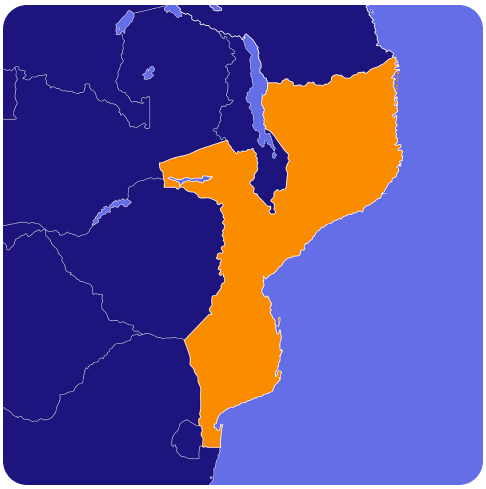
Understanding the barriers to and facilitators of access and use of sexual and reproductive health services among adolescents and young people in Nampula Province, Mozambique



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Adolescents and young people aged 10–24 constitute one-fourth of the global population, and ensuring their physical, social, emotional and financial well-being is essential for countries' overall development.[1] Globally, nine out of 10 adolescents and young people aged 10–24 live in less developed countries. Each year, adolescents aged 15–19 in low- and middle-income countries have 21 million pregnancies, 50% of which (about 10 million) are unintended.[2] In these countries, pregnant adolescents are at risk of unsafe abortion because of a variety of barriers to accessing safe abortion services, including unclear or restrictive laws, stigma and discrimination. The situation has been

While significant advances in reducing maternal and child mortality have been made in the past few decades, progress in sexual and reproductive health and rights (SRHR) has been limited in many Sub-Saharan countries, including Mozambique. Mozambique is characterized by low modern contraceptive prevalence among 15–19-year-old women (14% among those who are married and 43% among those who are sexually active and unmarried), high unmet need* for a method of family planning (31% among those who are married and 46% among those who are sexually active and unmarried), a high adolescent birth rate (158 per 1,000 women aged 15–19) and a high all-women maternal mortality ratio (233 per 100,000 live births).[4] The country liberalized its abortion law and penal code in the last decade, which confers the right to abortion on request during the first 12 weeks of pregnancy, and later in pregnancy for all other legal grounds.[5] The most recent modeled estimates indicate that the annual rate of induced abortion is 40 per 1,000 women aged 15–49.[6] Mozambique is among the five countries with the highest rates of child marriage worldwide;[7] 14% of girls enter into a union before age 15 and 46% before 18.[4]

Mozambicans with diverse sexual orientations, gender identity and gender expression face challenges in accessing health services because of stigma faced at home, in health care facilities and in their communities.[8] As of 2014,[9] the penal code no longer contains language criminalizing homosexuality.[10] The law criminalizes discrimination against someone based on their gender identity, but not on their sexual orientation, and the mechanisms for holding entities accountable are weak.

Some public policies are responsive to some of the health needs of gay and bisexual men and of transgender people.[11,12] One of the objectives of a recently approved Youth Policy Implementation Strategy is to promote equal opportunities for all, independent of sexual orientation, and to promote respect for the human rights of young people.[13] Associação LAMBDA, a Mozambican civil society organization that advocates for the recognition of the human rights of LGBT people, has been a part of the country's Ministry of Health technical working groups, discussing discrimination against homosexuality. Associação LAMBDA has also been collaborating with different government institutions for more inclusive and diversity-sensitive approaches. For instance, it has trained police officers and collaborated on the revision of the police training manual to include sexual orientation and gender identity issues.

Another impediment to young people's ability to access health services is violent conflict. Since 2017, northern Mozambique, particularly the province of Cabo Delgado, has experienced a protracted insurgency,[14] with armed forces from Mozambique, the Southern African Development Community and Rwanda fighting a loose coalition of

(IDPs).[16] The circumstances that allowed the insurgency to flourish likely include the area's long-standing social and economic conditions and poor governance, as well as the mismanagement of recently discovered natural gas and ruby resources.[17]

In Mozambique, previously identified threats to enjoyment of SRHR among adolescents and young adults include low levels of knowledge about sexual and reproductive health (SRH) in general,[18] and about HIV in particular,[18,19] as well as early marriage as it relates to both experiencing and accepting intimate partner physical violence.[20] There is little evidence on the barriers to and facilitators of access and use of SRH services among young people in Mozambique from their own perspectives. Also, little is known about the role of social norms in influencing access to SRH services among IDP and non-IDP youth in Mozambique.

Oxfam's Theory of Change encourages the assessment of threats, including harmful social norms, that may endanger the right of adolescents and young people to "have a satisfying and safer sex life" and to "make decisions concerning reproduction and sexuality free of discrimination, coercion, and violence."[21] To this end, the Guttmacher Institute, Oxfam Canada, International Planned Parenthood Federation and local partners in Mozambique—Centro de Pesquisa em População e Saúde (CEPSA, or the Center for Population and Health Research), Oxfam Mozambique, Associação Moçambicana para Desenvolvimento da Família (AMODEFA, or the Mozambican Association for Family Development), Associação Moçambicana da Mulher e Apoio a Rapariga (OPHENTA, or the Mozambican Association to Support Women and Girls) and Associação LAMBDA—initiated a project as part of the broader Stand Up for Sexual and Reproductive Health and Rights project. This project aimed to examine the barriers that marginalized and vulnerable adolescents and young people aged 10–24 in the country face in accessing high-quality SRH services, as well as the factors that potentially facilitate accessing care and enjoying SRHR. The project included a qualitative study, undertaken in 2023, exploring social norms surrounding knowledge of and barriers to accessing SRH services among male and female adolescents and young adults (15–24 years of age) in three districts (Nampula City, Nacala Porto and Mecubúri) of Nampula Province, which borders Cabo Delgado, and among LGBTQI+ (defined for this project as lesbian and bisexual) adolescent and young women (AYW) in Nampula City and Nacala Porto.

This report presents key findings and recommendations from the qualitative study, which had the following objectives:

- To understand the barriers and facilitators that impact access to SRH services among vulnerable and marginalized adolescents and young adults aged 15–24

3. To capture the health care–seeking experiences of young lesbian and bisexual women specifically

Methods

Study setting

Nampula City, Nacala Porto and Mecubúri Districts were selected for this study because of their high-risk demographic profiles. Located in the center of Nampula Province, the district of Nampula City is the main urban area of the province and northern Mozambique.[22] With approximately one million inhabitants, of which 22% are aged 15–24, Nampula City District has a roughly even proportion of Muslims and Christians (40% and 42%, respectively). The mean age at first marital union among women, 18.5, is higher in Nampula City District in comparison to Mecubúri and Nacala Porto.

Nacala Porto, situated in the northern coastal area of Nampula Province, has a population of 386,000, of which 22% are aged 15–24.[22] Roughly 79% of the population is Muslim. The mean age at first marital union among women is 17.9, and the proportion of female adolescents younger than 16 ever in a marital union is approximately 9%.

Mecubúri, located north of Nampula Province, is a predominantly rural district with roughly 248,000 inhabitants, of which approximately 19% are aged 15–24.[22] Although Nampula Province overall has a sizable Muslim population (40%), Mecubúri District is just 20% Muslim and predominantly Christian (61%). More than 20% of female adolescents younger than 16 were in ever in a marital union in Mecubúri, and the mean age at first marital union among women in the district is 15.7.

Data collection

Data were gathered via face-to-face, one-on-one in-depth interviews with lesbian and bisexual women aged 18–24. Only lesbian and bisexual participants residing in Nampula City District and Nacala Porto participated because Associação LAMBDA, which recruited these respondents, does not have a presence in Mecubúri.

ata were also collected during focus groups with adolescent and young women (AYW) aged 15–24 and adolescent and young men (AYM) aged 18–21 who were either in

are not asked about their personal behavior, but rather that of their peers and people like them. The field team struggled to recruit participants for focus groups, particularly younger respondents and IDPs in Mecubúri, because they were difficult to identify and, once identified, to persuade to attend a focus group.

Table 1: Inclusion criteria per study component

Study component	Inclusion criteria
In-depth interviews	Cisgender women aged 18–24 who identified as lesbian or bisexual and who resided in Nampula City District or Nacala Porto. All respondents were connected to Associação LAMBDA and engaged with LAMBDA's peer-support network.
Focus group discussions with IDP and non-IDP AYW aged 15–24	AYW aged 15–24, in school or out of school, who were residents of Nampula City District, Nacala Porto or Mecubúri. The parents had to consent for the adolescents aged <18 to participate.
Focus group discussions with IDP and non-IDP AYM aged 18–21	AYM aged 18–21, in school or out of school, who were residents of Nampula City District, Nacala Porto or Mecubúri.

Table 2: Description of focus groups, 2023

Sex	Group and age	Study district			Total
		Nampula City	Mecubúri	Nacala Porto	
Female	IDPs aged 15–19	2	0	1	3
	Non-IDPs aged 15–19	2	4	6	12
	IDPs aged 20–24	1	1	1	3
	Non-IDPs aged 20–24	2	2	2	6

	IDPs aged 18–21	1	1	1	3
Total		9	9	12	30

Field researchers conducted fewer focus groups with IDPs in Mecubúri and Nacala Porto because the field team had difficulty locating these individuals—many had reportedly returned to Cabo Delgado. Because the study focus was on AYW, the study design included more focus groups with AYW, which allowed for conducting separate focus groups with those in school and those out of school. As there were fewer focus groups with AYM, those who were in school and those out of school were included in the same focus groups.

Field-workers collected data in Emakhuwa, one of the main languages spoken in these districts. Bilingual transcriptionists transcribed and translated the audio files into Portuguese; field-workers reviewed and corrected the transcripts. Full details of the fieldwork have been described elsewhere (available on request).[23]

Results

Table 3. Sociodemographic characteristics of focus group respondents

Characteristics	Study district			Total	
	Nampula City	Nacala Porto	Mecubúri	No.	%
Sex					
Male	56	91	60	207	78
Female	18	21	20	59	22
Age					
15–19	41	81	38	160	60
20–24	33	31	42	106	40
Education status					
ı school	26	60	24	110	41

Education level					
No education	1	4	9	14	5
Primary	22	40	31	93	35
Secondary	51	68	40	159	60
Displacement status					
IDP	34	31	14	79	30
Non-IDP	40	81	66	187	70
Religion					
Christian	59	18	59	136	51
Muslim	15	94	21	130	49
Marital status					
Unmarried	61	93	51	205	77
Married/in union	13	18	29	60	23
Separated/divorced	0	1	0	1	0
Total	74	112	80	266	100

Table 4. Sociodemographic characteristics of in-depth interview respondents (lesbian and bisexual AYW)

Characteristics	**Study district**		**Total**	
	Nampula City	**Nacala Porto**	**No.**	**%**
Age				
18–19	4	2	6	21
20–24	9	13	22	79
Sexual orientation				
Lesbian	7	5	12	43

Education status				
In school	7	8	15	54
Out of school	6	7	13	46
Education level				
Primary	1	0	1	4
Secondary	10	11	21	75
Tertiary	2	4	6	21
Religion				
Christian	9	6	15	54
Muslim	4	9	13	46
Marital status				
Unmarried	12	11	23	82
Married/in union	1	4	5	18
Total	13	15	28	100

Contraceptive use

Young people expressed a preference for modern contraceptive methods but noted how stock-outs and the availability of a limited number of methods affected their ability to practice their sexual and reproductive rights.

Negative associations with contraceptive methods included beliefs that their use would incite promiscuity and could cause infertility.

> *They will say that one is planning to be a prostitute, doesn't want to have children now, is using contraception to be able to continue having sex when she wants to.* (young man, focus group with non-IDPs aged 18–21, Mecubúri)

> *using family planning and you haven't married yet, you don't have a kid, if in the future you're at the time in your life when you want to have a kid, you won't be able to have kids."* (young woman, focus group with IDPs aged 20–24, out of school, Nacala Porto)

Condom use

AYW and AYM acquired information about condoms when they visited health care providers, in school, in lectures at health facilities and from their friends and sexual partners. They were aware that the information they received in lectures at health facilities and in school was more comprehensive than information obtained from other sources; information they obtained in the community was more general.

> *Condom they usually teach, eh, for example in health talks with those activists….Besides what's written down on paper, they have another strategy. They usually bring a doll with them, with male genitalia. And also, they usually have a doll with female genitalia. Then, they take that male doll and they take that condom and open it, they teach how to take hold of it and how to put it on, and then how to take it off, they teach how to take it off and how to tie [it in a knot] and throw it away.* (young woman, focus group with non-IDPs aged 20–24, out of school, Nampula City)

There was little overall knowledge about female condoms. In Mecubúri, AYW who are able to obtain female condoms sometimes extract the internal rubber ring and use it as a bracelet.

> *The female condom is difficult to get, because within it there's a bracelet that we take out and wear on our wrists. Because we do this, they don't give us any…because what interests us are the bracelets.* (young woman, focus group with non-IDPs aged 20–24, out of school, Mecubúri)

> *There are people who wear ten or more on their wrists….Nurses in hospitals discourage that practice and say that the female condom must be used*

Respondents said that young people often learn about condoms after already beginning to be sexually active.

> *For example, a person who is age 12 or 13…doesn't know a person has to protect themself, usually [that young person] goes on like that [having sex without a condom]. Only when they get to be 20 or older, or [perhaps at] at age 18, does that person learn that, eh, a person must protect themself.* (adolescent woman, focus group with IDPs aged 15–19, out of school, Nampula City)

Focus groups with AYM spoke about how girls do not think about the need to use condoms to protect against STIs if they are already using another form of contraception.

> *Yes, if we focus on girls, I think that, I think that girls also don't care about diseases, they care about pregnancy only and nothing else, they think better to protect against pregnancy than diseases.* (young man, focus group with non-IDPs aged 18–21, Nampula City)

Few participants spoke about the value of using dual protection: hormonal contraception along with a condom to protect against STIs.

Adolescents in each district said that the use of condoms is uncommon, and even less common at first sex. Reasons that adolescents gave for this were that they and their peers do not like condoms (the most commonly given reason), that the couple was using another form of contraception, when the man is giving the woman money (i.e., he is paying for unprotected sex), because the people having sex do not know about condoms and because young women having sex think that they are too young to get pregnant.

> *Those that don't use anything are many, even when they tell us to use something to avoid diseases, we don't do it [*laughs*] because we're more interested in skin on skin. That's it.* (adolescent woman, focus group with non-IDPs aged 15–19, out of school, Mecubúri)

could migrate to her stomach, making her sick. Friends share information with one another about how the condom itself is a source of illnesses and infections.

> *There, when a woman refuses [to use a condom], usually it's because she's afraid of the condom remaining in her vagina and ending up going to her stomach…and when it reaches her stomach, it will rot and she will get a disease.* (adolescent woman, focus group with non-IDPs aged 15–19, in school, Mecubúri)

> *[A friend can tell you:] You must never use condoms. If you do, you'll infect yourself with HIV. Sometimes they say that condoms come with disease, come already with a disease, that's the advice of…that's what my friends tell me.* (young man, focus group with IDPs aged 18–21, Nampula City)

Partner communication about STIs

When interviewers asked how respondents evaluate the level of risk that a potential sexual partner carries, lesbian and bisexual participants most often responded that they get tested for STIs together with their partner. HIV was the most common infection risk mentioned, while a few respondents mentioned syphilis and one mentioned gonorrhea.

The second most common response was to ask if the partner had been tested for STIs.

> *I said to him that he was not going to touch me without him going there [to test].* (bisexual woman, aged 20, Nacala Porto)

Lesbian and bisexual respondents recognized that this strategy was problematic because people could hide information.

Focus group participants said that few young people ask their partners if they have an STI. Respondents said that young people do not ask because there is no time to ask: ^YM said that they do not want to lose the opportunity to have sex, while AYW said that ey do not ask when they are in love and fear rejection by the partner if they were to

would say in such situations:

> *"Why are you asking me that if you love me? If you don't love me, just go your way, I didn't come [here] so you could ask me that*." (young man, focus group with IDPs aged 18–21, Nacala Porto)

An adolescent woman shared her perspective on what her male peers would say if their sexual partners were to pose this question:

> *They ask, "Hey—are you sick or not?" And he replies, "I don't have a disease. If I was sick, would I ask you for a date? As you don't trust me, go and stay with someone who doesn't have a disease."...And you are in love, and when you think of asking again, you become afraid of being left.* (adolescent woman, focus group with non-IDPs aged 15–19, out of school, Mecubúri)

All respondents were asked if sexual partners tell the truth when asked about STIs. The majority of respondents said that not everyone tells the truth, especially when it comes to HIV infection, and not everyone tells the whole truth. Respondents stated that people lie if they have an STI and rarely reveal to their partner that they have an STI.

> *Ah they're all liars...[laughs]....But not all, it depends....But the majority lie.* (bisexual woman, aged 20, Nacala Porto)

> *And these days the boyfriends we're having, he may not tell you the diseases he has, and when he knows that he has an infectious disease, he will not tell you while he knows he has an infection....And if you don't know [he has an STI], he will leave you [implying] you're the one who gave him the disease, while he knows that he slept with another woman....And he will hide it, hide it until he's able to get an injection [of medication], get tablets, until he gets cured without you knowing it. It's difficult to have a boyfriend who gets infected and then tells you, "Hey...I have an infection*." (young woman, focus group with non-IDPs aged 20–24, out of school, Mecubúri)

situations, they knew their female partners much longer than they knew their male partners.

When asked why sexual partners may not tell the truth, respondents gave several reasons:

> *Shame, shame from others, fear of being judged....People aren't well [have STIs] but they'll never tell you they're not well....People will never say, "I'm ill," just out of selfishness.* (lesbian, aged 20, Nacala Porto)

Respondents perceived that partners were more likely to lie about the number of sexual partners they had than if they have an STI.

Observing or knowing a partner's behavior was another strategy that respondents mentioned to assess whether or not that individual was a risky sexual partner. Some bisexual respondents recognized that all sexual relations carry risk.

> *When I'm not around I don't know what the person will be doing, so I don't know....For me all relationships are risky, all relationships are risky...no...there's no...I don't trust...I don't know, maybe I'm wrong, but all relationships are risky, yahh.* (bisexual woman, aged 23, Nacala Porto)

Barriers to treating STIs

Focus group respondents spoke about getting treatment for STIs at health facilities as well as using traditional medicine. Young people use *socorristas*, or community health workers, in their neighborhoods or someone connected to a health facility to access care. Yet obtaining treatment for STIs could be challenging because young people feel ashamed for multiple reasons, including asking their partner to go with them to get tested, telling a health care provider about STI symptoms and showing genitalia to a provider.

> *When we go to the hospital, sick, and they tell us to go call our partner to get care together...we don't bring her, we feel shame, we prefer to go to the corner*

> *you come to want to blame me."* (young man, focus group with non-IDPs aged 18–21, Mecubúri)

> *I'd like to give an example of a friend of mine. He also had gonorrhea and he didn't tell anyone, nor did he go to the hospital. But only after two weeks with gonorrhea did people close to him discover it.…He wasn't even able to walk, and it was then that people discovered that he had gonorrhea and then they took him for treatment.…But that may be really shame [that prevented him from getting treatment sooner] as my friend was saying.* (young man, focus group with IDPs aged 18–21, Nampula City)

Additional concerns noted by respondents included the fear of being recognized and not wanting to know about or accept the diagnosis or the treatment given by the health professionals. Discussions suggest that stigma around HIV and AIDS is still strong among AYW and AYM. For instance, participants reported instances of peers denying their HIV diagnosis, with some believing that health professionals were lying about their HIV status. Respondents discussed AYW and AYM they know of who did not take AIDS medication given to them by the health professionals because they did not believe the diagnosis and eventually died.

> *For some it's due to fear, it's not because it [the health facility] is far, but yes, fear of going to the hospital and saying that I got infected, and of that information being shared*. (young woman, focus group with non-IDPs aged 20–24, out of school, Mecubúri)

One AYW related what she heard her peers say about seeking health care:

> *"They only want to give me [a diagnosis of infection]. They are lying to me. Where did I get it? I will not even take [the medication]." And they throw [the medication] away.* (adolescent woman, focus group with non-IDPs aged 15–19, out of school, Nacala Porto)

relationship is infrequent or casual, they find it difficult to ask partners to go with them to the health facility.

> *They make it complicated to test when you go alone, "because you didn't get that disease on your own,...you got it from another person." So they make it complicated for you to test alone....They say, "You have to bring that person who infected you with that disease to be tested as well, for us to know whether it is he or not, if it was him who infected you with that disease."* (adolescent woman, focus group with non-IDPs aged 15–19, in school, Mecubúri)

Some respondents spoke about peers avoiding health care altogether for fear of an STI diagnosis.

> *Many are afraid to go to the hospital because when they get to the hospital, they are told, "Do the test," and when it's positive [and they don't agree with the result], they want to fight with the nurses because the nurse told him that, "You are not well*." (young man, focus group with non-IDPs aged 18–21, Mecubúri)

Barriers to exercising sexual and reproductive rights

When asked about what challenges they face when exercising their sexual and reproductive rights, lesbian and bisexual respondents spoke about the lack of social acceptance, fear of being treated poorly by health care professionals, heterosexual norms, experiencing unwanted sex (within their marriages) and hiding their sexual identity from male partners.

> *Even my own mother doesn't accept me; society is even worse.* (bisexual woman, aged 21, Nampula City)

One-fourth of lesbian and bisexual respondents said that they did not experience any barriers to exercising their sexual and reproductive rights.

Lesbian and bisexual respondents reported feeling that health care professionals create a hostile and discriminatory environment through refusing treatment, ignoring lesbian and bisexual patients (i.e., leaving them to wait a long time), and subjecting them to value judgements, jokes and humiliation.

> *He left me there and went out….He was seeing other people and I was just waiting there.* (lesbian, aged 24, Nampula City)

> *We don't go to health centers because we're afraid they'll impose their will on us, expose us, so to speak. So we end up being afraid.* (lesbian aged 24, Nampula City)

> *The nurse drew attention to me, she even clapped her hands. "Are you a man dressed like that?"…You know,…everyone started laughing…some people were shocked, but she told her to go back…."Go back and take your clothes off, put pants on [and] come [back] here."* (lesbian, aged 24, Nampula City)

> *There are people who do go [to a health facility], and even if they meet a nurse who they think would treat them well…that nurse is influenced by others [to not treat all patients well] who say, "Haa…you can't treat her, she's a lesbian, she's worthless."* (lesbian, aged 22, Nampula City)

It is apparent from the respondents' narratives that the social norm is for health care providers to pressure one another to treat lesbian patients poorly. The majority of respondents believed that health facilities are not prepared to respond to the sexual and reproductive health and rights of people with diverse sexual orientations.

Barriers to accessing maternal health care

care if they are not accompanied by a male partner. They described how young women who do not have a partner have to ask family members and friends to play the part of the partner at the health facility to be able to access prenatal care.

> *There are some who don't go to the hospital because they [the hospital staff] usually want a couple, a woman and a man, to sign up for prenatal care,...but if you're pregnant and no longer seeing the man who got you pregnant, or he doesn't take responsibility for the pregnancy....There's no way to go to the hospital alone, because they will refuse to give you care,...they turn you away and they tell you, "Bring the man who got you pregnant."...You go and bring your brother [pretending to be your husband] to the hospital....There are some [who] sit at home until the child grows up because they have no medical card*. (young woman, focus group with non-IDPs aged 20–24, out of school, Nacala Porto)

Focus group participants reported these AYW receiving poor treatment by providers, including women being charged for services that should be free, experiencing long delays to be seen and enduring visible contempt from providers, even when the woman is very sick. AYW said that health care providers sometimes blame the mother of the young woman when the young woman gets pregnant.

> *The nurses sometimes give the pregnant woman's mother the job of supporting her daughter during labor....And when they ask [the mother], didn't you know that the hospital has contraceptives [the implant] to protect your daughter?..."Why didn't you bring her in a long time ago? Now you see [the consequences of not having done that].*" (young woman, focus group with non-IDPs aged 20–24 years, out of school, Mecubúri)

Because of the role that traditional healers play in addressing a specific set of health concerns, seeking care from them can delay getting care from modern medical providers. Some women were said to seek health care from a traditional healer if they suspect that a spell has been cast or fear miscarrying. In such cases, the traditional provider gives the woman a cord that she ties around her waist to "secure" her pregnancy.

> *how the birth will go. They tell you go to a traditional healer and there they tell you that someone put a spell on you, and the traditional healer seeks ways of removing the spell so the birth will go well. For example, for some diseases, you see, you go to the hospital to get treated, while for others, you go to the traditional [healer].* (young woman, focus group with non-IDPs aged 20–24, out of school, Mecubúri)

Abortion

Focus group respondents spoke about young women seeking abortion when they have been abandoned by their partner because these young women feel shame, hope to continue studying or are unsure of the paternity of the pregnancy.

> *But some other men won't take responsibility for the pregnancy and they run away or reject her [their girlfriend] and the pregnancy, saying, "I'm not dating her," even though he knows he's lying*. (young woman, focus group with non-IDPs aged 20–24, out of school, Mecubúri)

Respondents noted that decisions to abort are sometimes influenced by the young woman's parents or by her fear of telling her parents about the pregnancy. In cases where the partner has not abandoned the young woman, participants said that the decision to abort is often made by the man involved in the pregnancy.

> *It's not possible for a woman to abort without her partner's consent. First, she talks with her boyfriend who got her pregnant, and often the person who decides whether you can abort or not is the man*. (adolescent woman, focus group with non-IDPs aged 15–19 years, out of school, Nacala Porto)

Respondents noted that the most commonly used methods of abortion were traditional methods, including various mixtures of one or more of the following substances: Coca-Cola, powdered detergent, strike-anywhere phosphorous matchsticks, and roots and leaves (e.g., moringa, aloe vera) from traditional providers. Some AYW were known to obtain abortion services from health facilities. A few respondents mentioned that health

Strengths and Limitations

- The study gathered sensitive data about sexual and reproductive health (SRH) knowledge and behavior with hard-to-reach as well as vulnerable young people (i.e., sexual minorities, displaced populations, out-of-school youth) in northern Mozambique. The fact that the participants spoke predominantly Emakhuwa compounded their marginalization. Therefore, uncovering their SRH knowledge and care-seeking behaviors provides new, valuable insights into the risks they are experiencing and the challenges in addressing those risks.
- These data add significantly to what is known about the health care experiences of lesbian and bisexual young women in northern Mozambique. The dearth of data in this area has made their health care challenges largely invisible. Identifying barriers they experience to seeking care is an important contribution to what we know about their SRH needs.
- The information gathered through focus groups provides valuable insights into the social norms of these young people around SRH behavior and care seeking. These social norms can be specifically targeted to attempt to influence behaviors and actions in domains related to SRH.
- A limitation of the sample is that recruitment of lesbian and bisexual respondents through Associação LAMBDA excluded anyone who was not associated with this organization.
- Adolescents aged 15–19 were less forthcoming in the focus groups than the 20–24-year-old participants.
- Interviews were conducted in Emakhuwa and, during the process of transcription and translation into Portuguese, some information may have been lost or misunderstood.
- None of the field team supervisors or analysists spoke Emakhuwa, which meant that during fieldwork they could not observe data collection and gain the same information one would get observing fieldwork that the supervisor could understand. It also meant that any confusion in Portuguese had to be resolved by the data collectors by listening again to the audio file in Emakhuwa, a time-consuming and difficult process.

Social norms that impact access to and use or nonuse of SRH services among vulnerable and marginalized adolescents and young adults aged 15–24 include:

- A social perception that use of contraception incentivizes promiscuity and a belief in false information about hormonal contraceptives causing infertility, both of which are barriers to use of reproductive health services for adolescents
- Infrequent condom use in sexual interactions because of rumors that condoms get stuck inside women's bodies and that the condoms themselves can cause infection
- A social taboo against asking partners whether they have an STI because asking is perceived to be threatening and dishonesty is assumed, especially about HIV
- Shame related to seeking care for a suspected STI because of the embarrassment involved with telling a health care provider about symptoms and showing genitals to a provider, which creates barriers that prevent adolescents and young adults from seeking care
- Pervasive stigma related to having an STI—particularly HIV—leading some adolescents to avoid seeking health care for fear of being diagnosed or to reject STI diagnoses and medication, especially HIV diagnoses and AIDS medication
- The demand by health facilities that individuals bring their partners to get treatment for an STI or for prenatal care is a major barrier to seeking care
- Lack of social acceptance, having experienced poor treatment by health care providers and fear of being treated poorly by health care professionals hamper lesbian and bisexual AYW's access to SRH services

Recommendations

- Educators and health care providers should offer better education about condom use to reduce and address misinformation among adolescents and young adults. Furthermore, they should discourage AYW's misuse of female condoms to extract the rubber ring inside to wear as a bracelet, as this reduces health providers' willingness to provide female condoms and reduces the available supply.
- Given the critical role of partner communication about and disclosure of STIs for STI prevention and health care–seeking,[24] educators and health care providers should emphasize the importance of disclosure through destigmatizing STIs. Representing truthful partner communication about STIs in the media could model the importance of this behavior for young people.

seek STI diagnosis and treatment.

- Training and continuing education should help health care providers understand that adolescents are embarrassed to seek care for STI symptoms and how to provide care to this sector of the population in an appropriately sensitive way.
- While there are benefits to treating STIs in both sexual partners, this should not be a requirement for STI treatment. Health care providers should treat all young people, whether they seek care alone or with a partner. Medication can be prescribed for the partner, even if the partner is not present.
- Community and institutional advocacy interventions are important to encourage people not to discriminate against people of diverse sexual orientations. Specific interventions targeting health providers are necessary to increase sensitization regarding people of diverse sexual orientations and create a friendly, safe and nonjudgmental environment at health facilities in order to increase these individuals' comfort levels and ability to access SRH services.
- To minimize the likelihood that young people will use unsafe methods to end unwanted pregnancies, NGOs and medical providers should emphasize the fact that abortion services, including medication abortion, are free and accessible in health care facilities.

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Footnotes

*Using the traditional measure of whether the woman is not using a method of contraception and she does not want to become pregnant in the next two or more years.[4]

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