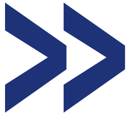
IOM International Organization for Migration



RISKS AND VULNERABILITY TO HIV:

ANALYSIS OF KEY DETERMINANTS ON THE NACALA TRANSPORT CORRIDOR

STUDY FINANCED BY **IOM**
RESEARCH CARRIED OUT BY **ANSA**

JULY 2012

"Having one partner is good, but having many is better"

Truck driver, Nacala port

A large quantity of maps were designed for this study, but not all of them are featured in this report. Please search for the title of this report on **www.iom.org.za** in order to get an overview of all these maps and view them online.

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Kerry Selvester

15 July 2011
Maputo

02 ACRONYMS

AIDS	acquired immunodeficiency syndrome
ANSA	Associação de Nutrição e Segurança Alimentar
ASWA	Pan African Sex Workers Alliance
AU	African Union
DPS	Provincial Health Directorate
GIS	geographic information system
GPS	global positioning system
HIV	human immunodeficiency virus
IEC	information, education and communication
IOM	International Organization for Migration
I-RARE	International Rapid Assessment, Response and Evaluation
Mt	meticais
NDC	Nacala Development Corridor
NGO	non-governmental organization
PSI	Population Services International
SAAJ	adolescent and youth-friendly services
SADC	Southern African Development Community
STI	sexually transmitted infection
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	voluntary counselling and testing

2.1 Glossary of key terms

Term	Definition
Casual partner	Sexual relationship between two people who have not had previous sexual relations
Hotspot	Areas where there is considerable movement of people with a high level of interaction (including sexual relations) between mobile and resident populations
Migrant worker	Person who works for longer than six months away from their home
Mobile populations	People who move from one place to another, temporarily, seasonally or permanently for voluntary or involuntary reasons
Regular partner	A person with whom there is a regular sexual relationship
Sex worker	A person who has sex for money or in-kind payments
Transactional sex	Receiving money, services or in-kind payments in return for sex

03 EXECUTIVE SUMMARY

ANSA (Associação de Nutrição e Segurança Alimentar) carried out this in-depth qualitative study in 2011 on the Nacala transport corridor in northern Mozambique, to determine the risks and vulnerabilities to HIV of migrants and host communities along the corridor. The study concentrated on areas of significant economic activity, where truck and public transport drivers spend long periods of time and where amenities, such as bars, guesthouses and restaurants have been established to serve increasing numbers of mobile populations. These areas are referred to as hotspots in this report.

A variety of groups of people were interviewed in the hotspots, including **public-sector workers** (police officers, health workers, customs officers), **sex workers**, **truck drivers and assistants, restaurant and bar staff, non-governmental organization (NGO) staff working** on HIV and AIDS programmes, and **formal and informal traders**. A **24-hour traffic tally** was carried out in each of the hotspots to indicate the volume of traffic in each of the areas. **Geographic information system (GIS) mapping** was carried out along the length of the corridor, indicating the **concentrations of people** in each of the hotspots, the **health and education services**, and the **social amenities**, such as bars, guesthouses and restaurants.

The Nacala corridor was chosen as an area of interest to study for a number of reasons. The area has experienced economic growth due to agricultural and extractive industry development in the central and northern regions of the country, and the corridor is the key transport link to Nacala sea port. This growth is leading to a greater number of people using the corridor, and benefiting from the economic upswing. These developments could affect the relatively low prevalence of HIV in the area (HIV prevalence is, in general, a lot lower in the north of Mozambique than the south) due to increase in high risk sexual behaviour, linking of new sexual networks, and the lack of capacity of social services, such as health, to adequately provide for the increasing volume of people.

All of the groups of people interviewed confirmed that the level of economic activity in the hotspots had increased in the last five years. People indicated that there were many more income earning opportunities in the formal and the informal sectors, one of which is sex work. In a number of the hotspots it was mentioned that people are being drawn from the interior of the provinces to the hotspots, seeking livelihood opportunities.

This report concludes that the rapid economic growth in the region of the Nacala transport corridor is having an impact on the social situation in each of the hotspots identified in the study. There are strong pull factors leading people to hotspots to seek entertainment and economic opportunity. The study shows conclusively that there are high levels of concurrent sexual relationships within and between the groups of people interviewed (both mobile populations and host populations), coupled with inconsistent use of condoms – especially within what people consider to be their "regular" partnerships.

While there is reasonable access to health facilities along the corridor, a number of key factors prevent the maximum uptake of services and reduce their efficacy in terms HIV and AIDS. One of the issues stated by the people interviewed is the lack of confidentiality of information – which in turn discourages people from testing for HIV and adhering to treatment regimes. Another factor is the reluctance of men to use health facilities, resulting in a one-sided (one-sex) dialogue with people who are vulnerable to HIV. The men interviewed during the study rarely use the health facilities as they work long and inconvenient hours and have little regular contact with the counselling and/or curative services. Finally, migrants stated that they did not use the health facilities due to the opening times of the clinics: clinics are closed at the time that they could seek treatment (in the evenings and at night).

The study shows that there are high levels of sexual abuse of young girls, as many of the sex workers are minors. Men are having sex with minors without any consequences since the legal frameworks in place to protect children are largely not enforced, especially in relation to child sex workers.

Questions aiming to assess levels of HIV awareness presented mixed results, with the majority of people having very basic knowledge of HIV (the main modes of transmission and key prevention methods). There were also misconceptions and myths about HIV transmission and the illness of AIDS, for example, that plump "good" girls cannot be infected. In terms of other HIV and AIDS related services (offered by NGOs, religious organizations, community-based groups), it was found that although there are programmes in a number of the hotspots their reach is limited, with stop-start funding for the majority of the programmes, and there were no programmes with high-coverage and long-term consistent funding.

The following are the key recommendations, which are described in further detail in Section 8, later on:

1 National recommendations:

   a. The Ministry of Health should promote patient confidentiality and health workers' professional codes of conduct.

   b. Cooperating partners should support state and non-state actors to develop and implement a male-oriented sensitization programme to improve male health-seeking behaviour.

   c. The Ministry of Health should increase accessibility of health services along hotspots.

   d. The Ministry of the Public Sector should promote safe sex practices amongst public-sector workers.

   e. Government and cooperating partners should support the "zero tolerance" campaign launched by the Ministry of Education.

   f. The Government of Mozambique should improve monitoring of internal migration to hotspots in Mozambique.

2 Local recommendations in the Nacala corridor:

   a. Partners should design and implement an intensive, comprehensive HIV and sexually transmitted infection (STI) prevention programme along the corridor – based on a social change approach.

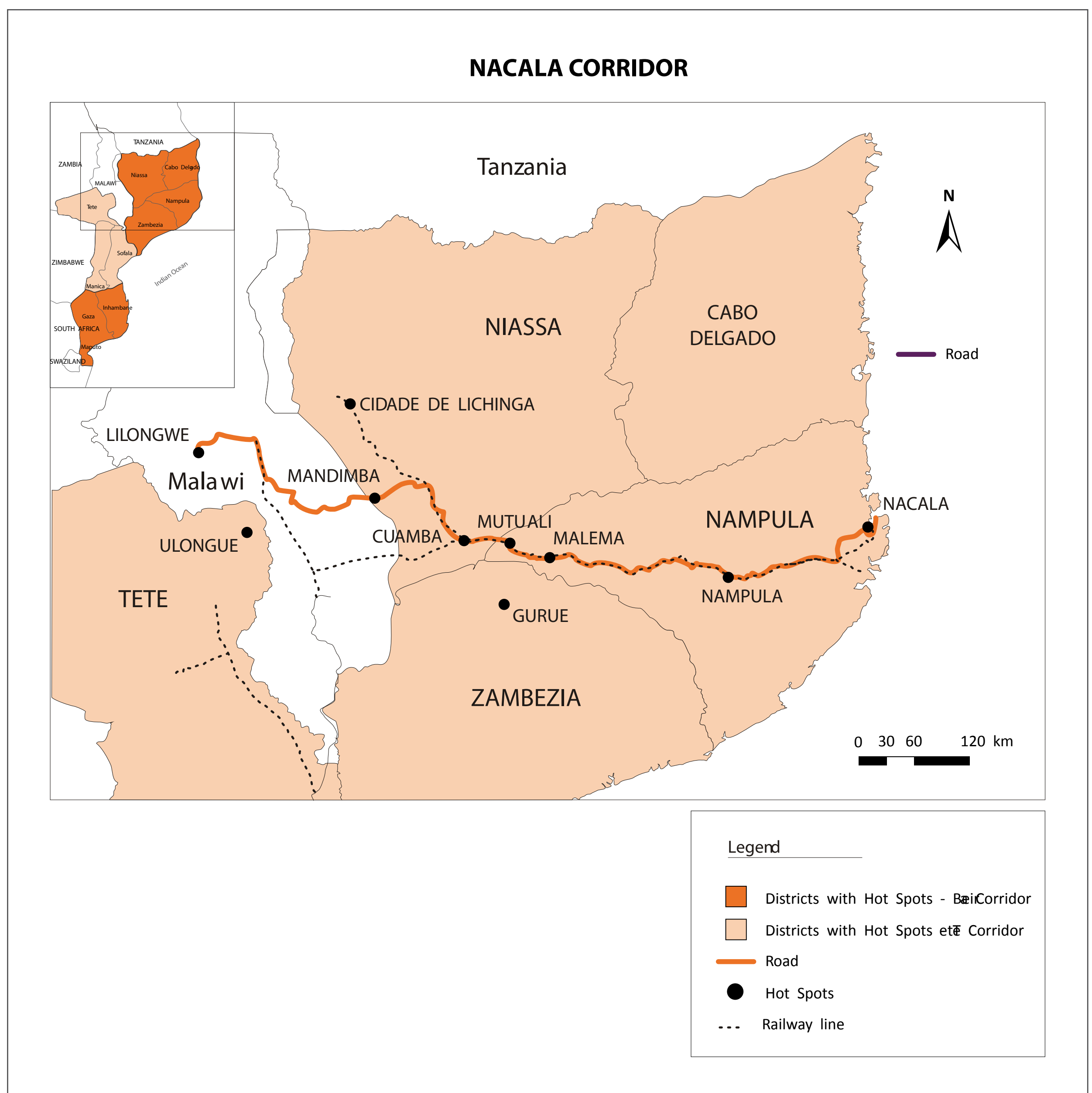
   b. Government should obtain a long term financial commitment from key private sector industries reliant on the Nacala transport corridor for the success of their businesses.

   c. Local service providers in the corridor should design a programme for the communities in the interior of the province and the hotspots, targeting youth drawn to the corridor.

04 INTRODUCTION

The economic situation on the Nacala corridor[1] is evolving in terms of the volume of traffic and commerce. There are indications that this will continue in the future. The corridor runs from Nacala port in Mozambique to Blantyre in Malawi, passing through the provinces of Nampula and Niassa, and provides access to the countries of Zambia, Malawi and Zimbabwe. There are indications that there will be an increase in labour migration in the future due to the high levels of investment and the dynamic nature of the economy along the corridor.

The objectives of this assessment are to provide an overview of the HIV vulnerabilities along the corridor, to identify opportunities and challenges for programming, and to address the priority activities that should be followed up.



1 The corridor runs between the Indian Ocean port of Nacala (province of Nampula) and the border post with Malawi (province of Niassa).

The following areas were examined: current prevention-related services available to mobile populations and host communities in hotspots on the corridor; the impact of regional and national policies and legislation; HIV vulnerability of different mobile populations sectors.

Mobile populations along the transport corridor include cross-border traders, truck drivers and their helpers, sex workers, construction workers working on the road, railway workers, transport workers, health workers, market workers, border officials, and roadside bar and lodging workers. The assessment has identified how these mobile groups view their vulnerability to HIV and how they behave in light of this.

Recommendations and strategies have been designed to reach different mobile populations and host communities along the corridor.

4.1 Methodology

The Nacala corridor runs from Nacala port on the Indian Ocean in Nampula Province, through Nampula city and various districts, reaching Cuamba in Niassa and leading into Malawi via Mandimba border post.

The assessment focuses on areas of HIV vulnerability along the corridor including:

1. **Infrastructure** such as location, number and accessibility of hospitals, health facilities, access to voluntary counselling and testing (VCT) and STI treatment, condoms, HIV programmes, and police and social services including VCT;
2. Truck stops, bars and lodging, liquor outlets, accommodation, nightclubs;
3. The number of trucks passing through specific truck-stops, interaction between the truck drivers, their helpers and sex workers, knowledge of HIV in these places, condom distribution;
4. Transportation routes, border control and behaviour between border officials and mobile (passing) populations.

RECRUITING RESPONDENTS AND UNDERSTANDING THE "HOTSPOT"

"Arriving at night in Nacala port, we decided to present our research authorization to the chief of police and explain our work to him, as we were anxious to start work that evening. He was extremely interested in the work and recognized that it was important to fight against HIV and AIDS, which was a growing problem in Nacala port. He also requested that we speak to the police during their morning briefing on the dangers of HIV. We led a discussion group the next morning.

He took us to meet some women who could help us with our interviews, and we started the process that very evening. The sex workers were very open and spoke frankly about their experiences. We met their clients in the bars and restaurants. Truckers and truckers' assistants were more difficult to interview as they arrived late at the trucking spot, were tired from many hours driving and often left very early in the morning. We also interviewed the customs officers and other public-sector workers working in the port, who identified another group of women who could help us with our study. They were the informal traders working on or near the docks. As we only heard about them on our last day we decided to make a return visit to meet with them (two weeks later). Health staff and NGO staff were easy to contact, although they tended to be very busy. However, with the right authorization papers the interviews ran smoothly.

The length of time for each interview varied and depended on the information the interviewees were willing to provide as well as the time they had available. Not all of the topics on the interview guides were covered during each interview. We would follow up information and corroborate with other sources. The process was slow but we gradually built up a picture of the sexual behaviour in the area, how people use the health services, and their knowledge and attitudes towards HIV and AIDS." (Social researchers, Nacala corridor, 2010/11)

4.1.1 *Sampling*

Sampling was based on an analysis of the main areas where mobile populations have prolonged contact with host communities, namely truck stops, border posts and the port of Nacala. The following areas were identified as fulfilling the criteria: Nacala port, Nampula-Namialo, Ribaúe, Cuamba and Mandimba.[2]

In each of the areas a mapping exercise was done to identify social amenities (bars, restaurants), accommodation, social infrastructures and estimates of the concentration of people in each of the areas.

Social researchers interviewed a cross section of people in each of the localities, to represent the opinions from a range of people in host communities and mobile populations. Typically the researchers interviewed truck drivers and assistants; public-sector workers posted in the area; health workers; NGO representatives and workers; sex workers; traders; and guest-house, bar and restaurant workers. The "entry point" for the sequence of interviews was different in each of the areas, and was dependant on the willingness of people to participate in the investigation as well as referrals from one person to another.

A total of 100 in-depth interviews were carried out, as well as two to three group interviews (mainly with sex workers) in each of the hotspots. The number of interviews in each of the hotspots was dependant on the type of mobile population, number of sex workers available for interview and the number of NGOs with active HIV programmes.

4.1.2 *Research techniques*

Key topic interviews

A series of key topic interview guides were prepared with the research team based on previous research carried out in the area and the principle objectives of study. Interview guides were prepared for: mobile populations (truck drivers and assistants, customs and police officers, and commercial traders); sex workers; clients (truck drivers and assistants, customs and police officers, commercial traders); health workers; and NGO workers. The topics to be explored in the interviews were: sexual relations and sexual behaviour; knowledge and attitudes towards HIV and AIDS; health services provision and use of health services. In addition, people were asked to give their opinions about the general environment in hotspots, both positive and negative aspects. See the interview guides in Annex I.

Traffic survey

A traffic survey was conducted to track the number of trucks and passenger transport vehicles that passed through and remained stationary in the hotspots. A team of three carried out a 24-hour survey working in pairs on a four-hour shift to tally the vehicles. The team were also asked to provide any pertinent comments on the locale, type of traffic in the area and the times of maximum traffic. See the tally sheet in Annex I.

Mapping

Mapping was carried out using global positioning system (GPS) technology. The team of four technicians worked in pairs to map the following: social amenities (bars, restaurants, guesthouses); social services (health facilities and schools); population concentration. A variety of maps were produced including representational maps and satellites images. A number of these maps can be found in Annex 2 of this report, and all of them can be viewed by accessing the IOM regional website (www.iom.org.za).

2 Monapo was also originally identified as a "hotspot" but due to time constraints it was removed from the study.

4.1.3 Limitations of the study

There were a number of limitations to the study:

1. The nature of the subject matter required extensive periods of time spent in an area to find the people to interview and triangulate the information received from different sources. Often it was only at the end of the planned time that sources of information were identified. This required return visits to research sites. This was the case for Nacala port and Nampula, where return visits were necessary, which proved costly and time-consuming.

2. As the information from the interviews accumulated, additional issues began to arise, and it was not always possible to investigate these as thoroughly as needed during the study period. One is left with the unsatisfactory recommendation of "more study needed". We have tried to avoid this in the study by following up on issues as they arose but it was not always possible.

3. The researchers were unable to find respondents willing to participate in a diary exercise that involved the researchers returning once a day to discuss the events of the day and record them.[3] This exercise was not concluded.

4. The issue of sexual abuse of children: children involved in sex work is a reality that was made clear to the researchers. Since there are ethical issues involved in interviewing children involved in the sex trade these children were not interviewed as part of this research. The findings about children involved in sex work were gathered through interviews with adult sex workers and clients. This important gap in the literature and in current research would require a specific study with researchers trained in participatory research with abused children and with specific understanding of the legal and ethical implications.

5. In Cuamba it was not possible to find any sex workers to interview as there had been a police operation in the previous weeks so there were no sex workers in the usual places. The researchers worked with mobile populations and health staff.

4.2 The Nacala corridor

4.2.1 Economic developments in northern Mozambique

The Nacala corridor stretches from the Indian Ocean port of Nacala to the border of Mozambique with Malawi and through to Blantyre in northern Malawi. The corridor serves Mozambique, Zambia and Malawi. A railway link was developed in the 1970s, before independence, and originally served the port of Nacala and the province of Nampula. The line was extended to take advantage of the agricultural surplus in Niassa Province and trading opportunities in Malawi. The war in Mozambique effectively closed the railway trade between the countries, but resulted instead in the movement of Mozambican displaced people and refugees to Malawi and Zambia.

With the end of the war, the extensive road and rail rehabilitation and the agricultural recovery programme has meant that the Nacala corridor is once again a busy route for goods from the hinterland to the port and vice versa. Traders from the Nacala corridor trade to the south of the country as well across the border in neighbouring countries. The area covered by the study is characterized by increasingly improved agricultural production

3 Previous attempts in other research projects (IOM mobile populations, 2006, and UNFPA Sex Worker vulnerability to HIV and AIDs) to ask sex workers to keep diaries themselves also proved unsatisfactory.

and agro-processing industries. In addition, in the last five years the port of Nacala has developed to become a busy and active importing and exporting centre in the north of the country. In Niassa there is vast potential of both agricultural production and exploration of natural resources but the province continues to battle with poor basic infrastructures, low population density and no marketing infrastructure.

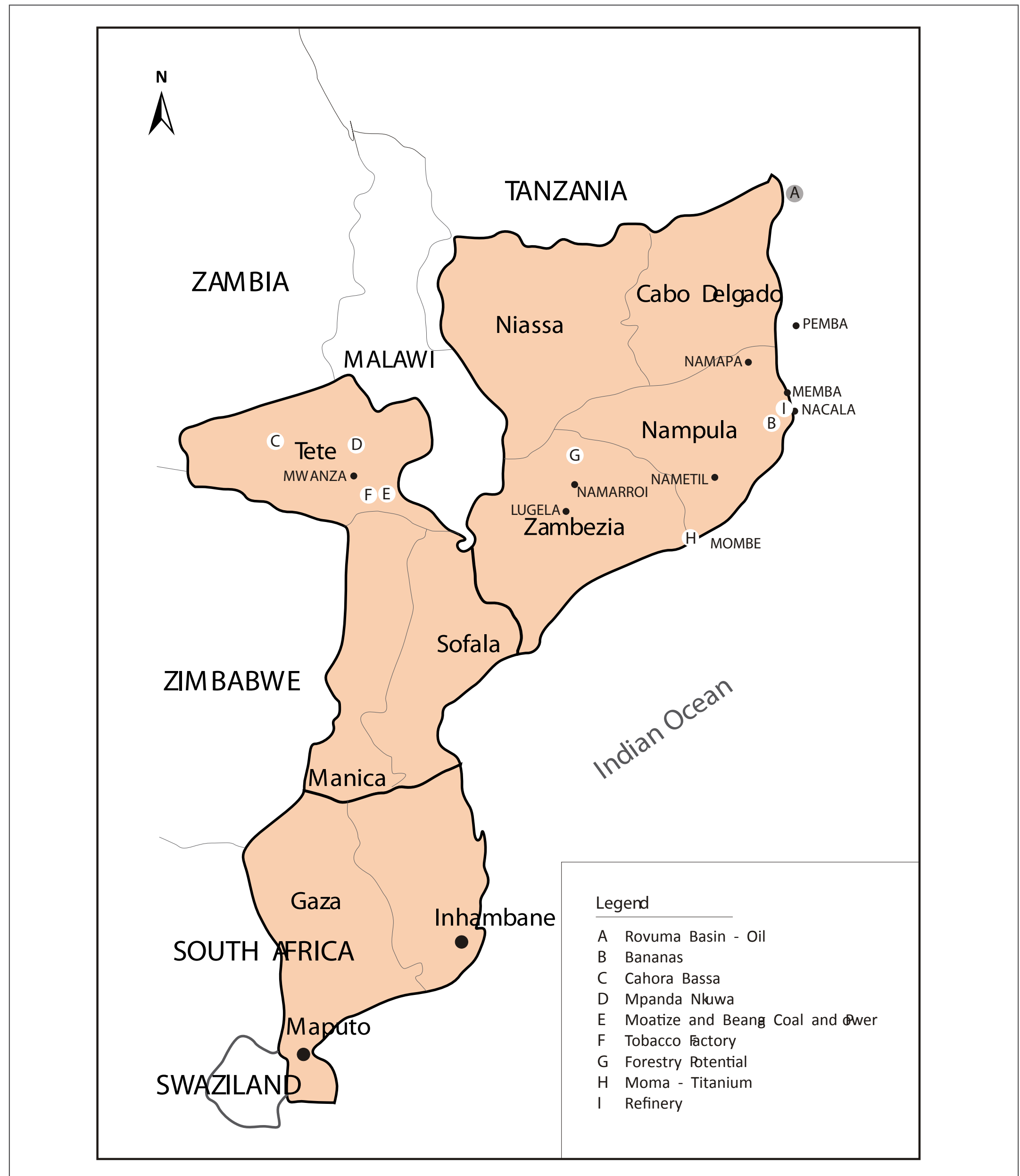
The Nacala Development Corridor (NDC) programme[4] is part of the New Partnership for Africa's Development (NEPAD) strategy to improve regional infrastructure. The NDC programme will help regional integration and competitiveness. There are an estimated 10.7 million inhabitants on the corridor, 3.3 million on the Mozambican side including populations from the provinces of Nampula, Niassa and northern Zambezia.[5] The NDC programme aims to develop both the road and railway infrastructures as well as improve telecommunications.

The Nacala corridor passes through areas of high agricultural potential producing: cashew nuts, maize, rice, millet, groundnuts, beans, cassava, cotton, citrus, bananas, tea, sisal, copra, sunflowers, sesame and tobacco. There is considerable forestry potential, giving rise to a thriving timber business for both the domestic and export market. The northern provinces also have a wide range of mineral resources. One of the major developments that will bring change to the whole region will be the use of the deep-water port in Nacala to export coal from the coal mines in Tete Province, which has experienced a sharp increase in investment in recent years. Other key exports from the port include timber and food (processed and unprocessed). The industrial developments on the corridor include food processing, cement factories, textiles and beverages. This formal-sector investment has given rise to a thriving informal sector and attracts a considerable number of internal migrants who reside and make a living on the corridor.

4 Geographically the Nacala Development Corridor extends from Mchinji in the west of the central region of Malawi and runs east across the country to Machinga and south to Nsanje. It covers the central and southern part of Malawi and extends eastwards into Mozambique to the coast at the port of Nacala. It also includes the Cuamba-Lichinga railway line to Lake Niassa.

5 The provinces of Nampula and Zambezia have the highest population densities of all Mozambican provinces.

Key economic developments (10-year perspective), northern Mozambique



1.1.1. HIV in the Nacala corridor

Nationally, adult HIV prevalence in Mozambique was 11.5 per cent in 2009. The epidemic is heterogeneous, with great differences between demographic groups – for example, the national HIV prevalence among young women aged 15 to 24 is 13.1 per cent (InSIDA, 2009). There are considerable regional differences, with a higher prevalence in the south of the country (up to 25% in Gaza Province) than the north (9.4% in Nampula Province and 3.7% in Niassa Province).

Although the prevalence in Nampula and Niassa is lower than the national average there is some indication that there are pockets of higher prevalence in port areas. The Centers for Disease Control and Prevention, in coordination with the Ministry of Health, carried out qualitative research – “International Rapid Assessment, Response and Evaluation (I-RARE)” – in three port cities of the country, namely Nacala-Porto, Beira and Maputo, on the risk

behaviours for HIV among injecting and non-injecting drug users, sex workers and their clients. Among those tested (which was 24 per cent of all interviewed) the positive results for HIV were as follows: sex workers, 48 per cent (30/63); drug users, 43 per cent (13/30); sex workers clients, 42 per cent (11/26). Although these rates are not statistically significant, they are indicative of higher rates of HIV in specific key populations.

In 2009, Projecto 100 per cent Vida, implemented by the Provincial Health Directorate (DPS), United Nations Population Fund (UNFPA), Population Services International (PSI) and Pathfinder in Nacala-Porto, Cidade de Nampula, Inchope, Maputo and Matola reported that 28 per cent (78/278) of the sex workers that attended counselling and testing services tested positive, representing approximately double the figure for the general population. Although these samples are very small, these results clearly show that HIV is a much bigger problem in certain geographic areas when compared to the general population. In order to extrapolate these figures nationally, models estimating the HIV modes of transmission were run: in 2008 it was estimated that about 2 per cent of all new infections occurred among sex workers and about 7 per cent among their clients. It was also estimated that sex workers, their clients and their clients' partners are responsible for about 19 per cent of the new infections. Ministry of Health epidemiologic surveillance data show that the highest prevalence rates occur along the transport corridors, suggesting that mobile populations and members of the communities affected by migration are particularly vulnerable (I-RARE, 2009).

A study of the vulnerabilities of mobile populations to HIV on the Nacala corridor and the southern corridor of Maputo to Inhambane was carried out in 2006 (IOM, 2006). The study mapped the hotspots along the corridors and the movements of a wide variety of mobile populations (refugees, traders, truck drivers, public-sector workers) and sex workers. The recommendations of the study were as follows:

1. Recognition of the complexity of the lives of mobile populations should be reflected in nuanced programmes aimed at these groups.

2. The habitual stopping-off places should be saturated with HIV information and condoms;

3. Government institutions[6] catering to transient populations should develop strong positive policies that protect their inmates (boarding schools, training colleges);

4. Peer education should target active leaders (even if they do not fit the stereotype of trainers or teachers) in the different groups;

5. Strong advocacy positions should be taken on sexual predators (older men having sexual relations with school children);

6. There is a need for flexible health services to cater for both isolated sedentary populations and mobile populations.

In addition, specific recommendations were provided for each of the mobile groups studied, ranging from proposed research into trading patterns and wholesale practice, to identify ways of reducing the volume and frequency of informal traders trips, through to curriculum development for teachers to equip them with sufficient professional training to turn the tide of inappropriate sexual behaviour in schools.

6 Ministry of the Interior, Ministry of Transport and Communication, Ministry of State Administration and Ministry for the Public Sector.

4.3 Legal and political framework for HIV and AIDS programming for mobile populations

Mozambique is the signatory of many agreements and has passed a number of progressive laws that provide an enabling environment for protection of mobile populations and the rights of people living with HIV and AIDS. However, there is a considerable gap between the laws and policies, and implementation or change on the ground.

The laws against human trafficking, domestic violence, the progressive family law and the decree protecting the rights of people living with HIV in the workplace, all have articles that protect the rights of people to live without abuse and exploitation. In addition, Mozambique has a minimum wage policy and a labour law that offers some protection to formal-sector employees. However, only an estimated 10 per cent of adults of working age are employed in the formal sector.[7] The majority of people in the country are farmers, self-employed in the formal or informal sector or unemployed. There is no legal protection for the working conditions of these people.

4.3.1 Sex workers and their legal position

Sex work is not clearly legislated within the Mozambican legal framework, and therefore can neither be punished nor protected under the law. Punishment under the law for sex workers takes the form of using the existing loitering and indecency laws.[8] There are articles in a 1962 law that make "facilitating the practice of prostitution illegal" – Article 2(1) – and maintaining houses of prostitution is also illegal – Article 3. Forced sex work or forced sexual acts, sexual violence and violence against another person are all illegal under the Mozambican penal code. Other relevant articles in the penal code include articles against third parties profiting from prostitution (405) and the law on the corruption of minors (406) from the law enacted in 2002, Law 8/2002.

The newly formed Mozambique chapter of the Pan African Sex Workers Alliance (ASWA) is pressing parliament to recognize the rights of sex workers, especially to ensure their health and security (ASWA is a Cape-Town-based group fighting for sex-worker rights). Currently ASWA is collaborating with organizations such as Pathfinder International, PSI, UNFPA, Mozambican Human Rights Organisation (known as Liga Moçambicana Dos Direitos Humanos) and the Lurdes Mutola Foundation (Gender Links) to strategize about how to work towards a safer environment in which sex work can take place.

4.3.2 Sexual abuse of minors

The rights of children are protected, not only through the signing of international declarations, but also through specific articles in the anti-trafficking law and the family law. The National Plan of Action for Vulnerable Children pays special attention to issues related to child trafficking, sexual and physical abuse of children and child labour. However, the labour law does not provide clear guidelines in terms of child labour and there are considerable gaps in the legislation. Once again, although there are some legal and political guidelines for child protection, there are considerable gaps in terms of upholding the rights of children either through cultural norms or legal action. In the northern provinces of Nampula and Niassa traditional culture considers that girls are sexually mature after the completion of initiation rites. The initiation rites take place after a girl's first menstruation (typically between 12 and 14 years of age). Traditionally after the initiation rites a child can marry and is ready for sexual relations.

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7 Inquerito do Orçamento Familiar (IOF), Instituto Nacional de Estatistica, Government of Mozambique, 2009.

8 US State Department report on Human Rights in Mozambique, 2007. Also the point of view of Deolinda Moiane (lawyer and researcher for this paper).

In article 19 of the Convention of the Rights of the Child, children are protected against obscene acts and violence (with criminal punishment). However, forced (commercial) sex is not specifically cited. Infant prostitution is therefore not a specific crime within the existing legal framework. In 2003, Mozambique opted to sign an additional clause of the Convention for the Rights of the Child pertaining to the prohibition of the sale of children, infant prostitution and infant pornography.

Family law, the law for the protection of children, the basic laws for the protection of children and adolescents, and the people trafficking law pay special attention to minors and provide protection. It should be noted that these frameworks have not been tested thoroughly in the courts in Mozambique.

Although there are some laws for the protection of the child against sexual abuse (both through international law that Mozambique has ratified and national law – 8/2002, articles 405 and 406) there is no specific legislation against child prostitution (either for those who abuse children or those who make profits from children). Child prostitution is not criminalized at present in Mozambique.

Table 1. Summary table of the legal and political framework in Mozambique

INTERNATIONAL AND REGIONAL TREATIES	
Declarations	Mozambique
The UN International Convention on the Protection of the Rights of all Migrant Workers and Members of Their Families	Not signed
The UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	Acceded to on 21 April 1997
The UN International Covenant on Economic, Social and Cultural Rights (ICESCR)	Not signed
The AU Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa	Signed on 15 December 2003 and ratified on 9 December 2005
World Health Assembly Resolution 61:17: "Health of Migrants" (2008)	Signed
UN Millennium Declaration (2000)	Signed
The Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001)	Signed
The SADC Protocol on Health (1999)	Signed
The Maseru Declaration and Commitment to AIDS in the SADC region (2003)	Signed
The Brazzaville Declaration on Commitment on Scaling up towards Universal Access to AIDS Prevention, Treatment, Care and Support in Africa by 2010 (2006)	Signed

INTERNATIONAL AND REGIONAL TREATIES	
The Declaration of Human Rights and the African Charter for Human and People's Rights	Ratified resolution 9/88 on 25 August 1988
The Convention of the Rights of the Child	Ratified resolution 19/90 on 23 October 1990
The African Charter on the Rights and Welfare of the Child	Ratified on 29 November 1999
NATIONAL CHARTERS, LAWS AND POLICIES	
The National Strategic Plan on HIV and AIDS (PEN IV) recognizes the importance of services and programmes aimed at highly at-risk populations, including sex workers and mobile populations	
Public-sector policies exist for the prevention of HIV and AIDS (mainstreaming; information, education and communication (IEC) campaigns; disclosure campaigns; benefits provided to support healthcare costs and family support for HIV-positive public-sector workers)	
The National Action Plan for Vulnerable Children (minimum care standards) 2010 takes into consideration child trafficking, sexual and physical abuse of children and child labour	
The National Strategy for Basic Social Security (April 2010) provides the framework for supporting HIV-positive people and households affected by HIV and AIDS (the operational plan for the strategy will be finalized in 2011 for budgeting in 2012)*	
Family law strengthens women's legal position within the family	
The law against domestic violence (2009) protects women in cases of domestic violence	
The anti-trafficking Law (2008) includes specific provision for the protection of children	
The anti-discrimination article in the labour law, Act No. 5 of February 2003, provides for non-discrimination against HIV-positive employees with regard to their work, training and promotion rights	

Sources: IOM Briefing Paper, 2009; UNFPA Background Paper for HIV and AIDS Vulnerability Study, 2009

* National Strategy for Basic Social Security coordinated by the Ministry of Women and Social Action (MMAS), with Health, Education and Labour as key cooperating Ministries. Cooperation partners supporting the Basic Social Security Strategy are the International Labor Organization (ILO), the Department for International Development (DFID), the Dutch Embassy and the United Nations Children's Fund (UNICEF), with additional collaboration from NGOs and civil-society organizations.

05 FINDINGS

5.1 Description of hotspots

The hotspots in this study were identified as areas where there is considerable movement of people with a high level of interaction between mobile and resident populations. These are typically truck stops, ports and border posts. See Annex 2 for the maps regarding the hotspots along the transport corridor for Nampula province (Map 2.1) and Niassa province (Map 2.2)[9].

The mapping exercise located the hotspots on the corridor from Nacala port to Mandimba on the Niassa-Malawi border. Although there were some differences between the hotspots in terms of changes over the last five years, they were differences of degree rather than fundamental ones. All those interviewed stated that there had been economic development (to a greater or lesser extent) in all of the areas covered. This was generally seen as positive, leading to greater prosperity and a greater flux of people through the areas, in particular truckers and traders, but also tourists from both inside and outside of the country. There were more casual jobs in bars and restaurants, and more clients with money to spend. This has led to more economic opportunities but also to some negative consequences. The negative consequences most frequently mentioned were:

- There is a widening gap between people with money and resources and people with no access to either.
- People with no money are exposed to goods and services they cannot afford.
- The corridor draws people from the interior of the province who participate in income-earning strategies which increase their vulnerability to HIV (for example, sex work).

Example of a typical comment on the changes on the corridor

> "The town (Namialo) has many more people, vehicles and goods. People have more employment in the biscuit factory, in cotton and many people are informal traders. This has an influence on behaviour. Because people see lots of good things and they need money to buy them, they end up having sex for money, sometimes they don't use condoms through ignorance."
>
> (Key informant, Namialo)

> "*A vila está a registar maior movimento de viaturas, pessoas e bens. As pessoas tem mais emprego nas fabricas como de bolachas, de algodão e há muitas pessoas com negocio de vendedores ambulantes.Isso influencia muito no comportamento de risco. Porque as pessoas vêem muitascoisas boas e precisam de dinheiro para comprar elas acabam fazendo sexo por dinheiro e as vezes sem usar preservativo por ignorância.*"
>
> (Informant chave, Namialo)

The interviewees were clearly of the opinion that the hotspots act as a magnet for young people who want to have new experiences, are not willing to keep working on the land, and subsequently are at risk of exploitation.

9 For maps of social amenities in the following hotspots along the northern transport corridor: Monapo district, Nacala district, Nampula city, and Ribáue and Malema districts, see the **www.iom.org.za** website.

5.1.1 Mapping of the concentration of people along the Nacala corridor

The maps of the Nacala corridor below show clear areas of concentration for prevention activities and how services can be offered in a relatively small geographical area to have an impact. The satellite images show that outside of the hotspots there is typically low concentration of people or infrastructures. Please see Annex 2 for the maps of estimates of people visiting the hotspots in Niassa (Map 2.3) and Nampula (Map 2.4) provinces.

5.2 Results from the traffic survey

The traffic surveys were conducted during a 24-hour period in the hotspots. They measured both the through-traffic and vehicles that were stationary for a period of more than five hours. The social researchers used these trucking stops as the starting point for their interviews.

Table 2. Through-traffic over a 24-hour period by type of vehicle and geographic location

PLACE	SMALL TRUCKS (1–3 T)	LARGE TRUCKS (>3 T)	PASSENGER TRANSPORT (MINI BUS)	
Nacala port	72	256	87	
Nampula	151	433	379	
Namialo	100	252	128	
Ribaúe	91	135	112	
Cuamba	315	350	220	
Mandimba	126	138	75	Bicycle 145

As can be seen from Table 2, there are high levels of traffic passing through the identified hotspots. Cuamba has the highest level of smaller commercial trucks (315). In terms of larger trucks Nampula has the highest number (433), followed closely by Cuamba (350). Nampula is the largest town in both provinces: it draws traffic to serve local commerce and is the evacuation point for goods going to both Malawi and Nacala port. The high level of traffic in Cuamba is due to the geographic position on the corridor; Cuamba is a passing point for traffic from Nampula, Zambezia and Niassa to reach the border post in Malawi. In Mandimba 145 bicycles were counted crossing the border. The bicycle traders are generally Mozambican and exchange grain and agricultural produce for money or processed foodstuffs (cooking oil and sugar). At the height of the agricultural commercial season (May–August) the number of bicycle traders increases exponentially.[10] In terms of passenger transport, Nampula has the largest number of vehicles (379), which reflects its population[11] as the largest city in the region.

10 Neighbours in development: Livelihood interactions between northern Mozambique and southern Malawi. A report for DFID by Martin Whiteside with case studies by Donata Saiti, Guilherme Chaliane and the Women's Border Area Development Programme, January 2002.

11 Nampula population: 471,717 inhabitants.

Table 3. Stationary traffic (over a 24-hour period) by geographic location

PLACE	SMALL TRUCKS (1–3 T)	LARGE TRUCKS (>3 T)	PASSENGER TRANSPORT (MINI BUS)
Nacala port	4	6	11
Nampula	53	104	108
Namialo	0	16	12
Ribaúe	25	43	50
Cuamba	160	108	70
Mandimba	31	51	32

From Table 3 it is clear that Nampula and Cuamba have the highest numbers of vehicles that are stationary for more than five hours. This tally may be misleading, as the trucks that go to the port of Nacala do not park at the control point (where the survey was conducted), but at the port itself, waiting for loading and unloading. This may have resulted in a sub-estimation of the number of truck drivers that spend the night in the city of Nacala.

5.3 Key recreational areas

Each of the different hotspots had different areas where sex workers met clients (see Table 4). See Annex 2 (Map 2.5) for a map of bars, restaurants and guest houses along the Nacala corridor.

Table 4. Recreational areas in the hotspots where sex workers meet clients

LOCATION	RECREATIONAL AREAS*
Nacala port	Baia Azul, the Triangulo, the port area, bars and restaurants in the Faina, and in the area of Bela Vista
Nampula	Air corredor, traffic lights and Bagdade (café), Clube de Tennis (restaurant) and all the discotheques
Namialo	The streets and the informal market at the side of the road
Ribaúe	The activities are more hidden in this small town. Often girls from the boarding schools are targeted by the truck drivers.
Cuamba	Police action made it impossible to reach the sex workers during the study.
Mandimba	Romão (guesthouse), border area and on the street

* Recreational areas in the hotspots refer to bars, restaurants, billiards halls, discotheques, parks and areas on the street corners where clients meet sex workers.

5.4 Knowledge and attitudes related to HIV and AIDS

People know the basic facts about HIV and AIDS, namely that it is an incurable disease that is transmitted through sexual relations without condoms, exchange of blood (through razors, needles or cutting instruments). No one mentioned the mother-to-child transmission or through breastfeeding. People were also aware that it is possible to take a test for the virus, but were not forthcoming about

a need for repeated testing, or how long after exposure before the test can be accurate. Although there appeared to be awareness about the treatment programmes and people stated that they knew about antiretroviral treatment, nobody admitted to knowing anybody (or themselves) who were undergoing treatment. This is a very different situation to the southern and central provinces where the majority of people know someone from their extended family, neighbours or friends who are on treatment. This reflects the variations in prevalence in Mozambique.

However, it was clear that in-depth understanding of HIV is uncommon and that there are many misconceptions. For example, a key informant stated:

> "AIDS is a *bichinho* [literally a small animal or insect] that lives in a person's stomach and cuts through the intestines, and that is when a person can't manage to work, gets sick and weak. A person doesn't have any appetite to eat or do anything. When a person gets this illness they always divide it with the others that they pass."
>
> (Truck driver)

> "*Sida é um bichinho que fica na barriga da pessoa e corta as tripas, dai que quando uma pessoa apanha não consegue trabalhar, fica doente e fraca. Não tem apetite de comer nem de fazer nada. Quando alguém apanha esta doença sempre divide com os outros por onde passa.*"
>
> (Camionista)

Some people continue to believe that condoms transmit the virus (as reported by the National Aids Council in Mandimba – Niassa), although this was mentioned less than in the study carried out in Ressano Garcia, where the majority of miners interviewed believed that the condoms from South Africa were infecting migrant workers (Selvester, 2007).

In terms of prevention strategies, most people listed the main methods for prevention of transmission via sex, namely abstinence, faithfulness and using condoms. Of all the methods only the use of condoms was considered to be a viable option for the population groups we were interviewing. As can be seen in Section 5.8 on condom use, there is a nuanced understanding of when and where condoms can reduce the risk of transmission.

5.5 Sexual behaviour

The mobile populations that were interviewed as part of the study were a cross section of truck drivers, truck drivers' assistants and public-sector workers, including port workers, customs officers, frontier guards. In Mandimba, traders who cross the border by bicycle with agricultural produce were also interviewed.

All of the people interviewed are at risk of contracting HIV due to the prevalence of concurrent sexual relationships, inconsistent use of condoms, misunderstanding of HIV, and poor health-seeking behaviour (especially among men).

Although a lack of knowledge may be one of the factors that could increase the risk of HIV transmission, the principle reason to classify these hotspots as "spaces of vulnerability" is because of the sexual behaviour of the communities which interact in them. People are aware of HIV; they know that it is a disease that has no cure and can be transmitted through unprotected sexual relations. People were also able to recount the ways of preventing or reducing the risk of transmission of HIV – namely abstinence, faithfulness and using condoms. However, none of these strategies was seen as viable. Below are illustrations of typical sexual behaviour of the mobile populations interviewed.

TRUCK DRIVERS AND THEIR ASSISTANTS

Truckers and their assistants typically take journeys of between 10 and 20 days along the corridor and into neighbouring countries. The journeys are arduous with often only a 24-hour turnaround. All of the truckers and assistants interviewed stated that they had sexual relations between two and three times a week while on the road. The sexual relations were with a range of partners: unknown sex workers; sex workers known to the men and regarded as regular partners; and women who were regarded as "wives". All of the truckers and assistants interviewed had partners and children. The following quotation is typical of the interviews held with the truck drivers:

> "I have various women on my journeys; there is no lack of them. When I travel there are places where I always have to take something, a sack of potatoes, a tin of maize and beans. There are at least three women on my trips to Zimbabwe. In this way I don't suffer on the road. I call them beforehand so they can prepare food for me when I arrive. With these women I don't use condoms because they are my women (wives)" (Truck driver, Nampula)

PUBLIC-SECTOR WORKERS

Public-sector workers are often located away from their families and, due to the nature of their work, it is often not possible to transfer the whole family each time they are given a new posting. One customs officer said he was from Maputo and had moved his wife and children to Niassa when he was posted there, but in less than two years he was posted to Nacala. The children were in school in Niassa so he felt he could not take them and move them again. As he said, "next year I may be somewhere else". He had started another relationship in Nacala and frequently visited his wife. He also occasionally paid for sex.

The following mini case studies illustrate the sexual behaviour of some of the public-sector workers interviewed that puts them at risk of transmitting and contracting the HIV virus and other STIs.

Two young customs officers (one male, one female). The two officers are having a sexual relationship with each other and do not use condoms. Both have partners in their places of origin and they believe that their partners probably have other relationships. They do use condoms with their partners or practice safe sex. The male customs officer also said he had additional occasional partners in the area, but he uses condoms with them.

Male customs officer. This officer is unmarried, has a number of girlfriends and has one more serious girlfriend. He also has sex with sex workers. He pays 150–300 Mt for sex two to three times a week but could be more often. He explained that payments are made in different ways for different types of relationships:

> "Brother! These women, in one way or another we end up paying for the relationship. I have a girl who is a university student – I pay the faculty, put fuel in the tank and also give her 3,000 Mt pocket money for her things. Some colleagues here give themselves to the guys in the customs in exchange for favours (money, clearly). They (female colleagues) earn less than us and as a way of getting more money in their pockets they get involved with us. Lots of these relations are made on the basis of material interest."

Police (female). This policewoman has a child in Maputo, a partner in one town and another in the town where she is stationed. Her partner (where she is stationed) is married with children. She states she now uses condoms with both partners. She receives some money from one of the partners to help with the household expenses.

> "I always insist on using condoms because I got pregnant very early, and early on I learned to protect myself against pregnancy and STIs. I insist that my lover uses condoms. It was very difficult but he ended up accepting because I started to refuse to have sex without protection. There was a time when I accepted to have sex without protection because I knew his wife and it was serious. But when I discovered that he had another badly behaved lover I started to demand that he used condoms."

As can be seen above, the frequency and fluidity of relationships – both in time and across geographical space – result in a high-risk scenario for the transmission of HIV and other STIs. Unless

there is a fundamental change in attitudes and sexual behaviour this scenario is unlikely to improve and has all the warning signs for increasing HIV transmission.

5.5.1 Health-seeking behaviour

Health-seeking behaviour among the mobile populations differs:

- Truck drivers and assistants have the lowest usage of health services due to time constraints.
- Female public-sector workers are more likely to use health facilities – for family planning, child healthcare and their own health.
- Male public-sector workers are familiar with health services but less likely than their female counterparts to have frequented the health services.

5.6 Sexual networks

The key risk behaviour prevalent in the study area was concurrent active sexual partners coupled with a lack of consistent condom use. Three typical examples of concurrent sexual relationships are presented in Figures 1, 2 and 3 below. These figures were developed from information provided by respondents (a customs officer, a fireman and a truck driver), who provided information about their sexual relations and, in a number of cases, the sexual relations of their partners. For example, in Figure 1, the customs officer was aware that one of his regular partners has a fiancé in another provincial town. In these figures, the terms used to describe different sexual partners are those of the respondents.

Figure 1. Network of concurrent sexual relationships (Customs officer)
Sexual relations network (a)

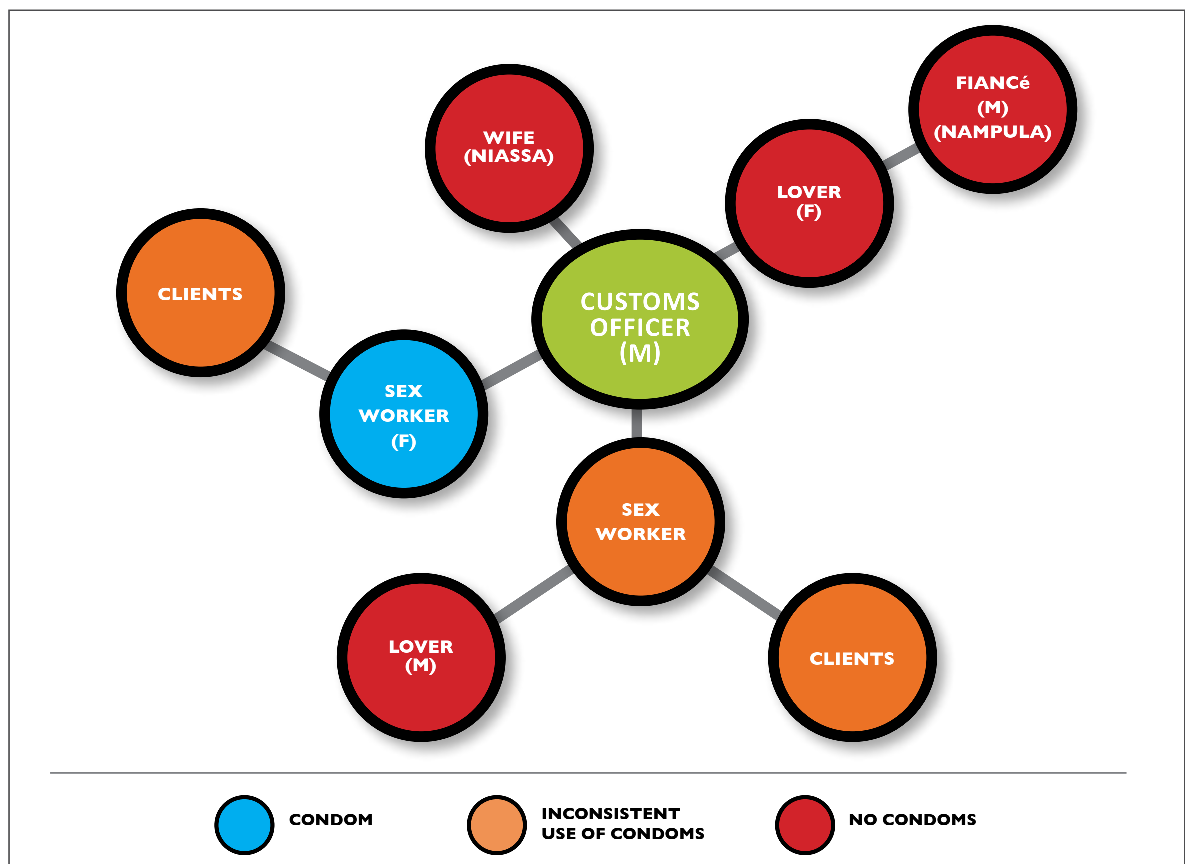


Figure 2. Network of concurrent sexual relationships (Fireman)
Sexual relations network (b)

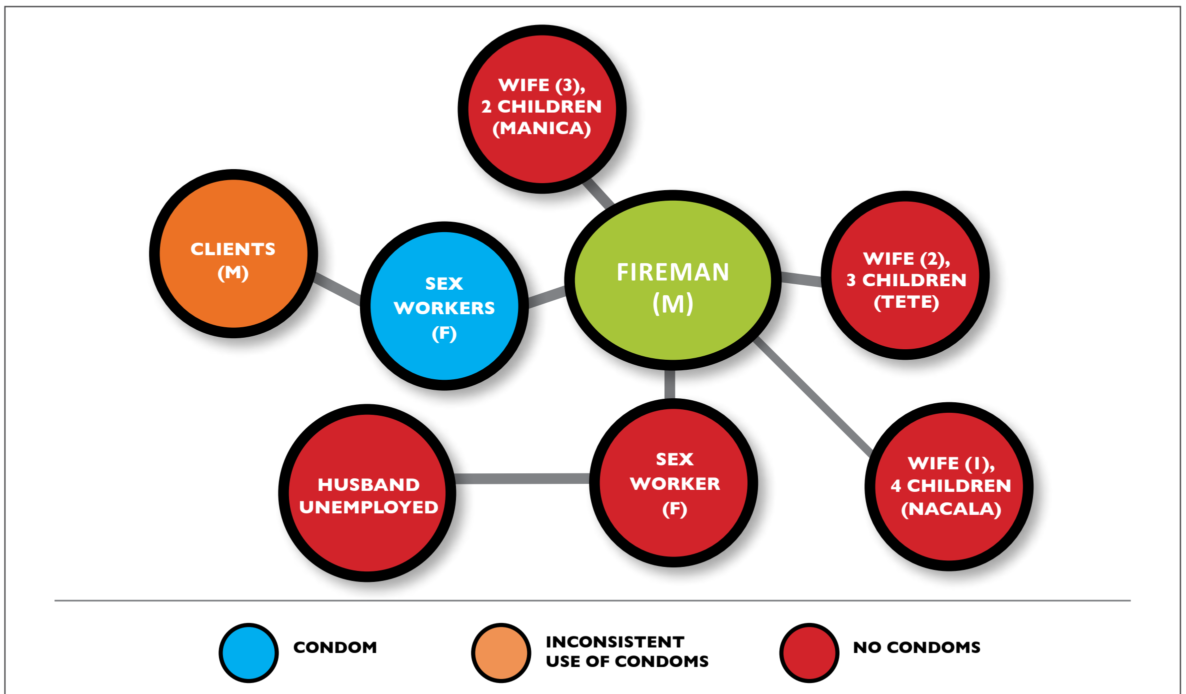
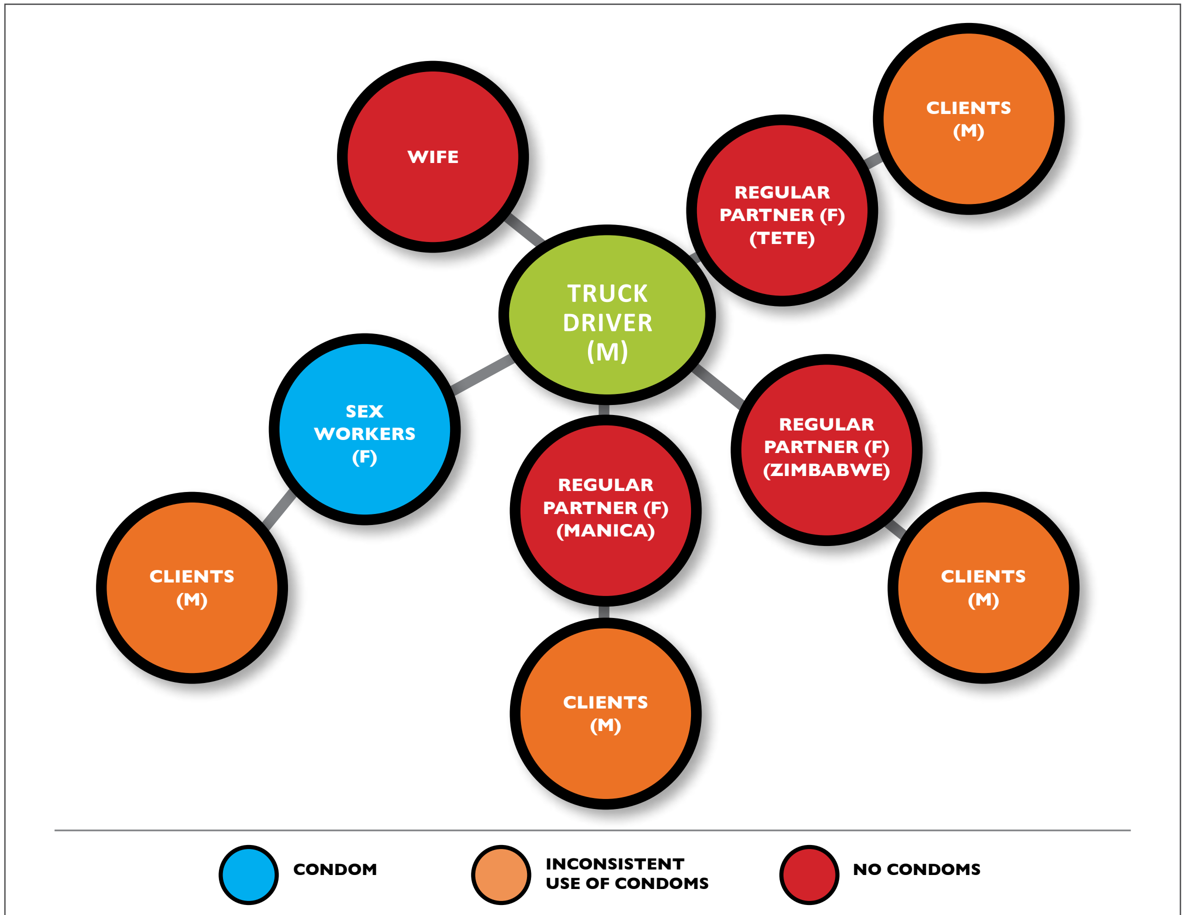


Figure 3. Network of concurrent sexual relationships
Sexual relations network (c)



Note: The truck driver has regular, long-term relationships with the women in Tete, Zimbabwe and Manica. However, there is no suggestion that they have an exclusive relationship with the truck driver.

Figures 1, 2 and 3 show the number of partners with whom the respondent typically had regular sexual relations (self-reported), and the patterns of condom use in the different relationships. These figures demonstrate the elevated vulnerability to HIV transmission of everyone in the networks – due to the **number of concurrent partners** and the **inconsistent use of condoms**. The networks are also (hypothetically) much wider as the respondents were not able to provide information about all their partners' other sexual relationships, and whether or not condoms were used.

The sexual relationship networks above also point to the increased HIV vulnerability of members of the network due to the geographical spread of the relationships. Figure 2 and 3 illustrate networks that exist in a number of provinces and, in the case of Figure 3, another country (Zimbabwe). The provinces of Tete and Manica have amongst the highest levels of HIV prevalence in the country (prevalence for both sexes in the central region are 12.5 per cent compared to 5.6 per cent in the northern region – 2009[12]) and Zimbabwe also has high rates of HIV (14.3% – 2009[13]).

The figures also show that in each case the "safest" sexual relationships that the respondents have are ones with sex workers in which they use a condom. All the other relationships involve high risk behaviour. However, it should be noted that the sex workers do not always practice safe sex with clients, or with non-client partners, thus putting themselves at risk of infection.

5.7 Profile of women receiving payment for sex

The sex workers interviewed were all female Mozambican adults. They spoke freely about their work, explaining the reasons they are involved in sex work, the behaviour of their clients, their own sexual behaviour and health-seeking behaviour.

The adult sex workers reported that much of the sex work was carried out by underage girls as young as 14. This was confirmed through observations by the researchers. The men interviewed are of the opinion that the young girls like to have older men as customers because they have more money than young men. Both men and women interviewed agree that the young girls are at risk of STIs and pregnancy as they do not know how to protect themselves.

In each of the hotspots there were both similarities and specificities in terms of the nature of the sex work.

In all of the hotspots, with the exception of Cuamba,[14] it was possible to interview sex workers who self-identified as sex workers. They worked in public places such as bars, street corners or discotheques. The majority of these sex workers had used condoms, with varying degrees of consistency. None of the sex workers used condoms with their husbands or partners.

In Nacala port both women and young girls were engaged in sex work. Many of the sex workers who worked at the control point (entrance to the town) were young girls who worked the bars and restaurants in the area. The researchers also interviewed women who made their living from sex work but did not work in public. They were generally older women who entertained clients in their homes. Clients knew where they lived and would go to their homes and also refer other clients. These women often had regular clients and received payment in terms of food, regular small income

12 INSIDA Inquérito – Nacional de Prevalência, Riscos Comportamentais e Informação sobre o HIV e SIDA em Moçambique, 2009, MoH, Mozambique.

13 United Nations General Assembly Special Session Report on HIV and AIDS follow up to the Declaration of Commitment on HIV and AIDS, Zimbabwe, 2010.

14 See the limitations section (4.1.3) of the methodology for more information on Cuamba.

or gifts. In addition, some of the women who sold drinks and prepared food on the dockside also supplemented their income by having sex with truckers who had recently arrived on the port and were waiting to upload or unload their cargo.

In Ribaúe, together with women who self-identified as sex workers there were young girls who exchanged sex for money or clothes. A school teacher in Ribaúe stated:

> “There is not much commercial sex in Ribaúe. Normally these so-called sex workers are students who don’t have a way to survive. They have sex in exchange for money to satisfy their whims, but this is carried out in a hidden way, because the town of Ribaúe is very small and people are scared they will be recognized.”

> “*Não há muito sexo comercial em Ribáue, normalmente as supostas TS são estudantes que não têm como se virar, elas fazem sexo em troca de dinheiro para satisfazerem os seus caprichos, mas isso é feito de forma muito escondida porque, a vila de Ribáue é muito pequena e as pessoas tem medo de serem reconhecidas.*”

In Namialo – a truck stop outside Nampula on the way to Nacala, and the cross roads for the road to Cabo Delgado – people noted that the “pull” factor for girls from the interior rural areas was a common feature of sex work in the area. A key informant in the area stated:

> “There are girls that we don’t know that come from the localities in the rural areas, mainly on Thursday and they stay until Sundays so they can work.”

> “*Há meninas que a gente não conhece que vem de localidades do interior principalmente na 5ª feira ficam ate sábado ou domingo a fazerem esse trabalho.*”

In Mandimba, a border town between Mozambique and Malawi, there were a number of different forms of sex work. Some residents of Mandimba worked in the bars and restaurants. Their clients were truck drivers, the resident population and the workers that came to seminars and workshops in the town.

> “The sex workers are women (young single mothers and divorced women), unemployed. When there are seminars or other events, the number of women that look for clients increases. They go to the places where the events are taking place and show themselves and seduce some of the participants of the seminars. The weakest ones end up involving themselves with them.”
>
> Focal point for the National AIDS Council, Mandimba)

> “As TS são Mulheres (jovens mães solteiras e divorciadas), desempregadas, *quando há seminários e outros eventos, o número de mulheres que procura clientes aumenta, elas vão aos locais onde se realizam estes eventos exibir-se e seduzir alguns participantes dos seminários, os mais fracos acabam se envolvendo com elas*.”
>
> (Ponto focal da Comissão distrital do CNCS de Mandimba)

As Mandimba is a border town, there are many cross-border traders. The female traders often try to get lifts on the trucks in order to reduce their costs (they have to pay on the passenger transport – *chapas*). Both the sex workers and the truck drivers confirmed this practice (similar to practices at other Mozambican border posts).

> "There are many female traders who, when they are travelling, don't want to go in the hired cars (*chapas*). They prefer to go in the trucks where the costs are low or they don't pay anything. They seduce the drivers through their conversation, take them to the cars to eat together and afterwards everything happens. It is them (the women) who seek out the drivers."
>
> (Driver, Mandimba)

> "*Há muita mulher negociante que quando está nas suas viagens não gosta de ir em carros alugados (chapas), preferem ir nos camiões onde os custos são baixos ou não pagam nada. Elas seduzem os camionistas através das suas conversas, levam-nos para as barracas para passarem as refeições e depois disso, tudo acontece. Elas é que procuram os camionistas.*"
>
> (Ponto focal da Comissão distrital do CNCS de Mandimba)

It is interesting to observe that the male respondents, such as in the quote above, perceive themselves as being helplessness when a woman is intent on seduction. They give the impression that the women are to blame for the events that unfold. It may be helpful to understand this dynamic in discussions on the complex issue of concurrent sexual relationships.

5.7.1 Reasons why women become involved in sex work

The sex workers gave a number of reasons why they became involved in sex work: economic motivation; to have different social experiences (the younger girls who are taken to restaurants and on trips to different towns); and sexual satisfaction.

Economic motivations differ for different sex workers, but are usually an important reason for entering into sex work in the first place. The majority of sex workers are single mothers with low job prospects who need money to feed and clothe their family. Some of the younger sex workers are more interested in dressing well, being taken to restaurants and bars and having someone to pay for them to enjoy their youth. There are also women who become involved in sex work with specific goals in mind. One of the sex workers had built her own home and was thinking of retiring (at 25 years old) and starting a small business. In Mandimba a community worker with Geração Biz said:

> "There is more transactional sex – because of the costs – at the beginning of the year (school registration for the children for example)."

> "The girls here are hungry. Lots of people like me who come to the city without their families: because they are people who are sexually active and with a reasonable guaranteed income, they end up being tempted by the girls who don't have anything to eat at home and who want good fashionable clothes. This means that women with few resources are vulnerable to having sex in exchange for benefits."
>
> (Customs officer, Nacala)

As meninas daqui tem fome, há muita gente como eu que vêem a cidade sem as suas famílias, por serem pessoas sexualmente activas e com uma renda razoável garantida acabam aliciando meninas que não tem o que comer em casa ou que querem roupa a altura das tendências actuais da moda. Isso torna a qualquer mulher com poucos recursos vulnerável a pratica de sexo em troca de benefícios.

(Customs officer)

Confirming this finding, one of the sex workers in Nacala port stated that her motivation to engage in sex work was strictly economic. When she made enough money to cover the household expenses she would stop, and then start again later in the month when she needed more money. Considering the high levels of unemployment and the low minimum wages in the formal sector, the profits from sex work are relatively high, and would be difficult to substitute with small trading businesses, or bar/restaurant work.

Variable rates for sex and typical earning potential

- Generally rates vary between 150 Mt and 400 Mt per sexual act.
- Extraordinary rates can be as high as 2,000 Mt – 3,000 Mt per sexual act. These rates are charged for sex without condoms, sex in groups or other sexual acts that are considered by the sex workers to be "out of the ordinary".
- Typically a sex worker could earn between 600 Mt and 1,200 Mt per night.
- Working for ten nights a month, she can earn between 6,000 Mt and 12,000 Mt per month.
- Women earning at the extraordinary rates can make between 20,000 Mt and 30,000 Mt per month.
- In addition, the women who earn on the higher end of the scale receive presents and other payments in kind from their regular customers.

The voices of the sex workers

There are people who do commercial sex work because of suffering, but there are some who like it. There are some women who say they do it because their husbands are polygamous, but the real reason is that they like sex. Here in [xx], it is common for men to have various women and we all know this. Women that say they look for other men because their husbands are polygamous use this as an excuse for revenge so they can also betray their husbands and take advantage of this to get some pleasure from other men.

(Sex worker, Nacala)

As pessoas fazem sexo comercial por causa do sofrimento mas, há quem faz por gostar. Há mulheres que dizem que fazem porque os maridos são polígamos mas, na verdade fazem porque gostam do sexo. Aqui em [xx], é normal um homem ter várias mulheres e todas nós sabemos disso. Essas que dizem que procuram outros homens porque os maridos são polígamos, usam isso como vingança para também traírem os maridos e aproveitam-se disso para obtenção de prazer com outros homens.

(TS de Nacala)

“No one likes to lose sleep. If we are here it is because of poverty and suffering. This work is due to suffering and has a lot of suffering.”

(Sex worker)

“Ninguém gosta de perder sono. Se estamos aqui é por causa da pobreza e sofrimento, este é um trabalho feito por sofrimento e com muito sofrimento.”

(TS)

“I charge 1,000 Mt and above, even for a short time. I charge this to foreigners and older men. I don’t like to have sexual relations with young men because they are tight-fisted (they don’t like to pay).”

(Sex worker)

“Os valores cobrados são de 1000 Mt em diante, mesmo se for um short-time. Esse valor é cobrado aos estrangeiros e aos cotas (homens adultos). Não gostamos de fazer relações sexuais com jovens porque eles são foretas (não gostam de pagar).”

(TS)

Age of sex workers

PSI in Nampula – working in a consortium with most-at-risk populations – estimate that between 5 and 10 per cent of transactional sex is with underage females. The current study is not quantitative but would suggest that this may be an under-estimate on the percentage of underage girls involved in the trade.

In the study area, initiation rites are undertaken as girls enter into puberty (with the appearance of breasts and onset of menstruation). This traditionally means that a girl is ready for marriage and sexual relations:

“There are many initiation rites and in the local context when they return from the initiation rites they are considered women and ready for sexual activity.”

(District health worker, Mandimba)

“Há muitos ritos de iniciação e no contexto local quando elas voltam dos ritos de iniciação são consideradas mulheres e aptas para a actividade sexual”

(Director dos Serviços Distritais de Saúde de Mandimba)

All the people interviewed stated that girls between the ages of 12 and 14 were sexually active and that many of the sex workers or girls/women involved in transactional sex were between 14 and 18 years of age. A truck driver (Nacala port) stated that the most risky sex was with the younger girls, “because they didn’t know how to prevent pregnancy”.

5.8 Condom use

Condoms are available in all of the hotspots and in a wide variety of locations including chemists, health facilities, bars, restaurants, petrol stations, shops and stalls. All respondents said that access to condoms was not a barrier to usage, as there was no shortage of condoms available. The cost of condoms varies between 5,00 Mt to 15,00 Mt for a pack of three. The price depends on the type of condom as there are a variety of brands available on the market. The majority of people know about the brand "Jeito", which is provided at low cost by the social marketing organization PSI.

The reason for inconsistent use of condoms is therefore not due to lack of availability or high cost, but to a wide variety of other reasons. These include familiarity with one's partner, sexual pleasure, the wish to get pregnant, higher payments (for sex workers) and religious beliefs. Figure 4 summarizes the types of relationship in which sex workers and their clients interviewed reported using condoms.

Figure 4. Typology of condom use vs relationship by mobile population and sex worker

SEX WORKERS SEXUAL PARTNERS	CONDOM USAGE	REASON FOR CONDOM USAGE
Husbands or boyfriends	No condom	They provide for the family
Clients that pay extra	No condom	Receive money
Clients	Condom	Receive money
Wife (could be more than one wife)	No condom	Not paid for sex but provided for
Lover	No condom	Not paid but provided for
Friends (regular)	No condom	Given gift or money
Sex workers	Condom	Money (food or lifts)

Source: Interviews with clients and sex workers along the Nacala corridor, 2010/11

5.8.1 *Rationale behind condom usage*

Below is a series of quotations from respondents, illustrating the complexity of the rationale behind condom usage.

Sexual pleasure and increased payments

"I have a South African friend – I don't use a condom with him, and this one pays very well. I do everything he wants, including oral sex. When I am physically attracted to a client, I don't use condoms, then I can have the pleasure of a good sexual relationship and I can receive money. I am worried about catching AIDS, but I still need to satisfy my desires. I know that having sex without a condom I am running the risk of getting the illness, but if I don't get it with a client I will with a friend (lover)."

(Sex Worker)

"*Tenho um amigo sul-africano com quem não uso preservativo, esse paga muito bem. Faço tudo o que ele quer incluindo sexo oral. Quando sinto uma atracção física por um cliente, não uso preservativo, aí junto o prazer de fazer uma boa relação sexual e o de receber dinheiro. Tenho medo de apanhar SIDA mas mesmo assim preciso satisfazer meus desejos, sei que fazendo sexo sem preservativo corro o risco de apanhar a doença mas, se não for a apanhar com um cliente vai ser com um amigo.*"

(TS)

"Condoms reduce the pleasure when you always use them. For this reason, after having sexual relations for a while with the same partner (you) need to go to the hospital with her and have the test. If the test is negative then I don't use condoms anymore. Having one partner is good, but having many is better."

(Truck driver, Namialo)

"O preservativo diminui o prazer quando é usado sempre, por isso, depois de manter relações sexuais com preservativo várias vezes com a mesma parceira vou ao hospital com ela fazer o teste, se acusar negativo posso não usar mais. Ter uma parceira é bom mas, ter muitas é melhor."

(Camionista de Namialo)

Making decisions on health status based on behaviour and appearance

"I don't use Jeito [condom] with my wife. But also on the street when I meet a girl that I trust, when I see that she is not one that plays around and she is cute (plump) and doesn't have any wounds or a cough [I don't use condoms]."

(Assistant trucker, Nacala port)

"Eu não uso jeito com a minha mulher. Mas também na rua quando encontro uma menina que não desconfio, que vejo que não tem brincadeiras e é fofinha (gordinha) não tem feridas nem tosse."

(Assistant trucker, Nacala port)

I don't use Jeito [condom] with my wife. But also on the street when I meet a girl that I trust, when I see that she is not one that plays around and she is cute (plump) and doesn't have any wounds or a cough [I don't use condoms].

People believe that condoms transmit the virus

"One of the main obstacles to condom use is that people believe that they transmit the virus. People say that when you use them you get spots on your sex (sexual organs). The other obstacle is cultural habits – people want to have more children."

(NGO worker, Mandimba)

"O maior obstáculo para o uso dos preservativos são as pessoas que dizem que o preservativo é o meio de transmissão do vírus. As pessoas dizem que quando usam, aparecem borbulhas no sexo. O outro obstáculo são os hábitos culturais, as pessoas querem ter mais filhos."

(NGO worker, Mandimba)

Pregnancy and (informal) social security

"Some women don't accept to use condoms because they see the possibility of having a man they can marry or to be the father of their children. This happens a lot with women who have children that are older and where they are having difficulties in bringing them up. There are sex workers with more than three children, but all with different fathers. The number of children increases because they let themselves get pregnant in the hope that they will find a stable partner. They will continue until they find one that will recognize the pregnancy. If it is a client with whom they have had sex various times, and if the client isn't clever, he runs the risk of taking responsibility for a child that isn't his!"

(Sex worker)

"*Algumas mulheres não aceitam usar preservativo porque, veêm uma possibilidade de ter um homem para casar ou para ser pai dos seus filhos. Isso acontece muito nas mulheres que já têm filhos crescidos e que tem dificuldades de criá-los. Há TS com mais de três filhos, mas todos eles de pais diferentes, o número de filhos das TS aumenta porque elas se deixam engravidar propositadamente sempre na esperança de acertarem um parceiro fixo. Vão tentando até conseguirem um que se prontifique a assumir a gravidez. Se for um cliente com quem já manteve relações sexuais várias vezes e se o mesmo não for esperto, corre o risco de assumir um filho que não é dele.*"

(TS)

Difficulty of using condoms in concurrent relationships

"Many times when we start extra-marital relationships we use condoms, but then after a time we abandon them. I'll give you an example. When I started the relationship with my girlfriend (student), we used condoms because she is engaged to be married and her fiancé is working in [xx] city, I'm married and my wife is in [xx] province. We came clean with each other and decided to use condoms at the beginning, because each of us doesn't use condoms with the person that we have a family commitment with. Things started to heat up. She has a lot of freedom in my house because I am by myself and on the other hand her boyfriend is never here. She practically lives with me because she spends most of her time here in my house. One day I was drunk and I didn't worry about putting on a condom, and even though she was more lucid she didn't demand [to use the condom] and we didn't use a condom. I held my head the next day, but the damage was done. Since then we haven't used condoms. My luck was that one day I asked her to take an HIV test so we could know our real status. Thank God we are negative, but who knows for how long, because she has a boyfriend who may have a friend that he has confidence in, and I have a wife. This is all so complicated."

(Customs officer, Nacala)

Muitas vezes quando nós começamos uma relação extra conjugal usamos preservativo, mas passado algum tempo abandonamos do nada. Vou dar-te um exemplo. Quando comecei a relação com a minha estudante, usávamos preservativo porque ela é noiva e o namorado está a trabalhar em [xx], eu sou casado e a minha esposa está em [xx]. Jogamos tudo limpo e decidimos usar camisinha no principio, pois cada um de nós não usa preservativo com a pessoa que tem um compromisso de família. A coisa começou a aquecer, ela tem muita liberdade em minha casa porque estou só e por outro lado o namorado nunca esta cá. Praticamente ela vive comigo porque passa a maior parte do tempo em minha casa. Um dia eu estava com copos e não me preocupei em por preservativo, ela mesmo lúcida não exigiu e assim começamos a não usar. Peguei a cabeça no dia seguinte, mas o mal já estava feito. Desde então não usamos o preservativo. A minha sorte é que um dia convidei a ela a fazermos teste de HIV para sabermos o nosso real estado. Graças a Deus somos negativos, mas não sei até quando porque ela tem um noivo que também pode ter alguém de sua confiança e eu minha esposa. É muito complicado isto.

(Customs officer, Nacala)

I use condoms with different partners but when I know a client and I don't distrust him I don't use one because I also like to feel the pleasure. There are clients that when they come to Nacala know who to look for – with these clients I don't use condoms. Even though this is a client–sex-worker relationship, when there is trust between us, if the client doesn't have money on that day they may not pay until the next day.

(Sex worker)

Uso preservativos com diferentes parceiros mas, quando conheço o cliente e não desconfio dele, posso não usar porque eu também quero sentir prazer. Há aqueles clientes que quando vão à Nacala já sabem a quem procurar, é com esses clientes que não uso preservativo. Apesar dessa ser uma relação entre TS e cliente, como existe uma confiança entre nós, o cliente se não tiver dinheiro nesse dia pode não pagar e deixar para o outro dia.

(TS)

5.8.2 Condoms: A glimmer of hope

As demonstrated above, barriers related to the availability, cost or unfamiliarity with condoms were not raised by respondents as reasons for not using condoms. The majority say that there are no tangible barriers to using condoms. However there is a long list of reasons why they prefer not to use them, as detailed above. In addition, some respondents mentioned the role of religion – especially amongst Muslims (Islam has a strong influence in the Nampula part of the Nacala corridor) the perception is that using condoms is prohibited by religious leaders. However, there is a glimmer of hope as many of the sex workers interviewed are using condoms (although still not consistently) and a group of sex workers in Nacala port appeared to have strong positive attitudes towards condom use. One of the sex workers spoke at length about why she would not risk her life.

When someone arrives and asks me to have sex without condoms I don't accept. He could give me three thousand or five thousand meticais, I wouldn't accept. Because if a person makes this type of proposal it is because he knows he has an illness. It is not normal for a person who doesn't know you to not want to use condoms. So for me if the person is like this it is because he has an illness, and if I take his money it won't be

of any value to me because I will spend all the money going to the hospital everyday and I won't be able to earn anything. I prefer to earn a little by little instead of wanting a lot all at once and then getting an illness. ”

(Sex worker, Nacala port)

“Quando alguém aparece e me pede para fazer sexo sem preservativo eu não aceito, ele pode dar 3mil ou 5mil meticais não aceito. Porque se a pessoa faz esse tipo de proposta é porque sabe que tem doença. Não é normal alguém que não te conhece e não quer usar preservativo. Quando é assim para mim essa pessoa tem doenças, se eu levar esse dinheiro não me vai valer nada porque vou gastar todo com a doença indo ao hospital todos os dias e não vou poder ganhar nada. Prefiro ganhar pouco a pouco do que querer muito de uma vez para depois apanhar doenças.”

(TS, Nacala port)

5.9 HIV and AIDS health-service provision and health-seeking behaviour

5.9.1 Health-service provision and health-seeking behaviour

Availability of health services

See annex 2 for the maps of schools and health facilities along the full Nacala corridor (Map 2.6), and the maps dividing the corridor up in Nampula province (Map 2.7) and Niassa province (Map 2.8). Although the National Health System covers the whole country, there are serious shortcomings in healthcare provision due to a lack of trained health staff, shortages of essential drugs and a limited number of health facilities. It should be noted that in all of the hotspots there are health facilities available that offer curative and preventive health services. See maps above.

The HIV and AIDS-related services that are offered at the health facilities in the hotspots include:

1. **Antenatal and post-natal clinics:**[15] In antenatal clinics, women are offered counselling and testing for HIV. The majority of women accept being tested during pregnancy. If the test is positive the nurse will counsel the women and offer to test the women's partners. We were unable to find statistics for the number of partners that agreed to be tested when the spouse was found to be HIV positive. (No fees are charged for this service.)

2. **Family planning services:** Free family planning services are available in all of the health facilities on the corridor. At the time of the research contraceptive methods – condoms, pills, injections and intrauterine devices were available. This was confirmed by health workers and the women interviewed during the research. (No fees are charged for this service.)

3. **HIV counselling and testing services** are available in all of the health facilities. (No fees are charged for this service.)

15 Percentage of institutional births by province: Nampula 60.8%, Niassa 78.8%. National average: 58% (MICS, 2010).

4. **Adolescent and youth-friendly sexual and reproductive health services (SAAJ).** The SAAJs offer counselling on all issues related to adolescent health, including counselling for HIV testing, family planning and awareness, and treatment of STIs. In Mandimba (border post with Malawi) the organization Geração Biz work with the SAAJ in the health centres, and also use community radio, education in schools and peer education to reach youth in the community. (No fees are charged for this service.)

5. **Out-patient consultation** is offered in the health facilities. It is provided by medical assistants or medical doctors. (The fee is 1 Mt per consultation.)

6. **Treatment and care programmes for HIV and AIDS** are offered in the health centres and hospitals on the corridor. People presenting with HIV to the health posts are referred to health centres for treatment and care. (No fees are charged for this service.)

All the women interviewed in the course of the study use the health services regularly. The services that were mentioned most frequently in the study were the mother and child health services, namely antenatal and post-natal clinics, and child-care clinics. In addition, the women were familiar with the curative outpatient clinics, and the vast majority stated that they would use these services if they had an STI or other illness.

The sex workers interviewed during the study generally used the contraceptive pill or hormone injections as a form of birth control. They accessed family contraceptives through the health service. The women were familiar with family-planning methods, and stated that there were no shortages of family-planning methods. However, they did not consider condoms as the primary family-planning method. A sex worker in Nacala port stated that she used both injections and pills to prevent pregnancy. She goes on to state that she does not use condoms because she prefers sex without barriers and believes that sex without condoms is healthy (the sperm provides her with vitamins).

“I prevent [pregnancy] with injections and pills. It is not possible to prevent [pregnancy] with condoms because, as well as not liking sex with condoms, we want to have flesh-to-flesh sex to get vitamins. Sex without condoms gives you many vitamins.”

(Sex worker, Nacala port)

“*Previno-me com injecção e comprimidos. Não é possível prevenir com preservativo porque para além de não gostar de fazer sexo com preservativo, queremos apanhar carne para termos vitaminas, sexo sem preservativo dá muitas vitaminas.*”

(TS de Nacala)

Awareness of Illness and attitudes to treatment (special reference to STIs and HIV)

The research indicates that there is awareness of STIs among the sex workers, clients and the host community, although the information that people have is not always correct. A guesthouse worker in Ribaúe stated:

“People catch diseases such as gonorrhoea and syphilis. People say that when you get all of these diseases at the same time that you have AIDS.”

(Guesthouse worker, Ribáue)

> *As pessoas apanham doenças como Gonorreia (mula) e síflis (ephwiri). Dizem que quando se apanham essas doenças todas juntas, já é SIDA.*
>
> (Empregado de Pensão de Ribáue)

In terms of STIs, HIV testing and treatment, the women interviewed were aware of HIV testing, and the vast majority stated that they had, at some point,[16] been tested (all stated that they had tested negative). None of the women interviewed were on antiretroviral treatment programmes. One of the female sex workers in Namialo was open about the subject of STIs, and felt it was a common complaint.

> Do you think it is possible that a person of my age who has sex hasn't caught an STI? Even you, have you never had one? Yes, I have caught one, gonorrhoea, and I went to the health centre to have it treated.
>
> (Sex worker, Namialo)

> *É possível mesmo uma pessoa da minha idade e que faz sexo não ter apanhado ITSs? Mesmo você, nunca apanhou? Eu já apanhei sim, uma gonorréia e fui ao centro de saúde tratar-me" trabalhador de sexo.*
>
> (TS, Namialo)

The majority of men stated that they had not been tested for HIV although they were aware of the service. Men were able to describe the services offered at the health facilities and stated that they would use the health services if they suspected they had an STI. However, only one of the men interviewed stated that he had had an STI and received treatment at the health centre. Health workers stated that they treated many STIs although they could not say whether they were sex workers, mobile populations or people from the community.

Health workers recognized that they are not the first calling place for many of the STIs and other opportunistic infections that occur when people are HIV positive. People will often go to the traditional healers first and then, when the situation worsens, will arrive at the health centre. One of the key informants working in Niassa said:

> The HIV and AIDS situation is serious because of the behaviour of people. We are in a rural setting and 80 per cent of the population will go first to a traditional healer. People will start with the traditional healer and then go to the hospital.
>
> (Health worker, Niassa)

> *A situação do HIV/SIDA é grave por causa do comportamento das pessoas. Estamos num meio rural no qual 80% da população já recorreu ao curandeiro. As pessoas começam pelo curandeiro e depois é que vão ao hospital.*
>
> (Health worker, Niassa)

One of the reasons put forward for the reluctance to test for HIV and the late presentation at the health centre for conditions related to HIV is due to the fact that there is currently no cure for HIV.

16 As all the women interviewed had young children it is likely that the testing was done as part of the antenatal consultation.

> People are frightened of taking the test because they know that AIDS doesn't have a cure. Tuberculosis was like this at the beginning, now tuberculosis is an illness that you can treat. You will see when there is a cure for AIDS, we will send our children, without thinking, to the chemist to buy medicines, like we do with malaria. Today it is common to hear 'Hey, Maria, go to the chemist and buy the malaria medicine'. With AIDS it will be the same when there is a cure.
>
> (Trucker, Mandimba)

> *As pessoas ainda tem medo de fazer o teste porque sabem que a SIDA não tem cura. Com a tuberculose também foi assim no princípio, agora, a tuberculose é uma doença que se pode tratar. Vai ver que quando houver cura para o SIDA, havemos de mandar os nossos filhos com muita naturalidade para irem as farmácias comprar os medicamentos, tal como fazemos com a malária. Hoje em dia é normal ouvir o seguinte: Ó Maria, vá lá a farmácia comprar medicamentos para malária. Com a SIDA vai ser mesma coisa assim que houver cura.*
>
> (Camionista de Mandimba)

The quotation above is important because it shows the complexity of managing HIV. HIV requires not only testing but then constant visits to the hospital. It is not an illness which can be treated through the pharmacy; it requires multiple visits to the health facilities (to control CD4 cells/T-cells, check medication and treatment of infections). This goes against all "normal" health-seeking behaviour, which involves at most one hospital visit or "delegation" of another person to seek healthcare solutions (such as a child fetching medicine from a pharmacy). In addition, the quotation clearly shows that the fact that HIV cannot be cured is a major obstacle in non-compliance to testing and treatment plans.

Accessibility of health services (mobile populations and host communities)

The respondents generally felt that there were health facilities available in or close to the hotspots, so physical access was not a problem in terms of distance to a health facility. However, there were a number of barriers to using these health facilities. One barrier is the opening hours: generally patients were seen in the mornings for all out-patient consultations, mother and child health clinics and family planning. There were some services offered in the afternoons until approximately 3:30 pm, and those with in-patient facilities maintained a small staff for 24 hours a day. However, the night staff do not do any clinic work during the night.

Alternatives people use when the clinics are closed

1. Friends or family with medicines in the house that are perceived to help with the self-diagnosed illness.
2. Buying medicines, without a prescription, from the pharmacy.
3. Going to a traditional healer.

Cost of healthcare on the Nacala corridor does not seem to be a great barrier to uptake of services. People were clear that the costs are low (1 Mt for the consultation and 5 Mt for the medicines). Many of the services that the women use are free of charge, for example: family planning, mother and child healthcare, antenatal and post-natal care. All respondents knew that both testing and counselling for HIV is free, as are antiretroviral medicines. They did not a see costs as a key factor in the under-use of the health services. This situation may

be very different in larger cities where the problems of "hidden"[17] costs are high and the range of medicines available in the hospitals and health facilities limited.

The other two challenges mentioned relating to health services were the long waiting times and the lack of medicines in the health facilities' pharmacies. The long waiting times in the health facilities were particularly important for truck drivers and their assistants, who do not have time to wait for a long time to be attended to. They work long hours, usually starting very early in the morning and arriving at the trucking stops after dark. The lack of medicines in the health facilities' pharmacies is a nationwide problem and the Ministry of Health is taking measures to increase the quantities of essential drugs supplied at different levels of the health service, but this will remain a problem for the near future. Medicines are available in private pharmacies but are expensive and beyond the means of most people.

The majority of respondents (host and mobile community) stated that longer opening hours would make a difference to access for truck drivers and their assistants, and people from the host community who had to work at night. They also suggested that it may reduce the waiting times during the morning sessions. However, they did not advocate for clinics that just treated STIs or HIV, as they felt that this would lead to discrimination in the community and that people would be reluctant to go to specialized clinics.

> "Care for STIs/HIV should be carried out in the hospital. Mobile clinics for the care of STIs/HIV lead to an atmosphere of discrimination. ... If my colleague goes to a mobile clinic to treat for an STI or test for HIV I would hide behind a corner just so I could see him go in and come out of the clinic. Then I would run and tell other friends and neighbours that the guy went to the clinic for a test and then everyone will know his health status because the news will have spread."
>
> (Trucker driver)

> "*Os cuidados de ITS/HIV devem ser feitos no hospital. As clínicas móveis para cuidados de ITS/HIV propiciam a ambientes de discriminação. ... Se o meu colega for a uma clínica móvel para fazer tratamento ou teste de HIV, eu vou ficar escondido numa esquina só para vê-lo entrar e sair da clínica. Depois disso, vou a correr dizer aos outros amigos e vizinhos que fulano esteve na clínica a fazer teste e aí toda a gente vai ficar sabendo do seu estado de saúde porque a notícia vai se espalhando.*"
>
> (Camionista)

Another key challenge mentioned by all of the respondents was the quality of attendance, in particular with regard to HIV services. People questioned the confidentiality of information obtained by the health workers. They felt that a professional code of conduct was not practiced and that information about their status would be shared with others in the community.

During the study a number of NGOs were interviewed that are providing various care, support and prevention activities in and around the hotspots. The NGOs included ESTAMOS in Niassa, and PSI, which runs an initiative for high-risk populations. Two of the challenges faced by the organizations are the lack of long-term funding for sustainable support to initiatives aimed at behaviour change, and an inability to provide significant coverage in the areas of highest risk. Given the complexity of changing sexual behaviour norms and practice without an investment of 10+ years, change will not be achieved.

17 Hidden costs include bribes for hospital staff to be seen in out-patients and cared for in the in-patients. In addition, the majority of people in the cities have to access medicines in private pharmacies.

The **economic development** along the corridor, while bringing positive results of greater prosperity, is exacerbating the differences between people who have disposable income and those who do not. In addition, there is more money available to spend on entertainment, including buying sex. This creates a situation where people recognize income-earning opportunities and are attracted to become involved in sex work to obtain money or supplement existing income.

Frequency and fluidity of sexual relationships. There is a high level of concurrent sexual relationships among the group of people interviewed in the study. Those interviewed represent a cross-section of the mobile populations and the host communities with whom they interact. The researchers did not encounter any difficulties in obtaining information about the different relationships that people had and there appeared to be little societal censure about maintaining more than one sexual relationship at a time. In addition, the social environment in the hotspots meant that sex was readily available with a range of women (declared sex workers, restaurant works or regular girlfriends – one for each trucking spot). Many people responded that abstinence was a way of preventing transmission of diseases but then went on to state that this was not possible or desirable.

There are a number of **religious and traditional practices** that facilitate the taking of more than one partner in the study area. A high proportion of people on the corridor, particularly towards the coastal region of Nampula, are Muslims. People stated that under Islam it is possible legitimately to have more than one wife, which is loosely interpreted as having more than one sexual partner.

The question of having more than one partner is even more complicated in the northern provinces of Mozambique as **women are also not expected to be (sexually) satisfied with only one man**.

> “Here in the north women are taught in the initiation rites that ‘man’ is not just one man; that men don’t refuse [sex]; and one man alone cannot fill the trunk [a wooden trunk given to girls on marriage]. For this reason the girls begin to have sex with many partners and they don’t have the capacity to negotiate the use of condoms.”
>
> (Health worker, Nacala)

> “*Aqui na zona norte as mulheres são ensinadas nos ritos de iniciação que homem não é a penas um; Que homem não se nega; Um homem sozinho não enche a mala. Por aí, as meninas começam a actividade sexual com muitos parceiros e elas não têm capacidade de negociarem o uso do preservativo.*”
>
> (Health worker, Nacala)

Although people stated that since knowing about HIV they had changed their behaviour, this behaviour change has not resulted in significantly lower risk of transmission. For example, one of the drivers stated that he was scared of becoming infected so now “chose” his partners with care and had reduced the number of occasional partners. However, he still:

- Had a wife with whom he did not use condoms;
- A lover with whom he did not use condoms;
- Generally used a condom with “friends”, except when they asked him not to.

Some of the reported behaviour to increase sexual safety included criteria for choosing partners more carefully ("good" girls who do not play around, plump girls with no sores or cough) and using condoms with some partners (condoms were never used previously). However, none of the people interviewed said that they were considering being faithful or abstaining from sex (outside of an exclusive relationship) or practicing consistent condom use.

People's **attitude to AIDS** often affects the way in which they perceive the need to change behaviour. Some of the attitude changes are positive and may, in time, reduce the risk of transmission. Other attitudes make it unlikely that there will be any change in risk-taking behaviour.

Below are illustrations of how a strong belief in fate hinders change, how the lack of communication between partners reduces the possibility of mutually decreasing risky sexual behaviour, and one example that could show how concerted social/family pressure might bring about behaviour change.

Fatalistic attitude

"I think that AIDS is fate. And you can't escape your destiny. When God says that you will die in an accident do you escape? It is like AIDS, if you are to get it there is no escape, but sometimes you just have to take care, but you can't escape."

"*Acho que sida é destino. Você não pode fugir de destino. Quando Deus escreve que você vai morrer de acidente, você foge? É como sida, se for para ter não escapa, mas as vezes é preciso andar com cuidado só, mas não se foge.*"

Reluctance to talk with partners

"When she was pregnant with the last child I didn't go with her to the hospital. I don't know if she did the HIV test or not because I wasn't close to her because of my work and I never asked."

(Truck driver, Nacala)

"*Ela quando estava grávida deste ultimo filho eu não acompanhei a ela ao hospital, não sei se ela fez teste de sida ou não porque eu não estava perto dela devido ao trabalho e nunca perguntei.*"

(Assistant truck driver, Nacala port)

Social/family pressure to reduce risky behaviour

"I have a woman who is 35 years old who has a market stall. She has been a widow for two years. When I go with her I don't need to have money straight away. I almost lived with her for a time because I used to sleep there. I lied to my wife. I would say that I was travelling and I would stay in the house [of the widow]. But my brother began to criticize me, saying that I didn't know what the widow's husband had died of so I don't got there anymore."

(Truck driver's assistant)

"*Tenho uma senhora de 35 anos que tem uma banca no mercado, é viúva a 2 anos quando vou ter com ela não preciso ter dinheiro logo. Eu quase vivi um tempo com ela porque costumava dormir lá. Eu mentia para a minha mulher, dizia que ia viajar e ficava aqui mesmo em Nacala em casa dela. Só parei quando meu irmão mais velho ficou a saber e criticou-me muito porque dizia que eu nem se quer sabia de que doença o marido dela morreu, entao nao vou la mais.*"

(Truck driver's assistant, Nacala port)

6.1.1 *The age of sex workers*

As a previous study carried out on the Nacala corridor shows (Selvester, 2006), the age of sex workers continues to be a major concern. For ethical reasons child sex workers were not interviewed during this study. However, information from adult sex workers, key informants and other mobile populations all confirmed that girls are involved in a number of ways in transactional sex. In Nacala port, Namialo, Nampula city and Mandimba, girls from 14 years of age are working as sex workers. In Ribaúe the researchers were informed that there was less direct sex work carried out by young girls but that the girls from the boarding school were sought after by truck drivers who gave presents and money in exchange for sex. There is concern about this situation for a number of reasons.

- Having sex with underage girls constitutes a crime and is technically rape, although not criminalized at present in Mozambique; it is seemingly accepted as normal, acceptable behaviour by adult men.
- Children involved in sex work are less likely to be able to negotiate safe sex to prevent illness and pregnancy, and are therefore at high risk of contracting HIV.
- There is a possibility that the children will become social outcasts and will not be protected by the extended family.
- There is a high probability that the children will suffer psychological damage.

6.1.2 *Risks, myths and misconceptions*

A number of myths and misconceptions abound, which add to the already high-risk scenario for HIV among the people interviewed. These should be taken into consideration when developing information, education and communication (IEC) materials.

A worrying number of people appear to believe that it is possible to "see" whether someone is sick with HIV or AIDS, and that by carefully selecting one's sexual partner one does not need to use a condom. Some of the common misconceptions are:

- Good looking, plump and clean women are not likely to have any diseases (conversely, women who do not wash and are thin are sick).
- Men choose women who they feel are "well behaved" in the belief that they would not have contracted any illnesses. However, using condoms consistently is not part of the good behaviour.[18]
- Men believe that within a short period of time (for example, three days) it is possible to know whether you have contracted HIV. And if, within that period, you do not have any signs of illness, then you can carry on having unprotected sex.

There are also serious gaps in people's understanding of HIV and AIDS that prevents them from making informed decisions. Some of the key issues highlighted in the research are:

- People believe that condoms can pass on the virus and infect people.

18 "When I arrive in a place, to find a women, first I analyse the situation, investigate the women to know if she is a tramp or not. When I see that she doesn't play around, then I can be with her." (Driver, Nacala port)

"Eu quando chego num sitio, para conquistar uma mulher, primeiro analiso, investigo a mulher para saber se é vadia ou não. Quando vejo que ela não tem brincadeiras, dai já posso me meter com ela." (Camionista, Nacala porto)

- The physiology of HIV is poorly understood, with people believing that it is a disease that affects the intestines or is the cumulative result of STIs.

- People believe that catching the disease is inevitable for someone who is sexually active (so there is no point trying to take preventive measures).

There is an ever-growing concentration of resources, development and programmes in the hotspots studied. These are attracting investment in both formal and informal businesses. There was some evidence from the study that these areas are now **acting as magnets for young men and women from the rural areas looking for employment and an escape from agricultural labour**. In both Mandimba and Namialo this factor was mentioned and we were informed that every week from Thursday onwards many girls arrive in the hotspots for the weekend to engage in transactional sex. These girls are seen as being very naive and easily fooled by clients into not using condoms or not charging enough for their work.

As the economic development increases along the corridor the "pull" factor from the rural areas will become stronger and there will be more in-migration to the economic development spots. Given the unregulated nature of income generation in the country this could give rise to extreme labour and sexual exploitation.

As part of an ongoing strategy to track and mitigate against the potential negative impact, actions should be undertaken both in the rural "feeder" areas and in the hotspots to protect youth from exploitation. Similar work was carried out by the government, the private sector and Save the Children Fund during the building of the bridge over the Zambezi river.

NGOs active on the corridor could play a positive role in engaging communities (particularly the youth) in dialogue about safety issues when considering internal migration to the hotspots. They could also play a pivotal role in IEC campaigns in the hotspots to increase knowledge, awareness and potentially influence sexual behaviour.

Access to health services

The results from the study point to weaknesses in the provision of services due to the quality of attendance and the long waiting times. However, there are health facilities in each of the hotspots with health staff and a full complement of preventive and curative services regarding HIV and AIDS. The questions raised are in terms of the confidentiality of results for sensitive illnesses (such as HIV and other STIs) and the length of time that people have to wait to be attended.

The main issue raised by the researchers during the study was the use of the health services by men in general, the inaccessibility of health services to truckers and assistants and the continued reluctance of all people to be tested for HIV (regularly) and treat STIs.

Reaching men is an ongoing theme in many health-related studies but has yet to be tackled in a comprehensive fashion that would yield results.

Although people are aware of STIs and all stated that they would go to the health centre if they suspected an infection, the vast majority claimed they had never had an STI. Health workers stated that people presented late to the health facilities with severe infections. Tackling sexual health is a complex, delicate issue that requires concerted, long-term effort and cannot be combated through short-term campaigns.

07 CONCLUSION

Rapid economic growth of the Nacala development corridor has not been coupled with necessary social infrastructure development, especially as relates to HIV and gender programming. The Nacala corridor is an exciting, vibrant development area in Mozambique and is beginning to change the economic prospects of millions of farmers, miners, traders and industrialists in the northern and central provinces. In addition, the transport infrastructures (rail and road) and the port are providing an important gateway for Zambia and Malawi to export and import. At present the provincial HIV-prevalence rate is lower than the national average of 11 per cent and than prevalence rates in neighbouring countries. However, there is legitimate concern that the Nacala corridor will follow the pattern of major transport corridors in southern and eastern Africa, triggering a rapid rise in HIV-prevalence rates.

There are extremely high levels of concurrent sexual relationships, coupled with inconsistent condom use (condoms are used more frequently with casual partners, but not with regular partners). Both host communities in the hotspots and the mobile populations using the corridor are practicing high-risk sexual behaviours. In particular we found extremely high levels of concurrent sexual relationships, coupled with inconsistent condom use. The study points to the extreme vulnerability of (regular) partners within non-monogamous relationships. Sex workers were more likely to use condoms with occasional partners therefore affording a level of protection. However, men and women in some sort of relationship (however loosely defined) do not use condoms for protection, thus affecting wives (including second, third wives) and regular partners, as well as dependent children.

There is reasonable coverage of health services, but the perceived quality – outside of mother and child health services (including mother-to-child transmission services) – is questionable. The areas covered under the study have reasonable coverage in terms of health facilities and services that offer treatment, care and support for HIV and AIDS: each of the hotspots has at least one health centre, and a number of hotspots have a range of health facilities which offer referral services. Mother and child healthcare services, including family planning, were frequently mentioned as the main point of contact with the health service for women. Questions were raised by the respondents about the quality of the services offered in the health facilities. In particular, attention was drawn to issues of confidentiality and professional ethics. Many people felt that health staff did not follow a professional code of conduct with regard to patients' HIV and STI status. Additionally, the vast majority of respondents were also concerned about the length of time spent in the health facilities due to the lack of staff and the number of patients to be seen. This was cited by the truck drivers and assistants as one of the main reasons they did not use the health facilities. There are no regular mobile clinic services offered in any of the hotspots or services offered out of normal working hours. This limits the real access of people to health services.

Women and young people are more likely to use health services than men. Women and young people are more likely to access health services and have contact with informed health staff. Young people are using the youth-friendly services and young women are attending antenatal clinics and baby clinics. Men are generally less likely to use the health services – truck drivers and their assistants have virtually no access to healthcare due to their work schedule and the opening times of the health facilities.

HIV-related services provision is inconsistent, in terms of scope and quality. Although, along the corridor, there were a number of international and national NGOs that are working on HIV and AIDS issues, the coverage is still limited and funding is on a short-term basis, resulting in many "stop–start" initiatives, such as provision of healthcare and testing through outreach clinics and sensitization campaigns about HIV and AIDS aimed at specific high-risk groups. The majority of the people interviewed had not had any direct contact with NGO activities and were largely unaware of the activities that were being undertaken. This is indicative of the low coverage of the NGO activities in the area studied.

08 RECOMMENDATIONS

8.1 National recommendations

8.1.1 Promote patient confidentiality in the health sector and health workers professional codes of conduct

The Ministry of Health should:

1. Conduct training of health workers on migrant-sensitive healthcare provision – based on the World Health Assembly resolution *The Right to Health of Migrants* (WHA 61:17).

2. Conduct/reinforce training of health personnel on professional codes of conduct and ethics, regarding issues of confidentiality (with particular reference to STIs and HIV status).

3. Investigate the introduction of a "Patient Charter" indicating key professional ethics in the health sector, linked to publicity campaigns to educate the public about the Charter.

4. Ensure that there are strong systems/tools to manage cases confidentially (for example, record keeping and private counselling space).

8.1.2 Conduct male-oriented programmes to improve male health-seeking behaviour

The Ministry of Health and partners should develop a programme to promote male health-seeking behaviour through an annual campaign week which focuses on:

1. Increasing the familiarity of men with health facilities and the services offered;

2. Increasing early treatment of STIs;

3. Delivering key IEC activities effectively to men in the workplace, at home and on the road.

4. Conduct gender sensitisation programmes with men – based on a ''One Man Can" model

8.1.3 Increase accessibility of health facilities for mobile populations at hotspotsn

The UN should promote policy discussion about the provision of healthcare to areas with high levels of mobility, through extended working hours of health service providers, including a cost analysis and a budgeted plan for implementation in key health facilities.[19]

19 It would be useful to engage the private sector in a financial investment plan for long-term support to the health facilities in hotspots.

8.1.4 *Promote safe sex practices among public-sector workers*

The Ministry of the Public Sector should review workplace HIV and AIDS policies in the public service, including targeted prevention programmes. The review should take into consideration the findings of this study and promote a frank discussion about: concurrent sexual relationships; inconsistent use of condoms; the illegality of having sexual relations with underage children (including child sex workers and girls involved in transactional sex). The review should have policy and programme recommendations to tackle these issues.

8.1.5 *Support the “zero tolerance” campaign launched by the Ministry of Education*

The Ministry of Education should promote the involvement of non-state actors in campaign “Zero Tolerance for Sexual Abuse of School-age Children”, targeting resources to schools at hotspots along transport corridors and the interior areas that draw children to the hotspots.

UNICEF and child-rights organizations should explore the possibilities of engaging with the legal sector (associations such as Mulleide, the Association for Women in the Legal Profession) to target and prosecute sex offenders who engage in sexual acts with children in the hotspots on the transport corridor.

8.1.6 *Monitor the number of people migrating to key hotspots on transport corridors*

Local govt partners should develop a spot check system for measuring the levels and nature of in-migration into the hotspots along the corridor. The system should provide information about the age and sex of the migrants, residency status (permanent or temporary) and reasons for frequenting the hotspots. The information should be processed and used to inform the IEC and prevention programmes, services and resource allocation, for use by non-state actors and the district services in order to plan for service delivery (health, education and social protection).

8.2 Nacala corridor recommendations

The following recommendations address the changing situation on the northern transport corridor of Nacala. HIV prevalence in the north continues to be lower than in the centre and south of the country. However, this study raises the spectre of accelerated transmission due to sexual behaviour change linked to the improved economic situation on the corridor. One of the phenomena noted during the study was the “pull factor” where girls are migrating temporarily to the hotspots during the weekend to have fun and earn money; these activities usually involve sexual relations.

8.2.1 *Conduct intensive combination prevention programmes along the corridor*

IOM and partners should implement comprehensive combination prevention programmes in key hotspots along the Nacala corridor. These should include communications for change and programmes which facilitate access to services, with information, space for debate, and written and verbal communication materials delivered through the following fora: mosques, churches, community and national radio, schools, local NGOs, and by engaging the local private sector (bars, restaurants and guesthouses). The prevention campaign should focus on the issue of concurrent sexual relationships and the inconsistent use of condoms (principal risk factors for HIV infection found in the study).

8.2.2 *Promote corporate social responsibility approach of companies which use the corridor*

This recommendation requires a change in the approach to negotiating corporate social responsibility with the main private-sector investors on the Nacala corridor. It is recommended that the non-state actors, in partnership with Mozambican Private Sector Association (CTA) and the Ministry of Commerce and Industry, develop a funding strategy to obtain a long-term financial commitment from key private-sector industries reliant on the transport corridor for the success of their businesses.

Key companies/industries to be approached:

- Nacala Development Corridor Programme
- Railways of Mozambique (CFM)
- Mining concessions (for example, coal mining in Tete – Vale do Rio Doce and Rio Tinto/Riversdale)
- Timber industries
- Hydroelectric dams
- Telecommunications.

The following suggestions could be used as a platform for discussion of the type of investment that would ameliorate the problems found during the research.

Suggestions for a 10-year investment commitment by the above-mentioned industries to support:

1. Provision of additional clinical and preventive healthcare in key hotspots (prolonging the opening hours, ensuring that there are sufficient staff for the longer opening hours, and ensuring that the health facilities in the hotspots capacity to for providing services to the host and mobile populations)
2. Implement a clean-up programme, including the development of a voluntary Code of Conduct, within the private-sector companies against employees engaging in sex with under-age girls, including contractual sanctions for individuals not complying with the Code of Conduct.
3. A continual education, counselling and support service for adult sex workers to maintain safety standards (consistent condom use and regular treatment for STIs).

8.2.3 Conduct a youth-specific prevention programme along the corridor

Design a programme for the communities in the interior of the provinces and the hotspots, targeting youth drawn to the corridor.

1. Learn from the "anti-trafficking" campaigns and target schools, recreational areas and religious organizations with material explaining the dangers of visiting the hotspots (even for weekends).
2. Saturate the media (radio and TV) with programmes, info-spots, debates highlighting the issues of children leaving school to seek precarious employment in the hotspots.
3. In the hotspots establish safe havens for youth who are scared, have been sexually abused, exploited or who have suffered from violence.
4. Use the information from the migration monitoring system recommended above - to decide resource allocation for health services – in particular, adolescent-friendly health services and youth counselling services – along the corridor.

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11 ANNEX I

11.1 Interview guides

11.1.1 Guide for social researchers

The separate interview guides were used as “key topic guides” and not as questionnaires. The researchers had extensive, in-depth conversations with all of the groups identified. It was recognized that it was not possible to obtain all the information from all of the interviewees.

Key pointers for the social researchers:

1. Use iterative questioning – build on knowledge obtained in previous interviews.

2. Use in-depth interviews – obtain as much detail as possible about the issues in the guides.

3. Use triangulation – confirm information through asking the same questions from a wide variety of people.

4. Be creative – do not necessarily limit your investigation to the topics in the interview guides.

5. Keep in mind potential recommendations for the report.

The research team spent a day discussing the guides and ways of obtaining information from the various groups. The researchers had experience of working with sex workers and clients.

The researchers provided written notes on each of the interviews and context (how the information was obtained – where, when) and any difficulties they found in talking to any of the groups.

11.1.2 Guide for sexual network exercise

Objective:

Understand concurrent sexual relationships and risk factors (sex workers and mobile populations)

Methodology:

Work with sex workers/mobile populations – clients

Ask the interviewee to describe the number of sexual partners they currently have. Plot this on a chart. Ask if they use condoms with any of the partners and mark these on the chart. Ask the interviewee if they know whether any of their partners have other partners – and if they know whether they use condoms with those partners.

Ask for as many details as possible about the partners (number of times they have sex with those partners, whether they are regular partners, occasional partners etc.)

If possible to work with a group of sex workers

Plot the sexual partners and identify any "cross-over" partners – plot condom use.

Ask for as many details as possible about the partners (number of times they have sex with those partners, whether they are regular partners, occasional partners etc.)

11.1.3 *Traffic tally*

Instructions for use:

Observe the area for a period of 24 hours.

Tally the vehicle movement in the boxes provided below.

Fill in page two of the form with a description of the area.

Objective:

Monitor the movement of transporters of people and goods in the areas where there are large concentrations of mobile populations.

Date: **Area:** **Time period:**		
Vehicles		
Passenger transport	Lorries (small)	Lorries (large)

Vehicles that are stationary for more than 5 hours		
Passenger transport	Lorries (small)	Lorries (large)

Observations in the area:

1. Description of the area (name, why is it a busy area, are there bars, guesthouses, rooms to rent etc.)

   ____

   ____

   ____

   ____

2. Description of the traffic (when is the place busy, when is it quiet etc.)

   ____

   ____

   ____

   ____

3. Type of goods that are transported:

   ____

   ____

   ____

   ____

4. Parking: patterns of parking in the area; how long do the transporters stay?

   ____

   ____

   ____

   ____

5. Other observations about the mobile populations in the area:

   ____

   ____

   ____

   ____

11.1.4 Sex workers

Questions to be selected for individual interviews and focus-group discussions.

Data on individual sex workers interviewed

Age: ____

Sex: ____

Level of education: ____

Marital status: ____

Any children (ages of the children): ______________________________________

The children live with the interviewee: ___________________________________

Where was the interviewee born? Where did she grow up? ___________________

Does she live at her place of work? For how long has she lived there? ______________

If not, where does she live? ____

(Add any other pertinent information.) _________________________________

We need to find out what they think about the situation in the area (social and economic) – have there been changes in the area (in the last year, for example)? Ask for details about the social changes and their opinion about them and whether they think that the changes will have an impact on high-risk sexual behaviour in the future.

1. **Characteristics of sex workers**
   - Is there much transactional sex in the area?
   - Who are the sex workers and where do they work?
   - Who are the clients?
   - Where are the places that people procure sex?
   - Where are the places where sex takes place?
   - What are the types of sexual relations that contribute to the transmission of STIs/HIV in this area? Why are these practices more risky?
   - Do young people (below 18 years of age) practice transactional sex?
     - If yes, what age?
     - Who are their sexual partners? What are the reasons that young people enter into sex work?
   - Are there any sexual practices that are untaken by young people who are particularly risky? Why are they risky?

2. **Health-seeking behaviour**
   - What are the main health problems that sex workers suffer from?
   - How can you prevent STIs/HIV?
   - Is there anything you would like to do to protect yourself better against but you don't always do? If yes, why do you not always use safe practices?
   - Why do you sometimes use safe practices and sometimes not?
   - Do you take measures to prevent unwanted pregnancy?
     If yes, what do you do, and how often?
   - Have you had a planed or unplanned pregnancy this year?
     - If yes, what did you do?
   - Do you regularly go for family planning at the health clinic?
   - Do you have to pay for family planning?
   - What contraceptive methods are available at the health facilities?
   - Are there times when you don't use contraceptives for the prevention of pregnancy or STIs?
   - Have you ever had an STI?
     - If yes, which one? What did you do?
     - Did you receive treatment? Where were you treated? How were you treated by the health workers or traditional doctors?
     - Did you pay for your treatment?
     - If no, what would you do if you suspected that you had an STI?

- Where is the best place to receive treatment for an STI?

- What would be the best way to offer treatment to groups such as sex workers or young people?

- Do people know about condoms?
    - If yes, where do they get them?
    - How much do you pay for the condoms?
    - Where would be the best places to put condoms so people could have access?
    - What could be done to make access to condoms easier?

- Do you use condoms with all of your sexual partners? Explain the logic for condom use.

- When do you use condoms? What are the main reasons for using condoms?

- When do you not use condoms? Why do you not use condoms?

- What are the main obstacles to condom use?

- What help could be given to people to encourage regular condom use?

- How often do you use male condoms during sexual acts? If you do not use them every time, why not?

- Have you ever used a female condom? If yes, with what frequency? If you don't always use the female condom, why don't you use them regularly?

3. Knowledge of HIV and AIDS

- What do you know about HIV and AIDS?

- What is the gravity of the situation in your opinion?

- Why do you think that?

- Has your life changed due to HIV? Why and how?

- Have you had the opportunity to take an HIV test? Did you do the test? (if possible, ask the result, and about treatment)

- What would help people to go and get tested for HIV?

- What can be done to make HIV testing as easy as possible?

- What do you think that health workers could do to teach people to avoid HIV?

4. Health services

- Which health services would you like to have?

- What don't you like about the existing health services?

- What do you think about the family planning services, the MCH, antenatal, STI clinics, HIV and AIDS services?

- Where would you prefer to be treated if you had an STI or HIV?
- Where would you prefer to receive family planning?
- What days/opening hours are there at the health clinics in the area?

5. Services linked to HIV and AIDS care and treatment

- In this area do you know any organizations that are working with aspects linked to HIV and AIDS (counselling, distribution of condoms, testing etc.)?
- Is there any information/publicity/IEC campaigns in the area about HIV and AIDS? Are they effective? How could they be improved?
- What type of services do you know?
- Do you think there are services (in addition to the health services) that could be useful?

6. Client characteristics

- Are there any types of men that are known to have multiple sexual partners?
- Who are they? For example, officials, miners, sailors, foreigners, married men etc.
- Who do they have sex with and why?
- Are there men who are at more risk of STIs or HIV? Why?
- Who are your regular clients?
- Why do you think your clients look for your services?
- Where do you meet the majority of your clients?
- What age are your clients?
- What is the most common occupation of your clients?
- What is the most common nationality of your clients?
- What is the sex of your clients?
- Have you ever had sex with clients that are the same gender as you? If yes, with what frequency?

7. Transactions

- Which days and at what time does sex work happen?
  (For example, are weekends, end of month busier?)
- What do you charge for sexual relations?
- In the majority of cases how do clients pay? What form does payment take? Types of payment? Tips or presents?

- On average how much would you earn in a month? Week? How much did you earn last week?
- Do you have any sexual partners that do not pay? If yes, who are they?
- Do you have any other work or income sources?
- On average how much do you earn from other income sources?
- On average how much do you earn from all your income sources, including sex work?
- Is your income important to your family?
- How many dependants do you have?
- Do you have any debts?
- Are you paying any debts for your family members?
- Have you managed to make any savings in the last three months?

8. Nature of sex work in the area

- What is your sort of work called in the area?
- What do you think of your work?
- What are the implications of your work – economically and/or socially?
- Do you like your work? Why (for yes or no answers)?
- How did you begin sex work? What made you start in sex work?
- What challenges do you face in your work?
- Would you like to stop doing sex work? If yes, what would you like to do? If no, why do you think you will continue with the work?

9. Physical or sexual abuse

- In the last three months have you been insulted while working?
- Have you ever been physically abused by any of your clients? If yes, how many times in the last three months?
- Why do you think the aggression occurs?
- What did you do when you were physically abused?
- Have you ever been forced to have sex against your will?
    - Why did it happen?
    - What did you do?
    - Did you notify the police?

- What do other sex workers do when they are abused or forced to have sex against their will?

- What are the main challenges in your work (legal, violence, discrimination etc.)?

10. Use of drugs and alcohol

- Have you ever used drugs?
  - If yes, which ones ?
  - If no, why?

- Do you drink?
  - What do you drink? How much do you drink?
    When do you drink (day or night)?
  - Do you drink at home?
  - Do you drink at work?
  - Were you drunk at any time last week?
  - Do you like to drink or take drugs. Is use related to your job?

11. Legal aspects

- What would you like changed in the legal situation of your type of work?

- Do you see that you have any role in making these changes?

12. Perception

- How do you see sex work?

- Do you think other people see sex work in the same way? How do you think other people see your work?

- What do you think about yourself as a sex worker?

- What aspects of your work do you like?

- What aspects do you like least about your work?

- How much longer do you think you will work as a sex worker?
  What would you like to do if you were not involved in sex work?

13. Social networks

- Do you have a close friend(s), in the area or work place?

- Do you have any family in the area?
  - If yes, who? Brother, sister, mother, father, husband, wife, children?
  - If not, do you have contact with your family? How often do you see your family?

- Are your work colleagues also your friends?
    - o Who would you count on for help in the following circumstance?
        - When you need money
        - When you need somewhere to stay
        - When you need food
        - When you need to go to the hospital
        - When you have a problem with the police
        - When you are sad or unhappy
        - When you have been involved in any abuse situation.

- Who normally comes to you to ask for help?

- Could you give any examples of when you have helped someone?

14. Stigma and discrimination

- Do your family and friends know about your work?
    - o If yes, how do they treat you?
    - o If no, why haven't you told them?

- Within the last year have you had any contact with the police?
    - o If yes, did they know you were a sex worker. Did this affect the way they treated you or your relationship with them?

- Within the last year have you used the health services? Or contacted a health worker?
    - o If yes, do you think they know you are a sex worker? How were you treated? Did they treat you differently because of your work?

- Could you describe any incident in the last year where you feel you have been stigmatized or discriminated against because of your work?

11.1.5 NGOs that work with sex workers or offer services to mobile populations

Mobile populations: Transporters, traders, construction worker, travellers

Name of the organization:

Describe the programmes that your organization has in the area. (How long have you worked in the area, what sort of programmes, activities, coverage?)

Why did the organization decide to work in the area and on the chosen issues?

We need to find out what they think about the situation in the area (social and economic) – have there been changes in the area (in the last year, for example)? Ask for details about the social changes and their opinion about them and whether they think that the changes will have an impact on high-risk sexual behaviour in the future.

Name and position of the people interviewed

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

The following questions should be part of the individual interviews or group interviews with the staff of the NGO. The topics should be selected in accordance with the work carried out by the NGO.

1. Characteristics of mobile populations:

Transporters, traders, sailors, miners, construction workers, public-service workers (customs officers, police), visitors (specify the type of visitors)

- Which are the groups of people that leave the area (men, youth etc.)?
- How long, in general, are they absent?
- Number of female-headed households?
- Describe the people who are arriving in the area or are frequent visitors.
- Do these people generally stay in the area or pass through?
- What are the impacts of these movements in the area, both positive and negative?

2. Details about the mobile populations

- Sex:
- Nationalities:
- Frequency of visits to the area:
- Average length of time they stay in the area:

3. Characteristics of the sex workers in the area

- Is there transactional sex in the area?
- What are the different types of transactional sex in the area?

- Who are the sex workers in the area?
- Who are the clients? Where do they work?
- Which types of sexual practices increase the risk of STI transmission? Why?
- Are young people are involved in transactional sex (sex where money or “in kind” payment is made)?
- Who are the sexual partners for these young people? Why do the youth become involved in transactional sex?
- Which are the sexual practices that put young people at most risk? Why?

4. Health-seeking behaviour

- What are the main health problems that people suffer from in the area – especially the mobile populations (do they use the health services) and the sex workers?
- Do the mobile populations know how to prevent STIs (including HIV)?
- Do the sex workers know how to prevent STIs (including HIV)?
- Any opinions about why sometimes people practice safe sex and sometimes do not?
- Do people know how to prevent unwanted pregnancies?
- Do you know many people who have unwanted pregnancies? Do you know if any of these women were sex workers?
- Are there contraceptives available in the health centre? If yes, which are now available – pills, condoms? In this year have there being any stock-outs of the contraceptives – if yes, which?
- Which are the main STIs treated at the health facility?
- Do people pay for the treatment?
- How are they treated (drugs, counselling, health worker attitudes)?
- In your opinion what are the best ways to provide care in the area of STI prevention – in particular for transient populations, sex workers and young people?
- Do people know about condoms?
    - If yes, where do they get them from?
    - How much do people pay?
    - Where are the best places for people to access condoms?
- What can be done to improve access to condoms?
- What can be done to improve use of condoms?

- What are the main obstacles for the use of condoms?
- Is the female condom available? Are women asking for the female condom?

5. Knowledge about HIV and AIDS

- What do people know about HIV and AIDS?
- In your opinion what is the seriousness of HIV and AIDS in the area?
- If the answer is that there is no problem ask the health worker to explain why he/she has that opinion.
- What would help to get people to test for HIV?
- What would help to improve adherence to testing for HIV?
- What do you think health workers should do to improve information flows about STIs and HIV?

6. Health services

- Are the health services accessible? Are they available to everyone, including the mobile populations and sex workers? What could be done to improve accessibility for these at-risk groups?
- In your opinion should these services be more accessible?

7. Client characteristics

- Are there any types of men that are known to have multiple sexual partners?
- Who are they? For example, officials, miners, sailors, foreigners, married men etc.
- Who do they have sex with and why?
- Are there men who are at more risk of STIs or HIV? Why?
- Where do sex workers meet the majority of their clients?
- What age are the clients?
- What is the most common occupation of your clients?
- What is the most common nationality of your clients?
- What is the gender of your clients?
- Do you know of sex workers having sex with people of the same gender?

8. Transactions

- Which days and at what time does sex work happen? (For example, are weekends, end of month busier?)

- What is the rate for sexual relations?

9. Nature of sex work in the area

- What is your sort of work called in the area?

- What do people think about sex workers?

- What are the implications of sex work – economically and/or socially in the area

- What challenges do sex workers face in the area?

10. Physical and sexual abuse

- Have you heard of any incidents where sex workers have been insulted or suffered from physical abuse (in the last three months)?

- Is this a regular occurrence? Is your organization working with these sorts of cases?

11. Use of drugs and alcohol

- Do drugs and alcohol play a part in the lives of the mobile populations and sex workers? Could you describe any incident that substantiates your opinion?

12. Social networks

- Who are the main people who support the sex workers?
  - Other sex workers
  - Clients
  - Partners (non-clients)
  - Family
  - Friends
  - Other

- Please explain your response (we would like to know who they turn to for advice and support, emotional and financial)

13. Stigma and discrimination

- Do you think there is discrimination against sex workers in the community by:
  - Family?
  - Friends?
  - Partners?
  - Police?
  - Health workers?
  - Religious leaders?
  - Others? Specify.

- Could you give any examples of behaviour or discriminatory attitude.
- Does the NGO work in any programmes to reduce stigma and discrimination?

11.1.6 Hot-spot mapping

Cartographers will plot the following information using handheld GPS devices at pre-identified hotspots on the Maputo–Swaziland corridor. Working along the corridors they will map infrastructures within 3.5 km on either side of the road:

1. Social infrastructures (health posts, schools)
2. Bars, restaurants, rooms for hire, guesthouses
3. Markets, commercial centres
4. Truck stops
5. Border posts

Further information from the traffic monitoring and the social research will be plotted on the maps:

6. Hotspots for sex workers
7. Traffic concentration
8. NGO activity

After the analysis of all the information the team will discuss if additional information can be represented on the maps.

11.1.7 Guide for people working in high-risk occupations (residents)

Waiters, bar workers etc.

Age:

Time of service:

Sex:

Nationality:

Working hours:

Average salary (with tips):

What aspects you like about your work:

What aspects you do not like about your work:

We need to find out what they think about the situation in the area (social and economic) – have there been changes in the area (in the last year, for example)? Ask for details about the social changes and their opinion about them and whether they think that the changes will have an impact on high-risk sexual behaviour in the future.

1. Clients

- Who are the clients (at the bar, restaurant, guesthouse)? Are they the mobile populations and/or the residents?
- (sex, age, nationality)
- Do the clients look for sexual relations?
- If the answer is yes, use the questions in the Sex Worker Guide to ask about the clients – where, when, how many times, with whom, use of condoms etc.

2. Perception of risk

- Does your work have risks?
- What are the risks?
- Explain.
- How can you reduce the risk?
- If you believe that your work is high risk, why do you continue to work at the place?

11.1.8 Health workers

1. Type of health facility

Specify the type of health worker (nurse, medical officer, preventive medical officer etc.)

Ask the health worker to describe the health services offered at the health facility, in particular treatment of STI, HIV testing and ARV.

Ask the health workers about how they feel the socio-economic situation in the area is changing – in the last year, for example. Request details of the changes and the opinion of the health worker about the future impact of the changes. In particular, will this change (sexual) risk behaviour?

2. Characteristics of mobile populations

Transporters, traders, sailors, miners, construction workers, public service workers (customs officers, police), visitors (specify the type of visitors)

- Which are the groups of people who leave the area (men, youth etc.)?
- How long, in general, are they absent?
- Number of female-headed households?

- Describe the people who are arriving in the area or are frequent visitors.
- Do these people generally stay in the area or are they passing through?
- What are the impacts of these movements in the area, both positive and negative?

3. Details about the mobile populations

- Sex:
- Nationalities:
- Frequency of visits to the area:
- Average length of time they stay in the area:

4. Characteristics of the sex workers in the area

- Is there transactional sex in the area?
- What are the different types of transactional sex in the area?
- Who are the sex workers in the area?
- Who are the clients? Where do they work?
- Which types of sexual practices increase the risk of STI transmission? Why?
- Are young people involved in transactional sex (sex where money or "in kind" payment is made)?
- Who are the sexual partners for these young people? Why do the youth become involved in transactional sex?
- Which are the sexual practices that put young people at most risk? Why?

5. Health-seeking behaviour

- What are the main health problems that people suffer from in the area – especially the mobile populations (do they use the health services) and the sex workers?
- Do the mobile populations know how to prevent STIs (including HIV)?
- Do the sex workers know how to prevent STIs (including HIV)?
- Any opinions about why sometimes people practice safe sex and sometimes do not?
- Do people know how to prevent unwanted pregnancy?
- Do you know many women who have unwanted pregnancies? Do you know if any of these women were sex workers?
- Are there contraceptives available in the health centre? If yes, which are now available – pills, condoms? In this year have there being any stock-outs of the contraceptives – if yes, which?

- Which are the main STIs treated at the health facility?
- Do people pay for the treatment?
- How are they treated (drugs, counselling, health worker attitudes)?
- In your opinion what are the best ways to provide care in the area of STI prevention – in particular for transient populations, sex workers, and young people?
- Do people know about condoms?
  - If yes, where do they get them from?
  - How much do people pay?
  - Where are the best places for people to access condoms?
- What can be done to improve access to condoms?
- What can be done to improve use of condoms?
- What are the main obstacles for the use of condoms?
- Is the female condom available? Are women asking for the female condom?

6. Knowledge about HIV and AIDS

- What do people know about HIV and AIDS?
- In your opinion what is the seriousness of HIV and AIDS in the area?
- If the answer is that there is no problem, ask the health worker to explain why they have that opinion.
- What would help to get people to test for HIV?
- What would help to improve adherence to testing for HIV?
- What do you think health workers should do to improve information flows about STIs and HIV?

7. Health services

- Are the health services accessible? Are they available to everyone, including the mobile populations and sex workers? What could be done to improve accessibility for these at risk groups?
- In your opinion should these services be more accessible?

8. Other services offered linked to HIV and AIDS

- In this area do you know any organizations that are working with aspects linked to HIV and AIDS (counselling, distribution of condoms, testing etc.)?
- Is there any information/publicity/IEC campaigns in the area about HIV and AIDS? If so, are they effective? How could they be improved?

- What type of services are offered?

- Do you think there are services (in addition to the health services) that could be useful?

9. Characteristics of the clients

- Do you know if any of the clients of sex workers have sought treatment in the health centre?
    - If yes, what type of treatment?

10. Sexual and physical abuse

- Have you ever treated sex workers for physical or sexual abuse? Do sex workers receive abuse from clients, family, the police?

- Does abuse occur frequently? How many times in the last month have you treated cases of abuse? Has the number of abuse cases increased in the last six months?

11. Use of drugs and alcohol

- Have you treated people who have abused drugs or alcohol?

- If yes, explain the treatment and the frequency that this occurs.

12. Legal aspects

- What do you think, legally, could be done about the sex trade in the area?

- Do you think the activity should be legalized?

13. Perception

- In your opinion what is the sexual behaviour that is prevalent in the area – especially among the mobile populations and the resident population?

14. Stigma and discrimination

- Do you know any sex workers?
    - If yes, how do you treat them?
    - Do you know of any cases where sex workers have been discriminated against? For example, in health facilities, police stations, public places etc.
    - If yes, give details.

11.1.9 Mobile populations

Drivers, assistants, construction workers, traders, public-service workers

The following questions are the basis of interviews with mobile populations.

Data about the interviewee

Age: ____

Nationality: ____

Sex: ____

Occupation: ____

How long are you in the area (each time you vist): ______________________________

How many times have you passed by this area in the last six months? _______________

We need to find out what they think about the situation in the area (social and economic). Have there been changes in the area (in the last year, for example)? Ask for details about the social changes and their opinion about them and whether they think that the changes will have an impact on high-risk sexual behaviour in the future.

1. Sexual behaviour

- When you are travelling do you have sexual relations?
  - With whom?
  - How many times?
  - Do you use condoms?

- Ask for details about sexual behaviour.
  - When?
  - Where?

- Have you used the services of sex workers? (You may want to ask: In the last month, or week, how many times have you had sex with a sex worker? Where? At what time? Was the sex worker female? What age was s/he? What nationality? How much did you pay? Do you always go to the same sex worker? etc.) Obtain as many details as possible.
  - How much do you generally pay for sexual relations?
  - What do you usually pay – money, supper, other presents?

- Do you have any sexual partners that you don't pay to have sexual relations? If yes, who are they?

2. Characteristics of sex work in the area

- Is there much sex work in the area?

- What types of sex workers are there in the area?

- Where can you find sex workers? Where do they work? Where are the most common places where you can find sex workers?

- Who are the clients of the sex workers? (It is possible that the interviewee will rather talk in the third person about experiences with sex workers.)

- Where do people have sexual relations?

- What types of sexual relations are most risky for the transmission of STIs/HIV? Why?

- Are young people practicing transactional sex?
    - If yes, at what age?
    - Who are their partners? What are the reasons for the young people practicing transactional sex?
    - Are any of the sexual practices particularly dangerous for the young people? Why?

3. Health-seeking behaviour

- How do you prevent STIs/HIV?

- Is there anything more you could do, but are not managing to do?
    - If yes, what? And why are you not doing it?

- Why do people sometimes practice safe sex and at other times not?

- Have you ever had an STI?
    - If yes, what did you do?
    - If no, what would you do if you suspected that you had an STI?

- If yes, where did you get treatment? What treatment did you get?

- Did you pay for the treatment? How was the quality of the treatment in your opinion?

- What type of services would be ideal for offering testing and treatment for STIs and HIV? If the response is a health facility, what would be the ideal opening hours – in the interest of the mobile populations? Ask their opinions about mobile clinics – late night services etc.

- Do people know about condoms?
    - If yes, do people use them?
    - Where do they get them from?
    - How much do people pay for the condoms?
    - What are the best places to access condoms?
    - What could be done to make condoms more available?

- Do you use condoms with your different sexual partners? If yes, explain.

- When you use condoms what are the main reasons for using them?

- When you don't use them, what are the main reasons for not using them?

- What are the main reasons for not using condoms?

4. Knowledge about HIV and AIDS

- What do you know about HIV and AIDS?

- In your opinion is HIV a serious problem?
- On what do you base your opinion?
- Has your life changed due to HIV? If yes, why? What? If no, why not?
- Have you ever had an HIV test? (If the person is willing, ask what was the result of the test.)
- What would help people to test more regularly?
- What can be done to make the test more accessible?
- What do you think that health workers or other community workers could do to improve AIDS awareness?

5. Health services

- What health services would you like to have (most useful to you given your work/ life style)?
- What don't you like about the health services that are currently available?
- What do you think of the health services at the moment – in particular the services for HIV and STI treatment?
- Where would you prefer to have treatment if you had an STI or HIV?
- What days and times would you prefer to access health services?

6. Other services linked to HIV and AIDS

- In this area do you know any organizations that are working with aspects linked to HIV and AIDS (counselling, distribution of condoms, testing etc.)?
- Is there any information/publicity/IEC campaigns in the area about HIV and AIDS? Are they effective? How could they be improved?
- What type of services?
- Do you think there are services (in addition to the health services) that could be useful?

7. Sexual or physical abuse

- Have you shouted at or insulted your sexual partner (either permanent partner or occasional partner) (in the last three months)? If yes, why? If no, do you know other people who do insult their partners? If yes, could you tell me about the incident?

- Have you ever physically hurt your sexual partner (permanent or occasional). If yes, how many times, why? If no, do you know of any cases of physical abuse against sex workers? Could you talk about it?

- If there was a problem, what happened? Were the police called? How was the situation resolved?

8. Use of drugs and alcohol

- Have you ever used any drugs?
    - If yes, what and when?
    - If no, why not?

- Do you drink alcohol frequently?
    - What would you normally drink (Monday to Friday)? What do you drink at the weekend? What do you drink when you are on the road? (You could ask when was the last time they had a drink, where and how much they drank.)

- Do you drink when you are travelling?

- Do you drink at home?

- Do you drink at work?

- In the last week have you been drunk?

- Why do you like to drink or use drugs? Is there any relationship between drink/drugs and sex?

12 ANNEX 2

Map 2.1

HOTSPOTS ALONG THE TRANSPORT CORRIDOR

MOZAMBIQUE NORTHERN TRANSPORT CORRIDOR - NAMPULA PROVINCE

1:1,154,000

Bar
Filling Station
Club
Guest House
Market
Grocery
Truck Stop
Police Station
Restaurant
Bus Stop
Villages
Railway
Road
3 Km to the corridor
5 Km to the corridor

Oceano Índico

1:171,900

1:67,500

Data Source:
Data Collection (Fieldwork) and
DINAGECA (Mozambique Spatial Data)

Map 2.2

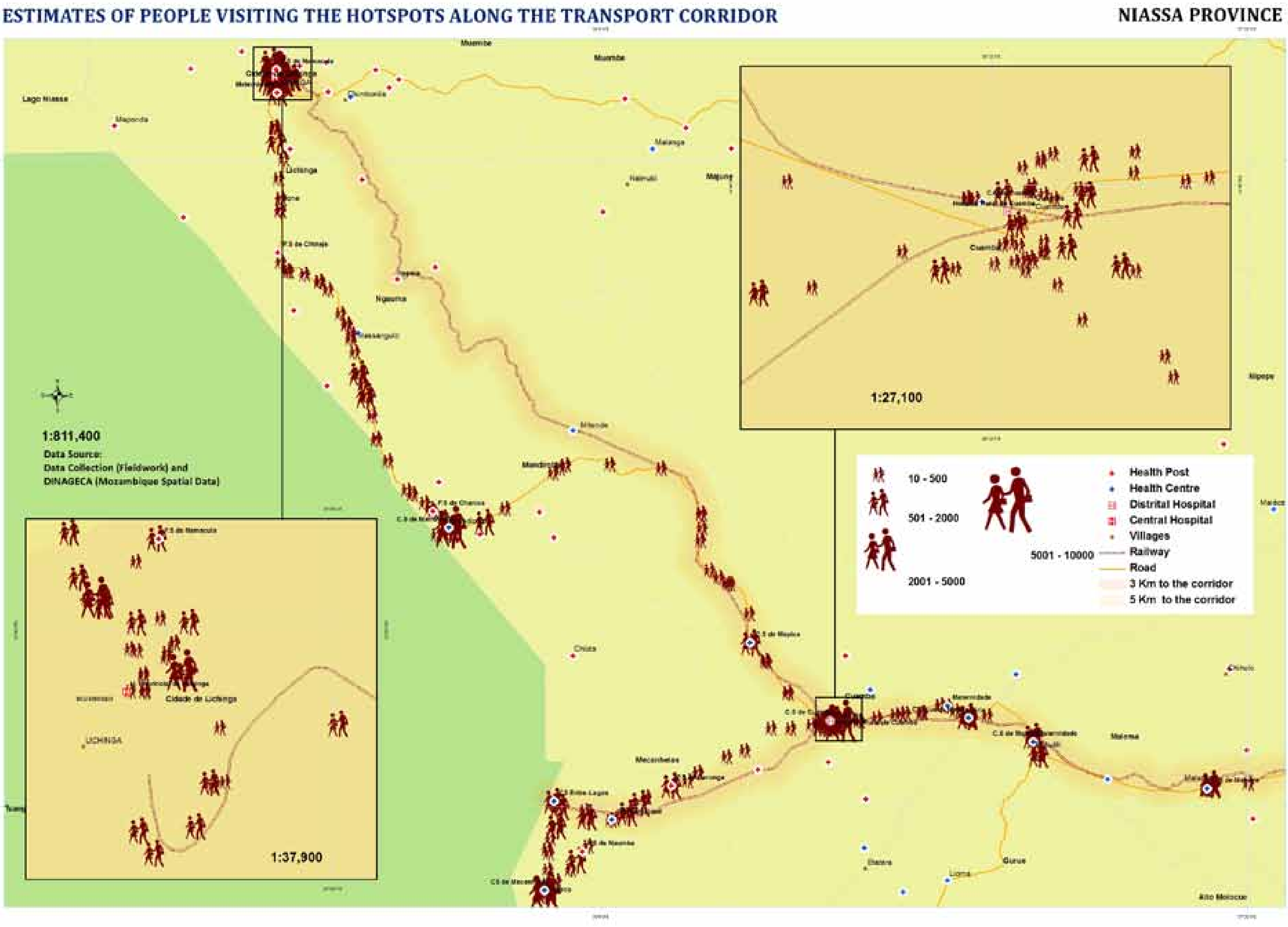
HOTSPOTS ALONG THE TRANSPORT CORRIDOR

MOZAMBIQUE NORTHERN TRANSPORT CORRIDOR - NIASSA PROVINCE

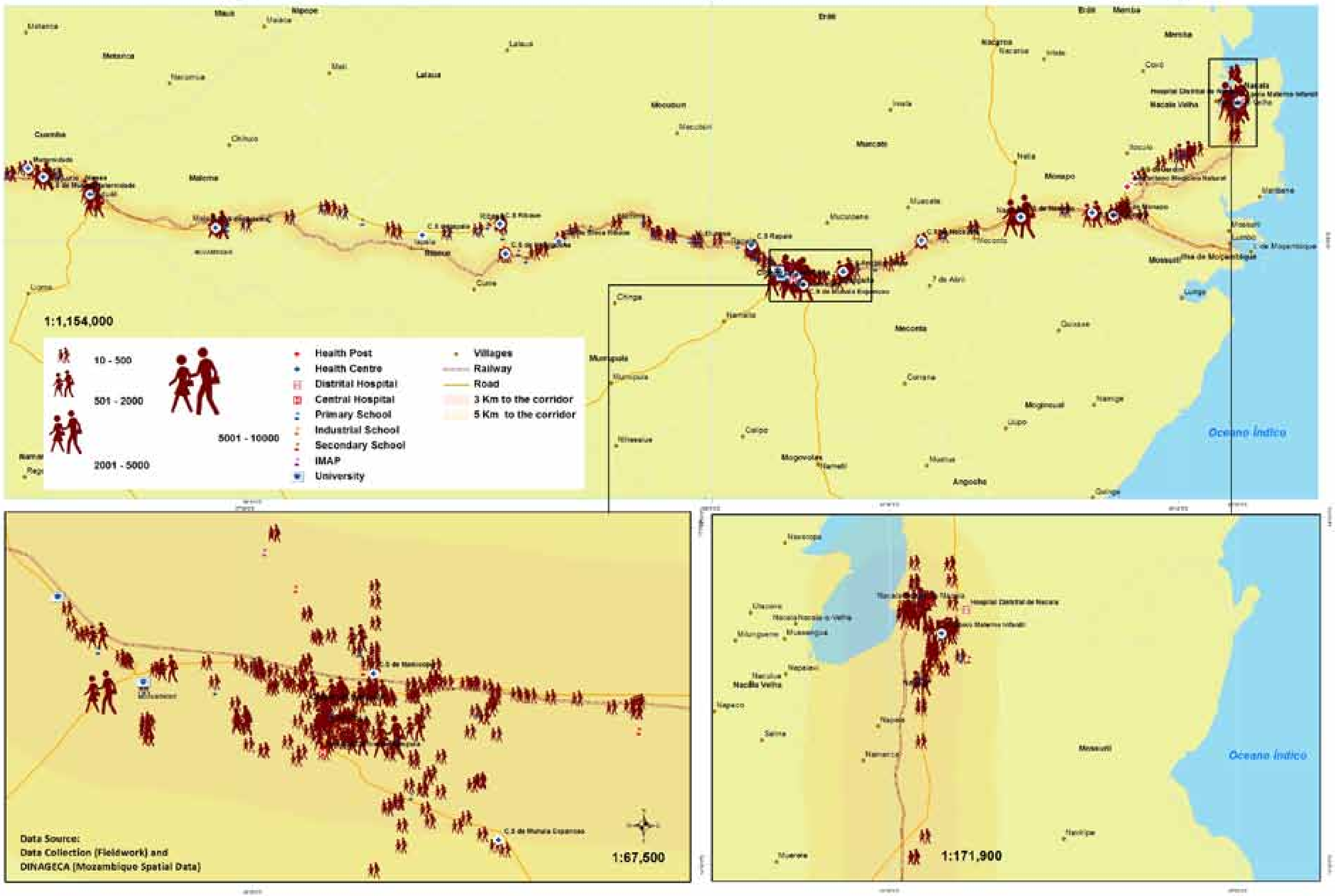
Bar
Filling Station
Club
Guest House
Market
Grocery
Truck Stop
Police Station
Restaurant
Bus Stop
Villages
Railway
Road
3 Km to the corridor
5 Km to the corridor

Data Source:
Data Collection (Fieldwork) and
DINAGECA (Mozambique Spatial Data)

Map 2.3



Map 2.4



Map 2.5

BARS, RESTAURANTS & GUEST HOUSES in a buffer of 3 and 5 km in relation to Nacala Corridor

1:1.637.000

Legend
- Guest House
- Bar
- Restaurant
- Border Post
- Road Nacala - Lichinga
- Railway

Map 2.6

HEALTH FACILITIES & SCHOOLS in a buffer of 3 and 5 km in relation to Nacala Corridor

1:1.637.000

Legend

Schools	Health Facilities
Communitarian School	Health Post
Primary School	Health Centre
Secundary School	Distrital Hospital
Industrial School	Central Hospital
IMAP	Road Nacala - Lichinga
University	Railway

Sanga
Muembe
Cidade de Lichinga
Lichinga
Majune
Ngauma
Mandimba
Maua
Metarica
Nipepe
Namuno
Cuamba
Malema
MALAWI
Mecanhelas
Gurue
Alto Molocue
Milange
Namarrol
Ile
Lalaua
Ribaue
Mecuburi
Nampula
Cidade de Nampula
Murrupula
Gilé
Mogovolas
Eráti
Muecate
Meconta
Mogincual
Angoche
Nacaroa
Monapo
Chiúre
Ancuabe
Mecufi
PembaCidade de Pemba
Memba
Nacala Velha
Nacala
Ilha de Moçambique
Mossuril
Lichinga
Cidade de Lichinga
Cuamba
Cidade de Nampula
Nacala
Mossuril

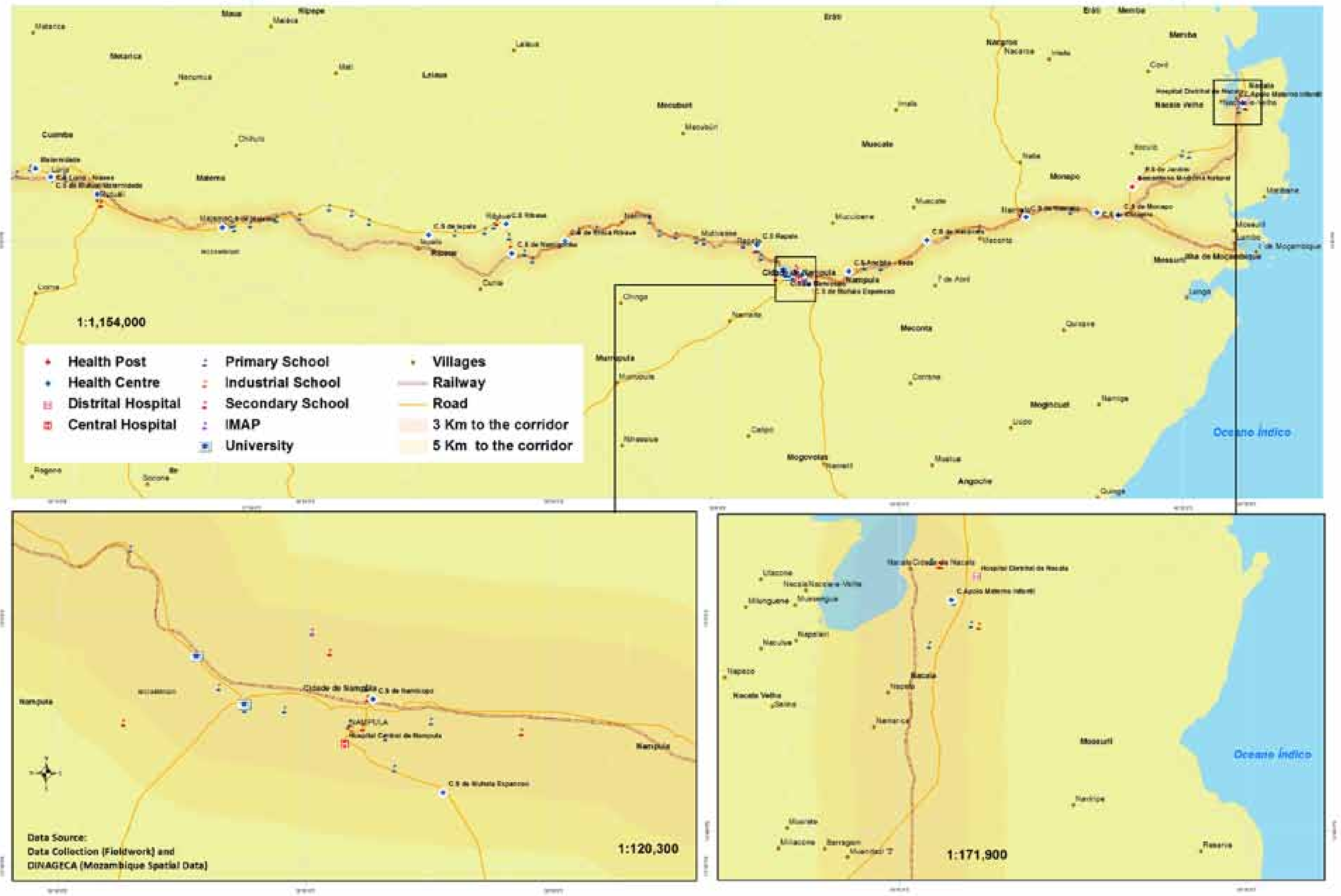
Map 2.7

SCHOOLS AND HEALTH FACILITIES

MOZAMBIQUE NORTHERN TRANSPORT CORRIDOR - NIASSA PROVINCE

Data Source:
Data Collection (Fieldwork) and
DINAGECA (Mozambique Spatial Data)

Map 2.8



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