private location out of

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<sup>4</sup> To measure hope, we used the 12-item Hope Scale (Abler et al., 2017; Fischhoff, B. et al, 2000; Coughlin, SS., 2006; Barnett, T. and Weston, M., 2008). It uses a 4-point Likert scale, where 4 indicates “totally agree” while 1 indicates “totally disagree.” Hopefulness has been associated with a reduction in adolescent engagement in sexually risky behaviors, (ibid), for instance, later sexual debut (Hill, L. et al., 2017).

earshot of others, including children and other family members, but within sight of another adult. A minimum of three attempts on two different days was made to conduct the interviews with adolescents.

Field supervisors reviewed the captured data daily. Once the questionnaire was deemed complete, they transmitted the data to the database in the cloud-based server using mobile Internet connection.

The data manager ran daily checks based on a predesigned data cleaning script in Stata 14 that included checks for structure, uniqueness, and external consistency of key identifiers; completeness of data; acceptable data; and unexpected data. An inconsistency report from the database was then generated and shared with the field team every two days. Field teams took immediate action/correction (e.g. re-interview, re-visit to households for confirmation, etc.) to ensure that high quality data were collected.

### **2.3.2. Focus Group Discussions**

A topic guide was developed to elicit the responses to the research questions and then translated into Portuguese. Key concepts and terms were translated in local languages and pre-tested. Following testing, the guide was revised and then implemented in a semi-structured manner.

All focus group discussion (FGD) participants completed (either on their own or with the assistance of a member of the data collection team) a written questionnaire asking for their age, current school attendance, educational level, civil status, childcare responsibility and, for girls only, if they were pregnant, post-partum or breastfeeding.

The FGDs took place within existing COVida youth groups. CBOs mobilized COVida adolescent beneficiaries to participate in the FGDs and scheduled the date and set the venue (usually the CBO office). For the adolescents who showed interest to participate in the study, the CBO obtained informed consent from their parents prior to the group discussion. Later, on the date of the FGD, the FGD social researcher joined the group and explained the study to all participants, offered information sheets and assent forms, explained the forms to the participants, and obtained documented assent. Adolescents who did not provide informed assent, or for whom informed guardian consent was not obtainable, did not participate in the study.

The FGDs were held in the language in which the participants felt most comfortable speaking: in Buzi and Mocuba, local languages were used (Ndau and Lomwe). In Matola, Portuguese was used. When a local language was used, the questions and conversation that followed were translated in real time to/from Portuguese. The FGDs were audio recorded with the documented consent/assent of participants and their guardians.

All focus group recordings were labeled and uploaded onto the password-protected study computer of the Qualitative Field Coordinator at the end of each day and sent to the Co-Principal Investigator during data collection.

## 2.4. Data Analysis

### 2.4.1. Household Survey

Once data collection was completed, additional checks were run on the full data file. Minimal edits were required as a result of real-time data cleaning as the data were being collected. Once all these checks were performed, a clean version of the data was saved for the analysis. The analytical files included data dictionaries with variable labels, value labels, and other standard specifications. Detailed metadata reports were also generated using Nesstar software. Missing data were minimal; thus, data imputation was not performed.

Although we designed our sampling approach to be self-weighting by using probability proportional to size sampling to select clusters and then randomly selecting a fixed number of households in each cluster, we applied survey weights in analysis. This procedure was necessary due to differences in the number of households in selected clusters that we expected based on the project registries and the household listings conducted during data collection. In calculating the final sampling weights, we considered weights for both probability of selection and probability for nonresponse.

The team performed data analysis using SPSS 23 with validation using SAS 9.4. We calculated indicator estimates and confidence intervals (95%) for the indicator estimates incorporating the sample design. We carried out statistical comparisons across categorical variables giving two by two tables, such as sex and location, and used a Wald chi-square test. For tests across categorical variables with more than two levels (such as age groups), an adjusted Wald F-test was used. These test for independence of the row and column variables based on the differences between the observed (weighted) cell frequencies and the expected frequencies, considering the complex survey design. In other cases where zero cell sizes were an issue, categories were logically combined to accommodate comparisons.

### 2.4.2. Focus Group Discussions

Focus group discussion recordings were transcribed in Portuguese and further supplemented with field notes. The transcripts were anonymized, meaning that all identifying information was redacted.

Transcripts were then uploaded into QSR's Nvivo version 10 and 11 software for analysis. An initial codebook following the research question topics was prepared and tested by two researchers who coded three randomly selected transcripts from each of the three study locations. The researchers noted necessary changes to the codebook based on differences in coding results, and emergent sub-themes and cross-cutting themes that were agreed upon and added to the codebook. The revised codebook was used by one researcher to code all transcripts. Code reports were then reviewed by the second researcher, and some changes to coding were made to accommodate different interpretations of specific codes.

Following coding, one of the researchers wrote up summaries of each key theme, which a second researcher then reviewed. Discussion of common themes and connections between themes were identified and noted. Finally, the researchers drafted this report, expanding upon the summaries for each key theme and highlighting common emergent themes across the analysis.

## 2.5. Research Ethics

Prior to the commencement of the COVida baseline survey, a study protocol was produced, submitted to, and approved by the *Comitê Nacional de Bioética para a Saúde* in Mozambique and Health Media Lab IRB in the United States. All study activities adhered strictly to U.S. and international research ethics guidelines, including 45CFR46 and CIOMS.

All group participants received refreshments and cell phone air time vouchers at the end of their FGD to compensate for their time. Confidentiality, anonymity, and voluntary participation were explained at the beginning of each group discussion. No individual names were mentioned during the FGD, note taking or production of transcripts. All audio files will be destroyed following reporting, and anonymized transcripts and consent forms will be archived with the Principal Investigator.

## 3. Results

### 3.1. Response rates

#### 3.1.1. Household survey

Of the randomly sampled 1,440 households, we were able to establish contact with 1,250 (87% of the sample).<sup>5</sup> The main reasons for nonresponse were that the caregiver was away for an extended period (93 households) and the household could not be located by the implementing partner (88 households). Five caregivers interviewed from COVida beneficiary households no longer had a child under their care at the date of interview, so they were considered ineligible for the survey (0.3% of the sample). Four caregivers refused to participate in the survey (0.3% of the sample).

In the 1,250 households with which we established contact, 817 had at least one adolescent between the ages of 12-17 years according to the caregiver surveyed as part of the wider baseline study. Within those 817 households, caregivers provided information on a total of 1,375 adolescents aged 12-17 years. We were able to interview 1,115 adolescents aged 12-17 years from 716 households (an 81% response rate considering only the households located). Assuming that the proportions of households with adolescents (817/1,250=65%) and the average number of adolescents per household (1,375/817=1.7) apply to all 1,440 households in the original sampling frame, we can estimate that we reached approximately 70 percent of adolescents in the full sample:

$$(1,440 \text{ households} * 65\% = 941 \text{ households with adolescents}) * 1.7 \text{ adolescents per household} = 1,584 \text{ adolescents in sample}$$

$$1,115 \text{ adolescents surveyed} / 1,584 \text{ adolescents in sample} = 70\% \text{ response rate (estimated)}$$

Just over half (54.2%) of adolescents were residing in rural areas (52.2% of female adolescents, 56.1% of male adolescents, 51.5% of adolescents aged 12-14 years and 58.2% of adolescents aged 15-17 years).

#### 3.1.2. Focus group discussions

A total of 91 adolescents aged 15-17 years participated in the nine FGDs that took place in the three study locations (from north to south: Mocuba, Buzi, and Matola), of whom 34 were boys (37%) and 57 were girls (63%). There were between 8-15 participants<sup>6</sup> in each group (see Table 2 below).

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<sup>5</sup> The location of surveyed households was almost evenly distributed among rural and urban areas. Around half (52%) of the surveyed households were in urban or peri-urban areas, while the remaining (48%) households were rural.

<sup>6</sup> The data collection team aimed to recruit between 6-8 people into focus groups. To obtain adequate numbers, the data collection team over-recruited adolescents, extending the invitation to participate to twice as many as required. In some cases, many more than eight showed up to the focus group discussion, and the data collection team opted not to exclude anyone at that point.

**Table 2. Number of participants in each focus group discussion**

	Matola (urban, south)		Buzi (rural, central)		Mocuba (rural, north-central)		Total
	Girls	Boys	Girls	Boys	Girls	Boys	
Married and/or with children <sup>7</sup>	10		8		9		27
Single and no children	10	11	13	15	7	8	64
<b>Total</b>	<b>20</b>	<b>11</b>	<b>21</b>	<b>15</b>	<b>16</b>	<b>8</b>	<b>91</b>

## 3.2. Participant Characteristics

### 3.2.1. Survey participants

Of the 1,115 adolescents surveyed, 679 were aged 12-14 years and 436 were aged 15-17 years. Half (n=536, 48%) of adolescents surveyed were female and half (n=579, 52%) were male. Just over half (n=557, 52%) of adolescents surveyed were literate (able to read a sentence provided by the enumerator). Nine percent of the female adolescents were pregnant and 1.3 percent of female and male adolescents were married. Nearly two-thirds of participants (n=699, 64%) were cared for by their mother and/or father, with the remainder cared for by a grandparent (n=229, 20%), sibling (n=77, 6%), aunt and/or uncle (n=116, 11%), or other person (n=43, 4%).

### 3.2.2. Focus group discussion participants

Respondent characteristics are outlined in Table 3.

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<sup>7</sup> We did not interview boys who were married and/or with children, as marriage is uncommon among boys in this age range in Mozambique (MISAU, INE, ICF, 2015).

**Table 3. Participant demographic characteristics\***

Characteristic	All (N=91)		Girls (N=57)		Boys (N=34)	
	n	%	n	%	n	%
<b>Age</b>						
15	26	28.6	18	32.6	8	23.5
16	28	30.8	14	24.6	14	41.2
17	37	40.6	25	43.8	12	35.3
<b>Marital status</b>						
Single	51	56.0	29	50.9	22	64.7
Married or cohabiting	10	11.0	9	15.8	1	2.9
Steady partner	24	26.3	17	29.8	7	20.6
Occasional partner	6	6.6	2	3.5	4	11.8
<b>Childcare responsibility (=yes)</b>	27	29.6	26	45.6	1	2.9
<b>Current school attendance</b>						
Attend school	62	68.1	32	56.1	30	88.2
Do not attend school	29	31.9	25	43.8	4	11.8
<b>Educational level</b>						
Primary schooling, partial	40	43.9	27	47.3	13	38.2
Full primary schooling	2	2.2	2	3.5	0	-
Secondary schooling, partial	49	53.8	28	49.1	21	61.8
<b>Pregnant, post-partum or breastfeeding (=yes)</b>	N/A	N/A	26	46	N/A	N/A
Pregnant	N/A	N/A	3	N/A	N/A	N/A
Breastfeeding	N/A	N/A	4	N/A	N/A	N/A

\*Missing values excluded.

In terms of age, slightly more participants were 17 years old than the other ages: 26 were 15 years old (28%), 28 were 16 years old (31%), and 37 were 17 years old (41%).

Just over half of all participants were single (56%), 26% had an occasional or steady partner, and 11% were married or living with their partner (n=10). Nearly one-third of the sample (30%) had at least one child under their care (26 female adolescents and 1 male adolescent).

The majority of participants were attending school during the time that the FGD was conducted (68%), with a much higher percentage of boys attending school (88%) compared to girls (56%). Slightly more than half of the FGD participants (54%) had partial secondary education. There were no major differences in educational level by sex.

Finally, of the 57 FGD female participants, 26 (46%) were either pregnant, breastfeeding, or had a child.<sup>8</sup> Four girls (7%) were breastfeeding and three (5%) were pregnant.

<sup>8</sup> The remaining 31 female participants, or 54%, did not report any of the above

### 3.3. Well-being of Adolescents

#### 3.3.1. Education

##### 3.3.1.1 Attitudes about Education

In the FGDs, we asked secondary school age participants (aged 15-17 years) how important they thought school was. Respondents universally described it as very important because school enables them to have access to economic opportunities, support their family, gives them a greater understanding of the world, and helps them learn how to live in society. As stated by a boy from Buzi, *"It is good to study. School is part of education (...) if you don't study, you'll regret it, the world around us is full of people who have studied (...) Knowledge is a way to fight poverty, plan for your life and your society."* Regardless of what they might be planning for their future, the boys and girls interviewed said it was essential to have schooling. As stated by another boy from Buzi: *"Even to farm a plot we must go to school."*

Participants also stated that they felt a duty to pass their learning onto their close relatives so their education could benefit the whole household. As stated by a boy from Mocuba: *"It is important to study, so that tomorrow we can help our family, have a skill. Our relatives like that you study for your own good, and also learn and teach your own family – those who go to school bring information for those who don't."* Support from family was commonly mentioned as an enabling factor for school attendance, together with financial means for supporting education costs: *"Our family must contribute, support, say that we must not quit. In the old times our parents went to school barefoot but they studied, they had no shoes, no notebooks, but they went to school"* (married girl, Matola).

Survey data also indicate that adolescents value schooling. A majority of adolescents (92%) agreed that it is important for girls to complete secondary school (see Table A1 in the Appendix), and a similar percentage (94%) agreed to the same for boys (see Table A2 in the Appendix). Similarly, when adolescents were asked if it is important for them to complete secondary school, almost all participants (93%) agreed that it was. There were no significant differences by age group or sex across these variables. See Table A3 in the Appendix.

##### 3.3.1.2 School Enrollment and Attendance

Table 4 below shows school enrollment rates for adolescents 12-17 years old. Eighty-one percent of adolescents in the younger age band (12-14 years) reported that they were enrolled in school. In the older age group (15-17 years), school enrollment was significantly lower (62%). There were no differences in school enrollment by sex.

**Table 4. Percent of adolescents surveyed who were enrolled in school, by sex and age group\***

Age Group (years)	All Adolescents (N=1114)		Female Adolescents (N=536)		Male Adolescents (N=578)	
	W % <sup>9</sup>	n	W %	n	W %	n
12-14	80.8	678	78.8	343	82.9	335
15-17	62.2	436	66.4	193	58.6	243
<b>All Adolescents</b>	<b>73.3</b>	<b>1,114</b>	<b>74.2</b>	<b>536</b>	<b>72.5</b>	<b>578</b>

\*Missing values excluded.

School attendance data are displayed in Table 5 below. Regular school attendance is defined as not missing any school days in the last week. Overall, 66 percent of adolescents aged 12-14 years were regularly attending school, as compared with 51 percent of adolescents aged 15-17 years.<sup>10</sup> There were no statistically significant differences by sex.

**Table 5. Percent of adolescents surveyed who were regularly attending school, by sex and age group\***

Age Group (years)	All Adolescents (N=1110)		Female Adolescents (N=533)		Male Adolescents (N=577)	
	W %	n	W %	n	W %	n
12-14	66.2	676	64.7	341	67.8	335
15-17	51.4	434	53.6	192	49.6	242
<b>All Adolescents</b>	<b>60.3</b>	<b>1,110</b>	<b>60.6</b>	<b>533</b>	<b>60.0</b>	<b>577</b>

\*Missing values excluded.

### 3.3.1.3 Reasons for not Enrolling or Attending School

While almost all adolescents interviewees and FGD participants agreed that it important for them to complete secondary school and school is crucial to their future, a majority of surveyed adolescents (65%) agreed or strongly agreed that it is difficult for girls to complete secondary school (see Table A4 in the Appendix), and over half (57%) agreed or strongly agreed that it is difficult for boys to complete secondary school (see Table A5 in the Appendix).

We asked adolescents surveyed, who were not enrolled in school, why they were not enrolled. Results are presented in Table 6 below. The most common response (55%) across both sexes and age groups was that the family did not have money for materials or transport to attend school. There were no statistically significant differences by age group or sex.

<sup>9</sup> Denotes weighted percentage in all tables.

<sup>10</sup> Unenrolled adolescents are included in this calculation and counted as not regularly attending school.

**Table 6. Percent of adolescents surveyed who cited various reasons for why they are not enrolled in school, by sex and age group**

	All Adolescents (N=291)		Female Adolescents (N=141)		Male Adolescents (N=150)		Aged 12-14 (N=135)		Aged 15-17 (N=156)	
	W %	n	W %	n	W %	n	W %	n	W %	n
No money for materials, transport	55	154	49.2	70	60.2	84	58.9	77	52	77
I don't like school	11.1	31	13.2	17	9.2	14	11.3	14	11	17
Too sick	3.6	15	3.8	8	3.5	7	5.3	9	2.4	6
Have to work	2.9	10	1.6	3	4	7	1.9	3	3.6	7
School is too far away	2.3	5	3.6	3	1.1	1	-	0	4	5
Guardian does not want me to go	2	4	3.1	3	0.9	1	2.5	2	1.6	2
Have to care for household members	0.3	1	0.6	1	-	0	0.6	1	-	0
Other (specify)	15.9	45	18.8	23	13.3	22	9.3	14	20.9	31
Don't know / no response	6.9	26	6.1	13	7.8	13	10.2	15	4.5	11

Reasons why adolescents missed days of school in the last week are presented in Table 7 below. The most commonly cited reason was being too sick. There were no statistically significant differences by sex or age group.

**Table 7. Percent of adolescents surveyed who cited various reasons for missing school days in the last week, by sex and age group**

	All Adolescents (N=149)		Female Adolescents (N=74)		Male Adolescents (N=75)		Aged 12-14 (N=95)		Aged 15-17 (N=54)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Too sick	39.1	54	44.7	29	33.1	25	46.4	37	24.8	17
School was not in session	10.4	20	9.2	10	11.8	10	8.5	11	14.3	9
Don't like school	4.8	4	-	0	9.9	4	3.8	3	6.8	1
School is too far away	2.9	4	2	1	3.8	3	4.3	4	-	0
Have to work	2.2	4	3.9	3	0.5	1	3.3	4	-	0
Have to care for household members	1.8	4	3.6	4	-	0	0.5	1	4.5	3
Other (specify)	22.5	36	20.5	18	24.6	18	17.1	18	33.2	18
Don't know / no response	4	8	1.1	1	7	7	4.7	6	2.5	2
No money for materials, transport	12.3	15	15.2	8	9.3	7	11.5	11	14	4

FGD participants provided some insight regarding reasons for unenrollment or missed school days. **Poverty** was the most commonly cited factor for school dropout by all FGD participants – male and female, single and married. Married girls, all girls from Matola (married and unmarried), and boys from Mocuba described how impoverished households, particularly those with unemployed parents, have limited resources to cover education costs (school materials, travel costs). They said that when adolescents need to work to support the household, they also have to drop out of school. As stated by a married girl from Matola: "(...) *there are families who are very vulnerable, buying a notebook is a problem for them. This also leads the adolescent to drop out of school, in order to get a job to help their mother or father with the household expenses.*"

FGD participants explained that they and their peers often face pressure to work hard to earn a living to support children, the elderly, and others under their care, and this can conflict with school attendance and enrollment. This is particularly the case for young mothers and child-headed households who must earn an income to support their families:

*"In some families the girl has to be the head of household because her mother and father abandoned their children and the older child has to care for the family. At that point she no longer thinks of going to school, she only thinks of taking care of her siblings, doing odd jobs, or taking care of a sick grandmother and doing all her chores (...)" (married girls, Matola).*

FGD participants also said it is also harder for children and adolescents in rural settings to stay in school (Buzi, Mocuba) because parents may prioritize farming over education, obligating them to work on the family farm to sustain the family.

FGD participants also explained that **early marriage, pregnancy, and the associated cultural gender roles** restrict female school enrollment and attendance. Girls who marry young are expected to become mothers and take care of the household, and thus are likely to leave school soon after marriage. As stated by an unmarried girl from Buzi: *"Girls abandon school because (...) they get pregnant, imitating their friends. When girls get pregnant, nothing can be done to get back into school."* At the family level, early marriage is sometimes promoted by parents, who believe that marriage, rather than education, provides a future for the girl and income for the family. As stated by a boy from Buzi:

*"In some communities there are parents who forbid their daughters to go to school, saying that the woman must cook and marry. Some parents treat their daughters like an asset, they even tell their sons to control their sisters so that they do not go to school."*

A similar view was given by married girls from Buzi and Mocuba, who said that *"Parents force us to marry and not go to school, arguing that at school the girl learns to be a bum"* (Buzi) and that *"Our mothers see their daughters as a source of income to help meet the needs of the house, so they force us to marry very early to get relief"* (Mocuba).

Interestingly, this pressure from family for girls to get married was described by respondents from Buzi and Mocuba (both boys and girls, married and unmarried), but not by the Matola respondents. Both boys and girls in Matola said that poverty, rather than gender roles, leads to school dropout and early marriage.

Respondents also noted that girls from impoverished households may make a strategic decision to get married or to engage in transactional sex to make ends meet (married girls, Mocuba and boys, Buzi). As put by a married girl in Mocuba: *"Other girls (...) are quicker to get married in order to have a source of sustenance."* This may lead to early pregnancy and ultimately force them to stop their schooling because of their sense of shame and bullying at school: *"(...) there are other girls who feel fear and shame. In my case, fear made me abandon school."* (unmarried girl, Matola), *"(...) at school, when there is a pregnant girl, everyone starts talking nasty things about her and she quits studying"* (married girl, Matola).

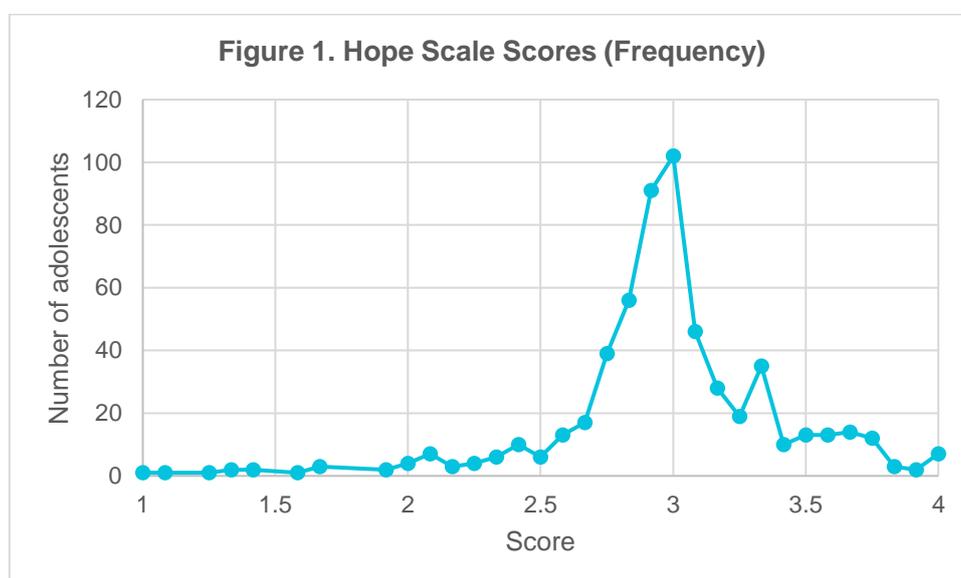
FGD respondents also described how husbands can pressure or forbid young married girls and women from attending school. For instance, respondents explained that a husband may not allow his wife to attend

school because he worries that she will leave the marriage as a result of attaining education: "(...) *our husbands say: 'I won't help you study so that afterwards you can leave me'*" (unmarried girls, Mocuba). This was particularly the case if the girl was already pregnant: "(...) *when they get pregnant their husbands forbid and say '... [if you want to study] you can go back to your mother's house'*" (unmarried girls, Mocuba).

Lastly, **sexual assault** by professors or staff in school was mentioned in half of the FGDs with girls (married girls in Matola; unmarried girls in Mocuba; unmarried girls in Buzi) as a reason for female dropout or a problem they faced in their lives: "(...) *sometimes sexual assault by professors or other staff at school [can lead to dropout]*" (unmarried girl, Buzi).

### 3.3.2. Hopefulness

Across age groups and sexes, high means from the Hope Scale – of close to 3, from the 4-point scale – indicate a high degree of hopefulness. There were no notable differences by age or sex. See Figure 1 below and Table A6 in the Appendix.



### 3.3.3. Support

#### 3.3.3.1 Perceived support

We asked adolescents a series of questions to assess the support they have in their lives. When asked if they had an adult in their life they could look up to, 78 percent agreed that they had someone in their life who filled this role (see Table A7 in the Appendix). Less than one-fifth (17%) said they disagreed that they had someone to fill that role. When asked specifically about their guardians and whether they care about their life and future, almost all adolescents (92%) agreed that this was the case, with just 5 percent of adolescents disagreeing (see Table A8 in the Appendix). Similarly, high numbers of adolescents agreed that their guardians respect their opinions (85%), with 11 percent disagreeing (see Table A9 in the Appendix). Adolescents also mostly agreed (87%) that their guardians tell them when they have done something really well, with just over one-tenth (11%) disagreeing (see Table A10 in the Appendix). We found no differences by age or sex across any of these indicators.

### 3.3.3.2 Sources of help and support

FGD participants reported receiving help, support, and information with reference to school, their health, and early marriage from a variety of sources, including (from most to least mentioned): community elders, local government structures (*chefe do quarteirão*, or block chief), the police, religious leaders, and *activistas* or community workers.

Religious leaders, community workers, and elders were described as providing counseling to adolescents on various matters that affect their life. FGD respondents also described local government representatives, police, and religious leaders as important mediators for conflict resolution and enforcing of law, including preventing child marriage: *"At the police station, it is not to arrest you, it is to issue an order (...): she does not want it [to get married], if your [parents] force her to do it they will be fined"* (married girl, Matola).

However, importantly, all married girls (in all three locations), in addition to boys from Mocuba and unmarried girls from Matola, felt that they had no source of help, support, or information to solve the problems they face. As put by a married girl from Mocuba, *"We do not have this kind of service and never heard of it. If there was, it would actually be a good thing, people would adhere to it because there any many cases [that need support services]."*

These findings mirror survey responses. When asked who they talked to the last time they had a problem at school, 40 percent said they had no one to talk to. One-third of respondents said they had no one to talk to about problems at home (33%); and close to one-third (29%) said they have no one they could talk to the last time they had questions about their future or when they had questions about sex (28%) (see Tables A11-A14 in the Appendix).

### 3.3.4. Perceived Safety

We asked adolescents a series of questions regarding their sense of safety in numerous settings where they might find themselves. The majority (83%) felt comfortable walking alone in their community during the day (see Table 8 below), with one in six (16%) not feeling safe in that context. Adolescents felt less safe walking in the community at night. Most adolescents felt safe at school; however, one-tenth did not. Almost all adolescents felt safe at home (95%), with no differences by age or sex.

**Table 8. Percent of adolescents who feel safe in various circumstances, by sex and age group\***

		All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
		W %	n	W %	n	W %	n	W %	n	W %	n
<b>I feel safe walking alone in my community during the day.</b>	Totally Disagree	4.5	37	2.7	17	6.3	20	4.2	24	5	13
	Disagree	11.7	132	13.7	74	9.7	58	12.5	80	10.4	52
	Agree	49.7	541	53.3	272	46.3	269	47.5	322	53	219
	Totally Agree	33.1	391	28.9	164	37.2	227	34.6	244	31	147
	Don't know / no opinion	0.9	14	1.3	9	0.6	5	1.1	9	0.7	5

		All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
		W %	n	W %	n	W %	n	W %	n	W %	n
<b>I feel safe walking alone in my community at night.</b>	Totally Disagree	23.7	266	27.3	155	20.1	111	26.5	182	19.4	84
	Disagree	42.6	502	44.8	244	40.4	258	44.5	311	39.8	191
	Agree	26.2	262	21.7	105	30.6	157	22.4	137	31.9	125
	Totally Agree	5.3	56	4.4	19	6.2	37	4.7	30	6.3	26
	Don't know / no opinion	2.2	29	1.7	13	2.6	16	1.9	19	2.5	10
<b>I feel safe at school.</b>	Totally Disagree	2.4	17	0.6	4	4.3	13	1.6	7	3.7	10
	Disagree	7.4	78	9.2	46	5.6	32	7.9	44	6.6	34
	Agree	53.9	587	55	287	52.8	300	55.1	363	52.2	224
	Totally Agree	25.2	300	23.8	135	26.6	165	27	195	22.6	105
	Don't know / no opinion	11	133	11.4	64	10.7	69	8.5	70	14.9	63
<b>I feel safe at home.</b>	Totally Disagree	0.9	6	0.4	3	1.4	3	0.8	3	1.2	3
	Disagree	3.7	40	3.2	20	4.2	20	4.1	26	3.1	14
	Agree	47.1	506	50.9	260	43.4	246	48.4	315	45.1	191
	Totally Agree	47.9	557	44.9	248	50.9	309	46.3	331	50.3	226
	Don't know / no opinion	0.4	6	0.6	5	0.2	1	0.4	4	0.4	2

\*Missing values excluded.

### 3.3.5. Sexual Behavior

#### 3.3.5.1 Sexual debut

Almost half (49%) of adolescents aged 15-17 years reported ever having sex, while just 12 percent of 12-14-year-olds reported the same. There was also a statistically significant difference in sexual debut between females and males (24% vs. 30%, respectively) (see Table 9 below).

**Table 11. Percent of adolescents who reported having ever had sexual intercourse, by sex and age group\***

Age Group (years)	All Adolescents (N=1101)			Female Adolescents (N=526)			Male Adolescents (N=575)		
	W %	n	N	W %	n	N	W %	n	N
12-14	11.9	83	669	9.5	31	336	14.4	52	333
15-17	49.3	219	432	46.8	93	190	51.4	126	242
<b>All Adolescents</b>	<b>27</b>	<b>302</b>	<b>1101</b>	<b>23.6</b>	<b>124</b>	<b>526</b>	<b>30.3</b>	<b>178</b>	<b>575</b>

\*Missing values excluded.

The median age of sexual debut was 13 among all adolescents and male adolescents, and 14 for female adolescents. The range in ages of sexual debut was 11-17 years (see Table A15 in the Appendix).

### 3.3.5.2 Age of first sex partner

Sexually debuted adolescents reported that the mean age of their first sexual partner was 14.6 years (see Table 10 below). Female adolescents were more likely to report older sexual partners at first sex than male adolescents (16.8 years vs. 13.0 years, respectively). The range in age of first sexual partners was from 5 to 24 years. Eighteen male adolescents (11% of all male adolescents) aged 12-17 years reported that their first sexual experience was with a child 10 years of age or under (see Table A16 in the Appendix).

**Table 10. Average age of first sexual partner\***

Age Group (years)	All Adolescents (N=302)				Female Adolescents (N=124)				Male Adolescents (N=178)			
	Median	Mean	Range	n	Median	Mean	Range	n	Median	Mean	Range	n
12-14	12.6	13.5	5-19	74	15.9	16.0	12-19	29	11.4	11.7	5-17	45
15-17	14.5	15.0	7-24	210	16.8	17.1	12-24	87	13.0	13.4	7-20	123
<b>All</b>	<b>14.2</b>	<b>14.6</b>	<b>5-24</b>	<b>284</b>	<b>16.5</b>	<b>16.8</b>	<b>12-24</b>	<b>116</b>	<b>12.4</b>	<b>13.0</b>	<b>5-20</b>	<b>168</b>

\*Missing values excluded. N=all observations who were eligible for question. Median and mean are weighted.

### 3.3.5.3 Number of recent sexual partners

Sexually active<sup>11</sup> adolescents reported a range of 0-8 partners, over the 12 months preceding the survey (see Table 11 below). Adolescents were most likely to report only one recent sexual partner.

**Table 11. Percent of sexually active adolescents reporting various numbers of sexual partners in the 12 months preceding the survey, by age group\***

Number of partners	All Adolescents (N=260)		Age 12-14 (N=67)		Age 15-17 (N=193)	
	W %	n	W %	n	W %	n
1	60.5	147	67.5	42	58.1	105
2	28.0	81	21.9	18	30.1	63
3	7.8	24	8.8	7	7.4	17
4	1.5	4	-	0	2.0	4
5	1.0	2	-	0	1.4	2
7	0.3	1	-	0	0.4	1
8	0.3	1	-	0	0.4	1

\*Missing values excluded. N=all observations who were eligible for question.

### 3.3.5.4 Condom use

Reported condom use both at first and last sex was low. Less than one-third of sexually active adolescents (30%) reported using a condom during the first sexual encounter, with 38 percent reporting condom use at last sex (see Tables 12 and 13 below). Reported condom use at first and last sex was higher among adolescents in the older age group, although differences were not statistically significant.

<sup>11</sup> Adolescents reporting sex in the 12 months prior to survey.

**Table 12. Percent of sexually debuted<sup>12</sup> adolescents who reported using a female or male condom at first sex, by sex and age group\***

Age Group (years)	All Adolescents			Female Adolescents			Male Adolescents		
	W %	n	N	W %	n	N	W %	n	N
12-14	21.4	18	83	29.2	9	31	15.9	9	52
15-17	33.3	80	217	34.8	39	93	32.2	41	124
<b>All Adolescents</b>	<b>30.2</b>	<b>98</b>	<b>300</b>	<b>33.4</b>	<b>48</b>	<b>124</b>	<b>27.7</b>	<b>50</b>	<b>176</b>

\*Missing values excluded.

**Table 13. Percent of sexually active adolescents who reported using a female or male condom at last sex, by sex and age group\***

Age Group (years)	All Adolescents (N=266)			Female Adolescents (N=116)			Male Adolescents (N=150)		
	W %	n	N	W %	n	N	W %	n	N
12-14	27.5	19	70	41.6	12	29	15.8	7	41
15-17	41.7	83	196	45.1	42	87	38.8	41	109
<b>All Adolescents</b>	<b>38.1</b>	<b>102</b>	<b>266</b>	<b>44.2</b>	<b>54</b>	<b>116</b>	<b>32.9</b>	<b>48</b>	<b>150</b>

\*Missing values excluded.

### 3.4. Attitudes about Early Marriage

We asked all focus group discussants about their knowledge and perceptions of marriages in their age group. All focus groups included participants who were personally familiar with cases of underage marriage. Participants described early marriage as girls younger than 18 years of age marrying older men, following arrangements made by the girls' parents or family: "*A girl aged 14 years gets married to a man aged 30 years, some [men] already have children and you must take care of those children*" (single girl, Mocuba). Single girls in Buzi linked early marriage with early sexual debut: "*Most girls start their sexual life earlier, aged 12, 13 or 15. Once pregnant they get married, those who don't get married stay as single mothers.*" Across FGDs, marrying before the age of 18 was described by participants as being "too young."

Survey data also indicate negative attitudes around early marriage. Eight-five percent of participants disagreed that it is acceptable for girls to marry before the age of 18, with no differences by age or sex. Furthermore, 80 percent of adolescent respondents believe that elders and other leaders in the community disapprove of early marriage (see Table 14 below).

<sup>12</sup> Adolescents who report ever having had sex.

**Table 14. Percent of adolescents who hold various opinions about early marriage, by sex and age group\***

		All Adolescents (N=1,115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
		W %	n	W %	n	W %	n	W %	n	W %	n
<b>I think that it is OK for girls to get married before age 18</b>	Totally Disagree	29.2	336	30.4	168	28.1	168	29.2	206	29.2	130
	Disagree	55.9	623	54.5	294	57.4	329	55.4	375	56.7	248
	Agree	8.9	86	9.5	41	8.3	45	8	46	10.2	40
	Totally Agree	1.3	11	1.7	7	0.9	4	1.3	7	1.2	4
	Don't know / no opinion	4.7	59	3.9	26	5.4	33	6	45	2.8	14
<b>Elders and leaders in this community think that it is OK for girls to get married before age 18</b>	Totally Disagree	22.7	260	22	119	23.3	141	22.7	156	22.6	104
	Disagree	57	642	58	314	56	328	55.2	379	59.7	263
	Agree	7.5	71	8.4	40	6.6	31	7.2	42	7.8	29
	Totally Agree	1.1	12	1.3	6	0.8	6	1.5	9	0.3	3
	Don't know / no opinion	11.8	130	10.3	57	13.2	73	13.3	93	9.6	37

\*Missing values excluded.

Unmarried survey respondents were asked if they wanted to get married before they turned 18, or if their guardians wanted them to. Ninety percent disagreed with both questions, with no significant differences by age or sex. Unmarried survey respondents were also asked if they wanted to marry someone under 18 years, or if their guardians wanted them to marry someone under age 18. Ninety percent of adolescents disagreed with both statements (see Table A17 in the Appendix).

FGD respondents were asked to share their ideas of the ideal age to get married. A wide array of ages was proposed, but the consensus pointed toward ages 20-22 years for girls and age 25 for boys. Respondents felt that young people of these ages were capable of providing for themselves and are mature enough to raise a child.

We probed FGDs respondents on their views of the age differences between couples at the time of marriage. All respondents said that women and girls are typically 5-10 years younger than their husbands. Some single girls in Buzi said that this age difference is a must, as a young girl "needs" an older, responsible man: "*Women must marry older men because they are more responsible, care for the family, no longer play around.*" Also, some participants stated that boys may need to get married at a later age than girls because they are still in school and need to study to provide for a family in the future: "*(...) girls are forced to get married while men can study in order to provide for their homestead in the future*" (boys, Buzi).

FGD respondents were asked about adolescents' decision-making power in marriage. Respondents described marriage decisions as being made at the family level, with the bride and groom having little decision-making power: "*Decisions about marriage, lobolo or traditional ceremonies are made by the elders; before the girl goes to her husband's house it is necessary to do the wedding ceremonies and this varies from family to family*" (married girl, Buzi). The decision is sealed with marriage ceremonies led by the elders of both families, which shows "respect" for the bride's family and are an indicator of a "proper" marriage.

Boys and unmarried girls from Mocuba were the only ones who mentioned that marriage decisions are made by youth. All groups mentioned that pregnancy leads to marriage, regardless of the age of the mother and father-to-be.

### 3.5. HIV Knowledge and Practices

In the FGDs, knowledge about HIV prevention and treatment services appeared to be lower than knowledge about HIV testing. Only a few participants (single girls, Buzi and married girls, Matola) demonstrated some knowledge of HIV prevention methods, specifically use of male and female condoms. In only two groups (boys and unmarried girls in Mocuba) did participants note the importance of initiating HIV treatment as early as possible after testing and adhering to the regimen.

Survey respondents were asked a number of questions about HIV to determine their knowledge. Eighty-five percent of all adolescents reported that they had heard of an illness called AIDS, with no significant differences by sex or age. See Table 15.

**Table 15. Percent of adolescents who have heard of the illness called AIDS, by sex and age group\***

Age Group (years)	All Adolescents (N=1109)			Female Adolescents (N=532)			Male Adolescents (N=577)		
	W %	n	N	W %	n	N	W %	n	N
12-14	81.4	555	679	81.7	279	343	81.1	276	336
15-17	91.1	405	436	92.6	178	193	89.9	227	243
<b>All Adolescents</b>	<b>85.3</b>	<b>960</b>	<b>1115</b>	<b>85.8</b>	<b>457</b>	<b>536</b>	<b>84.8</b>	<b>503</b>	<b>579</b>

\*Missing values excluded.

#### 3.5.1. HIV knowledge

Sixty-eight percent of all adolescents (63% of those aged 12-14 years and 75% of those aged 15-17 years) knew that being faithful to one sexual partner could help to prevent HIV acquisition. Sixty-one percent of adolescents (55% of those aged 12-14 years, and 70% of those aged 15-17 years) knew that condom use could prevent HIV transmission. Only 57 percent of adolescents (53% of those aged 12-14 years and 63% of those aged 15-17 years) knew that abstinence from sex could prevent HIV transmission (see Table 16 below). Male adolescents appeared to have slightly higher rates of HIV knowledge compared with female adolescents.

**Table 16. Percent of adolescents with HIV prevention knowledge, by sex and age group**

		All Adolescents (N=960)		Female Adolescents (N=457)		Male Adolescents (N=503)		Aged 12-14 (N=555)		Aged 15-17 (N=405)	
		W %	n	W %	n	W %	n	W %	n	W %	n
<b>(“Abstain from Sex”) Can people reduce their chance of getting HIV/AIDS by not having sexual intercourse at all?</b>	Yes	56.8	535	52.8	239	60.7	296	52.7	288	62.2	247
	No	28.3	272	29.8	128	26.9	144	26.9	147	30.3	125
	Don't know / No response	14.9	153	17.4	90	12.4	63	20.4	120	7.5	33

		All Adolescents (N=960)		Female Adolescents (N=457)		Male Adolescents (N=503)		Aged 12-14 (N=555)		Aged 15-17 (N=405)	
		W %	n	W %	n	W %	n	W %	n	W %	n
<b>(“Be Faithful”)</b> <b>Can people reduce their chances of getting HIV/AIDS by having just one uninfected sex partner who has no other sex partners?</b>	Yes	68	654	65.7	299	70.3	355	62.7	349	75.1	305
	No	18.3	168	18.9	79	17.7	89	18.5	98	18	70
	Don't know / No response	13.7	138	15.4	79	12.1	59	18.8	108	6.9	30
<b>(“Use Condoms”)</b> <b>Can people reduce their chance of getting HIV/AIDS by using a condom every time they have sex?</b>	Yes	61.4	587	57.2	262	65.5	325	55.3	305	69.5	282
	No	23.6	215	26.6	109	20.7	106	24.3	127	22.8	88
	Don't know / No response	15	158	16.1	86	13.8	72	20.4	123	7.7	35

Data on respondents' knowledge of prevention of mother-to-child transmission are displayed in Table 17.

Two-thirds of all adolescents surveyed (67%) agreed that the virus that causes AIDS can be transmitted from a mother to her baby during pregnancy (59% of adolescents aged 12-14 years and 75% of adolescents aged 15-17 years). Just over half of adolescents knew that the virus that causes AIDS can be transmitted from mother to baby during childbirth (56%), and during breastfeeding (55%).

**Table 17. Percent of adolescents with mother-to-child HIV transmission knowledge, by sex and age group**

		All Adolescents (N=960)		Female Adolescents (N=457)		Male Adolescents (N=503)		Aged 12-14 (N=555)		Aged 15-17 (N=405)	
		W %	n	W %	n	W %	n	W %	n	W %	n
<b>Can the virus that causes AIDS be transmitted from a mother to her baby during pregnancy?</b>	Yes	65.9	621	67.6	306	64.3	315	59.0	322	75.2	299
	No	15.1	144	16.7	67	13.4	77	16.3	89	13.4	55
	Don't know / No response	19.0	195	15.6	84	22.3	111	24.7	144	11.4	51
<b>Can the virus that causes AIDS be transmitted from a mother to her baby during delivery?</b>	Yes	56.1	525	56.9	255	55.3	270	51.9	288	61.5	237
	No	18.8	184	20.0	89	17.6	95	17.9	98	20.0	86
	Don't know / No response	25.1	251	23.1	113	27.1	138	30.1	169	18.5	82
<b>Can the virus that causes AIDS be transmitted from a mother to her baby during breastfeeding?</b>	Yes	54.9	519	60.3	270	49.7	249	48.6	268	63.4	251
	No	20.3	202	18.2	86	22.5	116	23.5	129	16.2	73
	Don't know / No response	24.7	239	21.5	101	27.9	138	28	158	20.4	81

We asked adolescents questions pertaining to misconceptions about HIV transmission. Seventy-one percent of adolescents rejected the misconception that HIV is transmitted through mosquito bites, and similarly, 71 percent of interviewees rejected the misconception that HIV can be transmitted by sharing food with someone who has AIDS. Seventy-five percent of respondents said that HIV cannot be transmitted to people

through witchcraft. However, only just over half of all adolescents (61%) rejected the fourth major misconception – that a healthy-looking person can have the AIDS virus. There were some differences in rejection of misconceptions by age group, with adolescents in the older age group having better information (see Table A18 in the Appendix for more details).

The Demographic and Health Survey uses an indicator: comprehensive knowledge of HIV, which is calculated by summing the numbers of people who responded correctly to five questions about HIV transmission and HIV prevention methods. The results of this analysis are presented in Table 18.

**Table 18. Percent of adolescents with comprehensive knowledge of HIV, by sex and age group**

Comprehensive knowledge of HIV	All Adolescents		Female Adolescents		Male Adolescents		Age 12-14		Age 15-17	
	(N=960)		(N=457)		(N=503)		(N=555)		(N=405)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Yes	23.0	230	23.5	113	22.5	117	16.9	106	31.2	124
No	77.0	730	76.5	344	77.5	386	83.1	449	68.8	281

\*Missing values excluded.

Less than one-quarter (23.0%) of adolescents have comprehensive knowledge of HIV. There are no differences between males and females, but adolescents aged 15-17 years were more likely to have comprehensive knowledge about HIV than adolescents aged 12-14 years (31.2% vs. 16.9%,  $p < 0.001$ ).

### 3.5.2. HIV testing knowledge and practices

#### 3.5.2.1 HIV testing knowledge

FGD respondents in all study sites were aware that there are tests to diagnose HIV and said that they knew where one could get tested for HIV. They cited debates at school with teachers and awareness-raising by CBO activists and peers as their main sources of information on this topic. These findings are echoed by survey data. Over two-thirds (72.3%) of all adolescents surveyed said they knew where to get tested for HIV (64% of adolescents aged 12-14 years and 84% of adolescents aged 15-17 years,  $p < 0.0001$ ). There were no differences by sex. See Table 19.

**Table 19. Percent of adolescents with knowledge of a place where people can go to get tested for HIV, by sex and age group\***

Age Group (years)	All Adolescents (N=946)			Female Adolescents (N=451)			Male Adolescents (N=495)		
	W %	n	N	W %	n	N	W %	n	N
12-14	63.7	329	543	64	164	275	63.4	165	268
15-17	83.6	327	403	86.5	148	176	81.1	179	227
<b>All Adolescents</b>	<b>72.3</b>	<b>656</b>	<b>946</b>	<b>73.1</b>	<b>312</b>	<b>451</b>	<b>71.6</b>	<b>344</b>	<b>495</b>

\*Missing values excluded.

By far, the most commonly reported testing location mentioned by adolescents were hospitals (98%), followed by community HIV testing sites (see Table A19 in the Appendix for more detail). FGD participants

named health facilities and associated locations (hospitals, private clinics, pharmacies) as the primary testing sites, but respondents said they would be open to testing at home or using mobile testing services.

FGD participants named a number of barriers to adolescents getting tested, most commonly shame, fear, stigma and the social exclusion that would result if they tested HIV-positive: "*There are reasons why people are ashamed to do the test, they are afraid that people will find out that they are receiving pills and soy porridge [commonly given to people living with HIV], and are also ashamed to be seen in the queue with other people who also receive such products*" (single girls, Buzi). Some adolescents also expressed concerns about confidentiality and the quality of services provided at the health unit. For example, this respondent from Mocuba said:

*"We would like them to improve these (testing) services, since it is a bit risky because there are nurses who do not have experience and do the test incorrectly. And not only the nurses. They can come out and just share the results of your test. There are nurses that don't have any notion that the results are confidential"* (boy, Mocuba).

When asked how they would counsel others their age about the importance of HIV testing, FGD participants said that they would highlight the importance of leading a healthy life and engaging in HIV treatment as early as possible, if found to be HIV-positive. As stated by a married girl from Matola:

*"The first thing to do is not to be afraid of the answer, positive or negative, you must face it. If positive, go after the treatment, if negative you are lucky, you escaped, so you have to pay more attention, use birth control methods (...) if you are a couple, you must protect yourselves."*

However, when asked how to encourage others to get tested, some participants from Buzi and Mocuba appeared to indicate that HIV testing was only needed for those people who were experiencing symptoms of HIV or AIDS: "*...sometimes it may seem like malaria, so it is better to go and get checked out [to see if you are HIV positive]*" (single girls, Mocuba).

### 3.5.2.2 HIV testing practices

Thirty-seven percent of all adolescents (30% of adolescents aged 12-14 years, and 47% of adolescents aged 15-17 years,  $p < 0.0001$ ) reported previously testing for HIV and receiving their results (see Table 20 below). There were no differences by sex.

**Table 2012. Percent of adolescents who have ever been tested for HIV and who have received the results<sup>13</sup> of their HIV test, by sex and age group\***

Age Group (years)	All Adolescents			Female Adolescents			Male Adolescents		
	W %	n	N	W %	n	N	W %	n	N
12-14	29.3	144	547	28.5	72	276	30.1	72	271
15-17	46.7	172	404	56.6	86	177	38.1	86	227
<b>All Adolescents</b>	<b>36.8<sup>14</sup></b>	<b>316</b>	<b>951</b>	<b>39.9</b>	<b>158</b>	<b>453</b>	<b>33.8</b>	<b>158</b>	<b>498</b>

\*Missing values excluded.

Participants across all FGDs also said adolescents their age get tested for HIV. Married girls in Mocuba noted the importance of the test being free of charge.

### 3.5.3. HIV treatment knowledge

Treatment knowledge among adolescents is high. Eighty percent of all adolescents surveyed (76% of adolescents aged 12-14 years and 85% of adolescents aged 15-17 years) concurred that treatment is available for free and 84 percent agreed that if people strictly adhere to the medication protocol, they can live a long life (see Table 21 below).

**Table 21. Percent of adolescents holding various beliefs about antiretroviral drugs, by sex and age group**

		All Adolescents (N=560)		Female Adolescents (N=266)		Male Adolescents (N=294)		Aged 12-14 (N=295)		Aged 15-17 (N=265)	
		W %	n	W %	n	W %	n	W %	n	W %	n
<b>Are these antiretroviral drugs (ARVs) available for free or do people need to pay for them?</b>	Available for free	80.1	448	79.8	211	80.3	237	75.6	230	84.9	218
	Need to pay	6.9	39	8.3	22	5.6	17	10.0	27	3.5	12
	Don't know / No response	13.0	73	12	33	14.1	40	14.4	38	11.5	35
<b>If people take their antiretroviral drugs (ARVs) strictly – that is they take each dose as directed by the doctor – they can live a long life.</b>	Totally Disagree	4.9	13	4.8	7	5	6	5.4	7	4.4	6
	Disagree	5.7	30	7.6	18	3.9	12	6.4	17	5.0	13
	Agree	62.6	355	64.6	174	60.7	181	63.4	194	61.7	161
	Totally Agree	21.5	127	17.6	49	25.2	78	20.4	61	22.7	66
	Don't know / no opinion	5.3	35	5.4	18	5.2	17	4.5	16	6.1	19

<sup>13</sup> Among those who said they had been tested, 93 percent received the result of their test (87% of adolescents ages 12-14 years and 99% of adolescents ages 15-17 years).

<sup>14</sup> Sixteen percent of respondents reported that they did not know if they had previously been tested for HIV (20% of adolescents ages 12-14 years and 10% of adolescents ages 15-17 years).

Furthermore, 71 percent of all adolescents surveyed (65% of those aged 12-14 years and 77% of those aged 15-17 years) said they knew that there are drugs a mother can take during pregnancy to prevent transmission of HIV to her child (see Table A20 in the Appendix).

### 3.5.4. Information Channels for HIV

Survey respondents were asked about their sources of information on HIV and AIDS. Radio (53%), friends and siblings (37%), television (35%), and teachers (32%) were the most commonly mentioned. Adolescents in the older age group were more like to report exposure to HIV information from all sources (see Table A21 in the Appendix).

When asked who they trust the most for information on HIV, adolescents surveyed most commonly reported their guardian (58%), followed by health workers (16%) (see Table 22). When adolescents were asked about their least trusted information source about HIV, the most common response was their friends (37%), followed by community leaders (14%).

**Table 22. Percent of adolescents reporting that a given information source is their most trusted regarding HIV, by sex and age group**

	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Guardian	57.9	666	59.5	331	56.4	335	57.7	405	58.2	261
Teacher	8.2	76	7.4	33	9.1	43	10.7	60	4.5	16
Friend	5.8	59	3.6	19	7.9	40	4.1	27	8.3	32
Health worker	16.4	186	17.4	91	15.5	95	14.3	97	19.6	89
Community leader	0.8	9	1.2	5	0.5	4	1.3	7	0.2	2
Radio / TV	4.6	53	4.5	22	4.6	31	4.6	32	4.5	21
Don't know / No response	6.2	66	6.4	35	6	31	7.2	51	4.7	15

Adolescents were asked if they felt comfortable talking to various people (their guardians, a male health worker, and a female health worker) about sex. Respondents were more likely to report that they felt comfortable talking to health workers about sex than their guardians, with females more comfortable talking to female health workers and males more comfortable talking to male health care workers: see Table 23.

**Table 23. Percent of adolescents who agree that they feel comfortable asking various people questions about sex, by sex and age group\***

	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
<b>Male health worker</b>	39.1	439	29.1	154	48.7	285	35.6	237	44.2	202
<b>Female health worker</b>	38.7	423	47.3	252	30.5	171	32.9	225	47.5	198
<b>Guardians</b>	24.1	261	26.6	143	21.6	118	22.1	143	27	118

\*Missing values excluded.

## 3.6. Family Planning

### 3.6.1. Attitudes about pregnancy in childhood

Two-thirds (67%) of unmarried female adolescents reported that it is important to them not to become pregnant before marriage; a similar proportion (69%) reported that it is important for them not to become pregnant before they finish secondary school, with little difference between age groups: see Table 24.

**Table 24. Opinions of unmarried female adolescents about pregnancy in childhood**

		Female Adolescents (N=521)		Aged 12-14 (N=336)		Aged 15-17 (N=185)	
		W %	n	W %	n	W %	n
<b>It is very important to me that I don't get pregnant before I am married.</b>	Totally Disagree	10.5	50	12.4	36	7.3	14
	Disagree	17.5	89	16.9	52	18.7	37
	Agree	43.6	218	42.4	141	45.5	77
	Totally Agree	23.7	136	24.6	91	22.2	45
	Don't know / no opinion	4.7	28	3.8	16	6.2	12
<b>It is very important to me that I don't get pregnant before I finish secondary school.</b>	Totally Disagree	7.5	37	8.9	26	5.1	11
	Disagree	13.9	71	15.2	46	11.7	25
	Agree	43.1	216	40.9	139	46.8	77
	Totally Agree	27.1	148	27.8	97	25.9	51
	Don't know / no opinion	8.4	49	7.2	28	10.5	21

FGD participants said that the ideal age for a girl to have her first child is between 18-25 years, while for boys it was 27 years or more.

### 3.6.2. Exposure to information

Similar to those reported for HIV, survey respondents most commonly reported the following information sources for family planning: radio (24%), friends and siblings (19%), and television (18%). Of note, for all sources, females and older adolescents (aged 15-17 years) were more likely to report exposure to information on family planning (see Table A22 in the Appendix).

### 3.6.3. Access to commodities

Female adolescents were asked if they knew a place where they could obtain a modern method of family planning (e.g., birth control pill or injections) – one-third (37%) of respondents said they knew of such a place (see Table 25 below). Female adolescents in the older age group had much higher knowledge of family planning locations: 59 percent of 15-17-year-old females knew where to find modern family planning methods, compared with less than one-quarter (23%) of 12-14-year-old females.

**Table 25. Percent of female adolescents who reported knowing a place where they could obtain a modern method of family planning, such as the birth control pill or injections, by age group**

	Female Adolescents (N=536)		Aged 12-14 (N=343)		Aged 15-17 (N=193)	
	W %	n	W %	n	W %	n
Yes	36.6	173	23.4	74	58.9	99
No	59.7	340	71.8	250	39.5	90
Don't know / No response	3.6	23	4.8	19	1.6	4

Health facilities were the most commonly mentioned location for obtaining family planning commodities (94%), followed by pharmacies (19%) (see Table A23 in the Appendix).

All adolescents were asked if they knew where they could obtain a male condom. Forty-six percent of female adolescents knew where to find a male condom, compared with nearly two-thirds (63%) of male adolescents (see Table 26 below). There was also a difference in responses by age group: less than half (43%) of adolescents in the younger age group reported knowing where to obtain a male condom, while 72 percent of adolescents in the older age group reported knowing where to find a male condom.

**Table 26. Percent of adolescents reporting knowledge of where they could obtain a male condom, by sex and age group**

	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Yes	54.6	597	45.8	233	63.2	364	43	287	71.9	310
No	41.1	466	47.3	261	35.2	205	50.8	348	26.9	118
Don't know / No response	4.2	52	7	42	1.6	10	6.3	44	1.3	8

The health facility was the most commonly mentioned location of where to find a condom (78%), followed by a shop (41%) and the pharmacy (30%) (see Table A24 in the Appendix).

Female survey respondents were asked if they had the skills for preventing unplanned/early pregnancy. Less than half (42%) of agreed that they had the skills necessary, with 20 percent reporting that they did not know or did not have an opinion on this question (Table 27 below). The proportion was slightly over half among girls aged 15-17 years (54%), and just one third in the younger age group (34%).

**Table 27. Percent of female adolescents who report skills for avoiding unplanned pregnancy, by age group**

I have the skills and information to avoid getting pregnant	Female Adolescents (N=521)		Aged 12-14 (N=336)		Aged 15-17 (N=185)	
	W %	n	W %	n	W %	n
Totally Disagree	12.1	71	14	53	8.8	18
Disagree	26	125	28.5	88	21.9	37
Agree	33.4	163	27.3	84	43.8	79
Totally Agree	8.1	39	6.6	20	10.6	19
Don't know / no opinion	20.4	123	23.7	91	14.8	32

When asked if they could begin a family planning regimen if they wanted to, about one-quarter (27%) said they could (see Table 28 below). Again, responses varied significantly by age – almost half (47%) of girls aged 15-17 years said they could begin family planning if they wanted to, while this was only the case for 15

percent of girls aged 12-14. Less than half (42%) of unmarried female adolescents reported they had the skills and information to avoid pregnancy.

**Table 28. Percent of female adolescents who responded that they could begin a family planning regimen if they wanted to, by age group**

	Female Adolescents (N=536)		Aged 12-14 (N=343)		Aged 15-17 (N=193)	
	W %	n	W %	n	W %	n
Yes	26.9	145	15	55	46.9	90
No	49.2	254	52.1	174	44.4	80
Don't know / No response	23.9	137	32.9	114	8.7	23

Respondents of both sexes were asked about their ability to acquire a male condom. Seventy-one percent reported that they could acquire a male condom if they wanted to (see Table 29). Male adolescents were more likely to report the ability to get a male condom (82% of boys vs. 55% of girls), as were adolescents in the older age group (60% of those aged 12-14 years vs. 80% of those aged 15-17 years).

**Table 29. Percent of adolescents reporting the ability to obtain a male condom if they wanted to, by sex and age group**

	All Adolescents (N=597)		Female Adolescents (N=233)		Male Adolescents (N=364)		Aged 12-14 (N=287)		Aged 15-17 (N=310)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Yes	70.7	436	55.2	139	81.6	297	60.3	183	79.9	253
No	22.9	110	37.3	70	12.7	40	28.9	65	17.5	45
Don't know / No response	6.5	51	7.5	24	5.7	27	10.8	39	2.6	12

### 3.6.4. Uptake of services

Sexually debuted female survey respondents were asked if they were using any method to delay or avoid getting pregnant and if they were empowered to begin a family planning regimen should they choose it. Almost one quarter (24%) of sexually debuted female respondents said they were using a family planning method at the time of the survey, with a wide difference by age group (see Table 30 below). Just 7 percent of sexually debuted female respondents aged 12-14 years said they were using a family planning method, compared to almost one-third (30%) of sexually debuted female respondents in the older age group.

**Table 30. Percent of sexually debuted female adolescents using any method to delay or avoid getting pregnant at time of survey, by age group**

	Female Adolescents (N=113)		Aged 12-14 (N=30)		Aged 15-17 (N=83)	
	W %	n	W %	n	W %	n
Yes	24	27	7.3	2	30.1	25
No	74.2	83	92.7	28	67.5	55
Don't know / No response	1.8	3	-	0	2.4	3

## 3.7. Preparation for the Financial Demands of Adulthood

### 3.7.1. Engagement in work

When survey respondents were asked if it was easy for young people to find work to earn money, most disagreed (65%), while 22 percent agreed (see Table 31).

**Table 31. Adolescents' opinions about whether it is easy for young people to find work to earn money, by sex and age group**

	All Adolescents (N=1,115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Totally disagree	21.3	241	22.4	118	20.3	123	18.2	130	26	111
Disagree	43.4	492	42.7	237	44	255	42.7	296	44.3	196
Agree	19.7	204	17.9	86	21.5	118	18.5	109	21.5	95
Totally agree	2	22	1.9	10	2.2	12	2.8	18	0.9	4
Don't know / no response / no opinion	13.6	156	15.1	85	12.1	71	17.8	126	7.3	30

FGD participants noted that the lack of work opportunities for adolescents is a major challenge for them, with boys from Buzi and Mocuba, and married and unmarried girls from Matola emphasizing this point.

Nonetheless, many of the FGD participants (boys and girls) reported that they were involved in some form of work.

Overall, 15 percent of survey respondents reported that they were currently working outside of their household (see Table 32 below), with older children and males more likely to report this ( $p < 0.01$ ,  $p < 0.0001$ , respectively).

**Table 32. Percent of adolescents reporting that they do any work outside of their household, by sex and age group\***

Age Group (years)	All Adolescents (N=1,111)			Female Adolescents (N=536)			Male Adolescents (N=579)		
	W %	n	N	W %	n	N	W %	n	N
12-14	11.3	86	675	7.2	28	340	15.6	58	335
15-17	19.5	91	436	8.5	19	193	28.7	72	243
<b>All Adolescents</b>	<b>14.6</b>	<b>177</b>	<b>1,111</b>	<b>7.7</b>	<b>47</b>	<b>533</b>	<b>21.3</b>	<b>130</b>	<b>578</b>

\*Missing values excluded.

Examples of types of work FGD participants reported include: self-employment on the street (e.g., washing cars, carrying heavy luggage, small businesses or petty trade, selling food or other items, reed cutting and sale for construction), running errands (e.g., fetching water, washing clothes), or working for others (farming labor, mason helper, *chapa*/taxi helper). Table A25 in the Appendix provides a breakdown of the types of work survey respondents cited, which aligns well to the types of work FGDs participants described.

FGD participants reported that work was not typically steady, although adolescents indicated that they seek work on a regular basis, which they said was due to pressure to earn money to cover their personal costs (e.g., schooling expenses, clothing) and/or contribute to their household income. As stated by boys from

Mocuba: "Some [adolescents] pay their own studies, care for the family. I, for an instance, help my mother because she doesn't work. (...) Others invest in their own businesses, those who help their families go more for food and other needs." The need to work was described as particularly acute in child-headed households, where a young person may need to provide the income for an entire household. Adolescents reported mainly part-time work, generally carried out alongside schooling and household chores. An exception was one adolescent who worked full-time as a nanny.

A few FGD participants cited examples of adolescents they know with skilled work: in the FGD with married girls in Mocuba, one participant noted knowing a skilled worker (nurse), and in the FGD with boys in Mocuba, participants referenced adolescent entrepreneurs who started their own businesses (e.g., a hair salon).

### 3.7.2. Payment for work

Survey respondents were asked if they were paid for the work they conducted outside of the home. Almost all adolescents (93%) reported that they did receive payment (see Table 33 below). There were no statistically significant differences by age or sex.

**Table 33. Percent of adolescents who reported having received money for work they have done outside of their home, by sex and age group\***

Age Group (years)	All Adolescents (N=177)			Female Adolescents (N=47)			Male Adolescents (N=130)		
	W %	n	N	W %	n	N	W %	n	N
12-14	91.9	79	86	87.9	25	28	93.8	54	58
15-17	94.2	84	91	94.1	17	19	94.2	67	72
<b>All Adolescents</b>	<b>93.1</b>	<b>163</b>	<b>177</b>	<b>90.4</b>	<b>42</b>	<b>47</b>	<b>94.1</b>	<b>121</b>	<b>130</b>

\*Missing values excluded.

### 3.7.3. Occupational training

In general, FGD respondents – both boys and girls, single and married – stated that their communities have little to no training opportunities for adolescents who wish to learn a skill or prepare for a job. The existing work-related opportunities are generally related to the set-up of small businesses (e.g., baking and selling cookies), rather than being designed to develop skills. This is well summarized by a single girl from Buzi: "There are no opportunities to learn new skills, but rather to do business – sell peanuts, bananas, popsicles."<sup>15</sup>

Despite this, male FGD participants from Matola and Mocuba (but not Buzi) mentioned that they informally learn skills by working as helpers of masons and carpenters, usually their relatives. These do constitute training opportunities, although they are not part of a formal training program and are limited to the family sphere.

<sup>15</sup> A few participants recalled past training opportunities, which are no longer in place, such as training in sewing by a local association (single girls, Matola).

Survey respondents also mentioned limited training opportunities. Twenty three percent said they received training for the work they do outside the home. Females were slightly less likely to report having received training for the work they do, especially those aged 15-17 years (see Table 34), but this finding was not statistically significant.

**Table 34. Percent of adolescents who reported having received training for any of the work they do outside their home, by sex and age group\***

Age Group (years)	All Adolescents (N=176)			Female Adolescents (N=47)			Male Adolescents (N=129)		
	W %	n	N	W %	n	N	W %	N	N
12-14	21.0	18	85	25.2	8	28	18.9	10	57
15-17	25.5	25	91	12.8	3	19	28.6	22	72
<b>All Adolescents</b>	<b>23.4</b>	<b>43</b>	<b>176</b>	<b>20.1</b>	<b>11</b>	<b>47</b>	<b>24.6</b>	<b>32</b>	<b>129</b>

\*Missing values excluded.

### 3.7.4. Savings

Survey respondents who reported that they were working outside the home were asked if they had saved any of the money that they had earned. Just over one-quarter (27%) of respondents reported that they had saved money, with female adolescents more likely to report this, although the difference was not statistically significant. There we also no statistically significant differences by age (see Table 35).

**Table 35. Percent of adolescents who report having saved any of the money they have earned, by sex and age group\***

Age Group (years)	All Adolescents (N=159)			Female Adolescents (N=40)			Male Adolescents (N=119)		
	W %	n	N	W %	n	N	W %	n	N
12-14	25.5	17	77	32.9	6	24	22.1	11	53
15-17	28.7	25	82	36	5	16	26.9	20	66
<b>All Adolescents</b>	<b>27.3</b>	<b>42</b>	<b>159</b>	<b>34.3</b>	<b>11</b>	<b>40</b>	<b>24.9</b>	<b>31</b>	<b>119</b>

\*Missing values excluded.

### 3.7.5. Employment aspirations

As for the future, all FGD participants said that they would like to work in skilled professions. The most common professions mentioned were related to the health (medical doctor, nurse), education (teacher), and transportation (mechanic, pilot, driver) sectors. Some participants also mentioned accountant and engineer. All FGD participants were aware that these professions require studies in higher education, and respondents noted that personal dedication, financial resources, and support from family are key to achieving success.

These findings are in line with those from the survey. Survey respondents were asked how they might earn money as an adult. Two-thirds (62%) said they would like to study to have a good job when they are an adult, and 20 percent cited their desire to have their own business (see Table A26 in the Appendix).

Survey respondents were also asked if they thought it would be easy for them to find work as an adult. Exactly half disagreed, with 29 percent agreeing that it would be easy for them to find work as an adult. A large minority (21%) did not know or did not respond to the question (see Table 36 below).

**Table 36. Adolescents' opinions about whether it will be easy for them to find work when they are an adult, by sex and age group**

	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Totally disagree	11.9	146	11.6	66	12.2	80	11.4	84	12.6	62
Disagree	38	399	38	195	38	204	34	218	44	181
Agree	25.9	300	25.3	134	26.4	166	28	197	22.7	103
Totally agree	3.5	31	4.1	17	2.9	14	4.7	22	1.7	9
Don't know / no response / no opinion	20.7	239	21	124	20.4	115	21.8	158	19	81

### 3.8. Civic Engagement

Data suggest low levels of adolescent civic engagement in decision making about their community and their schooling. That said, the majority of adolescents (66%) feel they can make a difference in their community (see Table A27 in the Appendix), and 86 percent agree or totally agree that is important for them to contribute to their community and society (see Table A28 in the Appendix) Thirteen percent of adolescents said they were leaders in the groups they participate in (see Table A29 in the Appendix).

#### 3.8.1. Community groups

Just 6 percent of all adolescents surveyed reported participating in community groups on a regular basis (see Table 37 below).

**Table 37. Percent of adolescents who currently participate in any community groups on a regular basis, by sex and age group\***

Age Group (years)	All Adolescents (N=1109)			Female Adolescents (N=532)			Male Adolescents (N=577)		
	W %	n	N	W %	n	N	W %	n	N
12-14	5.3	44	674	4.1	17	340	6.7	27	334
15-17	6.8	35	435	7	16	192	6.7	19	243
<b>All Adolescents</b>	<b>5.9</b>	<b>79</b>	<b>1109</b>	<b>5.2</b>	<b>33</b>	<b>532</b>	<b>6.7</b>	<b>46</b>	<b>577</b>

\*Missing values excluded.

All FGD participants, regardless of sex or marital status, stated that opportunities for adolescents to participate in decision making about community life are limited. The most commonly mentioned reason for this lack of participation was that community groups are limited to adults, with adolescents being excluded from decision-making processes: "(...) *the elders do not allow our [adolescents'] participation in decision making, because they think we are children (...)* They [elders] think that adolescents do not have the capacity to bring ideas for the society" (boys, Buzi).

This view expressed by FGD participants diverged somewhat from those recorded by survey respondents. When asked if they agreed that adults in their community listen to what they have to say, almost half (48%) agreed, with adolescents in the older age group more likely to agree (see Table 38).

**Table 38. Adolescents' opinions about whether adults in their community listen to what they have to say, by sex and age group**

	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Totally disagree	6.7	88	5.9	36	7.6	52	7.5	59	5.6	29
Disagree	31.1	352	30.9	172	31.3	180	33.3	213	27.8	139
Agree	44.3	461	47.6	233	41.1	228	38.9	253	52.3	208
Totally agree	3.9	35	4.4	18	3.3	17	3.5	20	4.5	15
Don't know / no response / no opinion	14	179	11.2	77	16.7	102	16.8	134	9.8	45

### 3.8.2. School groups

One-fifth (23%) of survey respondents reported participating in school groups on a regular basis (see Table 39).

**Table 39. Of adolescents enrolled in school, percent who currently participate in any school groups on a regular basis, by sex and age group\***

Age Group (years)	All Adolescents (N=821)			Female Adolescents (N=392)			Male Adolescents (N=429)		
	W %	n	N	W %	n	N	W %	n	N
12-14	23.4	136	542	21.8	61	265	25	75	277
15-17	22.7	66	279	21.8	27	127	23.6	39	152
<b>All Adolescents</b>	<b>23.2</b>	<b>202</b>	<b>821</b>	<b>21.8</b>	<b>88</b>	<b>392</b>	<b>24.5</b>	<b>114</b>	<b>429</b>

\*Missing values excluded.

FGD participants noted few opportunities to participate in decision making at school, stating again that decisions were made by adults, i.e., the school board and parents, and that adolescents were not engaged. "At school there are opportunities to participate in awareness-raising debates, but not in decision making. The latter is meant for parents only" (boy, Mocuba).

However, respondents said that adolescents (students) participate in debates and other awareness-raising activities at school about social and health issues, led by teachers: "There are not opportunities for [participation in] decision making, but instead we talk about all problems in the community, such as how to live in [the] community and avoid diseases." (boy, Buzi). FGD respondents across the three study locations mentioned having participated in at least one debate in school.

### 3.8.3. Church groups

One-fourth (25%) of survey respondents reported regularly participating in church groups, with females (particularly those aged 15-17 years) more likely to report participation ( $p < 0.01$ ) (see Table 40).

**Table 40. Percent of adolescents who currently participate in any church groups on a regular basis, by sex and age group\***

Age Group (years)	All Adolescents (N=1108)			Female Adolescents (N=532)			Male Adolescents (N=576)		
	%	n	N	%	n	N	%	n	N
12-14	24.1	169	674	28.1	92	340	19.8	77	334
15-17	26.9	132	434	32.8	66	192	21.8	66	242
<b>All Adolescents</b>	<b>25.2</b>	<b>301</b>	<b>1108</b>	<b>29.9</b>	<b>158</b>	<b>532</b>	<b>20.7</b>	<b>143</b>	<b>576</b>

\*Missing values excluded.

### 3.9. Impressions of COVida Interventions

#### 3.9.1. Youth groups

All FGD respondents – regardless of sex or marital status – said they would like to be part of a youth group. Participants’ main interest in youth groups was the opportunity to talk about their problems and learn new things (all respondents): *"Yes, we would like [to participate in the group] because there is exchange of experiences and ideas, and so we can develop well, interact with other adolescents and debate our problems"* (boy, Buzi). Additionally, participants noted that youth groups allow for meeting new people (boys, Buzi) and can help adolescents to learn to speak up (married girls in Matola said adolescents were often too shy to speak up in public).

The majority of respondents (all but one boy from Mocuba) expressed that they would like to participate in youth groups led by an adult to learn from adults’ knowledge and life experience. The gender of the adult leader was not specified. Other qualities sought in group leaders were responsibility, politeness, and ability to listen. Participants from two groups mentioned that this adult could be an *activista* or counselor (single girls, Buzi and married girls, Matola).

Respondents acknowledged that participation in youth groups may be limited by a number of personal factors, namely (from most to least commonly mentioned): lack of interest (unmarried girls and boys, Buzi, married girls, Matola, unmarried girls, Mocuba); a preference to participate in “grown-up” activities (unmarried girls and boys, Buzi and boys and married girls, Mocuba); wishes to spend time drinking, smoking, taking drugs – some adolescents would rather go out drinking than be with “children”; fear of being offended (married girls, Buzi); difficulties in speaking up (unmarried girls, Matola); a lack of time (married girls, Matola); and husbands prohibiting their participation (married girls, Buzi). As stated by boys in Buzi: *"Some would say 'Me, hang out with children? It would rather stay at home, sleeping.' Others prefer to go drinking rather than be in a group of children who can't even read."* This was seconded by single girls also in Buzi; *"Some friends know that we are going to debate good things, things that are useful to our lives, but they don't like it, they don't care, they just want to do their own things. Others just want to have fun. Others have no time."*

### 3.9.2. Youth-oriented savings groups

Many FGD respondents expressed interest in joining savings groups oriented to youth. Participants noted positive outcomes from adults' savings groups and based on this expressed that their parents would allow them to participate in a youth-oriented savings group. Adolescents felt that participation in a savings group would strengthen their ability to meet their personal needs (e.g., school material and fees, house rental, house appliances). Unmarried girls and boys from Buzi also felt that participation in a savings group could help them start up a small business and therefore have more productive means going forward:

*"We would like [to participate in such a group] because it would help us with many things. If you don't have money to pay for your school photocopies, you can take some from the group and pay it back (...) This kind of group helps a lot in the community. People can save with money earned from business, selling bananas, cakes, peanut"* (unmarried girls, Buzi).

Many adolescents cited barriers to participation, including a lack of time (boys, Buzi) and a lack of money to contribute to the group (boys and married girls in Buzi). Some participants in Matola explained that they had no need for savings (married girls, Matola). Other barriers to participation reported include: fear of losing money, fear of going into debt, and fraud. Some adolescents also were suspicious of the integrity of community savings groups and did not understand the model. As reported by one respondent: *"When you take money from the savings group, the way to pay it back is not fair. There are interest rates and when you don't pay they can break in your house and take your assets"*.

When asked where they would get money to participate in a savings group, participants said they could use their own income (i.e., earned from doing odd jobs or engaging in petty trade) or ask for money from their parents.

The majority of respondents said that savings groups for adolescents/youth should be led by an adult, who they felt is best placed to guide the group and control the money flow. Single girls from Mocuba expressed a preference for the group leader to be a girl their age or an adult woman. The majority of respondents reported a preference for mixed gender groups; however single and married girls in Buzi (and some single female participants in Mocuba) preferred a girls-only group.

### 3.9.3. Linha Fala Criança

None of the participants had heard of *Linha Fala Criança*. Once facilitators explained the concept of the helpline, all participants indicated interest in using it to report problems affecting them (e.g., physical and sexual violence, early marriage, child care issues): *"(...) we would use it to be helped and expose our problems to those who can solve them"* (boys, Buzi); *"When your mother forces you to marry someone you don't like, you can call [the helpline]"* (single girls, Buzi) and *"[We would call the helpline]... In case of rape, physical aggression, abandonment by parents, and alimony too"* (married girls, Matola). To increase the helpline's reach, participants recommended sharing information about the helpline through social media and at school/community debates.

## 4. Discussion

This study provides a situational analysis of nearly 1,500 adolescents aged 12-17 years served by the COVida project in 2017. This is the largest repository of information on adolescents aged 12-14 years that we know of in Mozambique and complements available data on 15-17-year-old adolescents collected during the 2015 DHS. The findings illuminate beneficiary population needs and will be used to inform program management decisions.

### 4.1. Education

Adolescents viewed education as critical to securing a strong future for themselves and their families. They described how higher education was necessary to obtain the types of skilled work they aspired to (doctors, nurses, teachers, engineers etc.).

Still, only three-quarters (73%) of adolescents reported being enrolled in school.<sup>16</sup> This is higher than the 62 percent enrollment rate found in the 2011 Demographic Health Survey (DHS) for the closest comparable age bracket (adolescents aged 13-17 years) (MISAU, INE & ICFI, 2011). Further, the DHS found that secondary school age males were more likely to be enrolled than females (68% vs. 56%) (data extracted from the 2011 DHS by Education Policy and Data Center, 2014); however, we did not note any differences by sex in this study. This difference in these findings may be attributable to increases in national enrollment rates between 2011 (year of the DHS) and 2018, or due to the nature of the COVida population surveyed. Community workers support COVida beneficiaries to continue in school or to re-enroll after drop-out.

Despite reasonably high enrollment rates, this study found that adolescents are prone to missing school days. Two-thirds of adolescents aged 12-14 years reported regularly attending school, as compared with half (51%) of adolescents aged 15-17 years.<sup>17</sup> By far, being too sick to participate was the most cited reason for not regularly attending school. This finding highlights the unique characteristics of the COVida population – households vulnerable due to exposure to HIV and AIDS and other chronic diseases.<sup>18</sup>

FGD participants cited pregnancy or early marriage as reasons that female adolescents drop out of school. Being pregnant and in school was described as extremely challenging due to stigma and bullying by peers and teachers.<sup>19</sup> Respondents noted that married school aged adolescents are often prevented from attending school by their husbands who prioritize their duties in the home. Pregnancy was linked to school drop out in a recent quantitative analysis of clinical data from Beira, Mozambique (Pizzol, et al., 2018).

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<sup>16</sup> The broader survey of COVida caregivers found that 70 percent of adolescents ages 13-17 years were enrolled in school (Chapman et al, 2018a)

<sup>17</sup> The broader survey of COVida caregivers found that 56 percent of adolescents ages 13-17 years were regularly attending school (52% of 15-17 year olds) (Chapman et al, 2018a).

<sup>18</sup> The broader survey of COVida caregivers found that 12 percent of 10-14 year olds and 14 percent of 15-17 year olds were too sick to participate in daily activities at some point in the two weeks prior to survey (Chapman et al, 2018a).

<sup>19</sup> In Mozambique, pregnant adolescents are only able to attend night school, by law (Decreto 39/GM/2003).

## 4.2. Hope and Social Support

Hope reflects a sense of goal-directed thinking (Snyder, Irving and Anderson, 1991). Hopefulness has been negatively associated with depression among children (Snyder, Hoza, et al., 1997) and positively associated with educational outcomes (Snyder, Harris, et al., 1991; Snyder, Hoza, et al., 1997). Furthermore, hopefulness has been positively associated with a reduction in adolescent engagement in sexually risky behaviors (Abler et al., 2017), including later sexual debut (Hill, L. et al., 2017).

Adolescents in this study were generally hopeful. However, the range of hope scores was variable, with some indicating very low hopefulness. Economic strengthening activities, vocational training opportunities, and family planning may be important interventions to improve adolescents' hopefulness and confidence in their future.

Children grow in part by modelling the behavior of those around them. While a majority of adolescents in this study reported that they had someone to look up to, almost one-fifth (17%) said they did not. Further work is needed in supporting guardians and older siblings to become active and available positive role models for younger children, and in supporting adolescents to seek and connect with positive role models from outside their households.

Similar to having someone to look up to, young people need someone to talk to about what is going on in their lives – someone that will listen, and someone that can help direct them to information and help if needed. In this study, a large minority (40%) of adolescents said they did not have anyone to talk to about their problems. Relatedly, we found that 10 percent of adolescents felt that their guardians did not respect them. This perceived disrespect would preclude a supportive relationship between guardians and adolescents. COVida can support guardians in their parenting roles and create opportunities for social support. We noted a great deal of interest among respondents in the FGDs in joining a youth group led by adults where they could talk about their problems.

## 4.3. Safety

Most adolescents said they feel comfortable walking in their community during the day and almost all adolescents feel safe at home. However, one-tenth of adolescents said they did not feel safe at school. This may be linked to the stories shared by focus group participants about sexual assault by professors and bullying at school (particularly of pregnant adolescent girls). Similar concerns regarding sexual assault and abuse of power were described in a recent study of adolescent girls and young women in Mozambique (do Nascimento, Costa and Chapman, 2018), and this finding has been echoed in other sub-Saharan African contexts (Dedy, 2010; Burton & Leoschut, 2013; Nyanzi, et al., 2000; and Mpangile, et al., 1993, among others). For OVC programs like COVida that are working to support girls and boys to stay in secondary school, it will be important to recognize this issue and address safety-related challenges at school.

## 4.4. Sexual behavior

This study measured four aspects of sexual activity linked to risk of early pregnancy and HIV transmission: age of sexual debut, number of recent sexual partners, age of first sexual partner, and condom use.

This study found that 27 percent of adolescents aged 12-17 years have ever had sex – 12 percent of those aged 12-14 years and 49 percent of those aged 15-17 years. The 2015 IMASIDA study reported that 25 percent of adolescents debuted sexually before age 15 (MISAU, INE & ICF, 2015). Although our study did not measure sexual debut prior to age 15, results appear to be reinforcing.

Although inconclusive, some evidence suggests that higher age differentials between sexual partners support greater sexual risk taking (Beauchair, Dushoff and Delva, 2018; Harling, et al., 2014; Maughan-Brown, Evans and George, 2016) and ultimately higher HIV incidence (Schaefer, et al., 2017; Gregson, et al., 2002; Kelly, et al., 2003; MISAU, INE & ICF, 2010) due to more complex power dynamics and the increased likelihood that older men, as opposed to younger men, are HIV-positive. Among adolescents surveyed in this study, the mean age of females' first sexual partner was nearly 17 and the mean age of males' first sexual partner was 13. Of great concern, boys reported sexual partners as young as 5 years of age. It is possible or even likely that this question was misunderstood, but this finding should be urgently explored with the intent to prevent abuse. We did not identify any recent studies in Mozambique on age of first sexual partner among adolescents aged 12-17 years; however, a recent study on the male partners of adolescent girls and young women in three urban and peri-urban locations in Mozambique found that adolescent girls did tend to have male partners who were slightly older in age (Chapman et al., 2018b).

More clearly aligned to HIV risk is condom use. In line with national data for older adolescents (aged 15-19 years), we found low rates of condom use at first and last sex among adolescents surveyed, with rates among 12-14 year olds lower than those among 15-17 year olds, and rates reported by males lower than those reported by females. Overall, less than one-third (30%) of all adolescents aged 12-17 years reported using a condom at first sex (only 21% of adolescents aged 12-14 years), going up to 38 percent at last sex (only 28% of adolescents aged 12-14 years). These statistics highlight the need for HIV risk reduction programming, including condom use promotion, among younger adolescents. The most recent IMASIDA report found that 43 percent of all female adolescents aged 15-19 years and 29 percent of all male adolescents aged 15-19 years who had at least two sexual partners in the last 12 months used a condom during their last sexual encounter (MISAU, INE & ICF, 2015). When asked if they could obtain a male condom, male adolescents were much more likely to report positively compared to female adolescents (82% of boys vs. 55% of girls).

#### 4.5. HIV Knowledge and Practices

HIV knowledge was mediocre among adolescents in this study, with boys and older adolescents generally having better knowledge than girls and younger adolescents. Adolescents named abstinence (57%), be faithful (68%), and use condoms (61%) as prevention strategies, respectively, and similar proportions understood mother-to-child transmission. A slightly higher proportion (up to 71%) rejected some of the major misconceptions around HIV transmission, but only 61 percent believed that a healthy-looking person could have HIV. This latter finding dovetails with a recent finding from a qualitative study conducted in Mozambique which reported that youth felt that only sick-looking people should be tested for HIV (do Nascimento, Chapman & Costa, 2018). Indeed, only 40 percent of adolescents surveyed had been tested for HIV. These data are on par with results from the IMASIDA survey, which found that 40 percent of females and 18 percent of males aged 15-19 years had ever been tested for HIV (MISAU, INE & ICF, 2015).

Unsurprisingly, older adolescents were more likely to have both tested for HIV and to have received the results of their HIV test. It is possible that younger children test for HIV with their guardians (by Mozambican law, caregiver consent is required for HIV testing under age 13<sup>20</sup>) and that caregivers do not share the results with their children.

HIV treatment knowledge was relatively high – 84 percent of adolescents knew that people living with HIV could live a long life on antiretroviral treatment. Participants in two focus groups noted the importance of initiating HIV treatment as early as possible after testing.

Importantly, adolescents overwhelmingly named their guardians as their most trusted source of information on HIV (58%); only 5.5 percent were comfortable talking to their guardians about sex, suggesting that adolescents do not speak directly about HIV prevention or their personal risk with their guardians. Engaging and training guardians on how to discuss HIV with their children may be an important avenue for increasing HIV knowledge and HIV testing among adolescents.

#### 4.6. Family Planning and Attitudes about Pregnancy

Our findings suggest that most female adolescents want to avoid pregnancy in childhood; however, female adolescents lack the necessary knowledge (37% of female adolescents reported knowing where they could obtain a modern method of family planning), skills (42% of female adolescents say they had the skills to avoid an unplanned pregnancy), and agency to prevent early pregnancy (49% of female adolescents said that they could begin a family planning regimen if they wanted to). Only one-quarter (24%) of sexually debuted female respondents said they were using a family planning method at the time of the survey.

Indeed, contraceptive use is low across Mozambique and unmet need for family planning among married women is high – just 16 percent of sexually active female adolescents aged 15-19 years are using a form of modern contraception, and 63 percent of married females aged 15-19 years have an unmet need for family planning (MISAU, INE & ICF, 2015).

Exposure to information on family planning was lower than for HIV, especially among younger adolescents. Efforts to integrate HIV and family planning messaging into adolescents' sexual education curricula and parenting interventions would broaden reach of behavior change communication.

#### 4.7. Attitudes on Early Marriage

Even though focus group participants reported knowing girls under 18 years who were married, almost all respondents said they do not want to get married before the age of 18, and that their guardians do not want them to get married before age 18 either. Early marriage in Mozambique is far too common of a phenomenon – 48 percent of girls are married by the time they turn 18 (UNICEF, 2014). In focus groups, early marriage was discussed in light of economic need (that of the immediate family of the adolescent girl,

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<sup>20</sup> However, within adolescent-specific health services in Mozambique, called *Serviços de Amigos dos Adolescentes e Jovens* (SAAJ), children aged 11 and above are able to obtain an HIV test without caregiver consent.

or the girl herself). Recent research in Mozambique with adolescent girls and young women identified that becoming pregnant before marriage was a driver of early marriage for adolescent girls (do Nascimento, Costa & Chapman, 2018). Projects like COVida can work to tackle some of the root causes of early marriage, such as poverty and unplanned pregnancy.

#### 4.8. Preparing for Adulthood: Work and Civic Engagement

Preparing adolescents for the financial demands of adulthood is a critical component of any development strategy. Education is important, but adolescents also need to be engaged in the workforce (in a way that does not interfere with their studies) at a reasonable age to build experience and skills. We hope to find low rates of reported work among 12-14-year-olds but higher rates among 15-17-year-olds who are preparing for the marketplace. In this study we found that 11 percent of adolescents aged 12-14 years and 20 percent of adolescents aged 15-17 years work outside of the home, and most earn money for the work that they do. Of those who reported earning money, one-fourth had savings. Adolescents were interested in working more to enable them to earn money to pay for their expenses, such as school supplies; however, they felt that opportunities to work or participate in any occupational training that would lead to a job were limited. Although we could not find any sources of data on adolescent employment in the 12-14-year-old age band, these observations broadly support national data. The most recent DHS found that only 52 percent of adolescents aged 15-19 years worked in the 12 months prior to the survey (MISAU, INE & ICF, 2015), and the International Labor Organization estimates unemployment among adolescents aged 15-24 years in Mozambique at 43 percent (ILO, 2018).

A majority of FGD respondents shared an interest in participating in savings groups, even those who did not have a source of income, saying that they could draw on the limited pocket money provided by their guardians. Certainly, working adolescents who have managed to save on their own would be strong candidates for savings group members. COVida interventions that target adolescents for economic empowerment and training were of great interest to both female and male adolescents in our study.

Another key component of adolescent development is civic engagement, which teaches leadership skills and empowers adolescents to promote change in their communities and schools. In this study we found that civic engagement was very low among adolescents – particularly at the community level. FGD respondents indicated that adults were not generally interested in their opinions and thoughts around the community, but that they could be more engaged in school settings. Close to one-fourth of participants (23%) were in school groups, and one-fourth participated in church groups (with girls more likely to be engaged than boys). Despite low levels of reported engagement, adolescents appear interested in voicing their opinions – FGD respondents reported interest in participating in COVida youth groups.

## 5. Recommendations

This study has identified a number of recommendations for donors and partners working to improve the health and social outcomes of adolescents aged 12-17 years in Mozambique:

**Improve on employment opportunities and community-level economic strengthening services for adolescents, including vocational training opportunities:** Unemployment among adolescents ages 15-19 years is estimated to be nearly 50 percent, and yet data show that adolescents need economic opportunities to care for their families and engage in productive lives. Donors may consider initiatives to improve employment opportunities in adolescence through tertiary education and vocational training programs, as well as partnerships with large employers. Adolescent poverty has also been linked to sexual risk-taking behavior, where largely females are forced into transactional relationships to feed their families or obtain materials goods. Adolescent employment initiatives create triple dividends in terms of health, economic growth, and even national stability. We further encourage the growth of economic strengthening programming such as savings groups tailored to adolescents. Savings groups were viewed by adolescents in this study as overwhelmingly positive yet unavailable in their communities.

**Address school safety:** Given the importance of education in securing productive employment and particularly in enabling adolescents to achieve their employment aspirations, and the protective effect of staying in school vis à vis HIV transmission, we recommend that OVC programs work closely with education projects, local government, the Ministry of Education, and the Ministry of Gender, Children and Social Action to ensure that schools are safe spaces for adolescents. We recommend a national effort to address bullying of pregnant teens and the predatory sexual behavior of school teachers and administrators.

**Encourage parental engagement in discussing sex, family planning, and HIV:** We found significant gaps in knowledge regarding HIV and family planning, a large unmet need in family planning, and limited condom use in sexual relationships among adolescents. We also found that guardians are the most trusted source of information for HIV. We recommend that projects leverage parenting training and education delivered through case managers to empower guardians to discuss these issues with their sons and daughters. Case managers can play a role of providing resources and education to caregivers and linking them and their children to necessary services in their community.

**Promote youth (or adolescent-specific) groups for information sharing on sex, early marriage, family planning, HIV, and discussing other problems in adolescence/youth:** Respondents explained that youth groups may fill a gap in their lives – providing an opportunity for them to discuss their problems with adults and other peers. Youth groups can also be a venue through which to share information on HIV and family planning, and link adolescents to services. Related to this, donors and programs could pilot role model initiatives through which productive peers or adults in the community are identified and trained to support younger adolescents.

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## Appendix 1: Additional Data Tables

**Table A13. Adolescents' responses to the question: *Girls should complete secondary school. Do you....?***

	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Strongly disagree	0.5	3	0	0	0.9	3	0.3	2	0.7	1
Disagree	4.1	39	4.1	17	4	22	4.1	23	4.1	16
Agree	60.2	680	61	335	59.4	345	58.5	397	62.8	283
Strongly agree	31.3	345	32.4	166	30.3	179	32	219	30.3	126
Don't know / no response / no opinion	3.9	48	2.5	18	5.3	30	5.2	38	2.1	10

**Table A14. Adolescents' responses to the question: *Boys should complete secondary school. Do you....?***

	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Strongly disagree	0.6	5	1	4	0.3	1	0.5	2	0.8	3
Disagree	2	23	2	11	1.9	12	2.5	17	1.1	6
Agree	61.5	673	64.1	341	59	332	59.9	402	63.9	271
Strongly agree	32.6	371	30.1	159	35.1	212	32.7	223	32.5	148
Don't know / no response / no opinion	3.3	43	2.8	21	3.8	22	4.4	35	1.8	8

**Table A15. Adolescents' responses to the question: *It is very important to me that I complete secondary school.***

	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Strongly disagree	0.3	3	0.3	1	0.4	2	0.4	2	0.2	1
Disagree	3.1	33	3.4	17	2.8	16	3.1	20	3	13
Agree	50.7	559	51	278	50.4	281	49.8	330	51.9	229
Strongly agree	42	469	41.7	217	42.3	252	42.8	293	40.8	176
Don't know / no response / no opinion	3.9	51	3.7	23	4.1	28	3.8	34	4.1	17

**Table A16. Adolescents' responses to the question: *It is difficult for girls to complete secondary school. Do you....?***

	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Strongly disagree	2.7	28	3.1	18	2.2	10	2.9	19	2.3	9
Disagree	23.5	264	25.4	136	21.8	128	23.2	161	24.1	103
Agree	44	508	44.8	248	43.2	260	41.3	284	48.1	224
Strongly agree	21.7	217	21.1	97	22.3	120	22.5	139	20.5	78
Don't know / no response / no opinion	8.1	98	5.6	37	10.5	61	10.1	76	5	22

**Table A17. Adolescents' responses to the question: *It is difficult for boys to complete secondary school. Do you....?***

	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Strongly disagree	4.6	51	4.1	22	5	29	4.5	32	4.7	19
Disagree	31.4	359	31.8	174	31	185	32.7	218	29.5	141
Agree	38.4	429	38.6	210	38.2	219	33.6	238	45.4	191
Strongly agree	18.3	186	18.6	86	18.1	100	19.7	120	16.2	66
Don't know / no response / no opinion	7.3	90	6.9	44	7.7	46	9.5	71	4.1	19

**Table A18. Overall Hope Scale Scores, by sex and age group**

Age Group (years)	All Adolescents (N=573)				Female Adolescents (N=275)				Male Adolescents (N=298)			
	Median	Mean	Range	n	Median	Mean	Range	n	Median	Mean	Range	n
12-14	2.93	2.98	1.0-4.0	328	2.92	2.98	1.4-4.0	164	2.95	3.01	1.0-4.0	164
15-17	2.91	2.99	1.3-4.0	245	2.89	2.96	1.3-4.0	111	2.94	2.98	1.3-4.0	134
<b>All Adolescents</b>	<b>2.92</b>	<b>2.97</b>	<b>1.0-4.0</b>	<b>573</b>	<b>2.90</b>	<b>2.97</b>	<b>1.3-4.0</b>	<b>275</b>	<b>2.95</b>	<b>2.99</b>	<b>2.0-4.0</b>	<b>298</b>

Note: Hope scores are summarized for those who have non-missing responses for all 12 items in the scale. N=all observations who were eligible for question. Median and mean are weighted.

**Table A19. Adolescents' responses to the question: *I have an adult in my life that I look up to. Do you...?***

	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Totally disagree	2.8	31	2	11	3.6	20	3.4	22	1.9	9
Disagree	14.6	177	15.6	92	13.6	85	13.1	99	16.8	78
Agree	52.1	574	52.8	274	51.4	300	49.4	334	56.1	240
Totally agree	25.7	265	25.1	127	26.3	138	27.5	169	23.1	96
Don't know / no response / no opinion	4.8	68	4.5	32	5.1	36	6.6	55	2.1	13

**Table A20. Adolescents' responses to the question: *My guardians care about my life and their future. Do you...?***

	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Totally disagree	0.9	9	0.8	4	0.9	5	1.1	6	0.5	3
Disagree	3.6	37	4	19	3.3	18	3.7	24	3.5	13
Agree	64.9	698	64.2	334	65.6	364	62.3	411	68.8	287
Totally agree	27.4	324	27.4	154	27.3	170	29.4	206	24.4	118
Don't know / no response / no opinion	3.2	47	3.5	25	2.9	22	3.5	32	2.8	15

**Table A9. Adolescents' responses to the question: *My guardians respect my opinions. Do you...?***

	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Totally disagree	1.4	16	1.8	10	1	6	1.5	10	1.2	6
Disagree	9.8	101	10.9	53	8.7	48	10.3	65	9.1	36
Agree	67.1	735	67.4	357	66.9	378	65	434	70.3	301
Totally agree	17.8	210	16.2	92	19.3	118	17.8	126	17.7	84
Don't know / no response / no opinion	3.9	53	3.6	24	4.2	29	5.5	44	1.6	9

**Table A10. Adolescents' responses to the question: My guardians tell me when I have done something really well. Do you...?**

	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Totally disagree	1.2	13	1.6	8	0.9	5	1	6	1.5	7
Disagree	9.8	99	9	48	10.6	51	9.7	62	10	37
Agree	69.1	753	73.1	379	65.3	374	68.6	452	70	301
Totally agree	17.7	219	14.5	88	20.9	131	18.7	139	16.3	80
Don't know / no response / no opinion	2.1	31	1.8	13	2.3	18	2	20	2.2	11

**Table A11. Percent of adolescents reporting who they talked to about their last problem in school, among adolescents attending school**

<b>Think about the last time you had a problem at school. Who did you talk to first?</b>	All Adolescents (N=824)		Female Adolescents (N=395)		Male Adolescents (N=429)		Aged 12-14 (N=544)		Aged 15-17 (N=280)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Mother	27.2	233	28.8	122	25.6	111	27.3	154	27	79
Father	4.4	44	1.9	8	6.8	36	3.3	23	6.4	21
Other adult family member	11.9	102	11	45	12.7	57	11.1	67	13.3	35
Husband/wife	0	0	0	0	0	0	0	0	0	0
Boyfriend/girlfriend	0.1	1	0.2	1	0	0	0.1	1	0	0
Sibling	4.4	46	5.1	28	3.8	18	4	26	5.3	20
Friend	2.8	28	3.2	15	2.5	13	3.2	19	2.1	9
Teacher	3.7	37	4.1	16	3.4	21	4.4	27	2.5	10
Community or church leader	0	1	0	0	0.1	1	0		0.1	1
Other	5.2	37	4.5	17	5.8	20	5.2	26	5.1	11
Did not talk to anyone	39.5	289	40.1	139	38.8	150	40.6	197	37.3	92
Does not have any problems at school	0	0	0	0	0	0	0	0	0	0
Don't know / no response	0.8	6	0.9	4	0.6	2	0.7	4	0.9	2

**Table A12. Percent of adolescents reporting who they talked to about their last problem at home**

Think about the last time you had a problem at home. Who did you talk to first?	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Mother	22.5	266	26	150	19.1	116	22.8	157	22	109
Father	4.2	48	3.3	18	5.1	30	2.4	20	6.9	28
Other adult family member	11.6	142	12.9	71	10.4	71	11.7	87	11.5	55
Husband/wife	0.1	1	0.2	1	0	0	0	0	0.3	1
Boyfriend/girlfriend	0.1	1	0	0	0.1	1	0	0	0.2	1
Sibling	6.6	84	6	40	7.2	44	6.6	50	6.7	34
Friend	4.8	54	3.7	22	5.9	32	3.1	23	7.4	31
Teacher	0.1	2	0	0	0.3	2	0.1	1	0.2	1
Community or church leader	0	1	0	0	0.1	1	0	0	0.1	1
Other	3.7	36	4	18	3.3	18	2.7	19	5	17
Did not talk to anyone	11.5	112	10.3	45	12.8	67	12.9	73	9.6	39
Does not have any problems at home	33.1	349	31.6	160	34.5	189	35.7	236	29.2	113
Don't know / no response	1.6	19	2	11	1.2	8	2	13	1	6

**Table A13. Percent of adolescents reporting who they talked to when they last had a question about their future**

Think about the last time you had a question about your future. Who did you talk to first?	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Mother	18.3	215	21.7	125	15	90	18.8	129	17.5	86
Father	4.4	57	2.8	17	5.9	40	2.9	25	6.7	32
Other adult family member	9.7	104	10.9	53	8.6	51	11	74	7.8	30
Husband/wife	0.1	1	0.2	1	0	0	0	0	0.3	1
Boyfriend/girlfriend	0.2	3	0.4	3	0	0	0	1	0.5	2
Sibling	7.3	84	7.2	43	7.5	41	6.2	41	8.9	43
Friend	7.8	79	5.9	28	9.6	51	6.1	40	10.3	39
Teacher	0.5	7	0.5	4	0.4	3	0.5	4	0.4	3
Community or church leader	0.1	1	0.2	1	0	0	0	0	0.2	1
Other	2.2	25	2	9	2.4	16	2	16	2.5	9
Did not talk to anyone	28.6	314	28.5	150	28.7	164	29.9	200	26.6	114
Does not have questions about the future	18.9	200	17.3	89	20.4	111	20	130	17.1	70
Don't know / no response	2	25	2.3	13	1.6	12	2.5	19	1.2	6

**Table A14. Percent of adolescents reporting who they talked to when they last had a question about sex**

Think about the last time you had a question about sex. Who did you talk to first?	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Mother	4.4	54	6.5	43	2.3	11	3.3	25	6	29
Father	1.1	16	0.5	4	1.7	12	1	8	1.2	8
Other adult family member	2.4	29	2.5	13	2.2	16	2.4	20	2.3	9
Husband/wife	0	0	0	0	0	0	0	0	0	0
Boyfriend/girlfriend	0.6	9	0.8	6	0.4	3	0.2	3	1.1	6
Sibling	3.5	38	3.1	18	3.9	20	2.4	15	5.1	23
Friend	17.8	215	14.2	86	21.2	129	11.4	89	27.3	126
Teacher	0.4	4	0.4	2	0.3	2	0.6	4	0	0
Community or church leader	0.1	2	0	0	0.2	2	0	0	0.3	2
Other	2.1	25	1.6	12	2.5	13	1.4	12	3.1	13
Did not talk to anyone	27.8	292	29.3	144	26.3	148	28.6	181	26.7	111
Does not have any questions about sex	34.8	364	35.1	173	34.5	191	41.4	267	24.9	97
Don't know / no response	5.2	67	6	35	4.4	32	7.4	55	2	12

**Table A15. Median age at first sexual intercourse**

Age Group (years)	All Adolescents (N=302)				Female Adolescents (N=124)				Male Adolescents (N=178)			
	Median	Mean	Range	n	Median	Mean	Range	n	Median	Mean	Range	n
12-14	12.0	12.7	11-14	83	12.2	12.8	11-14	31	11.9	12.6	11-14	52
15-17	13.9	14.2	11-17	219	14.2	14.4	11-17	93	13.7	14.1	11-17	126
<b>All Adolescents</b>	<b>13.3</b>	<b>13.8</b>	<b>11-17</b>	<b>302</b>	<b>13.6</b>	<b>14.0</b>	<b>11-17</b>	<b>124</b>	<b>13.1</b>	<b>13.7</b>	<b>11-17</b>	<b>178</b>

Note: Median and mean are weighted.

**Table A16. Percent of adolescents reporting that their first sexual partner was various ages, by sex and age group**

	All Adolescents (N=302)		Female Adolescents (N=124)		Male Adolescents (N=178)		Aged 12-14 (N=83)		Aged 15-17 (N=219)	
	W %	n	W %	n	W %	n	W %	n	W %	n
<b>5 years</b>	0.4	2	-	0	0.7	2	1.6	2	-	0
<b>7 years</b>	0.7	2	-	0	1.3	2	-	0	1	2
<b>8 years</b>	0.4	2	-	0	0.7	2	1.1	1	0.2	1
<b>9 years</b>	0.4	1	-	0	0.7	1	-	0	0.6	1
<b>10 years</b>	4.4	11	-	0	7.8	11	8.5	6	3	5
<b>11 years</b>	5.2	16	-	0	9.1	16	8	8	4.2	8
<b>12 years</b>	13.2	36	2.3	4	21.5	32	17.7	16	11.6	20
<b>13 years</b>	9.9	33	3.5	4	14.7	29	13.6	11	8.6	22

<b>14 years</b>	10.5	34	6.4	8	13.6	26	8.5	8	11.2	26
<b>15 years</b>	13.2	37	15.1	17	11.7	20	4.5	6	16.1	31
<b>16 years</b>	10.5	33	13.2	17	8.4	16	5.5	3	12.2	30
<b>17 years</b>	7.9	28	13.7	20	3.5	8	8.6	6	7.7	22
<b>18 years</b>	11.4	30	25.2	28	0.8	2	10	6	11.9	24
<b>19 years</b>	2	6	4.5	6	-	0	1.2	1	2.2	5
<b>20 years</b>	3.4	8	7.5	7	0.3	1	-	0	4.6	8
<b>21 years</b>	0.5	1	1.1	1	-	0	-	0	0.6	1
<b>22 years</b>	0.4	2	0.9	2	-	0	-	0	0.5	2
<b>23 years</b>	0.2	1	0.4	1	-	0	-	0	0.2	1
<b>24 years</b>	0.2	1	0.5	1	-	0	-	0	0.3	1
<b>No Response</b>	5.3	16	5.7	8	5.1	8	11.3	7	3.3	9

**Table A17. Adolescents' opinions about marriage, among unmarried adolescents**

		All Adolescents (N=1110)		Female Adolescents (N=531)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=431)	
		W %	n	W %	n	W %	n	W %	n	W %	n
<b>I want to get married before I turn 18</b>	Totally Disagree	37.8	443	35.1	200	40.5	243	39.8	284	34.9	159
	Disagree	51.7	556	53.3	271	50.2	285	48.3	321	56.8	235
	Agree	5.9	60	5.6	27	6.3	33	6.5	36	5.1	24
	Totally Agree	1.6	15	2.4	10	0.9	5	1.5	9	1.8	6
	Don't know / no opinion	2.9	36	3.7	23	2.2	13	3.9	29	1.4	7
<b>My guardians want me to get married before I turn 18</b>	Totally Disagree	38.9	437	39.3	209	38.6	228	40.5	281	36.6	156
	Disagree	50.5	556	48.8	257	52	299	48.5	325	53.4	231
	Agree	5.6	53	5.8	28	5.3	25	4.5	26	7.1	27
	Totally Agree	1.3	15	1.8	9	0.9	6	1.6	8	1	7
	Don't know / no opinion	3.7	49	4.3	28	3.1	21	4.9	39	1.8	10
<b>I want to marry someone who is less than 18</b>	Totally Disagree	32.7	373	31.6	179	33.8	194	35	239	29.3	134
	Disagree	56.3	626	58.9	305	53.8	321	54.9	375	58.4	251
	Agree	6.3	58	4.8	21	7.6	37	4.1	24	9.5	34
	Totally Agree	1.6	14	1.6	7	1.6	7	2	10	0.9	4
	Don't know / no opinion	3.1	39	3	19	3.2	20	4	31	1.9	8
<b>My guardians want me to marry someone who is less than 18</b>	Totally Disagree	34	394	32.2	188	35.7	206	36.2	259	30.6	135
	Disagree	55.8	605	58.3	293	53.4	312	52.9	351	60.3	254
	Agree	6.1	61	5.7	27	6.6	34	5	26	7.9	35
	Totally Agree	0.3	3	0.6	3	0	0	0.5	3	0	0
	Don't know / no opinion	3.7	47	3.2	20	4.2	27	5.4	40	1.2	7

<b>I want to have a baby before I turn 18</b>	Totally Disagree	37.1	419	33.9	191	40.1	228	39.1	272	34	147
	Disagree	51.7	589	53.3	284	50.2	305	51.1	352	52.7	237
	Agree	5.3	48	4.8	21	5.9	27	4.9	23	6	25
	Totally Agree	1.9	12	2.3	7	1.6	5	0.9	4	3.5	8
	Don't know / no opinion	3.9	42	5.8	28	2.1	14	4	28	3.8	14

**Table A18. Percent of adolescents who reject major misconceptions about HIV transmission**

		All Adolescents (N=960)		Female Adolescents (N=457)		Male Adolescents (N=503)		Aged 12-14 (N=555)		Aged 15-17 (N=405)	
		W %	n	W %	N	W %	n	W %	n	W %	n
<b>Can people get the AIDS virus from mosquito bites?</b>	Yes	17.2	165	17.9	81	16.5	84	16.6	90	18.1	75
	No	71.4	679	70.3	319	72.5	360	69.2	380	74.4	299
	Don't know / No response	11.4	116	11.8	57	11	59	14.3	85	7.5	31
<b>Can people get the AIDS virus by sharing food with someone who has AIDS?</b>	Yes	16.6	145	18.6	71	14.6	74	17.4	88	15.4	57
	No	71.2	687	69.7	324	72.6	363	66.1	369	77.8	318
	Don't know / No response	12.3	128	11.7	62	12.8	66	16.5	98	6.7	30
<b>Can people get the AIDS virus because of witchcraft or other supernatural means?</b>	Yes	11.4	105	11.4	48	11.3	57	12.7	66	9.6	39
	No	74.5	711	73.1	334	75.8	377	68.7	383	82.1	328
	Don't know / No response	14.2	144	15.5	75	12.8	69	18.6	106	8.3	38
<b>Is it possible for a healthy-looking person to have the AIDS virus?</b>	Yes	60.7	564	62.5	276	58.9	288	52.7	288	71.3	276
	No	22.3	216	20.2	92	24.3	124	25.1	136	18.5	80
	Don't know / No response	17	180	17.2	89	16.8	91	22.2	131	10.2	49

**Table A19. Percent of adolescents reporting various locations where one can get tested for HIV\***

	All Adolescents (N=656)		Female Adolescents (N=312)		Male Adolescents (N=344)		Aged 12-14 (N=329)		Aged 15-17 (N=327)	
	W %	n	W %	n	W %	n	W %	n	W %	n
<b>GATV/ATS</b>	11.7	70	14	39	9.4	31	8.6	26	14.8	44
<b>GATV/ATS Satellite</b>	1.2	11	0.9	4	1.4	7	0.6	4	1.8	7
<b>ATS</b>	3.6	17	5.0	12	2.2	5	2.7	7	4.4	10
<b>Blood Donation</b>	1.3	11	1.5	6	1.1	5	1.2	5	1.4	6
<b>Hospital/Health Facility</b>	98.1	645	96.8	304	99.4	341	97.6	324	98.6	321
<b>SAAJ</b>	1.2	11	1.2	6	1.2	5	0.4	3	2.0	8

<b>Clinic/Private Laboratory</b>	3.2	25	2.2	9	4.3	16	3.3	12	3.2	13
<b>PTV</b>	0.5	4	0.8	3	0.2	1	0.6	2	0.5	2
<b>Other</b>	1.2	3	2.3	3	0	0	1.5	2	0.8	1
No Response	3.1	18	4.0	10	2.2	8	2.7	7	3.5	11

\* Multiple responses possible.

**Table A20. Adolescents' responses to the question: Are there any special drugs that a doctor or a nurse can give to a woman infected with HIV/AIDS to reduce the risk of transmission from mother to baby?**

	All Adolescents (N=960)		Female Adolescents (N=457)		Male Adolescents (N=503)		Aged 12-14 (N=555)		Aged 15-17 (N=405)	
	W %	n	W %	N	W %	n	W %	n	W %	n
Yes	70.5	654	72.7	319	68.3	335	65.3	348	77.4	306
No	11.2	120	10.7	52	11.8	68	11.8	73	10.4	47
Don't know / No response	18.3	186	16.6	86	19.9	100	22.9	134	12.2	52

**Table A21. In the last few months, information channels through which adolescents have heard about HIV**

		All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
		W %	n	W %	n	W %	n	W %	n	W %	n
<b>Heard about HIV on the radio</b>	Yes	53.4	597	52.5	274	54.3	323	45.2	311	65.7	286
	No	45.6	504	46.3	253	44.9	251	53.7	358	33.6	146
	Don't know / No response	1.0	14	1.2	9	0.8	5	1.2	10	0.7	4
<b>Seen anything about HIV on the television?</b>	Yes	35.2	395	35.6	188	34.8	207	30.6	204	42	191
	No	63.4	703	62.5	338	64.3	365	68.4	466	56.1	237
	Don't know / No response	1.4	17	1.9	10	0.9	7	1.1	9	1.9	8
<b>Read about HIV in a newspaper or magazine?</b>	Yes	27	296	28	135	26.1	161	20.7	142	36.5	154
	No	71.7	803	70.5	391	72.9	412	77.9	526	62.6	277
	Don't know / No response	1.2	16	1.5	10	1.0	6	1.5	11	0.9	5
<b>Talked about HIV with your guardian?</b>	Yes	24.1	244	26.5	122	21.7	122	21.1	123	28.5	121
	No	74.7	856	71.8	404	77.5	452	77.7	545	70.3	311
	Don't know / No response	1.2	15	1.6	10	0.8	5	1.2	11	1.2	4
<b>Talked about HIV with your friends or siblings?</b>	Yes	37	399	35.5	175	38.4	224	30.6	197	46.4	202
	No	61.8	703	63.2	353	60.5	350	68.3	473	52.1	230
	Don't know / No response	1.2	13	1.3	8	1.1	5	1.1	9	1.4	4
<b>Talked about HIV with a</b>	Yes	10	101	10.6	46	9.5	55	9.0	55	11.6	46
	No	88.9	999	88.1	481	89.7	518	89.8	613	87.6	386

<b>community worker?</b>	Don't know / No response	1.1	15	1.3	9	0.8	6	1.3	11	0.8	4
<b>Talked about HIV with a health worker?</b>	Yes	19.7	202	22.3	106	17.1	96	15.9	100	25.2	102
	No	79.5	904	76.4	423	82.6	481	82.9	571	74.5	333
	Don't know / No response	0.8	9	1.3	7	0.3	2	1.2	8	0.3	1
<b>Talked about HIV with a Church leader?</b>	Yes	7.7	82	8.6	38	6.9	44	7.3	45	8.4	37
	No	91.3	1022	90	491	92.5	531	91.8	628	90.4	394
	Don't know / No response	1.0	11	1.4	7	0.6	4	0.9	6	1.2	5
<b>Talked about HIV with a teacher?</b>	Yes	32.1	342	33.5	163	30.7	179	29.7	187	35.6	155
	No	66.8	757	65.2	364	68.4	393	68.9	480	63.7	277
	Don't know / No response	1.1	16	1.3	9	0.9	7	1.3	12	0.8	4
<b>Talked about HIV with a sexual partner?</b>	Yes	9.9	114	10.5	56	9.3	58	3.7	26	19	88
	No	84.1	932	82.3	441	86	491	88.4	597	77.9	335
	Don't know / No response	6.0	69	7.2	39	4.7	30	7.9	56	3.1	13

**Table A22. Percent of adolescents who have heard information about family planning through various information channels, by sex and age group**

		All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
		W %	n	W %	n	W %	n	W %	n	W %	n
<b>Heard about family planning on the radio</b>	Yes	24.2	269	29.9	157	18.7	112	18.3	123	33	146
	No	73.5	819	67.9	367	78.9	452	78.8	535	65.5	284
	Don't know / No response	2.3	27	2.2	12	2.4	15	2.8	21	1.5	6
<b>Seen anything about family planning on the television?</b>	Yes	17.9	192	23.7	122	12.2	70	12.8	85	25.4	107
	No	78.9	885	73.5	398	84.2	487	82.7	563	73.3	322
	Don't know / No response	3.2	38	2.7	16	3.7	22	4.5	31	1.3	7
<b>Read about family planning in a newspaper or magazine?</b>	Yes	15.2	157	18.9	90	11.5	67	9.4	62	23.8	95
	No	82	925	78.2	430	85.7	495	87	592	74.6	333
	Don't know / No response	2.8	33	2.8	16	2.8	17	3.6	25	1.7	8
<b>Talked about family planning with your guardian?</b>	Yes	15.3	157	23	111	7.7	46	11.5	70	20.9	87
	No	81.9	922	74.2	407	89.4	515	84.9	582	77.4	340
	Don't know / No response	2.9	36	2.8	18	2.9	18	3.7	27	1.6	9
<b>Talked about family planning with your friends or siblings?</b>	Yes	19.2	192	26.6	128	12	64	13.9	81	27.1	111
	No	78.4	893	71.4	395	85.3	498	82.8	573	72	320
	Don't know / No response	2.3	30	2	13	2.7	17	3.4	25	0.8	5

<b>Talked about family planning with a community worker?</b>	Yes	4.5	48	5.4	28	3.7	20	3.8	22	5.6	26
	No	92.8	1033	92.5	495	93.2	538	92.7	629	93.1	404
	Don't know / No response	2.6	34	2.1	13	3.1	21	3.5	28	1.3	6
<b>Talked about family planning with a health worker?</b>	Yes	11.3	117	16.5	81	6.2	36	6.8	45	17.9	72
	No	86.1	964	81.6	443	90.6	521	89.5	605	81.1	359
	Don't know / No response	2.6	34	1.9	12	3.3	22	3.7	29	1	5
<b>Talked about family planning with a Church leader?</b>	Yes	3.3	38	4.5	23	2.1	15	3.4	22	3.2	16
	No	93.9	1045	93.5	500	94.2	545	93.3	633	94.6	412
	Don't know / No response	2.8	32	2	13	3.6	19	3.3	24	2.2	8
<b>Talked about family planning with a teacher?</b>	Yes	15.3	147	18	78	12.7	69	14.4	83	16.7	64
	No	81.9	932	79.7	442	84.1	490	82	569	81.8	363
	Don't know / No response	2.7	36	2.3	16	3.2	20	3.6	27	1.5	9
<b>Talked about family planning with a sexual partner?</b>	Yes	7.1	80	9.5	49	4.8	31	2.6	16	14	64
	No	87.3	968	84.7	453	89.8	515	89.8	608	83.5	360
	Don't know / No response	5.6	67	5.8	34	5.4	33	7.6	55	2.5	12

**Table A23. Places reported by female adolescents of where they can obtain a modern method of family planning, such as the birth control pill or injections\***

	Female Adolescents (N=173)		Aged 12-14 (N=74)		Aged 15-17 (N=99)	
	W %	n	W %	n	W %	n
<b>Health facility</b>	<b>94.1</b>	164	90.5	67	96.6	97
<b>Community Worker</b>	<b>1.6</b>	3	0.7	1	2.1	2
<b>Pharmacy</b>	<b>19.2</b>	35	20.2	17	18.6	18
<b>Shop</b>	<b>7.3</b>	12	10.3	7	5.4	5
<b>Community Organization</b>	<b>1.5</b>	4	2.3	2	1	2
<b>Other</b>	<b>3.9</b>	6	6.1	4	2.5	2

\* Multiple responses possible.

**Table A24. Percent of adolescents naming various places where they can obtain a male condom\***

	All Adolescents (N=597)		Female Adolescents (N=233)		Male Adolescents (N=364)		Aged 12-14 (N=287)		Aged 15-17 (N=310)	
	W %	n	W %	n	W %	n	W %	n	W %	n
<b>Health facility</b>	77.6	462	80.1	190	75.9	272	73.5	215	81.3	247
<b>Community Worker</b>	2	9	3.2	5	1.1	4	0.3	1	3.5	8
<b>Pharmacy</b>	29.9	158	30	64	29.9	94	20.2	53	38.6	105
<b>Shop</b>	41.2	254	44	104	39.2	150	39.4	115	42.8	139

<b>Community Organization</b>	1.4	9	2.1	5	0.9	4	0.9	2	1.9	7
<b>Other</b>	11.6	63	8.2	12	14	51	12.4	28	10.8	35
No Response	0.4	3	0	0	0.7	3	0.9	3	0	0

\* Multiple responses possible

**Table A5. Percent of adolescents reporting various types of work outside the household in the past week\***

	All Adolescents (N=177)		Female Adolescents (N=47)		Male Adolescents (N=130)		Aged 12-14 (N=86)		Aged 15-17 (N=91)	
	W %	n	W %	n	W %	n	W %	n	W %	n
<b>Hawk goods</b>	10	20	10.4	5	9.9	15	11.7	11	8.6	9
<b>Sell foods at the market</b>	3.8	7	11.5	5	1.1	2	2.9	3	4.6	4
<b>Household/ farm chores for other families</b>	33.4	59	41	22	30.7	37	35.3	30	31.7	29
<b>Restaurant or bar work</b>	1.8	3	3.9	2	1	1	2.9	2	0.8	1
<b>Work in a shop</b>	0.9	3	0	0	1.2	3	1.5	2	0.4	1
<b>Construction</b>	18.7	33	3.1	2	24.2	31	7.5	6	28.3	27
<b>Mining</b>	0.2	1	0	0	0.3	1	0	0	0.4	1
<b>Sewing</b>	0.6	2	0	0	0.9	2	0	0	1.2	2
<b>Mechanic</b>	0.2	1	0	0	0.3	1	0.4	1	-	0
<b>Clerk, delivery, administrative</b>	0.5	1	0	0	0.6	1	1	1	-	0
<b>Other</b>	37.8	63	37.5	14	37.9	49	40.7	36	35.3	27
No response	1.8	4	3.3	2	1.3	2	3.9	4	-	0

\* Multiple responses possible

**Table A26. Adolescents' responses to the question: How might you earn money when you are an adult?**

	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Have my own business	19.5	209	15.1	76	23.9	133	18.7	120	20.8	89
Having my own crops	7	77	7.5	43	6.6	34	7.3	50	6.6	27
Study to have a good job	61.5	694	63.4	344	59.5	350	63.1	429	59	265
Work with my parents	8.1	88	9.1	47	7.1	41	6.5	49	10.4	39
Other	3.9	47	4.9	26	2.9	21	4.4	31	3.1	16

**Table A27. Adolescents' responses to the question: I believe I can make a difference in my community. Do you...?**

	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Totally disagree	1.9	23	1.6	11	2.2	12	2.5	17	1.1	6
Disagree	14.7	170	15.5	84	13.9	86	14.8	100	14.6	70
Agree	56.1	605	58.9	297	53.4	308	52.8	347	61	258
Totally agree	9.5	96	8.4	41	10.6	55	8.6	56	10.9	40
Don't know / no response / no opinion	17.7	221	15.6	103	19.9	118	21.3	159	12.4	62

**Table A28. Adolescents' responses to the question: It is important to me to contribute to my community and society. Do you...?**

	All Adolescents (N=1115)		Female Adolescents (N=536)		Male Adolescents (N=579)		Aged 12-14 (N=679)		Aged 15-17 (N=436)	
	W %	n	W %	n	W %	n	W %	n	W %	n
Totally disagree	0.5	6	0.4	2	0.6	4	0.3	2	0.8	4
Disagree	6.4	67	6.8	31	6	36	6.2	38	6.6	29
Agree	74.6	814	74.7	390	74.5	424	72.1	478	78.2	336
Totally agree	11.5	135	11.5	64	11.4	71	13	91	9.2	44
Don't know / no response / no opinion	7.1	93	6.6	49	7.6	44	8.4	70	5.2	23

**Table A29. Percent of adolescents who are leaders in any of the groups that they participate in**

Age Group (years)	All Adolescents (N=410)			Female Adolescents (N=199)			Male Adolescents (N=211)		
	W %	n	N	W %	n	N	W %	n	N
12-14	12.3	31	242	13.2	18	125	11.1	13	117
15-17	13.1	25	168	10.7	9	74	15.3	16	94
<b>All Adolescents</b>	<b>12.6</b>	<b>56</b>	<b>410</b>	<b>12.3</b>	<b>27</b>	<b>199</b>	<b>12.9</b>	<b>29</b>	<b>211</b>