

# LESSONS LEARNED REACHING KEY AND VULNERABLE POPULATIONS

From Médecins sans Frontières' experience providing HIV and sexual and reproductive healthcare to sex workers, men who have sex with men, and adolescents at risk in Mozambique



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## ACRONYMS

<b>ART</b>	Antiretroviral therapy	<b>KP</b>	Key Populations	<b>SRH</b>	Sexual and Reproductive Health
<b>ARV</b>	Antiretroviral	<b>LDH</b>	Liga dos Direitos Humanos (Human Rights League)	<b>STI</b>	Sexually Transmitted Infection
<b>CAG</b>	Community ART Group	<b>LDTD</b>	Long-Distance Truck Drivers	<b>SV</b>	Sexual Violence
<b>CBO</b>	Community Based Organisation	<b>MSM</b>	Men who have Sex with Men	<b>SW</b>	Sex Worker
<b>CNCS</b>	Conselho Nacional de Combate ao HIV e SIDA (National Council to Fight HIV and AIDS)	<b>MoH</b>	Ministry of Health	<b>SWPE</b>	Sex Worker Peer Educator
<b>DPS</b>	Direcção Provincial de Saúde (Provincial Health Department)	<b>MULEIDE</b>	Associação Mulher Lei e Desenvolvimento (Association Women – Law and Development)	<b>TB</b>	Tuberculosis
<b>FP</b>	Family Planning	<b>PE</b>	Peer Educator	<b>ToP</b>	Termination of Pregnancy
<b>HTS</b>	HIV Testing Services	<b>PEP</b>	Post-Exposure Prophylaxis		
<b>ICRH</b>	International Centre for Reproductive Health	<b>PrEP</b>	Pre-Exposure Prophylaxis		
		<b>SGBV</b>	Sexual and Gender-Based Violence		

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## GLOSSARY

**Adolescents at high risk for HIV:** Adolescents younger than 18 who live in HIV high-burden areas and, in particular, girls engaged in transactional sex. As defined in the United Nations Convention on the Rights of the Child,<sup>1</sup> children under the age of 18 who exchange sex for money, goods or favours are sexually exploited.

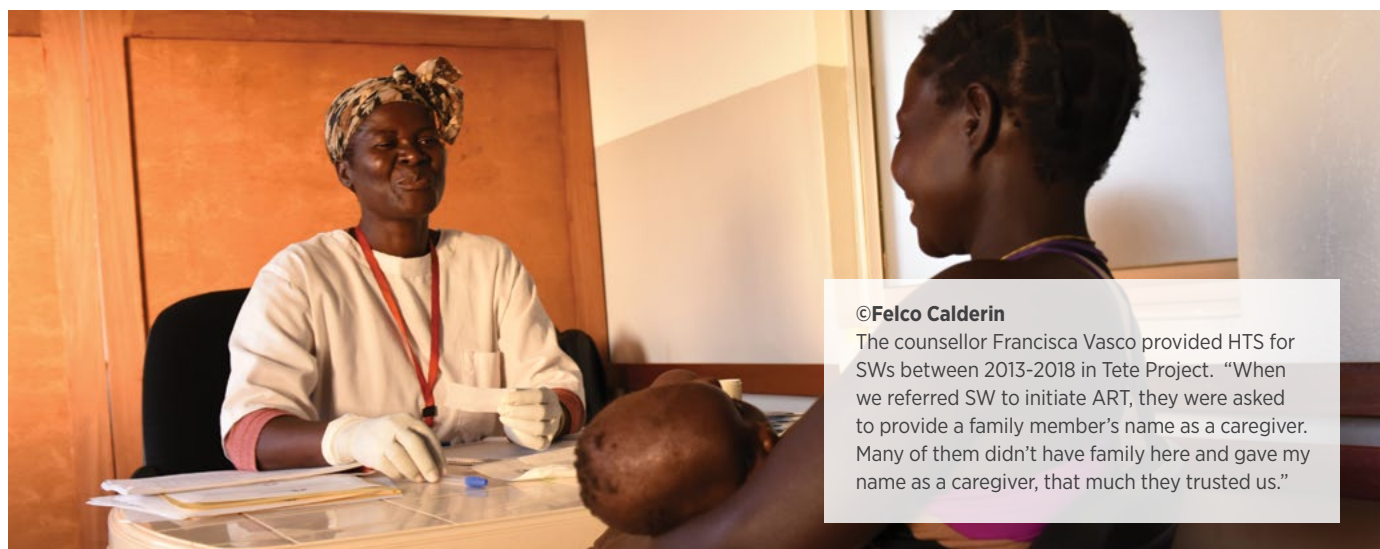
**Key Populations (KP):** Groups of people such as sex workers, men who have sex with

men, prisoners, people who inject drugs and transgender people who are at increased vulnerability to HIV irrespective of epidemic type or context, often engaging in higher risk behaviours due to criminalisation and social exclusion.<sup>2</sup>

**Men who have Sex with Men (MSM):** All men who engage in sexual relations with other men, regardless of multiple motivations for engaging in sex, their self-determined sexual and gender

identities, or their various identifications with any particular community or social group.<sup>2</sup>

**Sex Worker (SW):** Includes female, male, and transgender adults (18 years of age and above) who receive money or goods in exchange for consensual sex between adults.



### ©Felco Calderin

The counsellor Francisca Vasco provided HTS for SWs between 2013-2018 in Tete Project. “When we referred SW to initiate ART, they were asked to provide a family member’s name as a caregiver. Many of them didn’t have family here and gave my name as a caregiver, that much they trusted us.”

**Cover photo:** A sex worker celebrates a negative HIV result after a visit by an MSF counsellor and a peer educator who offered HIV testing services (HTS) in the privacy of her home in one of the Corridor sites in Malawi.

1. UN General Assembly, Convention on the Rights of the Child, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3, available at: <https://www.refworld.org/docid/3ae6b38f0.html>

2. WHO (2016 update). Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations.



# THE CORRIDOR

The Corridor project was established to respond to the needs of key populations (KP) based on the evidence that factors like mobility, discrimination and barriers to access to care have pushed these groups to the centre of the HIV epidemic.

In the era of accessible Antiretrovirals (ARVs), pioneer initiatives in the HIV projects of Mozambique and Malawi began to reveal a shocking reality: HIV prevalence among sex workers was over 50%, they were not being reached by the conventional health care system, and they were suffering violence and other human rights violations on a daily basis. Additionally, migrants in Mozambique and Malawi encountered difficulties when trying to access ART outside their countries, due to the restrictive policies which affect their continuity of care.<sup>3</sup>

This report focuses on the successes of MSF in partnership with the Ministry of Health (MoH) in Mozambique on reaching and providing specific

medical services to sex workers (SW), men who have sex with men (MSM) and adolescents at high risk for HIV. This was achieved by building a network of trust and confidentiality and adapting models of care.

## The early years 2011-2013

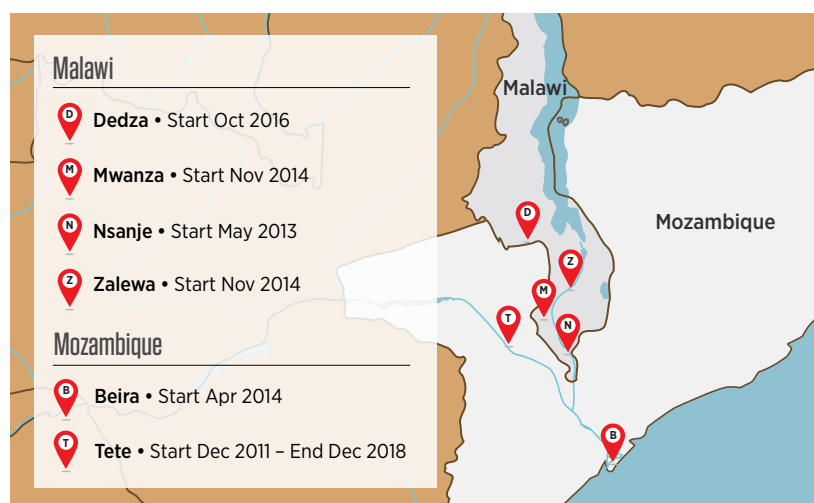
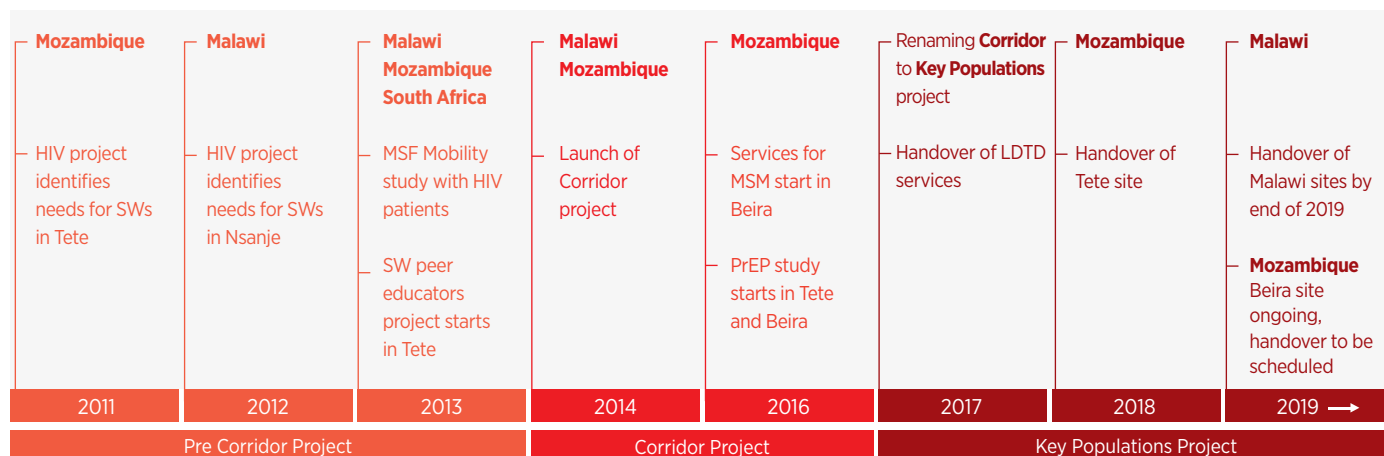
In August 2011, a Zimbabwean woman knocked on the MSF doors in Tete, in central Mozambique, to express her concern about the situation that SWs of her nationality were facing in Mozambique: they were living with HIV, many had started ART in their home country but were then forced to interrupt treatment because they were denied ART refills at local health care facilities on account of being foreigners and SWs. The woman was knocking on the right door. From there on, MSF started HIV Testing Services (HTS), distributing condoms and lubricants at community level, and initiated advocacy work for SW acceptance at public ART clinics.

Meanwhile, in Nsanje in southern Malawi, SWs were also facing challenges when seeking access

to treatment. The perceived negative attitudes of healthcare workers towards SWs, the long distances to and waiting times at clinics, and the stigma around sexually transmitted infections (STIs) as well as HIV diagnoses were among the reasons SWs were not attending health centres. In 2012, MSF's project implemented community strategies to overcome such difficulties.

## A project was born

The initiatives in Tete and Nsanje gave the background to design an exclusively dedicated project for SWs, launched in 2014. The Corridor project was set up in six locations along the two main transport corridors between Mozambique and Malawi, with the goal of adapting healthcare services to reach the most affected groups who had been identified. Initially, the project focused on long-distance truck drivers (LTDs) and SWs, but over time the Corridor project accommodated other KP and vulnerable groups with equally high needs, namely: adolescents and young women at high risk for HIV, and MSM.



In Malawi and Mozambique, six MSF project sites offer adapted peer-led HIV and sexual and reproductive health (SRH) services to SW, MSM and adolescents at risk following principles outlined in this report.

3. Pontheu & Incerti (2016). MSF study among patients on ART in South Africa, Mozambique and Malawi. Continuity of care for Migrant populations in Southern Africa: Refugee Survey Quarterly, Volume 35, Issue 2, June 2016, Pages 98-115, <https://doi.org/10.1093/rsq/hdw006>





## DISCRIMINATION, LAW AND HEALTH POLICIES

Offering accessible and affordable HIV and SRH prevention and care for KPs is not only a public health need, but also a human rights issue. Globally, the risk of acquiring HIV is 27 times higher among MSM and 13 times higher for female SWs and for transgender women than for the general population.<sup>4</sup> Despite the clear significance of these groups in the dynamics of the HIV epidemic, many of them are still excluded from care.

The high risk for HIV and other infections faced by KP due to behavioural and biological factors is further increased by structural violence such as non-inclusive law and health policies. For instance, in Mozambique, although sex work and same-sex relations are decriminalised, they are still highly stigmatised by society. This and other structural challenges, as presented in Table 1, need to be addressed in order to reach a more inclusive model of healthcare. Policy makers have a fundamental role to play in the development of health and social policies and regulations that directly recognise and address the stigma of discrimination and other barriers faced by KP.

### Peers as service providers and leaders

MSF peer educators – themselves SWs and MSM who have been recruited from their local communities and trained to raise awareness

about HIV among peers – visit hotspots to communicate with known SWs and MSM and identify those in the KP who are new to the area.

Peers have been progressively trained and supervised to assume tasks that were initially managed exclusively by counsellors, such as performing rapid tests (HIV, Hepatitis B and syphilis), offering pregnancy tests and providing basic counselling. As SWs and MSM peer educators began to take over further tasks, they were trained to assume more responsibilities and progress in their career within the organisation, as counsellors and supervisors. Having peers in different positions and participating in the different stages of a project

cycle (planning, implementation and evaluation) has produced useful insight into programming and thus a greater acceptance of the project by KP groups.

**Delegating the essential community-engagement work to peers without properly remunerating them is considered to be exploitation according to the criteria of the International Labour Organization (ILO) and a practice that cannot be justified even in low-resource settings.<sup>8</sup> MSF recognises the value of peer educators' work and employs them with full contracts and benefits compatible with their roles and tasks.**



©Morgana Wingard/NAMUH

Former MSF peer educator and now the counsellor, Theodora, teaches a SW how to use a female condom during an outreach visit in the project of Beira.

	Legal Frameworks		Health Policies		
	Sex work <sup>5</sup>	Same-sex relations	KP guidelines	Ministry of Health model of care for KP	Lay cadre (peers and counsellors)
Current situation	Decriminalised	Decriminalised	Specific guidelines of HIV care for KP <sup>6</sup>	KP accessing same service as the general population (integrated) HIV testing services (HTS) and peer approach at community level implemented and funded by CBOs and NGOs Community approach to be regulated by CNCS <sup>7</sup>	Funded by international NGOs and donors MSF peers trained to provide HTS
Challenges	Highly stigmatised Victims of systematic violence	Highly stigmatised	KP guidelines do not include transgender people	KP differentiated care and one-stop service are not included and not funded in the policies for KP Discrimination by health care providers, charging of illicit fees to foreign SWs	Peers and counsellors not regulated Sustainability of peer approach is not guaranteed if funds are cut

**Table 1:** Current legal frameworks and health policies regarding KP and challenges to be addressed in Mozambique

4. UNAIDS (2018). 2017 Global HIV statistics. Available at <[http://www.unaids.org/sites/default/files/media\\_asset/UNAIDS\\_FactSheet\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf)>

5. In Mozambique, sex work is not a crime, but living off the earnings of prostitution or forcing someone into prostitution is penalised, according to Article 227 of Mozambique Penal Code.

6. Ministério da Saúde (MISAU), Direcção Nacional de Assistência Médica (DNAM), PNC ITS-HIV/SIDA (2016). Directriz para Integração dos Serviços de Prevenção, Cuidados e Tratamento do HIV/SIDA para a População-chave no Sector da Saúde.

7. Conselho Nacional de Combate ao HIV e SIDA (National Council to Fight HIV and AIDS)

8. International Labour Organization (2009). Details of indicators for labour exploitation. <[https://www.ilo.org/wcmsp5/groups/public/@ed\\_norm/@declaration/documents/publication/wcms\\_105035.pdf](https://www.ilo.org/wcmsp5/groups/public/@ed_norm/@declaration/documents/publication/wcms_105035.pdf)>

# MODELS OF CARE

The models of care were implemented with variations in Tete and Beira – which are presented under the case studies – but abided by certain common principles as follows:

**Peer-Led Service Delivery:** Access to and delivery of care for excluded populations is critically dependent on a trained, paid, peer cadre working alongside a sensitised healthcare worker. Peers must be involved in the design, implementation and constant review of programmes.

**One-Stop Services:** A package of care, including HIV and SRH services, should be provided at the same place, on the same day, ideally by the same health worker.

Each additional venue a SW or MSM must visit to access care for each of their health needs represents an additional barrier to care.

**Community-Based Approach:** Prevention and treatment services should be offered at community level as a complement to facility-based care in order to overcome barriers of access to healthcare, to reach KP groups closer to where they live and work, and to reduce the burden in the health centres.

**KP-Friendly Services:** Ensuring that trained, sensitised clinicians and peer cadres provide dedicated care and give priority to KP groups in the health centre is a necessary step towards offering fully integrated care for KPs so that

they can access care in the same flow as the general population. To be perceived as KP-friendly, services need to be seen as being safe and efficient by beneficiaries.

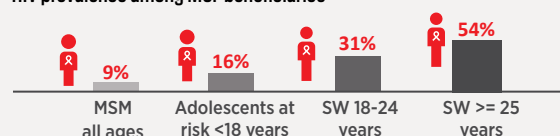
**Advocacy:** The creation of an environment that enables access to healthcare on equal footing is an essential component of effective programming for KP groups. To do so entails building public support to end violence perpetrated by police and others against these populations, plus training KP groups on their rights so they can denounce abuses and seek justice.

A basic package of HIV and SRH care is offered at community level, with referral to a health centre for a comprehensive medical package, as listed in Table 2.

Minimum package		Comprehensive medical package
<ul style="list-style-type: none"> <li>Health promotion and education on HIV, SRH, SGBV</li> <li>Distribution of condoms and lubricants</li> <li>HIV testing and counselling</li> <li>Post-Exposure Prophylaxis (PEP)</li> <li><b>Referral</b> to MoH for ART services</li> </ul>	HIV	Minimum package plus: <ul style="list-style-type: none"> <li>ART services (first and second line)</li> <li>Lab exams (CD4, viral load)</li> <li>Hepatitis B test and vaccination</li> <li>Hepatitis C for MSM<sup>9</sup></li> <li>Pre-Exposure Prophylaxis (PrEP)<sup>10</sup></li> </ul>
<ul style="list-style-type: none"> <li>Syphilis rapid test</li> <li>STI screening and treatment</li> <li>Contraceptive services including emergency contraception</li> <li>SV first aid</li> <li><b>Referral</b> to MoH for antenatal care, termination of pregnancy (ToP), cervical cancer screening</li> </ul>	SRH	<ul style="list-style-type: none"> <li>ToP<sup>11</sup></li> <li>Cervical cancer screening</li> <li>Sexual violence care</li> </ul>
<ul style="list-style-type: none"> <li>TB screening</li> <li><b>Referral</b> to MoH for TB treatment</li> <li><b>Referral</b> for to social services, human rights organisations</li> </ul>	other	<ul style="list-style-type: none"> <li><b>Referral</b> to MOH for TB and other opportunistic infections diagnosis and treatment</li> </ul>

Table 2: Packages of care of HIV and SRH for SW and MSM.

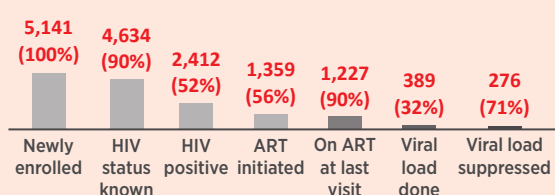
## HIV prevalence among MSF beneficiaries



Graph 1: HIV prevalence per groups enrolled at MSF, projects of Tete and Beira. Q1 2014 – Q2 2018.

In the four years of the project, over 6,000 members of KP and vulnerable groups accessed care in Tete and Beira. Over **95%** of all beneficiaries were tested at enrolment. As shown in the Graph 1, HIV prevalence was found to double in the transition from adolescence to adulthood.

## SW HIV Cascade of care



Graph 2: Cumulative number of SWs in the HIV cascade of care projects of Tete and Beira. Q1 2014 – Q2 2018.

When enrolling in an MSF programme, less than **30%** of the SWs were aware of their HIV status. Due to SWs good acceptance of HIV testing at community level, knowledge on HIV status increased significantly after enrolment, reaching **90%**, as shown in Graph 2.

In the beginning of the project, less than **30%** of the HIV-positive SWs had started treatment, due to lack of awareness and support. Over time, up to **70%** of the HIV-positive SWs started ART in the projects of Tete and Beira. SWs mobility still impacts their access to ART. Retention in care and viral load uptake and suppression remain a challenge among vulnerable and mobile groups.

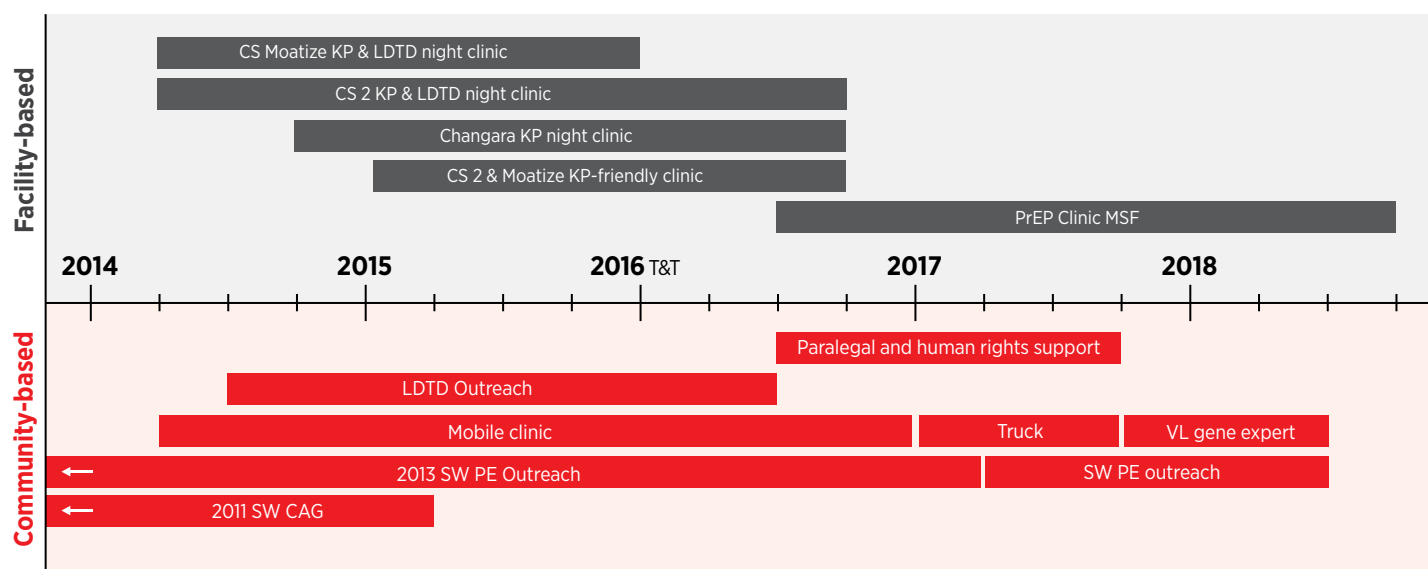
9. Implemented in Beira between 2016-2018. No positive case found.

10. Implemented in Tete and Beira as an operational research project between 2016-2018.

11. Performed by MoH in Tete and by MoH/MSF in Beira.



# TETE CASE STUDY



<b>When</b> <b>Daytime:</b> outreach and mobile clinics <b>Weekend:</b> Peers and mobilisers provide initial support for violence cases	<b>Where</b> <b>At community level:</b> outreach and mobile clinics <b>At MoH health centres:</b> navigation
<b>Who</b> <b>Community:</b> Community mobilisers, SWPE, counsellor, midwife or nurse and supervisor	<b>What</b> Comprehensive medical package at community level. Navigation for ART initiation and other services at MoH health centres

The Tete model started by offering outreach and integrated KP-friendly clinics within the MoH, but then concentrated on the community-based approach from 2017. The project was handed over to the Provincial Health Department (DPS) and International Centre for Reproductive Health Mozambique (ICRH) in December 2018.

## Highlights of the model

**Peer navigation:** A trained peer counsellor accompanied newly HIV-diagnosed individuals to their ART initiation and other necessary services at health centres.

**Community mobilisers:** Peer mobilisers were responsible for encouraging KP members to access healthcare and identifying cases of sexual and gender-based violence (SGBV), such as incidents of violence that happened outside working hours or during weekends, thereby quickly linking victims to a network of first aid and support.

**Community ART groups (CAG):** In HIV care, CAGs are groups of 4-10 HIV-positive patients who take a rotating turn to travel to the health centre for treatment follow-up and to collect ART refills for all members of the group, thereby reducing the burden of making visits to the health centre. CAG groups called GAZIMBAS (Grupo de Apoio às Zimbabweanas) were formed in 2010 to cater to foreign SWs. Initially facilitated by MSF, the groups were handed over to DPS and MoH in 2015 and remain active to date.

**Advocacy to respond to violence against SW:** Through a partnership with Liga dos Direitos Humanos from 2016-2017, SWs accessed

paralegal support as victims of human rights violations and advocated for their rights.

Preliminary results of the PrEP study showed high acceptability<sup>13</sup> and demand<sup>14</sup> of this method of HIV prevention among HIV-negative SWs, MSM and transgender beneficiaries.

***“Belonging to key populations does not mean you are HIV-positive. One SW would tell me ‘I’ve played too dangerous, I’m doomed to die’. She accepted to test and her result was negative. Up to now, she is on PrEP and remains negative.”***

(Supervisor, Tete Project)

**A mobile clinic with point of care diagnostics:** Viral load and CD4 testing were done at community level and results issued immediately, thanks to the GeneXpert and PIMA machines installed in the mobile clinic.

A common SW comment is that **they don’t get enough free condoms from other projects**. Uninterrupted supply of condoms and lubricants and in sufficient quantities is a basic need for KP groups.

**An average of 30 to 50 condoms per SW were distributed each visit**, usually weekly, adjusted according to the demand and respecting the needs expressed by the SW.



## Total SWs

**Total SWs ever enrolled in Tete Project = 3,365<sup>12</sup>**

**32% (1,091)** between 18 and 24 years of age, **68% (2,274)** above 25 years old

**43% (1,432)** primary level of education, **38% (1,292)** secondary level of education

**27% (914)** Mozambican, **37% (1,235)** Zimbabwean, **36% (1,216)** Malawian nationality

**42% (1,425)** had only one visit in the programme

**HIV prevalence among enrolled SW: 57%**

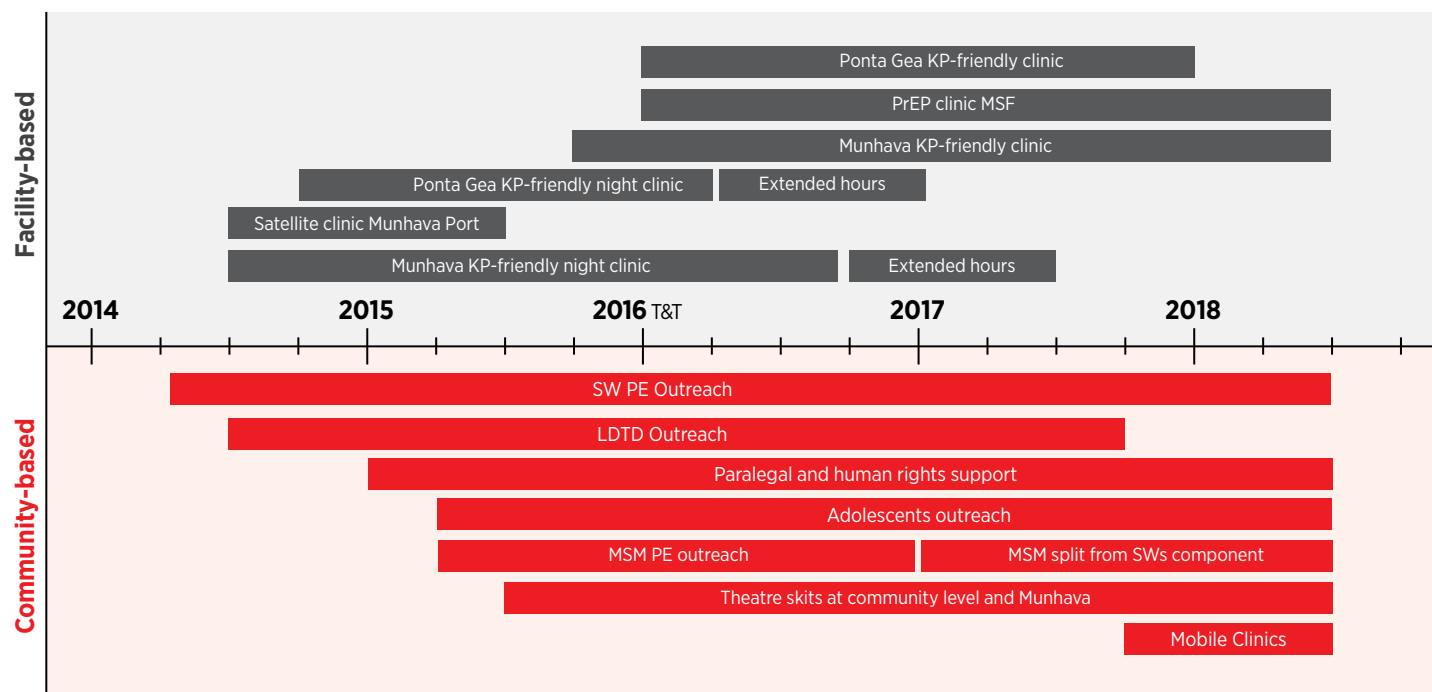
12. Enrolment is defined by the first time a person was contacted in the community and had a file opened, for both HIV-negative and HIV-positive beneficiaries. Follow-ups include all subsequent visits made to the same person, and both together were called “outreach visits”. The number of enrolled persons is cumulative over time and does not denote whether they are currently attending the programme.

13. Acceptability: Out of those contacted in the community and offered PrEP, how many accepted.

14. Demand: Among those who accepted, how many initiated PrEP.



# BEIRA CASE STUDY



<b>When</b> Daytime clinics Daytime and night outreach	<b>Where</b> <b>At community level:</b> door-to-door outreach and mobile clinics <b>At MoH health centres:</b> MSF KP-friendly clinic
<b>Who</b> <b>Community:</b> SW and MSM PE, counselor, midwife/nurse, paralegal counselor <b>Clinic:</b> peer navigator, clinical officer and midwife/nurse	<b>What</b> <b>At community level:</b> Minimum package + Hep. B vaccination and PrEP. <b>At health centre:</b> comprehensive medical package

not SWs are more difficult to reach. The main strategy when seeking to enrol MSM is the “snowball” method where one enrolled MSM spreads the word about the project to his fellows and acts as a trusted mediator between them and the healthcare team.

## Peer navigator at Munhava health centre:

An identified peer navigator was hired for the reception area of the health centre to receive KP individuals referred from the community.

**Knowing who will give them care when arriving at the health centre helped KP beneficiaries to overcome stigma and fear of approaching the clinic.**

**One-stop KP-friendly clinic:** The focal point clinicians and midwives are especially sensitised and trained to provide care for KP groups and offer an HIV and SRH comprehensive package of care at one clinic. This provides privacy, discretion and saves a lot of time for the patient.

**Targeted mobile clinics:** Mobile clinics are held weekly in the community as a way to gather KP groups and offer HIV testing, STI treatment and family planning (FP). In contrast to the model applied in Tete, the clinic here is not advertised as a KP-specific clinic, to avoid reinforcing certain stigmas. Instead, HIV testing campaigns are open to the general population and a risk assessment is done during individual consultations to identify new members of the target group and offer a differentiated package of care.

**Para-legal counsellor:** Through a partnership with MULEIDE (Associação Mulher Lei e Desenvolvimento) since 2015, a part-time paralegal counsellor has been responsible for informing new beneficiaries about their rights and identifying cases where paralegal support can help ensure access to justice. Meetings and workshops with the police are also held to stop police violence against SW.

**Theatre group:** The Tendeni theatre group, the winner of a theatre contest organised in 2015 among SWs and peer educators, helps to promote the empowerment of the community. Their performances focus on a variety of topics, such as human rights, SGBV and health promotion and take place at health centres and community events with MSF and the MoH.

## Highlights of the model

**Door-to-door:** SW and MSM peers and counsellors provided health promotion information and treatment follow-up in the community for priority cases, such as new diagnoses of HIV and SGBV.

**Night outreach:** Once a week, a driver, two peers (a SW and MSM) and a counsellor visited the main hotspots of the city to distribute and promote the correct use of condoms and lubricants among SWs and their clients.

**Snowball method:** MSM who are SWs may be identified at hotspots; however, those who are

*“My strategy is to open up that I am a sex worker too. They first need to trust me so I can start offering the services. It won’t work if you offer HIV testing straight away. I tell them we are enrolling those ladies who have two boyfriends or more. I also have my own network, so when a new sex worker arrives to the area, they call me and ask me to come.”*

(SW peer educator, Beira Project)





## SW

**Total SWs enrolled in Beira Project = 1,776**

**46% (822)** between 18 and 24 years of age, **54% (954)** above 25 years old

**22% (395)** primary level of education, **50% (880)** secondary level of education

**75% (1,340)** Mozambican, **24% (426)** Zimbabwean, **1% (10)** Malawian nationality

**1,940 (58%)** had more than one visit in the programme

**HIV prevalence among enrolled SW: 44%**

The increase in the number of SWs who adhered to a contraceptive method from the first to the last visit (from 27% or 363 SW to 46% or 612 SW) in the programme suggests that there was an unmet need for family planning (FP) among SWs that was addressed by the programme. In 2018, the presence of nurses/midwives within the community teams in Beira as well as the allocation of a SRH consultation room in the mobile clinic also helped to improve contraceptive methods uptake.

Dual protection, i.e. use of condoms together with another contraceptive method of choice, was highly encouraged and was a key health promotion message given in the community and in the clinics, in order to simultaneously prevent STIs and unplanned pregnancy.

Different groups of MSM were enrolled in the project in Beira. While those engaged in sex work were exposed to a higher number of partners, they were more aware of risks and preventative measures. Others, not involved in sex work, were mainly from two groups: MSM in homosexual relationships and MSM who were also in a heterosexual relationship but had concurrent relationships with other men. For each group, the main approach and standard messages had to be adapted.

Out of the 552 MSM enrolled, 4% (20) were known HIV-positive when enrolling in the

MSF programme. With the contribution of the programme and the high coverage of testing at enrolment, 94% (523) of the MSM beneficiaries became aware of their HIV status, either positive or negative.

Although homosexuality is not criminalised in Mozambique, a lack of social acceptance and a high level of discrimination at health facilities are viewed as the main barriers to access to care. Acting upon a referral or getting accompanied by a peer educator to a clinic can sometimes be perceived as risky by MSM beneficiaries, as it could involuntarily disclose their status as MSM if they are seen with an MSM peer educator, who is assumed to be gay or known to be working with MSM patients. Thus, certain strategies commonly used with other KP groups need to be adapted to achieve the fundamental discretion that MSM desire.

***“Some MSM have a heterosexual relationship and a family. For serodiscordant couples, PrEP would help to protect the one in the couple that is still negative. I would like MoH and the other organisations to consider this.”***

*(MSM peer educator, Beira Project)*



## MSM

**Total MSM enrolled in Beira Project<sup>15</sup> = 552**

**12% (66)** between 15 and 17 years of age, **54% (297)** between 18 and 24 years of age, **34% (188)** above 25 years old

**20% (108)** primary level, **63% (347)** secondary level; **13% (71)** technical or high level of education

**82% (453)** Mozambican, **12% (64)** Zimbabwean, **6% (35)** Malawian nationality

**81%** had more than one visit in the programme

**HIV prevalence among enrolled MSM: 9%**



## PEP barriers

SWs report they are denied access to PEP in MoH clinics due to frequent demands. The restricted protocol of PEP in cases of sexual violence and occupational exposure by healthcare workers leaves all other exposures, such as condom break, untreated by the MoH.<sup>16</sup>



## 2017 Beira survey

A survey held in Beira in 2017 among MSF project staff, including administrative, logistics and operational teams, found that more than 10% of staff had a negative perception towards MSM, which was an alert to the need to sensitise and educate staff on a regular basis.



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Filipe, an MSF MSM peer educator, providing health promotion messages in the community, Beira Project.

***“My life changed a lot with MSF. Before, I didn’t even believe HIV exists. I used to attend the traditions [alternative traditional medicine]. After joining MSF, I’ve learned that HIV really exists. So I started reducing my exposure [to sex] without a condom, and teach others to do the same. When I manage to help one person, it means a lot to me. It feels as a victory, because I’m helping lives.”***

*(SW peer educator, Beira Project)*

15. The number of enrolled persons is cumulative over time and does not denote whether they are currently attending the programme.

16. MSF is applying a universal protocol for PEP, i.e. for any case of exposure regardless of the reason. In Beira, strong advocacy was needed to get MoH health centres’ authorisation to apply universal protocol for KPs in MSF friendly clinic, in Munhava health centre.





# ADOLESCENTS AT HIGH RISK FOR HIV

According to IMASIDA (2015),<sup>17</sup> the HIV prevalence among girls between 15-17 years old is 5.1% in Mozambique. In the projects of Tete and Beira, MSF encountered more than 400 adolescent girls between 12 and 17 years of age who are at increased risk for HIV and other infections, as evidenced by a high HIV prevalence of 29% in Tete and 7% in Beira. As minors, they may be sexually exploited when they engage in risky sexual behaviours that range from transactional sex, to multiple partners and intergenerational sex, to premature engagement with sex work. Due to the rapid physical, emotional and mental development typical of the age and their poor access to health services in general, adolescent girls deserve special attention from prevention and care programmes.



## Adolescents at high risk

**Total of 439 adolescents at high risk for HIV ever enrolled (181 in Tete; 258 in Beira)**

**10% (42)** between 12 and 14 years old, **90% (397)** between 15 to 17 years of age

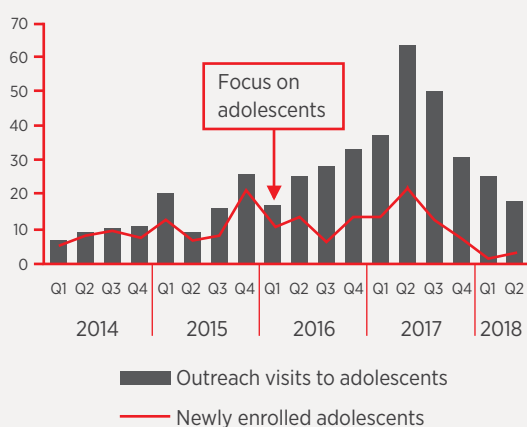
**40% (177)** primary level of education, **42% (186)** secondary level of education

**84% (367)** Mozambican, **14% (63)** Malawian, **2% (8)** Zimbabwean nationality

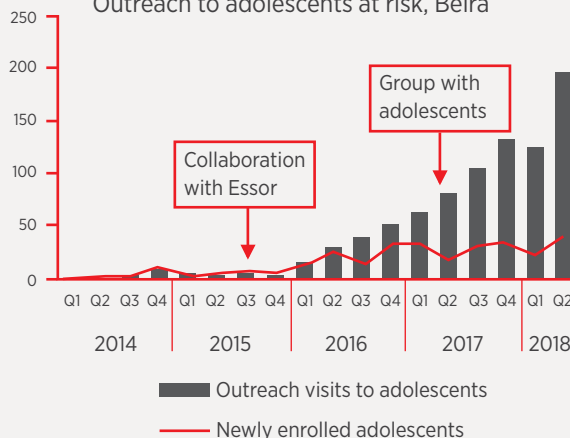
**HIV prevalence among enrolled adolescents: 16%**

A total of 96% of the adolescents<sup>18</sup> were tested for HIV, which highlights the significantly positive response among this group to the community and peer-led testing approaches. The linkage to HIV care is still a challenge, however, as among the 16% (71) who were found positive, only 28 initiated treatment. HIV status disclosure to family members and partners seems to be a major issue among adolescents. Some who are already at the age where they can give consent for HIV testing are still highly dependent on family members and partners when it comes to seeking healthcare. Additionally, only 35% of the girls claimed to be using a method of contraception, showing low levels of awareness of the risks of unplanned pregnancy.

Outreach to adolescents at risk, Tete



Outreach to adolescents at risk, Beira



Graph 4: Number of adolescent girls at risk enrolled per quarter and main programmatic changes in the projects of Tete and Beira. Q1 2014 – Q2 2018.

A collaboration with the adolescents-focused organisation Essor helped with reaching additional numbers of adolescent girls in Beira, starting in early 2016. An MSF programmatic decision to adapt interventions to cater to adolescents increased the number of outreach visits to this group, as shown in Graph 4. In Beira, educational group sessions were held over weekends during the second semester of 2017 and helped the project engage with them. In addition to providing HIV and SRH information and services, these adolescent-friendly spaces became a safe place and provided peer support. Many adolescents referred to having had no other similar environment in their lives where they could discuss health and sexuality in such a frank, informative, safe and confidential way.

**On the one hand, adolescents and parents of adolescents at risk might be fearful of being approached with healthcare advice and treatment, as transactional sex and sex work among minors are unlawful practices. At the same time, there are not many HIV or SRH projects that address the health needs of this specific group, as legal implications also constrain organisations from receiving funds and providing care for them.**

**Due to these reasons, this vulnerable and high-risk group is not sufficiently assisted by HIV projects, as these adolescents are not reached by the general healthcare programmes for adolescents, nor by programmes designed for adult KPs, with which some might not identify.**

## MSF experience from the region – Malawi

Providing thematic activities for girls separately from adults, such as the youth mobile clinics in Nsanje and teen group activities in Mwanza, improved their access to services and increased the healthcare staff's understanding of their health needs.

17. Ministério da Saúde (MISAU), Instituto Nacional de Estatística (INE), e ICF, 2015. Inquérito de Indicadores de Imunização, Malária e HIV/SIDA em Moçambique 2015. Maputo, Moçambique. Rockville, Maryland, EUA: INS, INE, e ICF.

18. Among the adolescents enrolled, those who didn't know their HIV status or didn't have a recent test were considered eligible for HIV testing.



## SGBV – SEXUAL AND GENDER-BASED VIOLENCE

*“When MSF leaves the area, I’m leaving too. I know I won’t be safe here. The police stopped bothering us because they know there is MSF backing us up. When there is no MSF, we will be vulnerable again.”*

*(SW community mobiliser, Tete Project, before its handover)*

MSF teams have been witness to accounts of violence suffered by SWs, MSM and transgender people across all project sites in the region, which occur on a daily basis. The most commonly reported incidents were:

**By clients:** Abuses ranged from robbery to psychological, physical and sexual violence. There were also accounts of clients removing the condom without consent or previously pricking it to purposely make it break, leading to unsafe practices.

**By police:** Coercion into providing sex and forced labour under threat of being repatriated (in the case of foreign SWs) or brought to the police station was described. Public decency and vagrancy laws were often misused to threaten and abuse SWs. Over the past few years MSF teams have consistently reported cases of violence



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MSF staff members Sebastiana Cumbe and Esperanza Mercelino provide community education on sexual and reproductive health in Beira.

during interventions by police to dismantle brothels and indications that foreign SWs in Beira city were especially targeted.

**By health care providers:** Discrimination, denial of access to care and the charging of illicit fees were types of violence commonly committed against foreign SWs.



### First semester of 2018:

43 testimonials of discrimination at health centres and incidents of violence were collected by MSF in partnership with Muleide in Beira.

Although teams are trained to identify and provide psychosocial and medical support to victims of SGBV, most cases still go unreported. There is a high normalisation of violence against women in these contexts.



### MSF advocacy campaign

As part of a local MSF advocacy campaign to respond to violence against SWs in Tete and Beira, SWs were given the opportunity to offer testimony about their experiences of abuse. In Tete, after meetings with the provincial Commander-in-Chief of Police of the Republic of Mozambique (PMR) and with the police sector responsible for SGBV sector of the police, the number of incidents of police violence against SWs decreased. However, incidents reportedly increased again once MSF was no longer present. Thus, a continuous investment is needed for longer term impact.



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Poster of the advocacy campaign held in 2017 in the Tete Project, in allusion to 17th December, the International Day to End Violence against Sex Workers.

*“I heard many cases of a policeman entering a female sex worker’s private room and pointing the gun to her sexual part, asking her for free sex and extorting money from her and her clients. It was a big effort to get an audience with the commandant to say that these things needed to stop; this is against human rights. We collected many testimonials like this. Violence perpetrated by police against sex workers reduced a lot after our interventions, however didn’t completely end yet.”*

*(Paralegal counsellor, Beira Project)*





## LESSONS LEARNED

- Shifting to a peer approach and assigning tasks of HIV testing to peers resulted in high acceptance and coverage of HIV testing among key and vulnerable groups;
- Assigning peers of diverse nationality and age groups to follow up a limited number of beneficiaries in their catchment areas, and to support the KP beneficiaries through the different stages of the cascade of care, were considered appropriate strategies;
- Offering services at points of care and mobile clinics in the community bridged barriers such as discrimination at health centres, which was higher against MSM and commercial and foreign SWs than against women engaged in transactional sex;
- Bringing MSF and MoH staff to work in the community where they could see the lived reality of KP groups was an effective way to promote empathy, friendly attitudes and an understanding of the health needs of these groups;
- Door-to-door visits were adequate for reaching commercial SWs in Tete, where the majority are foreigners who live together and have less fear of being disclosed as a SW. However, a snowball method and other discrete strategies were preferred in Beira to reach transactional SWs and MSM, who are more sensitive to disclosure and who live scattered across the city;
- SWs showed a high level of trust and satisfaction with the clinicians especially trained for seeing KPs as focal points within MoH centres;
- One-stop services were relevant to all KP groups, in particular SWs with high mobility;
- Lack of access to HIV treatment and obstacles to getting refills of ARV while in transit are still barriers to continuous care faced by HIV-positive SWs. Although a three months' supply of ARV is an approved policy in Mozambique for stable patients, it is not widely implemented and the official criteria do not fully match the needs of patients who are more mobile;
- There are a great deal of myths and misconceptions about family planning practices and options among SWs and adolescents at risk, which require consistent health promotion and education;
- Public campaigns, awareness sessions and high-level meetings with the police and justice bodies have reduced police violence against SWs in Tete and Beira;
- Adolescents who engage in transactional sex are at high risk for HIV and are an underserved and often overlooked group in HIV projects.



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During a health promotion session conducted at a hotspot, SWs receive male and female condoms and lubricants, precious commodities to protect themselves from HIV and other STIs.

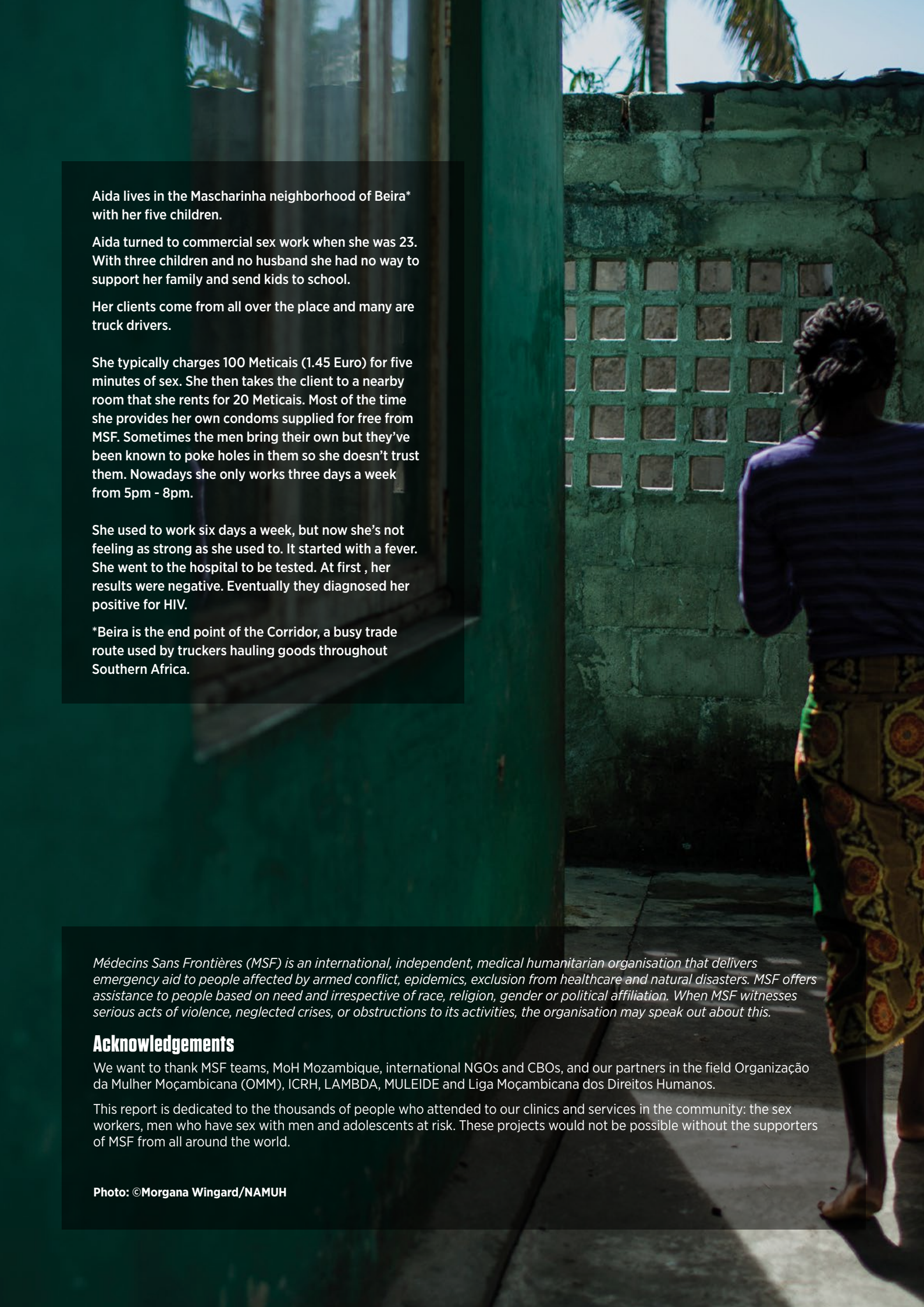
### Experience of MSF from the region

In the SWs project of MSF in Malawi, same-day HIV diagnosis and ART initiation at community level helped to reach a high rate of ART initiation among SWs in Nsanje, when compared the other sites where ART initiation was facility-based.

### A call for MoH, donors and partners

- As much as quality care and prevention is to be prioritised among KP groups, these services need to be adapted to their needs (uninterrupted supply of condoms and lubricants, universal access to PEP, access to PrEP and access to periodic retesting of HIV-negative individuals, for example);
- More KP-friendly policies require the reliable provision of HIV and SRH services and ARV supply to mobile populations while in transit;
- Transgender people need to be included as a KP in the national guidelines;
- Peer educators should be recognised for the work they do and receive a salary compatible with their roles and tasks;
- A multi-sectoral response is needed to tackle violence as the main structural barrier to care faced by SWs, MSM, adolescents at high risk for HIV, and transgender people, including violence perpetrated by the police;
- In projects for key and vulnerable populations, it is essential to sensitise staff at all levels on friendly attitudes and have clear policies against abuse, exploitation and harassment to protect teams and beneficiaries;
- More funds, programmes and policies are needed for:
  - Adolescents at high risk for HIV;
  - Focal point clinicians for KP and HIV and SRH one-stop services at health centres;
  - KP programmes that bring MoH healthcare providers to the field to see the lived reality of KP groups;
  - ART decentralisation.





Aida lives in the Mascharinha neighborhood of Beira\* with her five children.

Aida turned to commercial sex work when she was 23. With three children and no husband she had no way to support her family and send kids to school.

Her clients come from all over the place and many are truck drivers.

She typically charges 100 Meticaïs (1.45 Euro) for five minutes of sex. She then takes the client to a nearby room that she rents for 20 Meticaïs. Most of the time she provides her own condoms supplied for free from MSF. Sometimes the men bring their own but they've been known to poke holes in them so she doesn't trust them. Nowadays she only works three days a week from 5pm - 8pm.

She used to work six days a week, but now she's not feeling as strong as she used to. It started with a fever. She went to the hospital to be tested. At first, her results were negative. Eventually they diagnosed her positive for HIV.

\*Beira is the end point of the Corridor, a busy trade route used by truckers hauling goods throughout Southern Africa.

*Médecins Sans Frontières (MSF) is an international, independent, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, exclusion from healthcare and natural disasters. MSF offers assistance to people based on need and irrespective of race, religion, gender or political affiliation. When MSF witnesses serious acts of violence, neglected crises, or obstructions to its activities, the organisation may speak out about this.*

## Acknowledgements

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This report is dedicated to the thousands of people who attended to our clinics and services in the community: the sex workers, men who have sex with men and adolescents at risk. These projects would not be possible without the supporters of MSF from all around the world.

Photo: ©Morgana Wingard/NAMUH