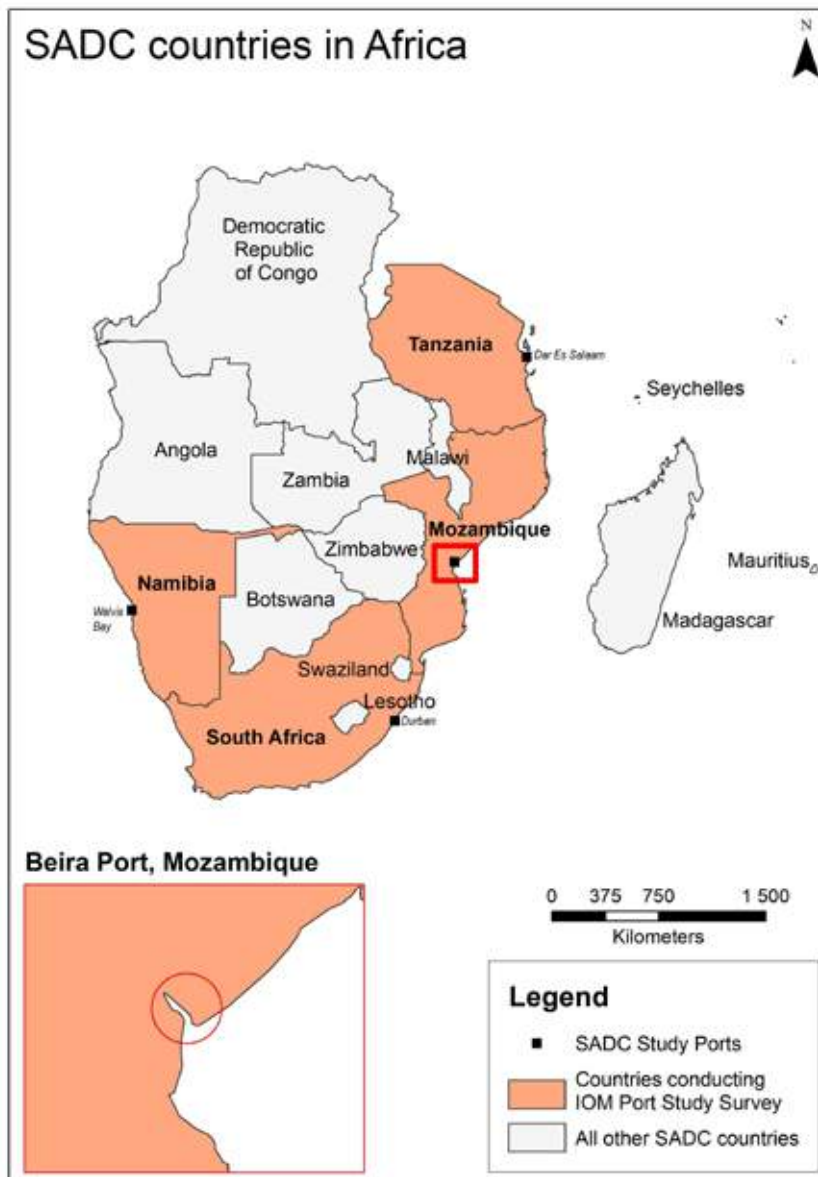

Health vulnerabilities of mobile and migrant populations in and around the **Port of Beira, Mozambique**



International Organization for Migration (IOM)
Organisation internationale pour les migrations (OIM)
Organización Internacional para las Migraciones (OIM)



A study on health vulnerabilities of mobile and migrant populations in and around the Port of Beira, Mozambique

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This study was carried out with the support of International Organisation for Migration (IOM) Southern Africa Regional Office and IOM Mozambique Office as part of a SADC funded initiative to identify HIV risk profiles for four Southern African ports using the concept of 'Spaces of Vulnerability' where the interaction of all groups in the space are discussed and key programming issues identified to reduce vulnerability to HIV transmission. The research was carried out at the port of Beira in Mozambique.

We would like to thank the people of Beira who participated and gave freely of their time to provide us with valuable insights into the interactions between residents and mobile populations in the environs of the Beira Port in both the quantitative and qualitative surveys.

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PREFACE

This study was carried out with the support of International Organisation for Migration (IOM) Southern Africa Regional Office and IOM Mozambique Office as part of a SADC funded initiative to identify HIV risk profiles for four Southern African ports using the concept of 'Spaces of Vulnerability' where the interaction of all groups in the space are discussed and key programming issues identified to reduce vulnerability to HIV transmission. The research was carried out in the city of Beira in the central province of Sofala.

We would like to thank the National AIDS Council (CNCS), the Provincial AIDS Nucleus, the City Health Department, Cornelder (Port Management Company) and Railways and Ports of Mozambique (CFM) for their support in carrying out the field work for the study.

We would like to thank all people who gave freely of their time to provide us with valuable insights into the interactions between residents and mobile populations in the environs of the Port of Beira in both the quantitative and qualitative surveys. A special thank you to the community-based organisations of Luz na Comunidade, Kufunana, VIDECA, PSI, AMODEFA, and AJULSIDA, for providing valuable insights into their work and continuing to work in challenging circumstances in the Munhava neighbourhood.

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ABSTRACT

The study was conducted to contribute to the reduction of HIV among migrants and mobile workers, their families and communities with which they interact in the port of Beira in Mozambique. The study utilized mixed methods of data collection which included a quantitative questionnaire-based survey and qualitative interviews. GIS mapping of the different areas inside and outside the Port was also produced. The survey population was 322 which included the following: port workers, long distance lorry drivers, female sex workers, and restaurant/bar owners and workers. The qualitative study population included: port workers, female sex workers, seafaring personnel, long distance lorry drivers, health care workers, NGO workers, and public sector workers. 55 individual in-depth interviews and 8 focus group discussions were conducted.

This study shows the existence of multiple concurrent partnerships between truck drivers, commercial sex workers, 'leisure workers' (individuals who worked at the bars and hotels next to the port), stevedores and other port workers. Stevedores constitute a relatively well paid worker population in Beira and they are regular clients of commercial sex workers. In contrast, international seafarers are not a significant constituent of these sexual networks due to their minimal presence in the city.

The study shows there is a blurring of the boundaries between commercial, transactional, and intimate relationships amongst clients of commercial sex workers. For example, commercial sex workers have casual liaisons with truck drivers but also some also have regular, personal relationships with other truck drivers and/or with other individuals in the city. Likewise, those partners of commercial sex workers have other commercial and personal relationships; for example, with leisure workers. Sexual liaisons do occur often in port environs due to the presence of hotels and bars but also elsewhere in the city. Reported condom use was inconsistent; most frequently and consistently in commercial sexual relationships but infrequently in transactional and intimate partner relationships. Generally, informants across all samples are knowledgeable about HIV/AIDS, express few prejudices, and seek professional medical care as and when necessary.

The port is a location where there is a concentration of porous sexual networks. There is a high risk of HIV and STI transmission within these networks due to the central presence of commercial sex workers and truck drivers within them.

ACRONYMS AND GLOSSARY

AIDS	Acquired Immune Deficiency Syndrome
CFM	Railways of Mozambique (Caminhos de Ferro de Mocambique)
Cornedler	Joint venture holding company
CSO	Civil Society Organisation
CNCS	National AIDS Council (Conselho Nacional de Comate a SIDA)
FBO	Faith Based Organisation
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
IDI	In-depth Interview
IOM	International Organisation for Migration
KII	Key Informant Interview
MARP	Most At Risk Population
MCP	Multiple Concurrent Partner
NGO	Non-governmental Organisation
SADC	Southern African Development Community
STI	Sexual Transmitted Infection
TB	Tuberculosis
UNDP	United Nations Development Programme

DEFINITION OF TERMS (SADC, 2009)

Population mobility

It refers to movement of people from one place to another, temporarily, seasonally or permanently for either voluntary or involuntary reasons. It describes the full range of mobility from short-term movement (e.g. truck drivers) to longer term or permanent relocation.

Internal mobility

It refers to movement of people from their homes to other places within the same country (e.g. from rural to urban areas).

External mobility

Refers to movement of people who cross international borders to a foreign country.

Migration

Refers to mobile people who are resident or remain in another place for an extended period of time, including seasonal migrants. Migration can also be internal or external.

Communicable disease

An illness due to a specific infectious agent or its toxic products which arises through transmission of the agent or its products from an infected person, animal or inanimate reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector or inanimate environment.

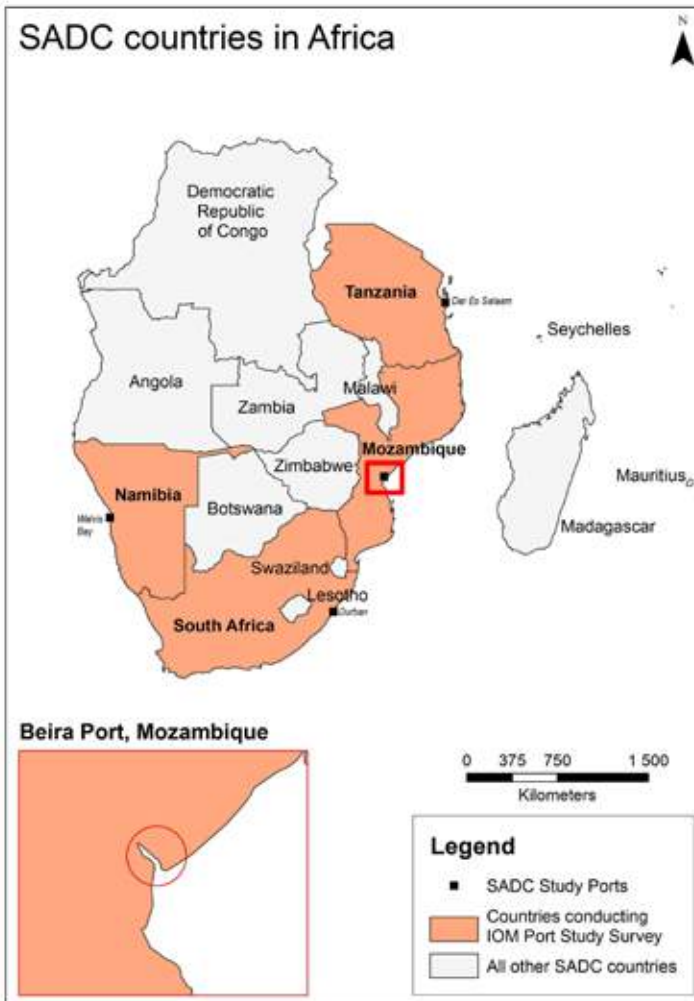
(Source: Control of Communicable Diseases in Man by A S Benenson, Editor, Fifteenth edition, 1990)1.

CHAPTER 1

BACKGROUND TO THE STUDY

1.1 Introduction

Map 1: SADC countries and the Port of Beira



Ports are dynamic places, in constant movement, employing thousands of people and attracting many more, constantly looking to make a living from these thriving centres. Southern Africa, from Angola to Tanzania, has approximately 18,000 km of coastline¹ and 15 major ports. Seafaring personnel from Europe and Asia pass through the ports, as do hundreds of truck drivers picking up and leaving cargo for import or export. These

¹ www.earthtrends.wri.org Approximate distance taken from various sources

interact with the stevedores, service industries, vendors and uniformed staff that people the Ports and the surrounding areas.

The fluid nature of Ports and Port communities presents a potentially high risk environment for the propagation of HIV and other STI transmission. A high proportion of the people frequenting the Ports are mobile and away from home for long periods of time; the economic relationship between residents in the area and the salaried and mobile workers is often unequal; opportunities for transactional sex are frequent; and access to health services may be limited. These are common characteristics of Ports in Southern Africa.

The Port of Beira study presented in this report, is part of a SADC initiative to study the risk factors for HIV and STIs in four Southern African ports, namely Walvis Bay in Namibia, Durban in South Africa, Dar es Salaam in Tanzania and Beira in Mozambique.

The Port of Beira has expanded in recent years due to the extractive industries in the central province of Tete and the expansion of the sugar industry in the province of Sofala. With the economies of Zambia and Zimbabwe stabilising the traffic through the Port of Beira has steadily increased.

The city of Beira has a long history of immigration and mobile populations, and the expected expansion of the Port will bring increased prosperity to the area. However, with the advent of the AIDS epidemic in the late 1980s, Beira also became one of the cities with the highest prevalence rates in the country, presenting a potential risk factor to both mobile and resident populations in the area. The 'Spaces of Vulnerability' research took place in the city of Beira, more specifically in the environs of the Port of Beira. The research used a mixed-method approach² to carry out an in-depth analysis of the vulnerability to HIV and AIDS of the population that is linked to the Port of Beira, either through residency or livelihood, and discuss practical ways to reduce risk and increase the resilience of these populations.

The study intends to provide evidence that will improve HIV programming, both in terms of treatment and prevention related to the populations using the social and economic 'space' of the Ports as reference.

1.2 Justification for study

In line with the SADC concern to map more thoroughly the knowledge, attitudes and practices of mobile and migrant populations in four key Ports in region³, the study in the Port of Beira will add to the knowledge of the SADC states about the potential for

² Both quantitative and qualitative research instruments were used

improvements in HIV and AIDS programming, and lead to policies and programmes that reduce the transmission of HIV and other STIs in these geographical spaces. The study is being undertaken in line with the main focus areas of SADC HIV and AIDS social and behavioural research (SADC, 2009).

A study carried in Mozambique under the auspices of IOM in Mozambique (Paul, 2010) found that there was a need for: structural measures to address job security, contracts and income generation for port-users; support for risk behaviour change, activities to include life skills and recreational activities for port-users and their families; targeted campaigns to address specific risk points for port-users, sex workers and families; increase the availability of HIV testing and counselling; promote the consistent use of condoms and the reduction of sexual partners. The study also drew attention to the importance of the Public-Private Partnership (PPP) campaign that was documented in the Port of Beira. The study concluded that more detailed work was necessary in the Ports to further contextualise the findings. The United Nations (UN) partners in Mozambique endorsed the findings and in the City of Beira the AIDS council began lobbying the provincial and city governments for additional resources to further investigate the situation in the Port of Beira. As a follow up to that study and in line with SADC priorities, the current study was undertaken. The study aims to examine in more detail the situation of key sets of workers in and around the Port of Beira, with a view to contributing to SADC policy on health provision for mobile populations and the government of Mozambique's HIV programming in the central province of Beira.

1.3. Objective of the study

The objective of the study is to investigate the risk factors for HIV and STIs in the mobile and resident populations that work in and around the Port of Beira in Mozambique. Specifically the study wanted to:

1. Understand the socio-economic dynamics of the migrant and resident population in the area of the Port.
2. Understand the sexual networks between the seafaring personnel, the truck drivers, the port and railway staff, sex workers and the resident population.
3. Evaluate the sexual risk behaviour of the populations using the Port of Beira.
4. Evaluate the level of concurrency in terms of sexual partnerships in and around the Port of Beira.

5. Evaluate the nature of transactional sex in the port communities, specifically, obtain information about the sex workers and their clients, the age group and the origin, motivation, and the use of health services.
6. Evaluate the utilisation and access to the health services of the populations using the Port of Beira.
7. Map the social services and health services used by the migrant and sedentary populations in the environs of the Port.

1.4. Framework of the research

The research is based on the premise that the Port of Beira and its vicinities represent a 'space of vulnerability' as defined by the International Organization of Migration (see box 1 below).

Figure 1: Spaces of vulnerability

Spaces of vulnerability

In order to work with HIV prevention in spaces of vulnerability there must be an understanding of the way in which both mobile and migrant populations interact with local communities. This should include understanding the relationship between sex workers and other potential sexual partners and the mobile and migrant populations. Spaces of vulnerability imply areas of high risk, conducive to multiple concurrent partnerships and higher risk sex due to economic, social and cultural factors.

Adapted from IOM documentation on 'spaces of vulnerability'

The study has a component of regional coordination between the four ports of Walvis Bay (Namibia), Durban (South Africa), Dar es Salaam (Tanzania) and Beira (Mozambique). Information collected in each of the ports will be harmonised in order to compare the ports and the design of common strategies and policy frameworks for action in the SADC region. Each country selected the port to be studied, taking into consideration the strategic interests of the country and the national HIV and AIDS plans. Each port has a specific set of socio-cultural and economic circumstances, and the research protocols were adapted to match the situations encountered in each of the area. The protocol for the Port of Beira research was presented to the Bio Ethical Committee of the Ministry of Health, and approval was granted for the study to take place. The research team worked in strict coordination with the National AIDS Council, the Provincial AIDS Council, the Port

Authorities and the Provincial Health Directorate in Sofala.

The study is consisted of:

- A mapping exercise (GIS) to determine the physical presence of the health and social services related to STIs and HIV/AIDS, as well as mapping the leisure areas near the port frequented by port users.
- A two parts study of knowledge, attitudes and practice. The first part is a quantitative study involving purposive sampling of the main target groups of the research, namely truck drivers, seafaring personnel, port and railway workers, workers in the leisure services in the area of the port, and sex workers. The second part is a quantitative survey involving to collect detailed information about sexual behaviour, and access to and use of health and social services. The qualitative research was carried out among the same groups targeted under the quantitative survey.

The study does not present a representative sample of the population of the City of Beira or the neighbourhood of Munhava. The sample is representative of the occupational groups that are the main users of the Port of Beira³.

The information gathered and analysed during this process will be used to develop policies and programmes relevant to the Port of Beira. It will also be used to develop a strategy for this ‘vulnerable space’ in terms of reducing the risk of transmission of HIV and other STIs.

1.5. Mixed methodology

The study used a mixed methodology using both quantitative and qualitative survey instruments and GIS mapping of key coordinates. The quantitative survey instrument was harmonised for the four port surveys, translated and pretested in Mozambique. Qualitative key topic guides for in-depth interviews with groups of adults working and living in the vicinity of the Port of Beira were developed and adapted in each of the countries. The survey instruments were based on instruments used in the region to study mobile and resident populations on major transport corridors. One can find survey instruments in Annexure 1. The primary research was supported by a literature review of relevant studies, policies and programmes in the country and the region. It was also supported by a formative study preceding the finalisation of the survey instruments.

³ Standardised in the study protocol and confirmed during the formative study phase of the research

The aim of the surveys is to provide a snap shot of the sexual and health seeking behaviour of specific groups living and working in this 'space of vulnerability'. The data does not pretend to be representative of the population of the city of Beira or to have wider extrapolation to other urban areas or ports. The data from the quantitative survey is descriptive in nature. The sample was purposive and no control groups were used.

Selection of respondents within occupational groups used a variety of techniques to ensure that the sample was representative of the group in question. In the case of port and railway workers listings were used to randomise the selection. In the case of the leisure industry workers all establishments in the environs of the port were visited and interviews carried out with staff. However, in the case of the sex workers and truck drivers this was not possible. Respondent driven sampling (RDS) or the snowball technique was used to identify sex workers willing to talk to the enumerators, after identifying key areas for sex work and working with civil society organisations engaging with the women. Due to the fluid nature of the truck drivers it was not possible to have listings and respondents were selected randomly in the parking areas. Randomisation was achieved through the selection process whereby in each of the parking areas the enumerators randomly selected a starting point for the survey work and requested every other driver for an interview. If the driver refused they passed directly on to the next truck. When they reached the end of the line of the parked trucks they reversed directions in the next line. When the trucks were organised in single line queues the enumerators proceeded to the end of the line of the queue and began to interview every other driver. If the driver refused they moved to the next truck and requested an interview. The enumerators worked for a period of ten days with each of the occupational groups. They took GIS coordinates of bars and restaurants, sex worker hot-spots, truck stop, and health facilities in the environs of the Port of Beira.

1.6. Training, enumeration and in-depth interviews

Quantitative survey

A total of twelve enumerators were trained for four days plus a one day field trial with corrections carried out jointly immediately following the trial. The enumerators were drawn from the community based organisations working in the area⁵. All the enumerators had previous survey experience and were familiar with the survey area. This was seen as particularly important given the level of insecurity in the neighbourhood and the sensitive nature of the questions. The team was supervised by the head of the monitoring and evaluation team of the Beira AIDS Council.

- Interviews with stevedores and railway/port workers were organised by Cornelder⁴ and the Railway and Port Company (CFM) respectively. The list of people to be interviewed was randomly selected from roster lists (in the case of stevedores) and staff lists (in the case of railway and port workers). All interviews were voluntary. There were no refusals to interview among the stevedores and the railway/port workers. The survey took place over a period of ten days.
- The interviews with truck drivers were carried out in the truck parks of Ceramics (just outside the city), Nhaizua – EMAP (entrance to the Port), and Toyota (within the city limits). The enumerators approached the trucks systematically interviewing the drivers who agreed to be interviewed. There were numerous refusals to participate in the survey due to time constraints (the drivers have to maintain their place in the queue for entering the port) and survey fatigue. The survey took place over a period of ten days.
- The interviews with the sex workers were carried out by approaching known sex workers⁵, interviewing and requesting a referral to another sex worker (RDS or snowball method). The sex workers were generally cooperative. However, some of the interviews were cut short as they had to return to work when clients arrived. The survey took place over a period of ten days.
- Interviews with bar and restaurant staff (Munhava). These interviews were carried out systematically over a period of ten days interviewing at least one staff member in each of the small bars and restaurants on the edge of the Munhava neighbourhood. The enumerators visited each bar and restaurant, and randomly selected a member of staff to be interviewed. Although the enumerators did not have many refusals they did have to return numerous times to complete the interviews. The survey took place over a period of ten days.
- The enumerators worked in pairs due to security concerns. The pairs that were interviewing truck drivers and sex workers encountered more difficulties in terms of cooperation. There were approximately 10% refusal to interview overall, and a proportion of the interviews were incomplete resulting in missing values in the survey forms.

Qualitative Study

The qualitative interviews were carried out by two experienced qualitative researchers who have worked on two previous corridor studies⁶. Interviews with NGOs, Cornelder and CFM were arranged through the AIDS Council in Beira. Sex worker interviews were

⁴ Mozambican and Dutch Company contracted to manage the Port of Beira cargo handling .

⁵ The NGOs work with the sex workers in the area.

⁶ Nacala Corridor Study and Maputo –Swaziland Corridor Study (2011)

self-arranged by meeting women in the main areas where sex workers gather in the city. RDS (snowball method) was used to gain access to the subsequent sex workers. The researchers worked with Mozambican and Zimbabwean sex workers. They worked with the bar and guesthouse employees in Munhava during the day but were unable to work in the evenings due to insecurity. They did not face difficulties in obtaining interviews in the community. There were more difficulties in obtaining in-depth interviews with stevedores and railway workers due to time constraints (they work long hard shifts and are reluctant to spend more time on the docks). Truck drivers were interviewed in the truck stops of Ceramics, Nhaizua – EMAP (entrance to the Port), and Toyota or at the Safe Stop Retreat run by the community based organisation Kufunana. Key informant interviews were held with health staff in the clinics in the area of the port, uniformed public sector workers in the port and members of NGOs and community based organisations working with port users.

1.7. Sample framework for the study

The following sampling framework was used for the quantitative study, drawing samples from each of the sub-groups in the study protocol. Due to restrictions in terms of budget, each group has a Confidence Interval of 0.1 and a level of confidence of 95% for the sub-sample.

The quantitative study¹⁰ covered the following groups:

- Port workers, including seafaring personnel
- Long distance truck drivers
- Sex workers
- Bar and restaurant workers

Table 1: Description of quantitative sample size and methodology

Target group	Planned sample by group	Actual respondent numbers	Est population. Confidence level (CL) and Confidence interval (CI) & probability
Port workers (seafaring staff, stevedores, railway staff, public sector workers)	Sample size 95	Respondents 99	Population. 5000/month CL 95% CI 0.1 Probability: 0.5
Long distance truck drivers	Sample size 96	Respondents 99	Population: 18.000/month CL 95% CI 0.1 Probability: 0.5
Sex workers	Sample size 35	Respondents 32	Population: no estimate CL 95% CI 0.1 Probability: 0.5
Restaurant and bar workers	Sample size 70	Respondents 77	Population: no estimate CL 95% CI 0.1 Probability: 0.5
Total	296	322	

During the qualitative study respondents from the following occupational groups were interviewed.

- Port workers, including seafaring personnel
- Long distance truck drivers
- Sex workers
- Bar and restaurant workers
- Migrant workers
- Health workers and workers in the NGOs
- Public sector workers linked to the Port

The sampling for the qualitative research was as follows:

Port workers, including seafaring personnel

Interviews were requested with the port workers through the respective employers (CFM and Cornelder). The researchers were provided with lists of employees and randomly selected names from the list for in-depth interviews. The interviewees were requested

by their employees to make themselves available for the interviews. Some difficulties were experienced with workers not willing to complete the interviews due to the time constraints.

Long distance truck drivers

Interviews were carried out in the parks and queues with the truck drivers. The sampling strategy was to request the time of the drivers who were waiting in their trucks or nearby bars and restaurants. There were refusals due to time constraints and survey fatigue, but the researchers were flexible, often returning after a number of hours to complete interviews (after the drivers had eaten, rested or carried out their paper work).

Sex workers

Sex workers were identified either through the community based organisations working in the area or in the locations where women wait for clients. The majority of the women were willing to speak to the interviewers. This was true for both the Mozambican and Zimbabwean sex workers. There were time constraints and some interviews were interrupted as the women needed to work.

Leisure industry workers (bar and restaurant)

The researchers visited the bars and restaurants in the Munhava area and interviewed staff members who were willing to spend their time with the researchers. The interviews were carried out during the day. The researchers could not work late at night due to the insecurity in the area.

Health workers and workers in the NGOs

Interviews were held with health workers in the clinics in the port area. The interviews were approved by the City health authorities and the directors of the health centres. Interviews were also held with nurses and technical staff who provide services in the area of mother and child health care, infection diseases and HIV.

Public sector workers linked to the port

Policemen and port officials were interviewed in their place of work. The interviews were approved by the command structure of the public sector employees.

Seafaring personnel

Foreign sailors were interviewed in the bars and restaurants near the port. The national sailors were interviewed in the bunk used for lay over as they waited to pilot ships into the port. No interviews with foreign sailors were possible due to access problems. They spend a short time on shore and it was not possible to contact the captains of the ships to arrange the interviews.

Table 2: Qualitative sample framework

Stakeholder	Individual interview and key informant interviews	Focus group
Port workers	2 focus points from Cornelder and CFM	Stevedores and CFM workers and sailors
Sex workers	12 in-depth interviews	2 focus groups with the NGO (FHI 360) working with the sex workers
Seafaring staff	4 interviews with national sailors	
Long distance truck drivers	10 in depth interviews with truck drivers	
Health personnel and NGO personnel	5 interviews with health personnel (KII) 8 interviews with NGO staff	4 focus groups with NGOs that work in the environs of the port
Leisure industry workers	5 interviews	
Public sector workers	5 interviews with police, immigration officers, customs officers, etc (KII)	
Total	55 interviews	

The authors of the report consider that the findings presented in the report represent key occupational groups interacting with the Port of Beira. The sample population is not representative of the population of the city of Beira, but represents the population who directly interact with the Port. This includes both residents of the City of Beira and mobile populations working in and around the Port of Beira. The findings from the quantitative survey were triangulated with the findings from the qualitative in-depth interviews. The mixed methodology increased the strength of the findings given that the work aimed to reach sub-groups that are generally difficult to access, discussing questions that are sensitive.

1.8. Data analysis

The data from the quantitative survey was analysed using SPSS. The data provides a descriptive analysis of the knowledge, attitudes and practice of specific population groups earning their living in connection with the Port of Beira. The data was analysed by questionnaire module. The data collected during the in-depth interviews was collated in thematic areas by respondent group. The thematic areas corresponded with the modules in the quantitative survey.

1.9. Limitations

Working in and around the Port of Beira. The neighbourhood of Munhava (abutting the gates of the Port of Beira) is a dangerous place for researchers after dark. Due to security concerns there was limited time available for interviews of the more difficult to reach groups, namely sex workers and workers in the bars and restaurants.

Limitations of the quantitative survey instruments. The enumerators found difficulties in obtaining clear and precise information using the closed questions in the quantitative survey. Due to the length of the survey instrument some of the interviews were not completed as the respondents did not want to spend over 60 minutes with the enumerators. Potential data gaps were partially overcome through the in-depth interviews that investigated the topics covered in the quantitative questionnaire and the information obtained was used to triangulate information from the quantitative survey.

The omission of male youth from the targeted respondent groups was, in hindsight, a missed opportunity to gain in-sight into the lives of this group in the area. A number of observations were made by the qualitative researchers but no in-depth interviews were carried out with this group.

CHAPTER 2

MOBILITY, HIV AND HEALTH CARE

2.1. Mobility in the SADC region

Historically the Southern African region has seen large migratory movements due to natural disasters, political persecution, civil conflict and economic factors. During the colonial period (forced) movements of men across the region provided labour for the extractive industries in South Africa, Zimbabwe (formerly Rhodesia) and Zambia, and wealth for the colonial governments. Agricultural workers also migrated throughout the region developing sugar and coconut and sisal plantations in Mozambique, Zimbabwe and South Africa. The independence struggles, including the struggle against apartheid in South Africa, and civil wars resulted in millions of people becoming internally displaced or refugees in neighbouring countries.

Although the region is largely peaceful, the movement of people between and across countries is still a distinct characteristic of the development in Southern Africa. Given the dynamic nature of the economies in the region, population mobility will continue to be a reality as the pull factors of migration take rural households towards the cities, and the burgeoning economies mean increased transportation of goods and services across borders. The promulgation of the Free Trade Area Protocol in 2008 and the Protocol on the Facilitation of the Movement of Persons have further encouraged movement across borders. Although civil conflict is now less of an issue than in the previous decades⁷, the geographical position of countries⁸, uneven economic development, high levels of poverty, and deep seated traditions of migrant labour⁹, will ensure that people and goods continue to flow through the countries in the region (Crush, 2005).

The face of migration is changing with considerable emigration of skilled health staff seeking improved working conditions. Thus, further weakening national health system in many countries; increased travel for reasons other than work (tourism, seeking health

⁷ Independence struggles (Zimbabwe, Mozambique, Namibia), the struggle against apartheid (South Africa) and post-independence conflicts (Zimbabwe and Mozambique).

⁸ Mozambique, Tanzania, South Africa and Namibia serve as access to the oceans for the countries of the hinterland.

⁹ Countries such as Mozambique, Malawi and Zimbabwe have long been the source of migrant labour for the mining industry in South Africa. Now with the development of the extractive industry sector in Mozambique and Tanzania labour migration to these countries is increasing.

care); and finally improved transport links (and less restrictive contracts) mean that migrant workers and mobile populations tend to go home more often (or receive visits from family members).¹⁰

Mobility and migration are not in and of themselves negative phenomena and provide the motor for development and social cohesion across the region. However, the Southern African Development Community (SADC) has long recognised the various challenges facing the countries of the region in terms of meeting the health needs of these populations and the control of communicable diseases is the main priority. HIV, TB and malaria are the greatest causes of morbidity and mortality in the region (SADC, 2009). Generally, weak public health care systems and the high population prevalence with these communicable diseases mean that, without targeted programming, there is potential for undermining efforts to control communicable diseases in countries across the region.

SADC has prepared a policy to address these issues (SADC, 2009). The main policy areas identified in the framework include: developing regional harmonisation and coordination of communicable disease control protocols; ensuring the equitable access to health services by cross-border mobile populations; coordinating regional public health surveillance and epidemic preparedness; producing information, education and health promotion messaging for mobile populations; commissioning operational research and dissemination of strategic information; and developing legal, regulatory and administrative reforms (SADC, 2009).

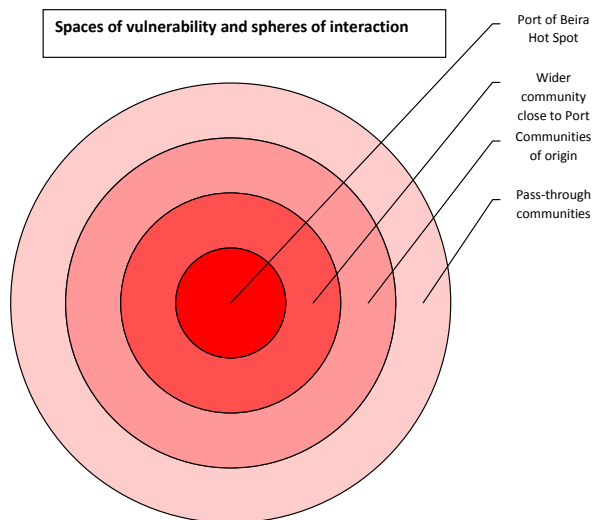
In a regional review undertaken by IOM (IOM, 2010) the report concludes that the most effective intervention to reduce HIV vulnerability of migrant workers and mobile populations is to develop 'space of vulnerability programming', rather than focusing on particular at risk groups. This entails attention given to service delivery and capacity of the health systems and health workers; advocacy and policy making (national and regional levels); research and evidence building and dissemination; within a geographical space or a series of inter-linked geographical spaces. Vulnerable space programming around HIV and AIDS explicitly recognises the sexual interaction between mobile populations and host communities and the potential for stress to be placed on weak public health care systems in those host communities.





¹⁰ For example in Southern Mozambique in the past miners would have 12 month contract with no home leave. They would return home at the end of the year. The miners are now allowed to travel freely and often return home for public holidays. Also wives and partners of the miners are more likely to visit their husbands in South Africa. Previously this was unheard of.

'IOM's approach to migration health considers the different health and HIV vulnerabilities associated with the migration process rather than considering the migrant as the health vulnerability. By identifying spaces of vulnerability, which are often places where migrant workers live, work or pass through as areas of high-risk HIV vulnerability'

Vulnerable space programming in this context aims to develop holistic plans to reduce risk taking behaviour and boost access to and use of adequate health services by mobile populations and host communities alike. Therefore, good programming using this concept would not limit action to a single geographical location but rather anchor programming in 'hot spot' (starting point) with activities radiating out to encompass all the geographical spheres of interaction.

Figure 2: Spaces of vulnerability and spheres of interaction



Colour code	Description
	Hot spot – A source of high concentration of interaction between mobile and resident populations. It is characterised by largely opportunistic, casual and transactional sexual relations.
	Wider community close to the hot spot – A source of the majority of people interacting with the 'hot-spot' working population. It is characterised by both opportunistic sexual relations (hot spot) and stable partnerships (areas of residence).
	Communities of origin – A source of the mobile populations. It is characterised by mobile populations returning periodically to stable partnerships (but not exclusive sexual relationships).
	Pass through communities – A source of communities where the mobile populations stay for short period of time (often on a regular basis). They are characterised by opportunistic or stable non-exclusive sexual relationships.

The approach taken in the Port of Beira research is premised on the ‘spaces of vulnerability’ concept and investigates the nature of interaction of the people in the different occupational groups. Also, it discusses potential impact on increased HIV transmission.

2.2. History of the HIV epidemic in Mozambique

2.2.1. Health care in Mozambique and HIV programming in Mozambique

Health statistics reveal that Mozambique continues to struggle with providing adequate care to the population of over 20 000 000 people. Only 6.6% of GDP is dedicated to the health centre, accounting for 7.7% of government expenditure in 2013. The ratio of trained health attendant to population is three medical doctors and 34 nurses per 100 000 people (WHO, 2008). Inadequately equipped and provisioned health facilities cannot meet the health care demands of the population. Although Mozambique has a nationwide public health care system that offers free services for children under age of five years, pregnant and lactating mothers (antenatal, birth and after car), the elderly (over 55 years of age for women and over 60 for men), patients with HIV, TB and sexually transmitted diseases, the lack of human resources and funds limits the quality of the service offered. Prescription charges are nominal (1 mt) for medicine from the public sector outlets. However, in the majority of the public sector pharmacies drugs are in short supply, and in the private sector pharmacies the medicines are expensive.

Figure 3: Key health and welfare indicators

Life expectancy at birth (2012)	54 (female) 53 (male)
Neonatal mortality per 1000 live births (2012)	30
Under 5 years of age mortality per 1000 live births (2012)	90
Maternal mortality per 100 000 live births (2010)	490
% births attended by skilled birth attendants (2011)	54.3%
Density of doctors per 1000 population (2008)	0.03
Density of nurses and midwives per 1000 population (2008)	0.34
Poverty headcount ratio at 1.25 USD a day (%pop) (2008)	59.6
Human development index ranking out of 186 countries (2012)	185

Mozambique continues to have one of the highest HIV prevalence rates in the world with 11.5% of the adult population infected with the virus (Ministry of Health, 2009). Women have higher prevalence rates, currently over 13% and people living in the urban areas have higher prevalence rates than those in the rural areas, 15.9% and 9% respectively. Young women, particularly in the Sofala and Gaza provinces, are disproportionately affected at rates five and six times higher in comparison to men. Less than half of HIV

positive people are currently in ART programmes, and there are considerable challenges to maintain regular adherence to the treatment regime of those already on ART (Ministry of Health, 2009).

The Northern province has historically been more isolated and has the lowest prevalence rate (6%) whereas the Southern provinces with the highest levels of migrant and mobile populations has the highest levels (18%). The central provinces that are fed by transport corridors and have multiple borders with Zimbabwe, Zambia and Malawi have a prevalence rate of 12%.

Figure 4: HIV key events timeline

Key Events Timeline

The early years

- 1986 The first recorded case of HIV
- Late 1980s to 2000. Management of opportunistic infections
Development of home-based care networks
Prevention programmes (A.B.C.)
Treatment pilots (operational research)

Prevention and treatment

- 2001 One million people identified as living with HIV
- 2004 Roll out of the nationwide ART programme (free), including PMTC
- 2006 Opting out protocol adopted for pregnant women (replacing voluntary testing for pregnant women)

Recent developments

- 2009 11.9% prevalence of Mozambican adults aged 15–49 years
13.1% prevalence of Mozambican women aged 15–49 years
- 2012 – 2013 Accelerated response. Partner testing and treatment as prevention
Option B+ (PMTCT increase from 15% in 2012 to 41% in 2013)
Community adhesion support groups – GAAC

The main drivers of the epidemic in Mozambique include: high risk sexual behaviours (multiple concurrent partnerships and inconsistent condom use); low rates of male circumcision; mobility and migration of the adult population; early sexual debut for girls; and cultural factors that reduce women's control and choice over their sexuality thereby increasing the transmission rates for young girls and women. The inability of the Ministry of Health to increase the coverage of effective ART is a key factor in the continued high levels of new infections and prevalence rates.

The Centre for Diseases Control and Prevention (CDC), in coordination with the Ministry of Health, carried out the research "International rapid assessment, response and evaluation – I-RARE" (Ministry of Health & CDC, 2009) 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 (only 24% of all interviewed) the positive results for HIV were as follows: sex workers, 48% (30/63); drug users, 43% (13/30); sex workers clients, 24% (5/26). CDC extrapolated these figures for national estimates by running the HIV modes of transmission models.

It was estimated that about 2% of all new infections have occurred among sex workers and about 7% among their clients. It was also estimated that sex workers, their clients, and their partners are responsible for about 19% of the new infections. There are no similar studies to estimate the source of the remaining four fifths of the new infections.

Ministry of Health (MoH) epidemiologic surveillance data show that the highest prevalence rates occur along the transport corridors, suggesting that mobile populations are at high risk (CDC, 2009) but there is no data about the transmission patterns.

In a report commissioned by IOM to discuss the impact of the extractive industries on HIV transmission (Bennett, 2013), the author postulates that the level of mobility within regions in Mozambique is one of the drivers of the incidence of new infections. This is caused by mobile populations that interact with wider partner pools, thus exponentially increasing the risk of transmission. Qualitative research carried out on the transport corridors in the north and south of Mozambique indicates that multiple concurrent sexual relationships coupled with inconsistent condom use among mobile and resident populations fuels the HIV prevalence rates (Selvester 2011/ 1 & Selvester 2001/2).

It is clear from these reports that it is the sexual behaviour of people within a high risk setting is relevant. The velocity and number of sexual relations, inconsistent condom use, and the high levels of multiple concurrency means all groups interacting in the 'spaces of vulnerability' are at risk of HIV transmission.

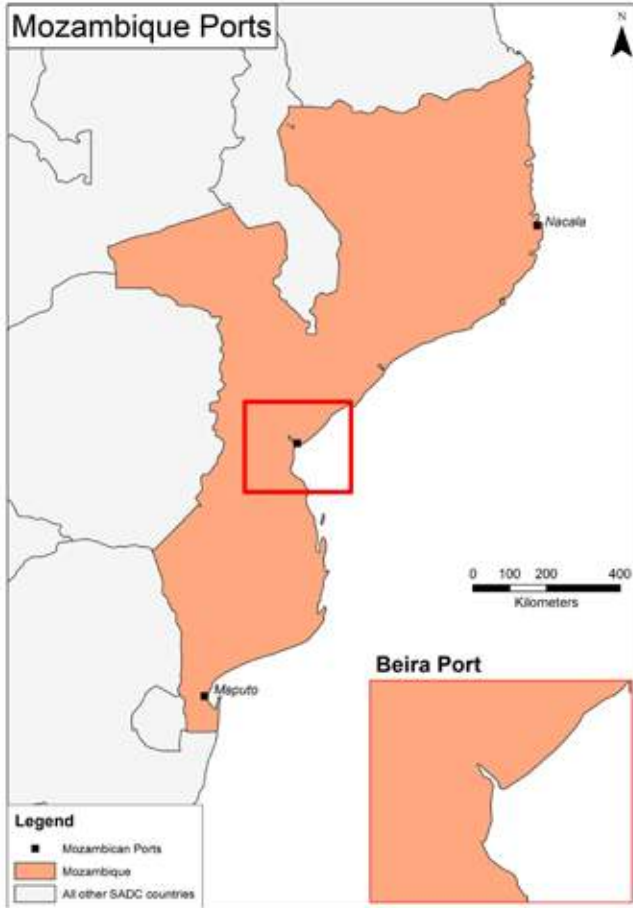
2.3. Beira city and health care access and provision

Beira city, in the central province of Sofala, is the second largest city in Mozambique, with a population of 457 799 people. The city is divided into 26 residential neighbourhoods (bairros). Although the majority of the local population in Beira speaks either Ndaou or Sena, due to the nature of the main commerce in the city (the port) there is a wide range of nationalities and ethnicities living and working in the city. In addition the lingua franca is either Portuguese or a Creole of local languages of the central region mixed with English¹¹.

Beira is a coastal city, set on the Indian Ocean, with a deep water port, railway and road connections to the hinterland. The city includes the interior of the country, as well as neighbouring land-locked countries of Zimbabwe, Zambia and Malawi. This city is slightly below sea level and has serious sea erosion, drainage and flooding problems, leading to water and sanitation problems that affect the health of the population.

¹¹ The local languages in the central region of the country and the neighbouring countries of Malawi, Zimbabwe and Zambia have similar linguistic roots.

Map 2: The Port of Beira, Sofala Province



The city of Beira has 14 health centres¹² and a Central Hospital in the public sector. There is also a Military Hospital in the city that is open to the public via referrals¹³. There are a number of private health care clinics that provide care through work place policies and fee paying patients. The public sector facilities provide care to the vast majority of people in the City of Beira. Private health insurance coverage is low and the cost of consultation and treatment in the private facilities is high. Companies such as CFM and Cornelder provide private health care coverage for a limited number of their personnel. Seafaring

¹² The official 2008 statistics from the National Institute of Statistics states that Beira has 1 central hospital and 11 health centres. However, the municipal government built 3 new health centres inaugurated in 2013.

¹³ The Military Hospital is hosting the main circumcision programme in the city of Beira.

personnel have access to private health care through company health care schemes. There are no formal restrictions for migrant workers or mobile population to use the public health system as there is no national registration system to control the nationality or place of origin of the users.

Health care for HIV, STIs, TB, antenatal and post-partum care, and family planning are all free services in the public sector health facilities. In order to benefit from free antiretroviral (ART) and tuberculosis (TB) treatments, a patient needs to reside in the catchment area of the health facility. Residential details and telephone numbers are taken in order to improve follow-up through programmes that seek to improve adherence rates for both ART and TB programmes. However, there are no national databases that can match personal data and residency information.

All the public sector health facilities in the City of Beira provide counseling, testing, and ARV and TB treatments. All health facilities provide antenatal and post-partum prevention of mother to child transmission programmes (PMTCT). Health facilities offer adolescent friendly health services, with free family planning, HIV counselling and testing and treatment of STIs. In the past Beira offered a night clinic to attend to the needs of night workers, including sex workers. However, this service was suspended due to lack of funds in the health budget.

Although the above mentioned services are free and available in the City of Beira, there are supply constraints in terms of the number of qualified staff in the health facilities, and the constant cuts in the supply of essential drugs. The public health system is currently (as in 2014) suffering from breaks in the pipeline for ARVs, leading to national shortages in the health centres. Although this situation is critically affecting rural health centres, restrictions have been placed in Beira, where patients reported receiving one 15-day supply of drugs, rather than a month supply when visiting the treatment centres.

Mozambique has introduced the WHO recommended plan B+ treatment regime for HIV positive pregnant women, that would provide them with life-long ARV drugs¹⁴. The introduction of the protocol is currently not viable due to the drug shortage in the system.

The main problems cited by health staff regarding the HIV and STI related programming are: drug shortages; adherence problems for patients on ARVs; late presentation for HIV testing resulting in delay administering ART as opportunistic infections require urgent treatment (esp. TB and malaria); and partners (men) not appearing for testing after

¹⁴ Option B+, in which all pregnant women living with HIV are offered life-long ART, regardless of their CD4 count that WHO and UNICEF recommended.

identification of HIV status of pregnant women. Patients refer to problems of patient confidentiality, long waiting times, poor quality attendance by staff and drug shortages.

Malaria is endemic in the City of Beira. The poor sanitation and water logged nature of the neighbourhood means that danger of malaria is high and this coupled with the high prevalence of HIV results in significant levels of ill health for people living with HIV in the city. When there is a HIV and malaria co-infection, there is a high risk of complications, in particular anemia. A recent study showed that severe malaria was more common in HIV-positive patients. However, it was found that in patients treated with CTX prophylaxis, malaria infection was rare. There was no independent anti-malarial effect for patients treated with non-nucleoside reverse-transcriptase inhibitors (NNRTIs) (Nacarapa, 2013).

The health system aspires to integrating HIV and tuberculosis treatments due to the strong correlation found between the two infectious diseases. Tuberculosis is prevalent in Beira; the treatment is free and restricted to the public health system. According to a post- doctoral study carried out by the Nossal Institute for Global Health in 2011 (Saifodine, 2011), the TB control programme in Beira city is strong and well organised and has been successful in treating patients. The study highlights problems in delays in patients presenting with symptoms and the inadequate diagnostic services at the primary health care level.

2.4. HIV prevalence and programming in Beira city

There are no population HIV prevalence rates for the City of Beira but the statistics from the sentinel site health centres in the city, show rates of 34% for pregnant women attending antenatal clinics (City Health Department (SDSMAS), 2013). In addition, there is partial, indicative information from the campaigns for HIV and STI testing held by the Port Authorities handling company, Cornelder, and the city health department since 2008. Infection rates of the Cornelder workers and their female family members ranged from a low 7.8% for workers (largely male) in 2013 to a high of 25% of female family members in the same year (see figure 1 below). It is not possible to draw conclusions in terms of population tendencies from the statistics below due to biased and limited sampling frame. However, it is possible to indicate that there are high levels of HIV infection in the people working for CCM and Cornelder in the Port of Beira.

Figure 5: Information from Cornelder and the City Health Department

2008	19% workers	25% female family members
2009	17.5% workers	20% female family members
2012	13% workers	19.3% female family members

Source. Cornelder. Register of HIV activities. 2013

2.4.1. Port of Beira

Map 3: Beira Port and Munhava neighbourhood



The Port of Beira has a long and interesting history, with the first channel buoys placed in 1889 to mark the entrance to the Port on the Pungue River estuary. Access to the port is obtained through the Macuti Channel (17n.miles from the Macuti lighthouse). Dredging of the channel is necessary to maintain a depth of 8 to 12 metres. A comprehensive dredging exercise was completed in 2011, with EU funding support. An east–west railway was built that carried both passengers and cargo from Zambia and Zimbabwe (formerly Rhodesia). The railway also served the national sugar estates and Malawi (formerly Nyasaland).

The economy of the Port of Beira mirrors the turbulent history of political and civil conflict in the Southern African region. It was affected by the Rhodesian UDI (unilateral declaration of independence) in 1965, the Mozambican civil war from the late 1970s to 1992, and the economic collapse of Zimbabwe in the 1990s. Business dried up and

communication routes were disrupted in each of these periods. However, from the late 1990s to early 2000s considerable investment was made in the port and in 1998 a joint management venture was formed between Cornelder Holding, based in Rotterdam (67%) and the national company Mozambique Ports and Railways (CFM). Cornelder manages the multi-purpose container terminal and CFM controls the chemical and petroleum terminal. Cornelder maintains relations with a large number of stevedore companies and is responsible for the overall management of the container cargo.

As the second largest port in Mozambique, the Beira port handles 1.5 million tons of cargo per annum. The port has 11 berths and a pipeline that was constructed in the 1960s, transporting petroleum products to the hinterland. The port is linked to Zimbabwe and Zambia by rail, and Malawi by road. The Sena railway that previously served the sugar estates in Sofala and Zambezia province is once again operational and transports coal from the newly re-invested mines in the province of Tete. There is an additional berth that acts as a fishing harbour for local fishing trawlers. The port is open 24 hours a day although night navigation is restricted to vessels up to 7m draught and LOA of 140m. Pilotage and tug assistance is compulsory at all times, with pilots joining ships near P Buoy.

Beira has a geographical advantage in terms of both internal trade from the coal mines, and the potential for the agricultural sector¹⁵export, and imports for Mozambique and the African countries in the hinterland. Beira port is facing significantly increased activity due to the coal exportation and importing of equipment for the mining sector in Tete province, and the recovery of the sugar industry. Dredging of the channel was completed in 2011 and this increased potential traffic. However, there are efficiency problems that are currently limiting the potential. Currently dwell period is 18.25 days compared to 4 days in Durban. This is mainly caused by container problems and customs which use container space. The truck cycle time is better but still below international standards; truck cycle time is 4 hours in Beira against international standards of 1 hour.

Beira will soon exceed its terminal capacity. A study carried out in 2013 (Murithi, 2012), found that the port was operating at 91.8% efficiency, and would therefore soon reach capacity. There are plans to increase the capacity of the port by twenty-foot equivalent units (TEU) from 175 000 to 280 000 in 2015. There are other infrastructures planned for the port including new terminals, warehousing and quay expansion. This will impact on the neighbourhood of Munhava and is a key consideration in the municipal urban planning process.

¹⁵ (Murithi, 2012)

Mozambique has introduced changes in the customs clearance procedures, with the introduction of a single electronic window system (SEWS) for customs. This has improved clearance and turnaround time for the cargo in the Port of Beira; it now takes less than half a day and is competitive with the majority of East African ports (Murithi, 2012). It is interesting that the perception of the people working and living in the surrounding areas of the port is that the introduction of the SEWS has cut traffic as all traders have to be registered and fully tax compliant to use the port¹⁶. The perception lower traffic in and around the port may be due to cutting of illegal or irregular traffic that was previously using the port or that turnaround time is less so trucks are spending less time in the environs of the port.

One of the major bottlenecks is the arterial roads leading to the port; the quality of the roads is poor and there are serious maintenance problems. In addition, many of the trucks are over loaded causing additional maintenance problems for the road authorities. There is one main road leading into the port that passes close to the neighbourhood of Munhava where criminality is rife and loss of cargo and fuel are common.

'...as I sat in the project car at the traffic lights on the main roundabout leading to the Port of Beira, in Munhava, I observed two lads with an empty rice sack bending down at the side of a truck also waiting at the traffic lights. With practised movement the lads opened the fuel tank of the truck and began to cipher petrol in the sack. In the 20 seconds that the lights took to change they had filled the sack, slung it over their shoulder and disappeared into the labyrinth of alleys that make up the shanty town of Munhava. I turned to our driver, shocked and speechless, he shrugged and said this was a daily hazard for the truck drivers...' field notes from Beira Port Study.

There are major structural and administrative issues faced by the City of Beira, the host to the Port of Beira. Beira is a municipality and as such has administrative and financial autonomy within the Government of Mozambique to raise taxes (in some restricted areas) and manage service delivery. However, the City of Beira does not receive income tied to the revenue from the port or the railways. These entities are managed by Central Government and the City of Beira is awarded an amount annually as a contribution to the municipal budget. As pointed out by Maason in 2011:

'It seems, there are no institutional links between the Municipality of Beira and CFM. In a port city whereby the port business is the economic motor of the city this is strange. As can be derived from Plano Beira, the port business puts a significant claim on facilities (health,

¹⁶ Notes from field work in current study

HIV/AIDS) and infrastructure (land, roads, parking areas, etc) in town, yet at the same time there is no direct contribution (financial or otherwise) to the municipality.' (Maason, 2011)

The lack of direct fiscal ties with the port and the railways means that municipal negotiations with these entities is brokered through Central Government and not directly in the geographical space of Beira. As the port continues to expand, it will attract both formal and informal commerce to the area that will have to be managed by the municipal authorities.

2.5. The neighbourhood of Munhava

The Port of Beira and the densely populated neighbourhood of Munhava that abuts the gates of the port demonstrate all the characteristics of 'spaces of vulnerability'. In pre-colonial times Munhava was an informal settlement where people from the neighbouring provinces and districts lived illegally working to service the port or the residents of Beira city. Although attempts were made post-independence to urbanise the neighbourhood, Munhava continues to be disorganised, vibrant, with serious sanitation and basic services failures. There are many different ethnicities living in Munhava, attracted by the possibility of casual and permanent work in the port. Mozambican residents come from Manica and Tete province, as well as the interior of Sofala province looking for work. The foreign residents are generally from Zimbabwe or Malawi, although there may be Zambians who are resident in the area. In addition, there is a considerable volume of mobile populations passing through the area, in particular truck drivers/assistants and sailors, interacting daily with local residents. There is a large a number of bars, restaurants and places with rooms for hire in Munhava, frequented by the resident population, uniformed personnel from the port, the stevedores and the seafaring personnel.

The most active time in Munhava is between 18h00 and 22h00. Drugs and cheap alcohol are freely available from the stalls, bars and restaurants. The people working in the area stated that there was considerable insecurity in the zone due to the consumption of drugs and alcohol by youth in the area. There was also the lack of lighting and the instability of the resident population. Direct observation in the neighbourhood showed large groups of young men in various stages of intoxication at all times of the day. They range around the access road and perimeter fence of the port and are seen as a focus of insecurity in the zone.

2.6. Service provision in the area of the port

The port is an integral part of the City of Beira, and as such the port users have access to the city health facilities. However, the municipal council, civil society organisations and the private sector involved with the port recognise that there are specific issues relating to the high concentration of people, goods and services in the area that require attention.

The city health department worked closely with the Port Authorities, Cornelder and CFM in the 'Healthy Port' initiative, offering testing services and follow up in the neighbourhood's health centres. Cornelder is the management company for the Port of Beira and has an active HIV prevention programme. The programme is headed by the Director of Human Resources and run by the focal point for HIV in the company. The programme began in 2005 with talks on HIV to staff members and sub-contracting firms (stevedores), and peer education training for company employees. However, in 2006, given the fact that the sub-contracting firms did not have access to HIV services, Cornelder with the support from the German organisation, DED, it started working with the workers, wives and families of workers to improve access to testing and counseling services.

In 2007 they expanded the programme to all subcontracted firms. This started the initiative of the 'Healthy Port' (Porto Saudavel) and was co-financed by GTZ (German Cooperation – 40%) and Cornelder (60%). Testing was offered to families, sub-contracting firms, sailors, drivers and other workers. Due to a lack of adherence of other firms to the 'Porto Saudavel' initiative, Cornelder now works alone with the City Health Department to support the national health weeks twice a year and carry out annual campaigns for male circumcision in collaboration with the Military Hospital in Beira where the circumcision is performed. This programme is rolled out with the support of the non-government organisation PSI. PSI have also been working with the armed forces to improve testing rates and with a programme called '*100% Life*' for sex workers in the City of Beira (not specifically around the Port of Beira).

The Mozambican Railway Company (CFM) also has an active HIV prevention programme, with lecture and active peer education programme. CFM has a work place policy for staff members with HIV that includes: financial support and support with medical costs. CFM participates in the 'Healthy Port' initiative and the annual health fairs. CFM recognises the mobility of their workers as a risk factor, and has an active policy to try and keep families together by providing housing and financial support. However, they recognise that as children reach school going age it is more difficult for families to relocate every two or three years, and families may be forced to live separately, thus increasing the risk of concurrent sexual relations. CFM recognises that despite all of their efforts they

do not have a strong programme for the various types of workers that spend days away from home and are aiming to develop a more focused programme. At present there are condoms available in all bathrooms and on the trains; they provide safe accommodation in the train stations for staff who have to overnight (although many prefer to sleep in the cabs of the trains to save money); they also provide health care for all staff, encourage testing and adherence to antiretroviral treatment. The company has a strong non-discrimination policy in terms of people living with HIV and AIDS. They partner with PSI, Cornelder and the city health department in the HIV initiatives.

One of the coordinating bodies for the private and public sector initiatives is Eco Sida, a civil society association that works with the private sector on HIV and AIDS awareness and programming. Eco Sida works closely with the 'Porto Saudavel' programmes, together with Cornelder, CFM and the provincial AIDS council. The organisation is currently working with 156 firms. The package that they offer to the private sector firms consists of awareness raising, counseling and testing, support to develop work place policies and training of peer educators. Eco Sida is aware of the influx of foreign male workers who move towards the port looking for casual work, and female migrants involved in the sex trade. They work with these groups but are aware that their programmes do not adequately cover the specific needs of these populations as they operate largely in the informal sector and are therefore not covered by work place policies or peer education session. Eco Sida works with the FHI 360° project as part of the 'Partners competent in accessing health services' project. According to the project coordinator there are a number of key issues that need to be addressed urgently; low use of condoms among sexually active adults with concurrent relationships; the problems of accessing male circumcision due to the lack of facilities to carry out the procedure; and the lack of programmes specifically for migrant populations taking into consideration their particular vulnerabilities.

However, many of the people who test positive at work will follow up with clinics outside of the area and not in the neighbourhood clinics, making the triangulation of information on follow-up extremely difficult. In the past the city health department was able to run a night clinic in one of the health centres closest to the port – Health Centre Ponto Gea. However, there are no longer funds for this popular service. The health department works with the NGOs who are providing services close to the port, namely, Luz na Comunidade and Kufunana (NGO running the safe stop facility for truck drivers and assistants) and PSI. At present CDC is running a research exercise to measure the number of new infections in the city. Its results will be available in 2014 and will be used as references in the 'Spaces of Vulnerability' research. The lack of night or after-hours clinics restricts access of mobile populations (in particular truck drivers) to accessing health care.

There is a number of local NGOs working under the umbrella of a road and ports programme funded by USAID and implemented by FHI 360 that aim to tackle issues related to mobile populations and the residence populations interacting with these groups on the Beira transport corridor and the Port of Beira. The organisations work with previously identified groups that are considered to be high risk, namely truck drivers, sex workers, women with the low income working and/or residing in the area of the port, disaffected youth, and children in school (on the corridor of Beira).

- **Kufunana (Amar –se) – love yourself.** The association has a community level Resting Stop for truck drivers on a busy corner leading into the port. They offer billiards, soft drinks, talks, videos, and internet access. The Resting Stops also offers counseling and testing facilities. They have links with the health centres of Munhava and refer clients onto the health facilities if they are HIV positive or require treatment for STIs. One of the main concerns of the staff at Kufunana is the insecurity situation in the neighbourhood of Munhava due to the high levels of abuse of drugs and alcohol and criminality in the area. They stated that the main livelihoods for the youth in the area are selling alcohol, drugs, stealing from the trucks and the port and procuring women for the truck drivers. They stated that there are very few healthy opportunities for either leisure or work for the young people in the area.
- **AJULSID (Associação de Juventude na Luta Contra SIDA e DROGA) Youth Association for the Fight against Drugs and SIDA.** This association works specifically with youth, to fight against HIV and AIDS, drug and alcohol abuse. Amadeo Haje (project coordinator), echoed the concerns of Kufunana, and added that the youth most at risk are between 15-24 years old, due to the high levels of unemployment, lack of education and attractive and profitable illegal opportunities (sex trade, drugs and illegal alcohol sale and petty crime) in the area. At present the association is working with youth in schools along the Beira transport corridor using an interactive package called ‘Walk with Me’ based on live situations and debate. They have extended their work to prisons and technical schools using the same package of teaching materials.
- **VICED.** The association has two HIV projects at present. One with FHI 360° and the second with USAID to work in the schools with children to discuss abstinence, fidelity and use of condoms. With FHI 360° they are working along the Beira corridor with truck drivers and assistants, sex workers, youth that consume drugs and alcohol and petty traders (often a euphemism for sex workers). They work through peer educators, have film and theatre groups. They also distribute free condoms both male and female types.

- **Luz na comunidade – Light in the Community**¹⁷. The association works with lower income women’s groups in the neighbourhood of Munhava. They have 50 female peer educators of women traders and 578 sex work peer educators. Through their work with the sex workers they also interact with truck drivers (between 400 and 500 per month) referring them to the Community Stop run by Kufunana. They work on sensitisation about HIV, prevention, and condom distribution. They also have a rotating credit scheme with women in low income group. The association works with local health centres, the office for violence against women and the police, for cases of gender based violence.

It is interesting to note that although the FHI 360 programme has taken a *‘Most at Risks Population Approach (MARPS)’* the nature of the problem leads the different organisations to recognise the importance of integrated programming for the whole area; working with one or other groups in isolation in the ‘space’ (corridor or the port) will not be sufficient. For example, Kufanana who have a mandate to work with truck drivers, are concerned about the youth in the area as they see the issues that face the youth on a daily basis and how this affects the truck drivers. AJULSID working with school children recognises the need to work with truck drivers and out of school youth to reduce sexual abuse of minors and high levels of criminality.

AMODEFA (Association for the Development of the Family) is a Mozambican organisation that specialises in family planning, sex education and counseling, and HIV and AIDS, based on a belief in the right of all people to access family planning and counseling. In Beira, AMODEFA works with sex workers through peer educators, theatre groups, IEC materials and providing counseling and testing facilities. They work with women both in the city and close to the port. The sex workers range from 14 to 30 years old. One of the community theatre groups has worked extensively in the port area with the sex workers and youth groups. Many of the sex workers they work with are economic migrants from Zimbabwe and Malawi. One of the particular concerns of AMODEFA is the number of minors involved in the sex trade, increasing the vulnerability of these adolescent girls to HIV and other STIs.

2.7 Key occupational groups working in and around the Port of Beira

The study of the Port of Beira, using a ‘Space of Vulnerability’ construct will highlight the sexual practices, knowledge of HIV and other STIs and access to health care services by specific occupational groups that use and reside in the area of the port, namely truck drivers, port and railway workers, sex workers, workers in the leisure and recreational sector and seafaring personnel.

¹⁷ Meeting with Albino Tempo (coordinator), Pedro Felizardo Viageiro, Joana Filipe, Paulo Simango (Monitoring and Evaluation officer) and Nakene Paulina (economist).

Truck drivers. There are no publicly available records that indicate the number and origin of the Trucks that use the Port of Beira. There are no toll roads entering the city and municipal council has no authority to tally the truck count. Estimates obtained from Cornelder indicate an average of 400-600 truck daily entering the city to access the port. The trucks can be divided into two groups. First group is the national trade originating from the Provinces of Tete (serving the extractive industry), Sofala (sugar industry and agricultural produce), Manica (agricultural produce) and Zambezia (timber and agricultural produce). Second group is the international trade to and from Zimbabwe, Malawi and Zambia. During the formative study it was ascertained that the turnaround time is generally rapid due to the introduction of an electronic clearing system that requires that the paper work concerning the cargo is completed before arriving at the gate of the port. In a previous study carried out in the port (Lind et al, 2010), drivers typically stated that their home residence was between 300-700 km from the City of Beira.

The truck drivers and their assistants are male with ages ranging from early 20s to early 40s.

There are three main trucking stops where drivers hold their cargo as they wait to enter into the port or wait for information about unloading containers arriving in the port. The three trucking stops are:

- Ceramics (just outside the city)
- Nhaizua – EMAP (entrance to the port)
- Toyota (within the city limits)

The truck drivers and assistants tend to stay in their trucks and interact with the local resident population during their stops. This will generally include purchasing food and drink, and in many cases sexual activity. Sexual activity may be with commercial sex workers, women they have brought with them in the trucks, or regular partners among the resident population (girlfriends or second wives). The truck drivers and their assistants do not generally interact with the health services, largely due to time constraints. The only night clinic in Beira closed due to funding constraints. The NGO Kufanana has set up a leisure 'Stop' for the mobile population that also offers counselling and testing services for HIV. There are no other dedicated services for the truck drivers.

Port and railway workers. The Port of Beira is managed by a joint Mozambican and Dutch Company, Cornelder. The railway, including the piloting of boats into the port is managed by the Mozambique Railway Company (CFM). Cornelders works with the ships, haulage companies and companies hiring stevedores. During the formative study there were suggestions that many of the stevedores were migrant workers. This was not the

case and the study showed that the majority of the port workers were residents of the City of Beira and neighbouring town of Dondo¹⁸. The stevedores were young adult males, and generally had casual work contracts or were employed as piece workers when the ships were ready for unloading.

The railway workers were also predominantly male, living in the City of Beira. Older railway workers had often worked in a number of railway towns in Mozambique, generally moving with their families. CFM has a family-friendly human resource policy to try and place workers with their households, providing houses and allowances to facilitate the move. All of the sailors employed by CFM are male and the sailors interviewed for the study were long term residents of Beira.

Sex workers. There is a long history of sex work in Beira, linked to the development of the railways and the ports in colonial times. There has long been a thriving local sex work industry in the city serving both the male migrant populations during the colonial period, the Portuguese colonial men and the users of the ports and railways. Testimony from the wife of an ex-railway worker indicates that during colonial times young Portuguese girls were bought from Portugal to work as sex workers, serving the Portuguese and foreign port and the railway workers.

'...in the early 1960s, I was a young mother bringing up my children and we were housed in a building in Beira owned by the railway company. I saw young girls arriving from the countryside in Portugal to live in the building, and there were men who had books of their photos. These men would go to the port and the railway and show others the pictures. The girls would then disappear for a number of hours. This is how they worked. I asked my husband to leave the building – it made me sad to see those young girls. I don't think they knew when they left Portugal what life they would have!' Mozambican wife (74 years old) of an ex-railway worker.

The imported sex workers worked in particular with railway and port workers, and were part of a colonial strategy to reduce interracial sexual relations.

The economy of the city grew from the 1960s through to independence, and Beira became a crossing point for: trade to the hinterland, internal commerce (coal and sugar), and tourism from Zimbabwe (formerly Rhodesia) and the sex trade became an integral part of the economy. After independence and with the start of internal hostilities, Beira became isolated from the hinterland and military convoys replaced tourists and traders. During this period the petroleum pipeline was maintained open to allow the economy

¹⁸ Approximately 10 km from Beira

of Zimbabwe to flourish and troop movements along the corridor were intense. The sex trade became focused on the mobile populations still using the port and the military members manning the convoy. There was also an internal market for sex workers in the city, providing services to (mainly) male public and private functionaries.

Sex work has been decriminalised in Mozambique with the latest revision of Penal code (July 2014). Although there are no specific laws that state that providing sexual services in exchange for money or goods is illegal, it was possible that sex workers could be punished using the penal code under loitering and indecency laws²³. This has been revised. Forced sex work or forced sexual acts, sexual violence and violence against another person remain illegal under the Mozambique Penal Code.

The act of ‘facilitating’ sex work is illegal and remains a crime, which can be punished with a prison term of up to two years. Pimps who threaten or commit violence against sex workers, or who trick women into becoming sex workers can be sentenced to up to eight years. So can relatives or guardians who force women into prostitution.

None of the studies carried out in Mozambique that involve sex work indicates that female sex workers are prosecuted under the law for their activities. The majority of the sex workers are sole traders and do not have managers or do not work as part of a syndicate. Informal fluid groups are formed for company and (sometimes) protection. Although there is a number of establishments that are used for commercial sex in the City of Beira there are no established brothels.

Sexual abuse of minors. In 2003, Mozambique opted to sign a clause of the Convention for the Rights of the Child relating to the prohibition of the sale of children, child prostitution and child pornography. Under the Mozambican 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 protects them. 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) up until the reform of the Penal Code (July 2014) there is no specific legislation against child prostitution (either those abuse the children or those that make profits from the children). However, in an addendum to the revision the penal code states that sex with children under 16 years of age is punishable under the law. In the same revision it states that children involved in the sex trade will not be criminalised but receive “measures of assistance, education and correction envisaged in special legislation” through the Court for minors.

CHAPTER 3

DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS OF THE MOBILE AND MIGRANT POPULATIONS IN THE ENVIRONS OF THE PORT OF BEIRA

3.1. Age groups of respondents

The group of respondents in the quantitative study is predominantly young adults, with 70%-75% of respondents between the age of 20-34 years. For both the qualitative and quantitative studies working age adults were interviewed by occupational group. The people below 19 years of age interviewed during the survey (10% male and 5% female) were included as they fell into the groups of people working in the environs of the port either as stevedores, assistants to the truck drivers (male) or sex workers (female).

3.2. Nationality of the respondents

The vast majority of the respondents were Mozambican; 94% of women and 91.5% of men were interviewed. Zimbabwean women were interviewed as part of the sex worker interviews (6% of female respondents). Among male respondents 3% of the respondents were Malawian and 4.5% were Zimbabwean.

Table 3: Nationalities of the female and male respondents

Nationality	Female respondents	Male respondents	Total
Mozambican	94% (79)	91.5% (184)	263
Malawian	0	3% (6)	6
Zimbabwean	6% (5)	4.5% (9)	14
Tanzanian	0	1% (2)	2

Only 9% of the population sampled was recent migrants (Zimbabweans and Malawians), and were working in the Port of Beira. The majority of the respondents were originally from more than 30 different places in Mozambique, Zambia and Malawi, but had resided in the city for a considerable length of time.

Table 4: Percentage of respondents who are migrant workers

Migrant status	Number	%
Migrant	29	9
Non-migrant	292	91

The qualitative and quantitative studies indicated that only a small percentage of the stevedores were migrants, although many of them had not been born in Beira city. During the formative study, in preparation for the main research, stakeholders had posited that

up to half of the stevedores were migrants. Interestingly this was not proved to be strictly true when the research was concluded. They were fully resident in the city and part of a large informal group that worked regularly on the docks.

3.3. Mobility by occupational groups

The main mobile elements among the occupational groups were truck drivers, a small number of contracted port workers, and a sub-sample of the sex workers (from Zimbabwe). For these populations the 'Space of vulnerability' concept extends from the environs of the port to communities they pass through and to their places of origin. For the respondents residing and working in the port area of Beira the 'Space of vulnerability' is limited to the City of Beira.

The truck drivers are by far the largest single group of mobile people who use the port and interact with the resident population in the City of Beira. Although the volume of shipping has increased in Beira port, giving rise to increased road traffic, due to recent efficiencies in the customs processes and the high costs of berthing, sea faring personnel do not spend long periods in the port city and their impact on the population is relatively low.

On the other hand there are an estimated 400-600 trucks passing through the port on a daily basis. The trucks are largely coming from the hinterland countries of Zimbabwe, Malawi and Zambia, and from the Province of Tete (coal haulage and serving the extractive industry). Trucks also manage the domestic distribution of good from the provinces of Tete, Manica, Sofala and Zambezia. The truck drivers interviewed were all male and there was no mention of female drivers.¹⁹ The truck drivers have a rapid turnaround in the City of Beira and unless there are unexpected delays in the port their waiting time is between 24-48 hours. They make frequent visits to the port and can return up to 4 times a month. The majority of the truck drivers interviewed (quantitative interview or in-depth interview) indicated that they have sexual relations both during their journeys and in Beira while waiting to leave or collect cargo.

Contracted railway staff and the pilots that steer the ships into the port are mobile workers. The railway men can spend 2-3 days away from home on regular trips. During this period they will sleep on the train or in rooms provided by CFM. The CFM sailors wait for long periods to steer ships into the harbour. They are on call for 24 hours and have a bunk house where they wait. Information from the qualitative survey indicates that for the

¹⁹Female grain traders work within Mozambique buying grain in the central provinces for sale in the southern provinces but they do not seem to interact with the Port of Beira.

majority of the sailors and the railway men when they are away from home they do have sexual relations with casual partners or girlfriends.

Other mobile populations include international seafaring staff. The research showed that the international seafaring staff does not stay for long periods in the Port of Beira. They do not use the public health system, as the shipping companies provide health care through private clinics contracted in the city. The companies will often also arrange accommodation and eating arrangements for the staff members.

The current research failed to connect directly with any of the international seafaring personnel, although there were four in-depth interviews with Mozambican sailors. We were unable to learn whether international sailors are using internet services to meet up with women on shore. Generally, time-on shore is limited as most of the waiting time is when the ships are held off-shore in the entrance to the port before berthing. It is our view that international seafaring personnel do not represent a major risk factor for HIV transmission in Beira.

A segment of the sex workers interviewed during the qualitative research were from Zimbabwe. These women generally spend up to a month at a time in Beira²⁰. On their arrival in Beira they will sell goods purchased in Zimbabwe and on their return will buy goods to sell at home. During the month they work as sex workers in the area of the port. There was no indication from either clients or sex workers that this sex work is an extension of illegal human trafficking²¹.

There were some indications from the formative study that there is a number of mobile traders from other African countries working in and around the port. However, the quantitative study did not identify people with these nationalities. Follow-up during the qualitative study indicated that people from the Democratic Republic of Congo, Guinea Conakry and Nigeria are involved in the formal and informal sector trading in alcohol, car spare parts, hair products and clothes, and make frequent journeys to their countries of origin to purchase goods. Although respondents in the qualitative study said that nationals from the above mentioned countries were also involved in the illegal drug and alcohol trade, this was not ascertained during this study.

²⁰ After a month they are required to leave the country due to visa restrictions.

²¹ The women come of their own accord to Beira and move freely in the city. They do not have pimps or managers that control their work

3.4. Marital status of the respondents

Three quarters of the women interviewed in the survey did not have stable marital relationships (76%). A quarter of the women interviewed were married (24%), almost a third was single (30%), a tenth divorced (13%) and a tenth widowed (10%). This is in contrast with the men, where a high proportion of men were married or living in marital unions (74%), with only a fifth of the men stating they were single (18.6%). However, as was seen in the in-depth interviews, living in a marital state is not synonymous with exclusive sexual relationships or faithfulness. As it will be discussed further in Chapter 4 exploring sexual behaviour, the marital status of the partnerships of both men and women is not linked to notions of faithfulness.

Table 5: Civil status of the female and male respondents

Nationality	Female respondents %	Male respondents %
Married	24.1	74.4
Single	30.1	18.6
Divorced/separated	13.3	2.5
Widowed	10.8	1.5

National urban literacy levels in Mozambique are an estimated 85.8% for men and 64.6% for women (INE, 2012). In the Port of Beira study only 3.5 % of women and 4% of men did not respond to this question, and all who responded had attended school²². The level of education of the respondents is higher than the national statistics. This is probably due to the influence of the working and contracted workers in the Railway and Port Company (CFM) and Cornelder (management agent for the port) where there is a requirement for higher levels of education in order to be employed in these companies (see table 6 below).

Table 6: Education levels of female and male respondents

Education levels	Female respondents %	Male respondents %
Primary	50.0	33.8
Secondary	44.0	57.2
University/College	2.4	5.0
Non-response	3.6	4.0

²² From this we are assuming minimal literacy

In the sample, half of the women had completed primary education (50%), and (44%) secondary education. Men’s levels of education were higher (mirroring national statistics) with over half with secondary education (57%). Only 5% or less of both men (5%) and women (4%) had tertiary education. None of the respondents indicated that they were illiterate.

The findings from the quantitative survey were confirmed by the in-depth interview, where all respondents were literate. The level of education of the Zimbabwean sex workers was higher than that of the Mozambican sex workers, and they were generally slightly older than their Mozambican counterparts. A number of the Mozambican sex workers claimed they were still studying, trying to finish high school or in the case of one sex worker her university degree.

3.5. Type of work by selected demographic characteristics

3.5.1. Proportion of respondents by occupation

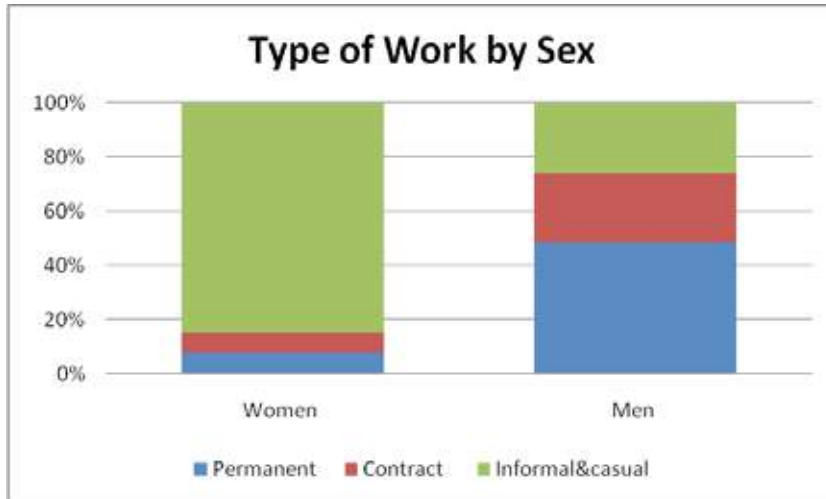
The sample was purposively selected for target occupational groups of key workers in the port area. In the total sample 10% were sex workers, 32.1% were port or railway workers, 32.1% were truck drivers and 25% leisure industry workers.

Table 7: Occupation of the survey respondents

Occupation	Number of respondents	%
Sex worker	32	10.4
Truck driver	99	32.1
Port or railway worker	99	32.1
Leisure industry worker	77	25
Police man	1	0.3

Graph 1 below clearly shows that the majority of men respondents work in the formal sector either with permanent contracts or with short-term contracts, while the women interviewed work in the informal sector. This has important implications for HIV programming; it indicates the need to target workplace interventions, and the continual engagement of the private sector companies in HIV awareness and prevention. But at the same time it develops strategies for the majority of women and young people who are working in the informal sector.

Graph 1: Type of work by sex



The sample was not purposively sampled by gender (only by occupation group), it is still interesting to note that men are over represented in the formal sector and women and youth in the informal sector (table 7). The occupations selected to represent the work in and around the Port of Beira, indicate strong biases, i.e. dock and railway workers were mainly men; and sex workers were exclusively women.

Table 8: Employment category by sex of respondent

Occupation	Female %	Male %	Youth (14-19 years)
Contract	7.6	25.3	14.3
Informal	78.8	8.8	64.3
Permanent	7.6	48.5	7.1
Casual	6.1	17.5	14.3
Total number	66	194	14

Employment category by age of respondent

From graph 2 and tables 7 and 8 you can see that the type of work carried out follows a clear and expected pattern, wherein for the younger age groups, informal or casual work is the predominant type of work (80% for those 24 year olds or younger) (table 7), and permanent work only featuring for the older group (60% for the over 45s and 40% for the 40-44 year olds). For the group 25-29 year olds this appears to be a transition phase where *contractual arrangements* in each of the four categories is evenly spread for the group (see table 8).

Graph 2: Type of work by age group

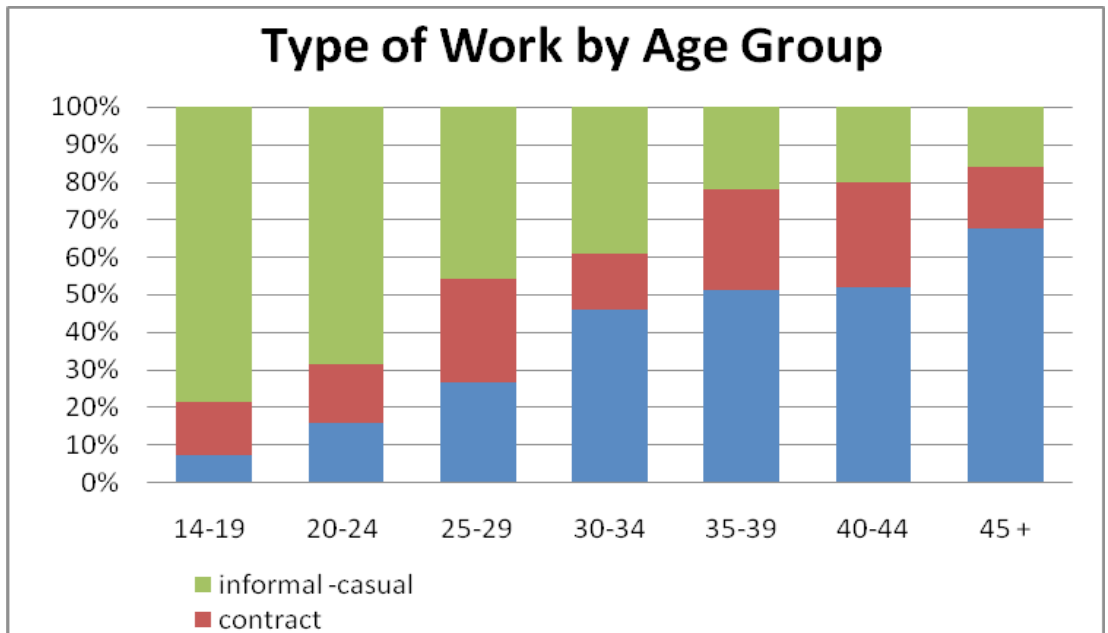


Table 9: Employment category by age of respondent

Age group(years)	Type of work (contractual relationship)			
	Contract %	Informal %	Permanent %	Casual %
14-19	14.3	64.3	7.1	14.3
20-24	15.6	42.2	15.7	26.7
25-29	27.8	27.8	26.4	18.1
30-34	14.8	31.1	45.9	8.2
35-39	26.6	15.4	51.3	7.7
40-44	28	12	52	8
44 +	16.1	6.5	67.7	9.7

This form of work by age group is important in terms of tailoring preventive activities to the specific groups and improving message absorption. For example, circumcision campaigns can justifiably be targeted to the ports, railways and truck drivers through workplace policies and internal HIV prevention programmes. But these campaigns will not reach young men who mainly work in the informal sector and who do not have regular links with formal workplaces.

The predicted expansion of the port (by 2015), will continue to attract more young people from the impoverished rural areas and neighbouring countries. On the one hand, this will be a welcome injection of energy to support the increased business in the port and subsequent procurement of goods and services, thereby increasing job prospects and trading opportunities for the city population. However, direct revenue from the Port of Beira does not revert to the municipal council, and the council does not raise taxes on the port operations. The municipal council is allocated a sum of money from the central government as revenue from the port but the revenue links between the city revenue and the port and railways is weak. This means that any of the wealth creation from the port may not directly work in favour of the municipality and residents, as the city has to provide services to meet the needs of the growing populations. The discussion of state and municipal fiscal negotiations is beyond the scope of this study. However, the predicted expansion of the port will exert additional pressure on scarce services and resources provided by the municipality.

CHAPTER 4

SEXUAL BEHAVIOUR OF PORT USERS AND RESIDENTS

4.1. Marital status and sexual behaviour

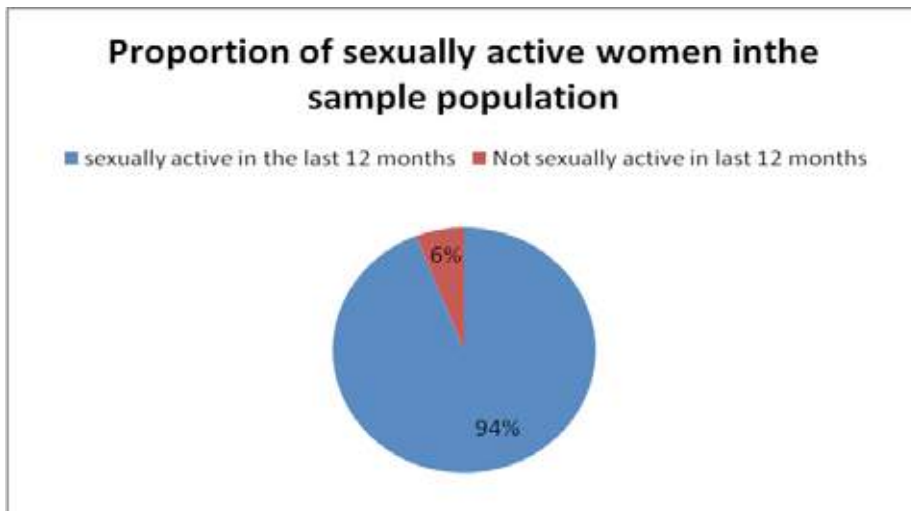
4.1.1. Marriage age of respondents

The average age of marriage of respondents is between 20-26 years of age, varying slightly by level of education (20 years for those with primary education, 21 years for those with secondary education and 26 years for those with tertiary education). Women on average married at 18 years old and men at 22 years old. As noted in the previous section a larger proportion of men are married or are in stable relationships than the women in the survey.

4.1.2. Sexual behaviour

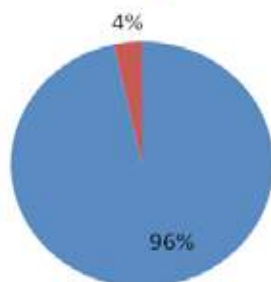
The sample population is sexually active, with over 90% of both sexes having engaged in sexual relations in the last year.

Graph 3: Proportion of sexually active men and women in the sample population



Proportion of Sexually Active Males in the Sample Population

■ sexually active in the last 12 months ■ Not sexually active in last 12 months



4.2. Occupation and number of sexual partners

Taking the sample as a whole, only a third of respondents stated that they had only one sexual partner in the last twelve months (32.8%), a fifth had 2-3 partners (21.2%), nearly a quarter between 4-9 partners (24.1%) and a further fifth had more than ten sexual partners (20.4%). This data does not provide us with the level of concurrency but given that three quarters of the male respondents stated that they were in stable marital relationships one can extrapolate a high level of sexual concurrency. Information from the in-depth interviews strongly indicates that multiple concurrency is the default position for both men and women in the survey.

Table 10: Number of sexual partners in the last twelve months

Number of partners	Number	Percentage of respondents
1	98	32.8
2-3	68	22.7
4-9	72	24.1
10 +	61	20.4

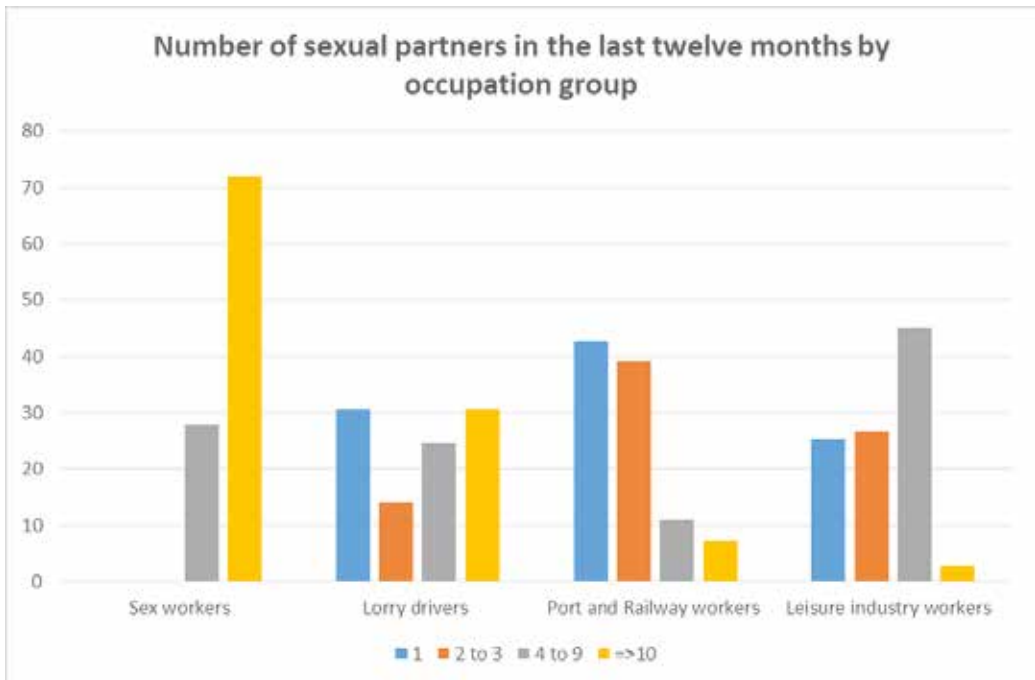
Disaggregating the above data by occupational group shows that a third of truck drivers (30.6%), almost half of port and railway workers (42.7%) and a quarter of leisure industry workers (25.4%) only had one partner in the last twelve months. This information is in sharp contrast to information gained from the qualitative research, whereby interviewing

members from the same occupation groups only two persons stated that they had had only one sexual partner in the last twelve months. This notwithstanding, between a half and three quarters of the respondents (by occupational group) had more than two partners. A third of truck drivers (30.6%) had more than 10 sexual partners and almost half of leisure workers had between 4-9 sexual partners (45%) (see table 11 and graph 6 below). For the sex workers, as would be expected the majority had more than 10 partners in the last twelve months (72%).

Table 11: Number of sexual partners by occupational group

Occupational group	Number of sexual partners in the previous 12 months (% by occupational group)			
	1	2-3	4-9	=>10
Sex workers	0	0	28	72
Truck drivers	30.6	14.1	24.7	30.6
Port and railway workers	42.7	39.0	11	7.3
Leisure industry workers	25.4	26.8	45.1	2.8

Graph 4: Number of sexual partners by occupational group



As stated previously, in only two of the in-depth interviews the respondents stated that they only had one sexual partner. All other respondents, both men and women, had at least two partners. Generally, the men interviewed had at least two fixed partners and numerous casual partners. This will be discussed more thoroughly in the section on **condom use**.

Typical conversation with men in study

“When I am travelling I have my fixed ‘friends’ that I have met during my time on the railways, and when I return home I have sex with my ‘friends’ at home and my wife. Sometimes I use condoms and sometimes I don’t use condoms” (Railway worker. 33 years of age. He has three day shifts away from home.) Mozambican 2014

The evidence points to the fact that the norm for the sexual behavior of respondents in the study was multiple concurrent stable partnerships, with additional occasional or casual sexual encounters.

That said, a number of respondents stated that they had changed their sexual behaviour because of HIV, namely using condoms in certain situations and reducing the number of partners. However, the action taken does not necessarily reduce risk due to the inconsistent condom use. Messaging on risk reduction, concentrating on testing, treatment of STIs and early treatment of HIV may be more effective than messaging around faithfulness.

Examples of behaviour change

- Men stated that they now limited the number of stable sexual partnerships to two or three BUT did not use condoms with these partners because they were in a ‘trust’ relationship AND they did not expect these relationships to be exclusive.
- Men generally used condoms in casual and transactional sexual relationships. This was noted as a change from previous behaviour where condoms would not have been used at all.
- In over 50 in-depth interviews only two respondents²³ stated that they now limited their sexual relationships to only one partner as they were worried about HIV.
- Adult female sex workers stated that they used condoms with all clients.
- Adult female sex workers stated that they did not use condoms with their stable partners (boyfriends or husbands).
- Testing for HIV was common among all the people interviewed during the qualitative survey.

²³ 41 year seafarer and 29 year old railway worker.

Abstinence was discussed, but the majority of women and men felt that it was not possible because sex was so enjoyable. Alcohol was widely seen as having a role in reducing the sense of risk and the non-utilisation of condoms.

4.3. Condom use

Even though the majority of the women and men recognise the preventive nature of condom use (78% of women and 74% of men stated that condoms help prevent the transmission of HIV), only 14.5% (12% of women and 14.9% of men) reported that they used condoms in their last sexual relationship.

Of the people in stable relationships only 15% reported use of condoms the last time they had sex with their (marital) partner. Of these 60.3% said they never use condoms with their stable partners. Of people who had had sex with a lover or casual partner 60.3% stated that they had used a condom and only 18% said they never used condoms with their lovers.

Table 12: Condom use in marital-stable) and lover-casual relationships

Nature of the relationship	Used a condom in the last sexual relationship	Use of condoms		
		Always	Sometimes	Never
Marital-stable	14.5%	6%	31.5%	60.3%
Lover-casual	60.3%	29.7%	52.3%	18%

Use of condoms by occupation group (sexual relations with casual partner)

High levels of condom use were found for truck drivers (96.4%) and sex workers (89.3%), and lower levels for port workers (73.1%) and leisure workers (78.6%).

Table 13: Use of condoms by occupational group

Occupational group	Use of condom in last casual sexual relationship		
	Yes	No	Don't know
Sex worker	89.3	3.6	7.1
Truck driver	96.4	1.8	1.8
Port and railway workers	73.1	23.1	3.8
Leisure industry	78.6	19	2.4

From the total number people who responded to the questions about commercial sex (137 respondents) 65.9% had had sex on a commercial basis and of those 86.5% had used condoms. The above data indicates that there is highest usage of condoms in

commercial sex relations, and some casual/stable lover relationships, and low usage in marital or stable relationships. This finding, together with the high percentage of men and women that have had multiple partners in the last twelve months, indicates the extreme risk taking in sexual relations, in particular within stable or longer term non-exclusive relationship.

Truck drivers: The in-depth interviews support the quantitative data and show that the majority of the drivers have multiple concurrent stable relationships, namely a spouse plus 2-3 girlfriends along the trucking route or at home. They do not use condoms with these stable partners. In Beira, they may have sexual relations with sex workers who hawk food and goods in the Stops, and generally use condoms.

The drivers are aware of HIV and HIV transmission, stating that due to the information campaigns and the workplace policies, they have changed their sexual behaviour and now use condoms with occasional or casual sexual partners.

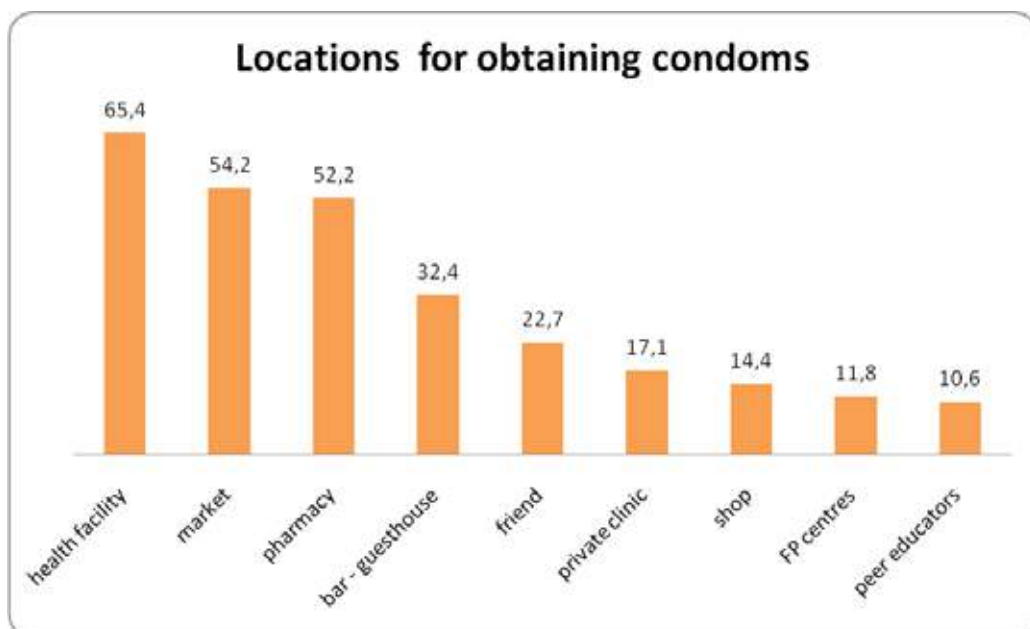
“I usually have one constant ‘friend’ who I have sex with when I feel like it and when I am available. I don’t use a condom with my ‘friend’ but I do when I have casual sexual relationships. I don’t use condoms with my ‘friend’ or with my wife because I trust them. The casual relationships just happen; I don’t go looking in the street for them. I don’t know if my wife and my ‘friend’ have other lovers – even though I know the risk of having sex with my ‘friend’ and my wife without condoms.”

The idea of faithfulness to only one partner was practised by only one of the truck drivers interviewed.

Physical and/or economic access to condoms is not a barrier to condom use

The main places for obtaining condoms were health facilities and workplaces (free), in pharmacies or at the market stalls (purchased). There is no shortage of places to buy condoms or any reluctance or embarrassment to do so.

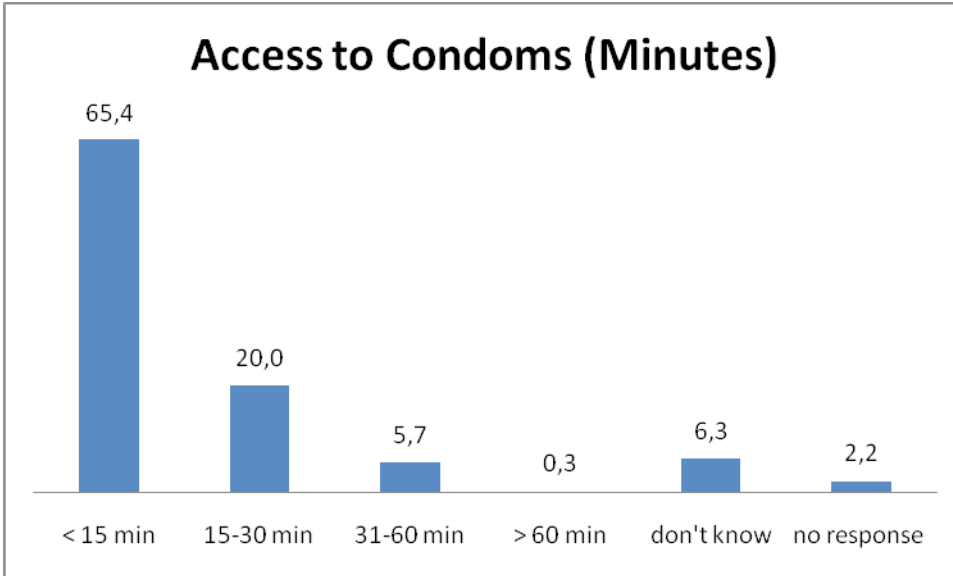
Graph 5: Locations for obtaining condoms



Note: Respondents could choose more than one option.

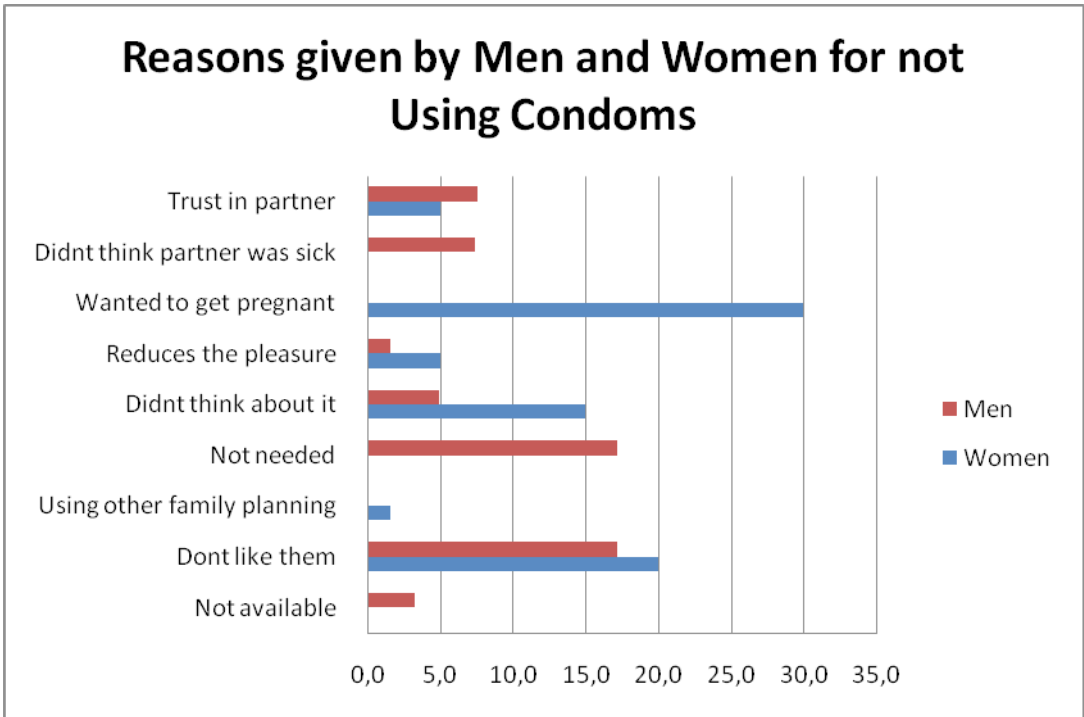
For over 60% of the people interviewed they could obtain condoms in 15 minutes or less and 20% in less than 30 minutes. Condoms in the shops and markets are 5mt (approximately 0.07 USD).

Graph 6: Time needed to access condoms



In the quantitative survey the main reasons that people gave for not using condoms were different for men and women. One of the main reasons given by women was that they wanted to get pregnant, followed by not liking sex with condoms. For the men the main reasons were not liking sex with condoms and not feeling that it was necessary to use a condom. This coupled with the replies linked to trusting a partner (much higher in men than women), leads to the impression, confirmed in the qualitative research that when men and women feel they are in a stable relationship, even if it is concurrent, then condom use reduces.

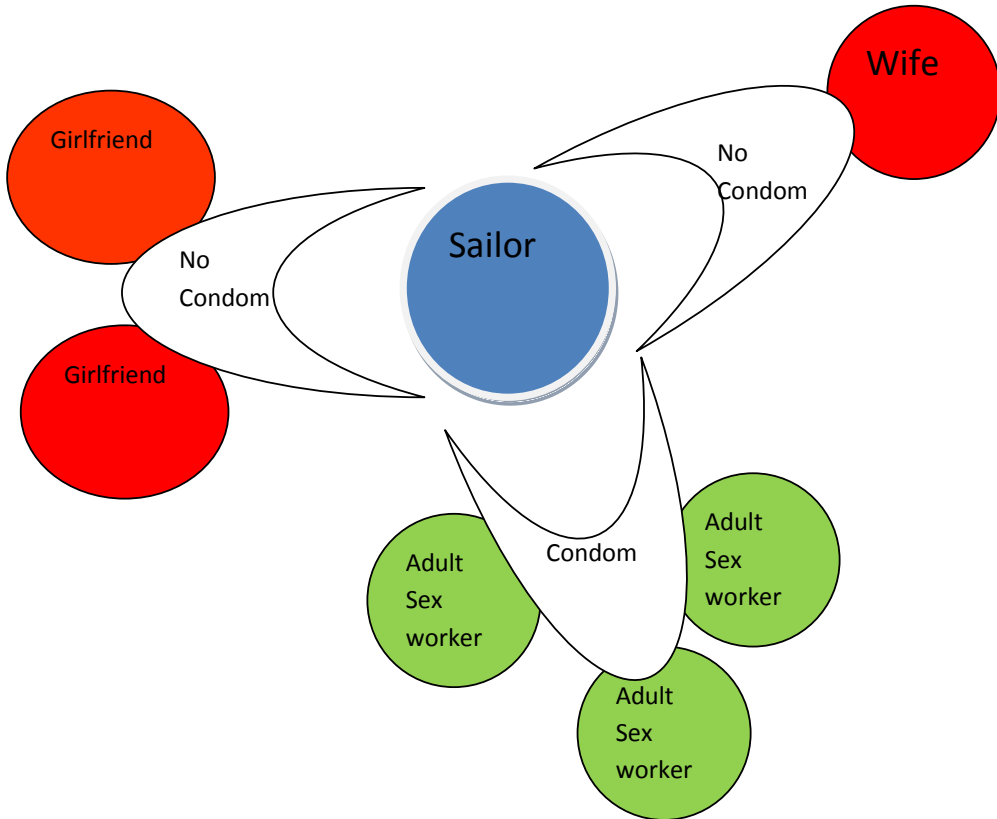
Graph 7: Reasons for not using condoms (female and male respondents)



Knowledge of the risk of transmission of HIV does not seem to affect behaviour in terms of safe sex. The overriding issue is linked to the concept of trust; trust is connoted with 'regular' partners with whom the person has a relationship beyond sexual relations. There appears to be no expectation of exclusivity (sexual faithfulness) in the relationship. This is clear in the statement from the sailor (see below). He does not use condoms with his wife or 'friends' but is now using it with sex workers. There is no suggestion that his 'friends' are exclusive lovers or for that matter whether his wife has other sexual partners. During the interview he stated,

"I have changed my behaviour because of HIV and AIDS. I have reduced the number of 'friends', (earlier conversation indicate that he is married and has two regular 'friends'), and I use condoms with sex workers (he had had sex with three sex workers in the last month)' Sailor. 2014

Figure 6: Sailor's sexual network



The problem with condoms

In-depth interviews revealed the complex nature of sexual relations reflected in decisions about condom use. One of the respondents in the qualitative study stated that the ***'problem with condom use is the question of 'trust'***. When people are in stable relationships, even multiple concurrent non-exclusive relationships, condoms are not used. This may appear to be contradictory but further probing reveals that decisions about condom use involve complex emotional decisions, made by both parties, that affirm them as being part of an affectionate and committed, if not exclusive, relationship.

Men stated that even though they were aware that their wives and lovers were not necessarily sexually exclusive, they did not use condoms because they were in a 'trust' relationship.

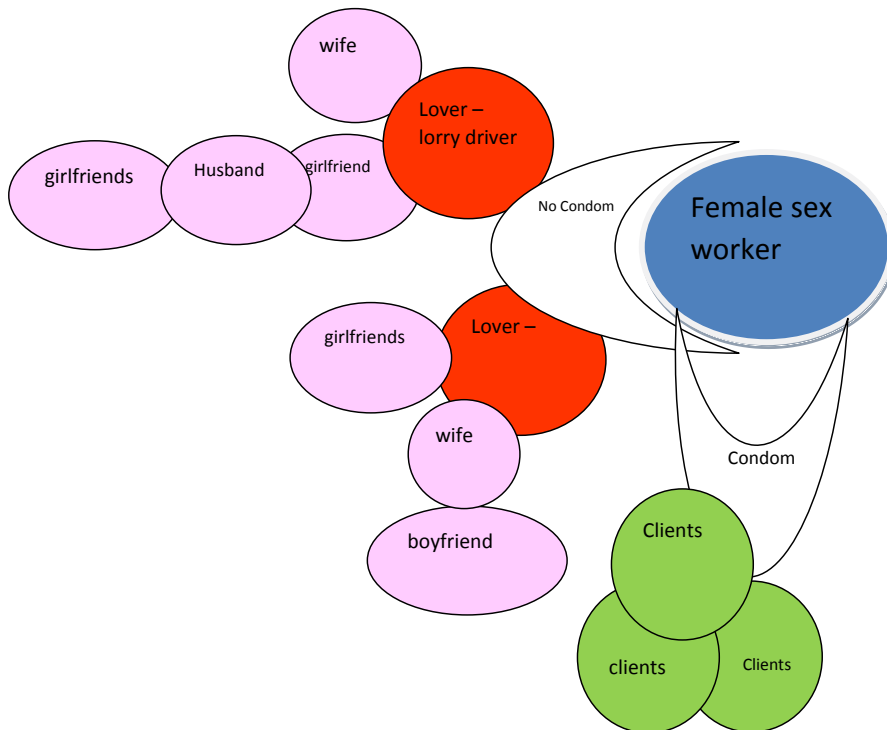
“If I use a condom with my wife, I will be showing that there is no trust between us. We use the pill so she won’t get pregnant, but using a condom does not make sense with my wife.” Truck driver. 2014.

“If she is my wife why should I use a condom? If there isn’t any trust then what is the point of having a wife” This respondent openly discussed the multiple sexual partners he had, including sex workers (where he used a condom) and ‘friends’ where he didn’t.

Women stated that when they had permanent (even nonexclusive) lovers they did not use condoms but used other forms of contraception to prevent pregnancy. The question of familiarity with the man was considered more important than safety from HIV. One female interviewee said she had a husband who travelled a lot and she had a regular boyfriend. She did not use condoms with either the boyfriend or her husband. When asked about her expectations of faithfulness from her husband she laughed and pointed out her own situation. She also told the interviewers that when she went out in the evenings to a club or a bar she would sometimes have sex with someone she met, but she would always use a condom during that sexual act (because there was no expectation of a relationship with that partner).

A HIV positive sex worker explained her sexual network. She has clients and with them she uses condoms. However, she also has two regular boyfriends, one of whom is a truck driver. She does not use condoms with them. She knows that both of her lovers are married and that they have various other girlfriends. She knows that the wife of one of her lovers also has a boyfriend. She did not know whether her boyfriends use condoms with their other partners. She relies on her boyfriends to provide money for her and her children’s expenses.

Figure 7: Sex worker's sexual network



If either the man or the women requests that a partner uses a condom, this breaks the 'trust', bond and both are forced to recognise and acknowledge the non-exclusive nature of their relationship. For many men and women this is a price that is too high to pay for safe sex.

On the other hand, as seen from the statistics above, and confirmed in the qualitative in-depth interviews, the majority of people use condoms in transactional sexual relations. The sex workers interviewed were all aware of the importance of using condoms and the majority stated that they would not have sexual relations with men if they did not use condoms. From the data it also appears that truck drivers are the most cautious group in terms of transactional sex with almost 100% stating that they use condoms. This data was supported by the qualitative interviews. However, because of the complex classification of regular or stable partners (with whom the truck drivers do not use condoms) the risk of transmission of HIV within their sexual network is still high (see sexual network diagram above).

Figure 8: Classification of sexual relations based on information from quantitative and qualitative data

Classification of sexual relations	Condom use	Reasons	Risk of HIV transmission
Casual relations			
Transactional relations with adult sex workers	High percentage use	<ul style="list-style-type: none"> . Perception of risk of disease transmission . Perception of risk of pregnancy . Insistence by sex worker . No trust relationship 	Low
Sex with minors (transactional) (1)	Low use	<ul style="list-style-type: none"> . No negotiation skills (unequal power relations) . Lack of knowledge . Low sense of risk 	High
Non-transactional	Inconsistent use	<ul style="list-style-type: none"> . Perception of risk at the beginning of the relationship (condom use) . Alcohol reducing inhibitions and care (no condom use) . Mutual pleasure seeking relationship (no condom use) 	Medium to high
Longer term relations			
Marital/stable relations	Low use	<ul style="list-style-type: none"> . Trust relationship . Wanting to get pregnant . Mutual pleasure seeking relationship 	High
Girl or boy/ friends/ lovers	Low use	<ul style="list-style-type: none"> . Trust relationship . Wanting to get pregnant (2) . Mutual pleasure seeking relationship 	High

Note: (1) Information about this category of relationships is not derived directly from the survey data but from key informants and in-depth interviews with clients and adult sex workers; (2) Usually it is the women who would like to get pregnant in these relationships.

CHAPTER 5

THE RISK OF HIV TRANSMISSION – KNOWLEDGE, ATTITUDES AND PRACTICE

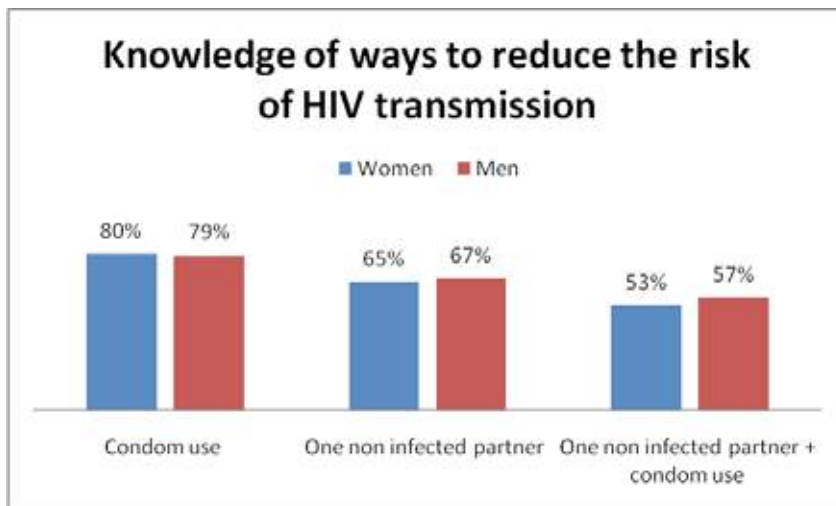
“People don’t have nightmares when there is talk of HIV and AIDs anymore. People are more frightened of cars (being run over).” Policeman. In-depth interview. 2014

5.1. Knowledge of HIV and HIV transmission

All of the people in the survey had heard about HIV.

The majority were aware of methods of transmission. In terms of prevention, the majority (women 80% and men 79%) mentioned using condoms as a key prevention method. However, only just over half of the respondents mentioned only having one non-infected partner together with the use of condoms as a key preventive practice. This may be due to the notion that having only one non-infected partner there is no need to use condoms (faithfulness).

Graph 8: Knowledge of the ways to reduce the risk of HIV transmission



In the graph 10 above you can see that 65-67% of respondents mentioned limiting partners as a prevention method, demonstrating knowledge of this risk reduction practice. However, from earlier results, in practice the majority of respondents had at least 2 partners in the last twelve months, and multiple concurrent sexual partnerships was the norm for this group. During the qualitative study, people mentioned practicing abstinence or faithfulness as a prevention method. However, all stated that this was not possible as sex was such a major part of their lives.

“I would like to abstain or only have one partner but it is not possible, I am human and I have very hot blood” 39 years old truck driver. Malawian 2014.

“I would like to have only a few lovers, but it is difficult, I am young and I still want to enjoy my life” 24 year old truck driver. Mozambican. 2014

The age group with the lowest levels of knowledge was the group of 9 respondents between the ages of 14-19 years. Of this age group only 42.9% of the boys and 66.7% of the girls knew about reducing risk using condoms and only 34% of boys and 44.4% of girls stated that having one non-infected partner and condom use reduced the risk of transmission. This finding bears out information provided during the in-depth interviews that children engaged in the sex trade are unlikely to negotiate the use of condoms, both due to lack of awareness and lack of power within the transactional relationship.

In the quantitative study the majority of people were aware that someone who looks healthy could have the virus; the message seems to be clear. However, when discussing this in the in-depth interviews many people still judge by the appearance of a person to know whether they are healthy. Men would state that they would look at a woman and see whether it was OK to have sex without a condom. If she was clean and healthy looking (fat) then she was not sick. There was mixed data around rejecting erroneous beliefs (mosquito transmission and transmission through someone preparing food) with the majority of people recognising that these were erroneous concepts²⁴.

Evidence from the quantitative survey suggests that even with wide spread understanding of the basic risks of HIV transmission people develop a personal risk index, and engaging in multiple concurrent sexual partnerships, with inconsistent condom use, is low on the potential personal disaster list.

Table 14: Concepts about HIV transmission

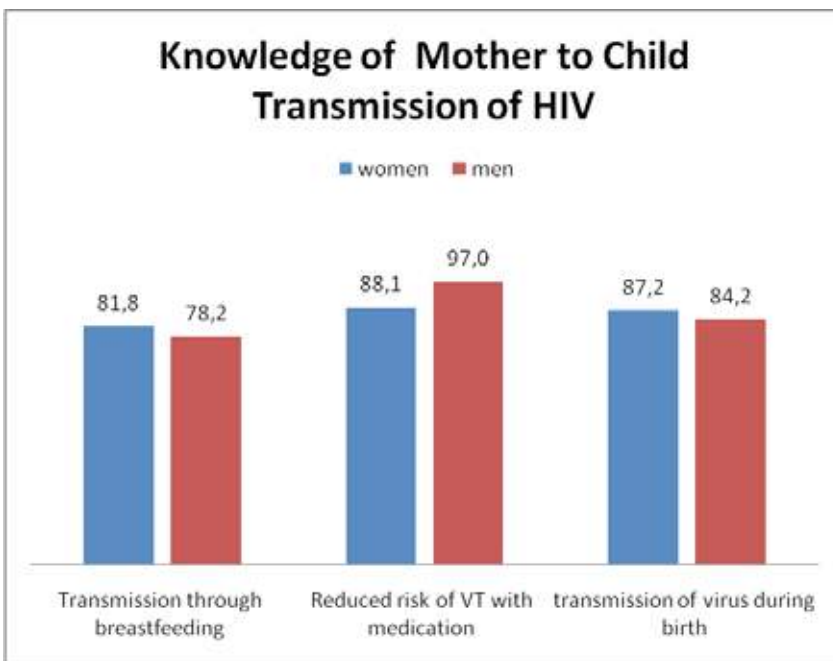
Sex of respondent	A healthy looking person can have HIV	HIV is not transmitted by mosquitoes	HIV cannot be transmitted by a HIV+ person preparing food
Women	79.7	69.6	81.6
Men	89.8	74.1	80.2

²⁴ This question required extensive training because of the use of double negatives in the question potentially leading to misinterpretation.

Knowledge of mother to child transmission is high for both men and women (see graph 11 below).

This attests to the power of good dissemination programmes and pro-active health sector programming. Women attending any antenatal clinics in Mozambique, receive HIV counselling, are tested for HIV and offered prophylactic medicine. The women have to opt out of testing. If they do not opt out they are routinely tested during the pregnancy. If women test positive they are encouraged to ask their partners to come to the clinic for testing. These programmes are free and widely publicised, and are clearly having an impact on knowledge levels.

Graph 9: Knowledge of mother to child transmission of HIV



Interestingly both men and women are aware of the dangers of transmission and the possibility of reducing the risk of transmission through medication during pregnancy and post-partum, even though men do not accompany women to their antenatal visits or post-partum visits. This is an encouraging sign and demonstrates the strength of the health messages passed through the health system. How this occurs and who are the key people transmitting the messages within the household or between partners requires additional study?

From the evidence it appears that people are aware, and concerned but not frightened anymore of HIV and AIDS. This is partially due to effective treatment regimes and partially due to the precarious lives that many of the people interviewed, where euphemistically, “they can be run over by a car” at any time. Unemployment, poverty, diseases such as malaria and cholera are rife, and people’s lives are ruled by immediate risks and not by possible (future) risks such as contracting HIV.

5.2. Stigma and discrimination

In terms of stigma and discriminatory behaviour, the data reveals low levels of declared discriminatory behaviour among both the men and women involved in the survey. Attitudes were measured by asking people if they would use selected services from people living with HIV; 83% of women and 91.3% of men think that teachers should continue to work and 82.1% of women and 88.9% of men would buy food from a HIV + food seller. The vast majority of both women and men stated that they would look after a family member with HIV (94.9% and 91.4% respectively).

Table 15: Reactions to HIV+ people

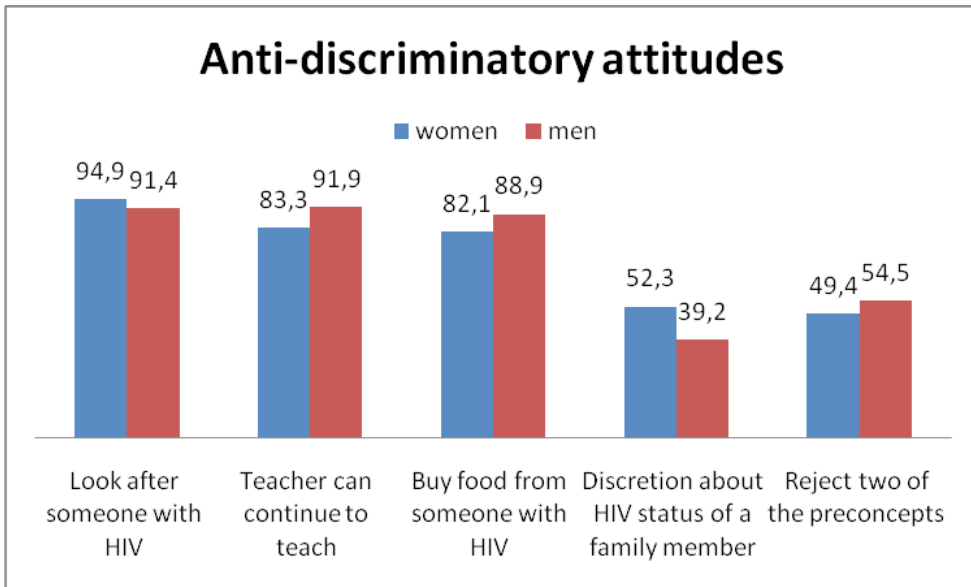
Sex of respondent	Would care for a HIV+ family member	Agree that a HIV+ teacher could continue to teach	Would buy food from a HIV+ food seller	Would reveal the status of a HIV+ family member
Women	94.9	83.3	82.1	47.7
Men	91.4	91.9	88.9	60.8

The indicator asking whether people would keep the status of a family member secret, is more difficult to interpret with just under half of all women survey (47.7%) and two thirds of all men (60.8%) stating that they would reveal the HIV status of a family member. This could either suggest that there are low levels of stigma because people are not fearful of revealing the HIV status. For example, there is a feeling that HIV status does not have negative social consequences; or the finding could be interpreted as family members not respecting the rights of family members to confidentiality in terms of their HIV status. Further work on this particular attitude is needed to understand social moirés about revealing HIV status.

Evidence from the qualitative study was clear in that people are still reluctant to discuss their status or the status of their family members during interviews. People will explain that family members have died of HIV but rarely state whether there is a family member living with HIV. One of the sex workers interviewed was clearly unwell and spoke about her treatment for TB and recurrent malaria. But she categorically stated that when she

was tested at the Health Centre her HIV test was negative. The reluctance to discuss HIV is not limited to this serious disease. People in Mozambique will rarely discuss cancer or TB or other potentially fatal illnesses²⁵. Misinformation about the cause of death of family members through illness is extremely common with death often attributed to agency other than simply illness.²⁶

Graph 10: Anti-discriminatory attitudes to HIV and people living with HIV



Beira has one of the highest prevalence levels of HIV in the country and was one of the first cities to begin to systematically tackle the problem. Thousands of families in Beira have lost members to HIV or are living with people with HIV. There is a tradition of strong programming in the city; initially aimed to encourage testing and treatment of opportunistic infections; and followed by the opening of one of the first day hospitals. Beira has continued to be at the forefront of many treatment initiatives, including PMTC and the introduction of ART. The familiarity of the disease (and the adversity) coupled

²⁵ It is common that if someone is suffering from a serious, possibly life threatening illness, doctors will often break this news to a family member rather than directly to the patient in the first instance. The information is then filtered through the family member to the patient. Detailed information is rarely discussed in the family even after the death of a member.

²⁶ Although people will recognise the medical reason for the death, the reason that the particular person at the particular time was affected by the illness is attributed to another agency (either witchcraft or ancestors).

with the pro-active health and community programmes is reflected in the relatively low levels of stigma and discrimination found in the survey.

5.3. HIV counseling and testing

Over three quarters of both men and women have been tested at one point in their lives. For a quarter of the women (24.4%) the testing was non-voluntary, most likely in the antenatal clinics where testing is carried out as part of routine practice. In contrast, only 13.5% of men stated that testing was involuntary, and is probably connected to workplace practice and job seeking. From key informant interviews it appears that both the major employers of port and railway workers have proactive testing and treatment policies in collaboration with the City Health Authorities.

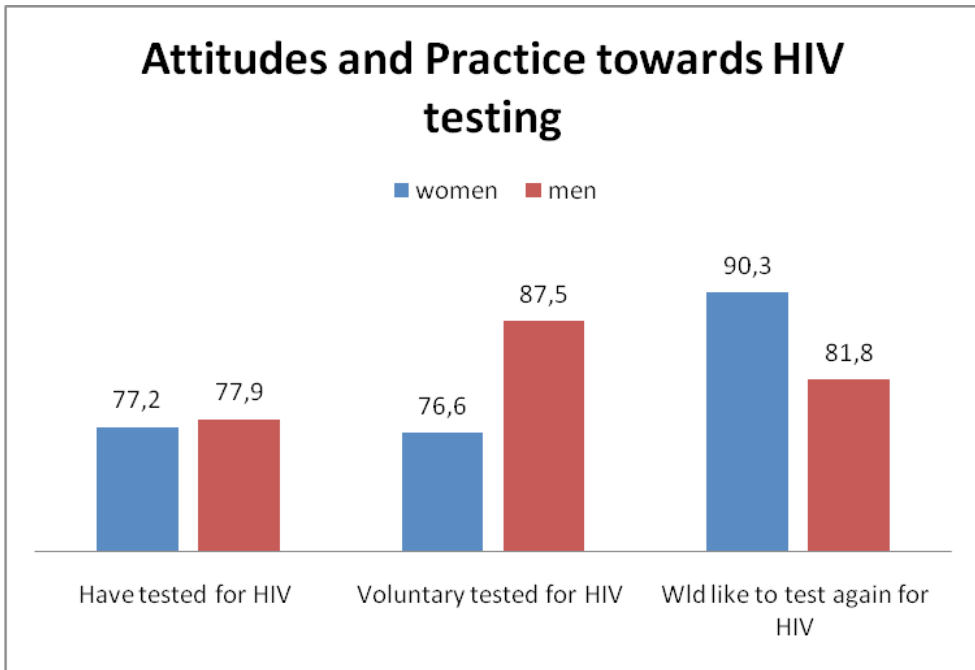
The disaggregating of the information by occupational group is clear that across the spectrum levels of testing (at least once) are high, with the majority of sex workers, truck drivers and port and railway worker having being tested (80%, 79.8% and 79.2% respectively). Leisure industry workers have lower levels of testing but still two thirds of them also stated that they had been tested (68.5%).

Table 16: HIV testing by occupational group

Occupational group	HIV test (%)			
	Yes	No	Don't know	No response
Sex workers	80%	13.3	3.3	3.3
Truck driver	79.8	18.2	2	0
Port and railway workers	79.2	18.4	1	1
Leisure industry workers	68.5	23.3	8.2	

In-depth interviews revealed a more nuanced picture where many of the respondents stated that they had been tested, but were not routinely been tested. So although the positive attitude to testing is encouraging, given the continuation of high risk sexual behaviour (multiple concurrent sexual partners and inconsistent condom use), one off testing is not necessarily a useful practice. Regular campaigns for testing would be a way of taking advantage of positive attitudes (90% of women and 80% of men would like to take the test again).

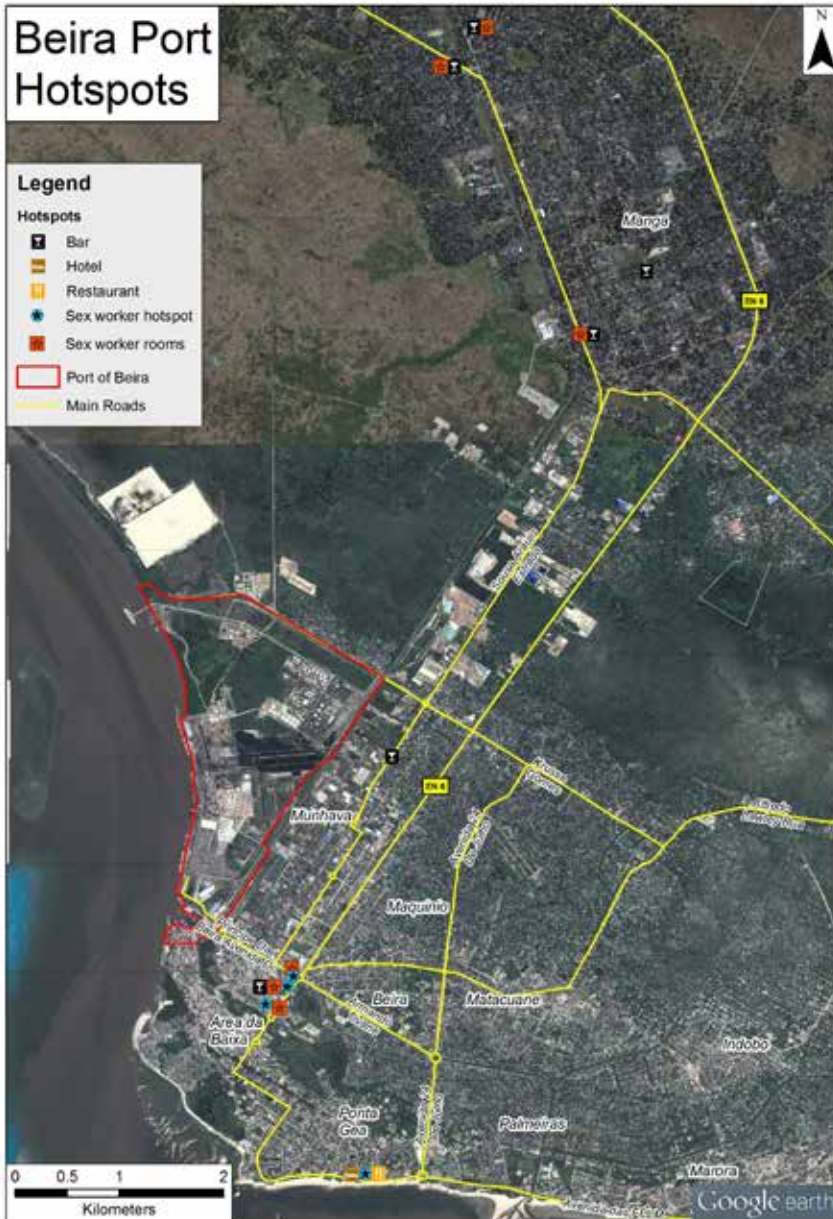
Graph 11: Attitudes and practice to HIV testing



CHAPTER 6

HIV TRANSMISSION RISK – SEX WORKERS AND THEIR CLIENTS

Map 4: Hot spots in the area of the Port of Beira



6.1 Categories of sex worker in the Port of Beira

There were three distinct groups of sex workers working around the Port of Beira, namely Mozambican adult female sex workers, Zimbabwean adult female sex workers, and Mozambican child sex workers. Interviews were carried out with the first two groups, but not directly with the child sex workers.

Figure 9: Description of sex workers working in the environs of the port

Declared sex worker (Mozambican)	The Mozambican self-declared sex workers in Beira are sole traders. They are not managed by a third party. They generally work part-time (Thursday to Sunday). Although throughout the week it is possible to find sex workers in these areas. They work in the same areas and will often socialise in groups waiting for trade. This may be on the street or in a bar/restaurant. They are paid in cash and have rates for different sexual acts. They have sex on the street corners, in cars, the beach, rooms for hire in houses or specific hotels.
Declared sex worker (other nationalities)	The nationality of the majority of the foreign sex workers in the Port areas is Zimbabwean. The women have varied livelihoods with the main source of income as sex work in Mozambique. They also trade goods from Mozambique back to Zimbabwe and vice versa. Although they are sole traders they provide one another with support and work in a close knit group. They are paid in cash and have rates for different sexual acts. The rates are generally lower than the Mozambican sex workers. They have sex on the street corners, cars, rooms for hire in houses or specific hotels.
Women engaging in transactional sex	Transactional sex is practised mainly by younger women working from bars, clubs and restaurants. They are sole traders but often socialise in pairs or groups of other girls. They do not have a fixed rate for their services and sex will often be additional to the meal and drinks consumed by the girls. Payment is made in cash or in kind. Sex takes place in cars, rooms for hire or hotels. These workers do not classify themselves as sex workers.
Children engaging in transactional sex ³²	Children, generally girls, as young as 12 year old are visibly involved in the sex trade in Beira. The clients find the children in the 'sex worker' hot spots in the town, in the bars or on the street corners abutting the bars and restaurants. The sexual abuse of these children takes place in cars, on street corners, in hotels or in rooms for hire.
Male sex workers	In a study carried out in Mozambique (INE. CDC. UCSF. PSI. Pathfinder. I-TECH. Lambda, 2011) estimated that there were a total of 2,624 men having sex with men (1.8% of adult male population) in Beira and of these 239 (9.1%) were infected with HIV. Of these men 15.3% had more than 3 male sexual partners in the last 12 months, and 43.8% had had anal or vaginal sex with a woman in the last 12 months, 19.7% did not use a condom during anal sex and 67.8% did not use lubricant during anal sex. The same study indicated that 26.5% of the men interviewed received money, goods or services in exchange for sexual relations. However, male sex workers proved to be a very difficult group to reach during the study. The main group of male sex workers mentioned in the study are (young) men having sex with (older) women who receive money or in kind for their services. They do not work on the street and their services are procured through word of mouth (from one client to another). Men who have transactional sex with men were not detected during the research ³³ .

6.2 The clients

With the exception of two male respondents in the qualitative survey, all had had sex with sex workers at some point. The client base of the Mozambican adult sex workers were truck drivers, stevedores, sailors and male residents of Beira city. They found their clients in bars near the port, the police mess (run for policemen), restaurants on the seafront and street corners. Clients were also referred by barmen, restaurant owners and taxi drivers.

The quantitative survey indicates that half of the male respondents had had commercial sex the last twelve months (48.8%). The majority stated that they used condoms (87.3%). It should be noted that for the same group of men, 82% had sex with a casual partner, and the majority of those that responded to the question stated that they had paid money to their casual sexual partner (85%). In keeping with the use of condoms with sex workers, 85.5% of the men said they used a condom with their casual partner. This data underlines the discussion in the previous section that highlighted the blurring of the lines between commercial sex work and transactional sex.

Men responding in the in-depth interviews were able to state accurately the price for sex with the sex workers, and were aware that sex with the Zimbabwean sex workers was cheaper than with the Mozambicans. All the men interviewed in-depth stated that they had used condoms when having sex with sex workers, and although this may not be strictly true, the fact that they are aware that it is important to use condoms in casual or transactional sexual relationships strongly indicates that messages about risk reduction have reached the target audience.

The clients are principally adult men and cut across all of the occupation groups interviewed during the qualitative survey. The quantitative study indicates that half of the men who had commercial sex in the last 12 months were between the ages of 19-29 years old (46.6%) and a further fifth between 30-39 years old (20.9%). Young boys do not have enough money to go to sex workers. One male respondent mentioned that some older women have young lovers who they pay to have sex but this was not considered to be a common practice. None of the women sex workers interviewed during the research had been approached to have sex with women.

When discussing why the men have sex with sex workers, in addition to simply the 'need' to have sex and the availability of the sex worker, some of the men in the survey stated that it was cheaper to have sex with a sex worker than have a girlfriend because the girlfriend need to be taken out, have clothes and other gifts, and a sex worker you just pay once.

Many male respondents said that ‘men with means’ often look for the under-age girls because they can tell them what to do and the young girls do not have any power to negotiate the use of condoms. Whereas the adult sex workers demand that they use condoms.

6.3 Locations for finding sex workers and having sex

The sex workers work from the bars and on street corners and are sent clients by bar staff, restaurant staff or taxi drivers. They work around the Police Mess, Robert Mugabe Square (Zimbabwean sex workers), MiraMar restaurant and bar, and the Seaside Promenade. Many of the women working at the gate of the port selling food and beverages are also part time sex workers. The truck drivers normally seek sex workers in the Stops where they also sell kebabs, cooked food and soft drinks.

6.4 Mozambican sex workers

Information from in-depth interviews and key informant indicates that the sex workers are self-employed (informal sector) and not managed by a third person. They sometimes work in pairs or groups of ‘friends’ (as in sitting together in bars waiting for clients). For some of the women this was their full time job, and for others was part-time, mainly on weekends, to supplement their income. Other income streams included, selling of food and soft drinks at the gate of the port, selling traditional beer, and working in bars or petty trading.

More than 80% of the sex workers are below 30 years of age. All of the sex workers interviewed were active and therefore had had numerous partners in the last twelve months. Thirty percent (30%) of the sex workers had only primary school education, and 60% with secondary education.

None of the sex workers were married although just over a quarter was divorced (27%). From the data one can see that of sex workers 89.3% of them stated that they had used condoms the last time they had sex. Nearly a fifth of the women had been treated for genital ulcers or sores in the last 12 months (18%) and 89% had been tested for HIV (at least once). The statistical data is supported by the in-depth interviews where the majority of the women stated that they used condoms with clients (although not with stable partners). The majority of the women interviewed had been tested at least once for HIV (generally when they were pregnant at the antenatal clinic) and demonstrated high levels of knowledge about STIs and where to receive treatment.

The majority the women interviewed had children, and many stated that abandonment by the father of the children was the reason they had started working as sex workers. It was clear (from the age of their children) that many of the women had started working as child sex workers (under 18 years old). A number of the women were using their wages to pay for their school or university fees, although the majority stated that they just used the money to pay living expenses and support extended. The reasons for starting sex work were complex, rooted in economic questions but also linked, at least initially for the younger girls, to wanting to experience restaurants and bars (have fun) and potentially find a well -placed boyfriend or husband.

They work in loose friendship groups but are not organised by a person (madam or pimp) or any organisation. We did not find any evidence of trafficking during the study.

Complex tale of a young sex worker, 18 years old, showing both the pragmatic nature of the work, but also the mixed emotions she feels about sex work.

“I started with this ‘programme’ last year. I go out with my friends on Fridays and Saturdays and I manage to earn 1.500 meticaís (50 USD). I have had truck drivers who are Malawians and South Africans. The majority are Malawians. They pay with charcoal, dried fish and they give me money. They send me home in a txopela (local taxi). I always use a condom. My brother and sister both died of AIDS. My sister was pregnant when she died. My friends are the only ones that know what I do, at school they don’t know. If people know they call you names but if they don’t it’s OK. I pay my school fees myself. I practically do this because I want to, I like the money, and my boyfriend is married so he can’t go out all the time. I go out on Fridays and Saturdays, and on Sunday I go to Church, I pray at the Gods Assembly Church.”

The Mozambican adult sex workers claimed that they always used condoms with clients, and that if clients did not want to use condoms then they were willing to lose the business. Although it is not possible to confirm these statements, the claim was consistent with reports from the ‘clients’, truck drivers, stevedores and other port workers interviewed.

The women were familiar with, and used the health facilities in the City of Beira. A number of the women were on ARV treatment and all had been tested for HIV – generally at the time of their pregnancies. There were no discrimination problems in the clinics, but they did complain about the waiting time and the lack of drugs in the hospital pharmacies.

The rates charged for sex vary between the Zimbabweans and the majority of the Mozambican sex workers.

Figure 18: Price range for sex work services by nationality of sex worker

Nationality of sex worker	Service offered(1)	Price range MTs	Equivalent in USD
Mozambican adult	30 min	300 - 500	10 – 15
	All night		50 – 75
Zimbabwean adult	30 min	100 – 300	3 – 10
	All night	1.500	50

Note: (1) There was no price variation for different sexual acts, only the length of time.

One of the sex workers interviewed who was in poor health and worked selling meat kebabs in the trucking stops admitted that she worked for much lower rates than those in the table above, she stated

“when my clients have a good heart they pay 200 mts but some will just leave 50 mts.” HIV positive sex worker. 2014

One of the Mozambican sex workers said she could earn up to 7.000 mt per month (230 USD), another stated that she could earn 18.000 mts (600 USD) to 20.000 mts (680 USD) per month. One should note that the minimum wage in Mozambique is approximately 3.000 mts per month (100 USD). The earnings stated by the sex workers far exceed minimum wage jobs and many of the public sector health workers or teachers.

The Zimbabwean sex workers stated that they could earn up to 1.000 mts per day and up to 15.000 mts per month (500 USD). They work part of the month and they return to Zimbabwe to sell the products they purchase in Mozambique with their earnings.

6.5 Zimbabwean sex workers

As stated previously the Zimbabwean women have complex livelihoods, they bring goods from Zimbabwe to sell in Beira, and then to make additional funds through sex work to buy goods to take back to Zimbabwe. They are organised and have formed an informal group that look out for one another. They work in an area called Robert Mugabe Square (named because of the Zimbabwean sex workers). As seen in figure 10 they charge less than Mozambican sex workers and according to the women, they will only have sex with condoms. They try to care for the younger Zimbabwean women and encourage them to only have sex with condoms.

Most of the women interviewed had families in Zimbabwe and came to Mozambique for a month or two at a time to earn a living. Some of the women had a more settled existence

in Beira. At the time of the study there did not appear to be any underage Zimbabwean sex workers.²⁷

One of the women explained how she began to work as a sex worker:

“I had a business in Zimbabwe, but one night all the goods I had stored in a warehouse caught fire and burnt. Since then I did not have any money to send the children to school. This happened on the 29/11/13. After this a friend of mine from Zimbabwe, who lives in Beira, invited me to come here. She invited me to go out with her and some friends and she presented me to some men friends. At first it was difficult, but then I thought of my children, and decided to go into this life. With the money that I get I help my children. I change all the money into dollars and take it to Zimbabwe.”
38 year old widow with 5 children.

They usually cross the border once every month. The impression of the researchers was that they had higher levels of education and were able to negotiate their rights more directly with the police. This was referred to by the women themselves and by the Mozambican sex workers.

Their client base was mainly men working in and around the port area. All of the women interviewed had family and children in Zimbabwe. They undercut the prices of the Mozambican sex workers which caused some resentment.

The Zimbabwean sex workers use the Mozambican health facilities, but if they have a serious illness they will try to pay for care in the small private clinics or wait until they return to Zimbabwe. None of the women admitted to being part of ARV programmes.

6.6 Phenomena of sexual abuse of minors in Beira (child prostitution)

The study was not authorised to work with minors so interviews were not carried out with underage sex workers. However, all the interviews, with adult sex workers and in-depth interviews with other respondents, pointed to the proliferation of the sexual abuse of underage girls by adult clients. An adult sex worker stated:

“...men prefer the children, 13, 14, 15 and 16 years, that is why we are dying of hunger. They say that they prefer children because they are pure and don't have children. Most times when the clients arrive they grab our breasts and when they find they have dropped they don't want us”. 24 year old sex worker. Beira. 2014

²⁷ Underage Zimbabwean sex workers have been reported in Manica and Tete Province.

Some of the truck drivers commented on the reasons why there were young girls in Stops where they park up to wait to get into the port. As one of the drivers said:

“there is no reason for girls to be here, there are no houses or schools, they are not selling anything... except themselves” Truck driver. 2014.

Direct observations were made by the study researchers of young girls entering cars of adult men in the environs of bars and surrounding restaurants, and the sex workers they were interviewing stated that this was a common sight. Respondents stated that girls as young as 12 years old are working in the sex trade in Beira.

There were a number of reasons that the adult sex workers gave for clients using children, namely, the girls cannot negotiate the use of condoms, they accept low fees for the service, and the men can make them perform sexual acts that the adult sex workers refuse. In particular they referred to anal sex.

The clients of these children are adult male residents of Beira – both Mozambicans and foreigners. There does not appear to be an organisation that ‘runs’ the girls, and although they are seen in pairs or groups they do not work formally together.

The presence of children working as sex workers is visible, commented upon and well known by both the mobile populations and the resident populations in Beira. This practice is clear violation of the law, of the rights of children, and is perpetrated by adult men in full public view and with no apparent sanctions from the police or the municipal authorities.

These girls are the most vulnerable and at risk group identified in the study as it is reported that they are not able to negotiate the use of condoms and may be subjected to cohesive sexual practices (anal sex, sex with more than one man, pornographic photos, etc).

The adult men sexually abusing the girls are breaking the law and damaging the future of these children. Given that this practice is well known it is incumbent on the municipal authorities to take measures against the clients of the children to eradicate this growing practice of paedophilia in the City of Beira.

CHAPTER 7

TREATMENT OF STIs AND HIV

7.1. Knowledge of STI symptoms

Over 90% of all respondents had heard about STIs (93.9%). Respondents, both male and female below 40 years of age were aware of STIs. The age group between 40-44 years of age were the least likely to know about STIs (80%). Three quarters of women (76%) and a high proportion of men (85%) knew where to obtain treatment for STIs and HIV.

The most commonly identified STI symptoms were swollen genitals (68%) and itching genitals (63%), followed by genital ulcers (45.6%) and smelly discharge (43.5%).

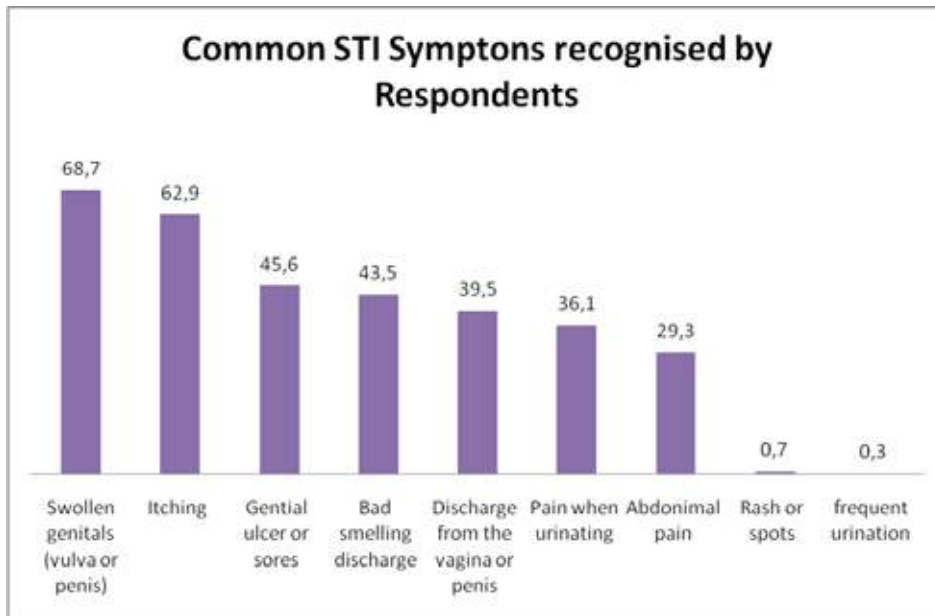
In terms of having suffered an episode of STIs in the last twelve months, no more than a fifth of the people in the occupational groups interviewed stated that they had had a genital ulcer or sore in the last twelve months.

Table 17: Genital ulcer or sore in the last 12 months by occupation group

Occupational group	Genital ulcer or sore in the last twelve months	
	% Yes	% No
Sex workers	13.8	72.4
Truck driver	22.9	77.1
Port and railway workers	7.5	91.4
Leisure industry workers	13	85.5

The qualitative interviews indicate that people are aware of STIs, and by preference seek treatment in the public hospitals where treatment is free. The majority of the interviewees stated that they had at least one episode of STIs and had been tested at least once for

Graph 12: Respondent recognition of symptoms of STIs



7.2 Seeking treatment for STIs

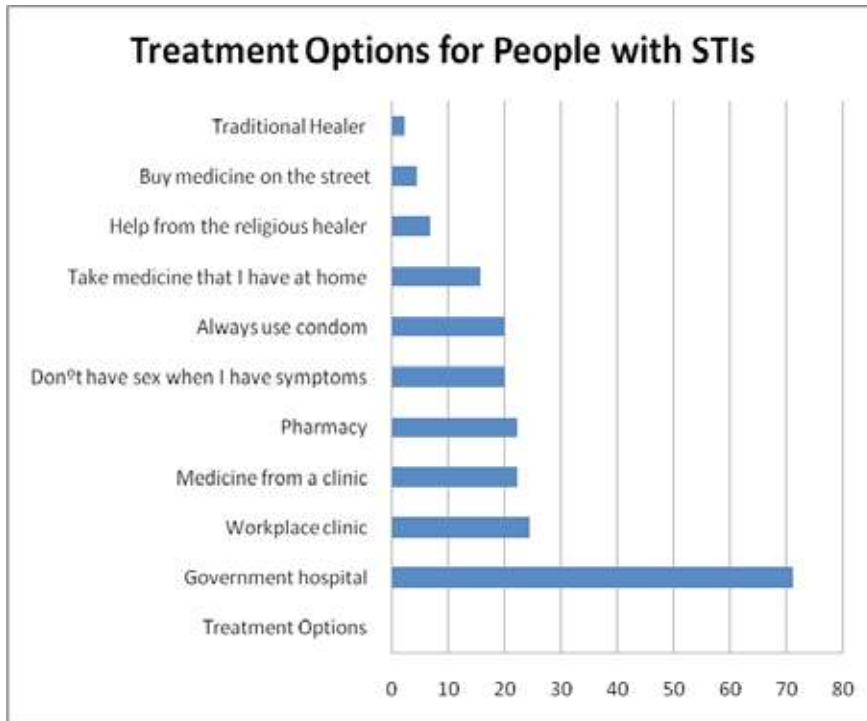
The City of Beira has one Central Hospital, a Military Hospital and between 11-14 health facilities. All the health services offer HIV counseling and testing, prevention of HIV mother to child transmission, ante-retroviral treatment programmes free of charge. Antenatal, post-partum and family planning services are also free. Diagnosis of STIs is free and treatment is covered by symbolic cost for the medication²⁸.

Of the group of people who had STIs, the majority of respondents (71%) was aware of and had used public health facilities for the treatment of STIs, including HIV. A fifth of respondents indicated that they would go to a workplace clinic, buy medicine directly at a clinic or go to a pharmacy. A fifth of respondents also stated that they did not have sex when there were visible symptoms of the STI and a further fifth stated that they used condoms during an STI episode. Less than 10% of people mentioned buying medicine on the street, going to a traditional healer or a religious healer. (see graph 13 below)

One of the female sex workers stated that she had received numerous treatments for candida that caused wounds in her vagina. She also stated that she had received treatment for cervical sores as part of the cervical cancer treatment campaigns.

²⁸ When available in the health clinic pharmacy

Graph 13. Treatment options for people with STIs



Note: Respondents could chose more than one option.

All respondents were aware of the HIV and STIs services offered by the health clinics. Women respondents use the services frequently due to pregnancy and child care. The men go to the health services for treatment of STIs, although the level of reported seeking of health care is lower than the women. None of the men mentioned the circumcision programme '*tira chapeau*'²⁹ when discussing their contact with the health services or in terms of prevention of HIV.

On the negative side respondents mentioned time wasted at the clinic and the shortage of key drugs as problems to using health services. Neither, distance to health centres nor discriminatory attitudes by staff were noted as reasons for not using the public sector health services.

²⁹ Translation 'take off your hat'

“Our health system is sick. The services do not cover all needs, when someone is diagnosed they give you a prescription, but then there are no drugs in the hospital, and in the private pharmacies there are no quality drugs and if you find them they are very expensive. ” Male respondent 2014

These issues were also raised by the health staff in the public sector clinics, who spoke about the lack of staff, problems with the drug pipeline and long waiting times for the patients. Currently there are shortages of ARVs in the adult treatment programmes. Regarding the HIV and AIDS treatment programmes, health staff stated that it was difficult to know the levels of adherence to treatment as people were often tested in one clinic but preferred to sign on with another clinic and there was no central registry. Health staff also confirmed the importance of antenatal HIV testing (carried out routinely in the clinics), stating that this was the main way that women were identified and put into the PVTC programmes. Both staff and the respondents knew about and praised the PVTC programmes; feeling that the new protocol would make a difference to the lives of women and their babies.

As mentioned in the first section of the report both of the major companies working in the port (Cornelder and CFM) have a strong relationship with the city health department. In the past there was a port-wide programme called ‘Porto Saudavel’ (Health Port) that was sponsored by Cornelder with donor funding, collaborating with CFM. However, this programme folded as the other private sector forms were not willing to contribute to costs when the donor withdrew funding. Cornelder and CFM still continue to work with the Health Department during the National Health Week, and both companies have strong HIV workplace policies and programmes. The positive momentum built up by the Porto Saudavel initiative is a loss to HIV and AIDS programming in Beira, as it provided not only information and advice about HIV, but regular testing for staff and family members.

The work of the NGOs and community based organisations in the area of the Port was not widely known by respondents in the quantitative study. A number of the key groups interviewed in the qualitative study knew about the work of the community based organisations, in particular the truck drivers mentioning the Community Stop at the entrance to the port, and the sex workers who worked as peer educators with Luz da Comunidade. In the study the principle sources of information about HIV and AIDS were TV, radio and the health centres.

Interviews with the truck drivers and NGO staff working with this sub-section of the population, confirmed the fact that the drivers are not generally using the health services, largely due to time constraints. One NGO has established a leisure ‘Stop’ for the mobile

population that also offers counseling and testing services for HIV. The 'Stop' is used by some of the drivers although many are concerned about leaving their trucks for any length of time due to the lawlessness in the area.

Although the evidence from the survey presents a generally positive picture in terms of knowledge and access to health services, with highlights in terms of the cervical cancer screening and the expanded PMTC programme, there are extreme resource constraints.

CHAPTER 8

INFORMATION ABOUT HIV AND OTHER STIs

8.1 Forms of transmission of information about HIV and STIs

Television and radio programmes were the main source of information on HIV and STIs, followed by information from friends. As the majority of respondents in this study reside in cities, this reflects access to TV (see graph 14 below). It should be noted that almost half of the respondents replied that they talked to their friends and received information via this network (44.5%). A third of people stated that they received information from the health facilities. These four information channels were the most cited by the respondents.

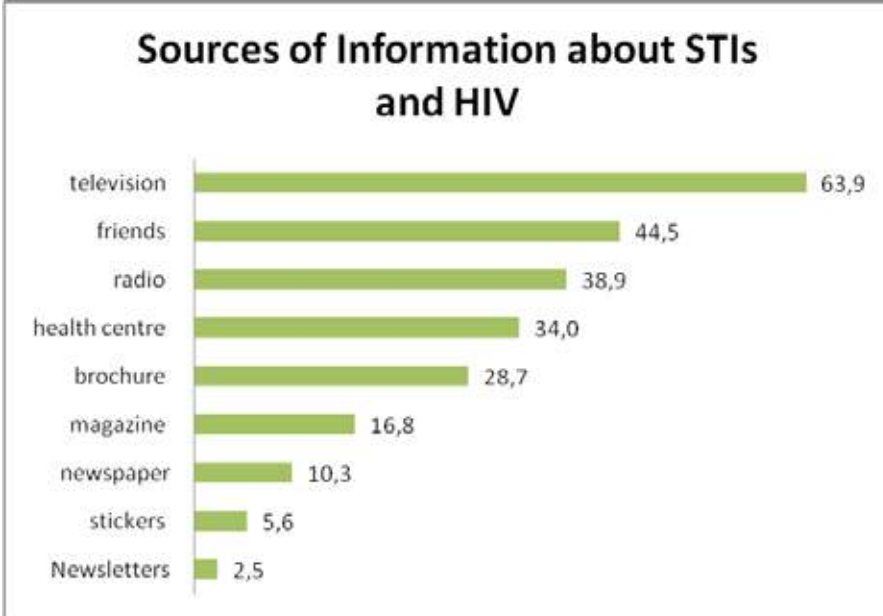
Television and radio are powerful instruments for conveying information and messaging around HIV and HIV prevention. The excellent work carried out by the media is most likely responsible for the information on HIV. Of the respondents in both surveys, social media (Facebook, Twitter and SMSs) was not mentioned. This may be due to the group interviewed (working age adults and not teenagers), or may indicate that this medium is still under developed in Mozambique.

Women in the qualitative interviews stated that much of the information they receive comes from the health facilities during the antenatal, postnatal and child consultations. As indicated in graph 14. Both men and women were equally informed about prevention of mother to child transmission of HIV, a service mainly discussed in TV and radio debates and in the health facilities. It is clear that written material is less assessable to the majority of respondents.

In the war against HIV transmission, fully staffed and functional public health services, offering comprehensive HIV and STI services, including, provision of information, counseling and testing, adolescent friendly services, PMTC programmes, ART programmes, and the control of opportunistic infections (TB, malaria), are a powerful preventive weapon. People are using the services, people know about the services and in a city such as Beira innovative measures, involving strong public-private partnerships, can be taken to ensure the quality, outreach and sustainability of the service.

Knowledge dissemination of relevant information about HIV and STIs, and supporting people to take decisions about what to do with the knowledge is crucial. Now is not the time to ease off from media campaigns. It is important to maintain the momentum that has led to the high levels of knowledge about HIV in the study population, and from the research results one can see that media and entertainment play an important role; more TV programmes, more interactive radio shows and more road-shows are needed. Investment in dissemination pays dividends but it must be tailored to the urban audience.

Graph 14: Sources of information about STIs and HIV



Carrying out HIV campaigns, road shows, interactive radio and TV programmes - promoting periodic testing, family planning clinics and treatment for STIs and HIV - will reap rewards in this area, where the audience is vast, young and sexually active. These high impact events should feature as a regular part of the HIV programmes and replace the use of pamphlets and peer education.

CHAPTER 9

CONCLUSIONS

The study investigated the risk factors for HIV and STIs in the mobile and resident populations that work in and around the Port of Beira in Mozambique and the use of HIV related social services in the City of Beira. The sexual behaviour does not differ greatly from behaviour on other major transport corridors studied in Mozambique (Selvester, 2011). The the high baseline prevalence rates in Beira, the rapidly expanding port and railway network and the fluidity of the port users with income to spend, increases the potential number of high risk sexual encounters. Stretched public health facilities, leave the City of Beira with a complex set of social and health related questions to solve in the near future.

9.1 Socio-economic dynamics of the occupational groups in the area of the port

The respondents in the survey were of working age, and mainly of Mozambican origin. Less than a tenth of the respondents were migrants with only small proportion of the people interviewed were from Zimbabwe, Malawi and Tanzania. The men in the sample had higher levels of education than the women, and were more likely to be married. In terms of economic engagement, formal sector permanent work is more common for older males, and the younger men and women of all ages can be found working in the informal or casual economy. Less than 10% of the sample was resident migrants in the City of Beira. The three mobile occupational groups were truck drivers, a sub-sample of sex workers from Zimbabwe and the railway workers directly involved with the trains (drivers, machinists and maintenance staff) and sailors piloting the ships into the port.

The research sought to understand the complex interactions between the resident populations and the mobile and migrant populations in and around the Port of Beira. Much of the interaction takes place in and around the densely populated neighbourhood close to the gates of the port called Munhava, where labourers from the port, mobile populations and residents interact; trading, eating and drinking and maintaining sexual relations.

Munhava is busy and disorganised, with poor sanitation and few basic amenities (streets, electricity or water infrastructures are all in poor repair). Most of the housing is precarious and densely packed, with rooms for rent, as well as owner occupiers. There are bars and restaurants at the edge of the neighbourhood frequented by the port staff, stevedores and truck drivers. Key informants stated that the sale of cheap alcohol and the availability of drugs caused a sense of insecurity in the neighbourhood. There is considerable lawlessness in the neighbourhood, mainly perpetrated by the young unemployed men who steal fuel from moving trucks and carried out numerous acts of petty crime in the neighbourhood.

The concept of ‘spaces of vulnerability’ is a useful way to take in the whole environment and the problems therein. Findings from the study suggest that HIV programming could be improved by: a) concentrating resources in the first instance on the inner circle of vulnerability, namely the ‘hot-spot’ of the Port of Beira; and b) develop programmes that recognise the risk of HIV and STI transmission to partners and spouses in the concentric circles of vulnerability beyond the ‘hot-spot’, namely in the pass-through communities and the places of origin.

Through effective engagement with the private sector it is possible to: strengthen existing workplace policies on HIV and AIDS; encourage extensive health outreach activities benefiting not only staff members and their families but also the wider community of Munhava neighbourhood; and concentrate messaging around the need to protect families through regular HIV testing, early and consistent adherence to ART for HIV positive workers and extending condom use beyond transactional and casual sexual relations.

In order to ensure that the populations working in the informal sector in and around the Port of Beira are included in HIV programming, the Municipal Government needs to leverage the fact that the Port of Beira is expanding. Thus, bringing subsequent increase in revenue, to negotiate additional resources from both the private sector and central government to; improve health conditions in the residential areas close to the port; develop innovative ways of engaging local youth in the productive potential of the port and services; and boosting access to the health services in the area through increased supplies of personnel and drugs in the health facilities, including the re-opening of the night clinic that serves both the mobile populations and the sex workers in the area.

9.2 Risk behaviour of the populations using the Port of Beira and level of concurrency in terms of sexual partnerships

The research highlighted the high level of multiple concurrent sexual relationships among the groups working in and around the Port of Beira. The majority of both men and women had at least two sexual partners during the last twelve months. All of the occupational groups show similar sexual behaviour patterns, with truck drivers and sex workers having the highest number of declared partners. Less than a third of the respondents stated that they have only one sexual partner.

Although there are overall high levels of understanding about HIV and HIV transmission, this knowledge is not translated into sufficient behaviour change to reduce overall risk. Condoms are now used but not consistently across all partnerships. Some respondents reported reducing the number of sexual partners but abstinence or faithfulness are not common choices for people in the survey.

Attitudes towards HIV and AIDS indicate that there are low levels of stigma and discriminatory practices among the groups surveyed. The majority of the people in the study have been tested for HIV at least once, but there was still some reluctance to openly discuss HIV status. This is considered to be private matter and health workers reported that people often preferred to receive ART in health facilities not connected to their residential areas.

People receive information through the medium of TV and radio. Social media was not cited as a way in which information is disseminated. Interestingly the information passed through the health centres and health personnel appears to be particularly effective as evidenced by the widespread and detailed knowledge of PMTC by both men and women in the survey.

The highest levels of risk were found in the stable relationship within sexual networks comprised of stable, casual and transactional sexual relationships. Condoms are not used in sexual relation between spouses and people in stable lovers, even though there is no expectation of exclusivity. The use of condoms is connoted with a lack of 'trust'. The term 'trust' does not refer to faithfulness but rather to a sense of belonging, affection and a degree of commitment.

From the analysis it is possible to conclude that sex between adult sex workers and truck driver clients is probably the safest sex in Beira, as both workers and clients stated that they used condoms³⁰, and are aware of the risk of HIV transmission. This does not however mean that truck drivers and adult sex workers have lower risk of HIV infection within the occupational groups as they are also involved in complex sexual networks, characterised by inconsistent condom use (outside of transactional sex) with other lovers and stable partners.

Although the sexual behaviour of child sex workers was reported rather than discussed first hand with the children, there was consistency in the reports from the adult sex workers and men respondents, that the sexual abuse of children is rife in the port area. The children are not able to negotiate condom use or control the sexual practices with the male clients. This unequal power relationship is one of the main selling points for the men and elevates the risk of HIV transmission for the children, making them the most vulnerable group in the port area. Given that sexual relations with children below 16 years of age are a criminal act and engaging in transactional sex with children is also

³⁰ This excludes sex with minors who are at higher risk of HIV and STI transmission as they are unable to negotiate use of condoms (from reported conversation and not direct interviews with children).

illegal there is no reason for the sexual abuse of children to continue to be practised in Beira without municipal and civil society taking action to stamp out the paedophile sexual trade.

The loud siren of non-exclusive 'multiple concurrent stable (trust) relationships' continues to spread the risk of HIV transmission through the concentric circles of the 'spaces of vulnerability' into homes across Southern Africa. At present, using condoms in these relationships is not considered feasible by the participants in the study. A conceptual leap and new programming front needs to be opened up to concentrate efforts on this complex emotional question.

9.3. Utilisation and access to the health and social services related to STIs

Access to health facilities for the occupational groups in the survey is not a critical factor. The City of Beira has 14 health centres and two hospitals (Central Hospital and the Military Hospital) and there are private clinics that provide care through work place policies and fee paying patients. In addition, Cornelder and CFM collaborate with the city health department to boost HIV and STI services through health campaigns, information dissemination, and reasonable work place policies. Additional support from other private sector companies would extend these initiatives and improve coverage.

The public health services provide free care for mother and child care, including PMTC, and free ART for both adults and children. The treatment of TB is also free and there is integration of the HIV and TB services. The treatment of STIs is practically free (10 cent consultation fee) but patients are often required to buy medicines in the private pharmacies due to drug shortages in the public outlets.

However, there are serious issues about the quality of care, the lack of human resources and critical shortages of essential drugs. For example, at the time of the survey antiretroviral drugs were in short supply and people on treatment were only receiving 15-day supplies rather than the usual 30 days. This gave rise to fears from the health workers that adherence rates for ART would drop further.

There are no formal restrictions for migrant workers or mobile population to use the public health system as there is no national registration system to control the nationality or place of origin of the users. However, for some of the mobile groups there are issues about the opening times of the clinics for treatment. Clinics close at 15.30 in the afternoon. The night clinic that had provided full STI and HIV services is no longer working due to a

lack of resources. None of the respondents indicated that there was discrimination from health staff in terms of occupation (sex workers) or HIV status.

The majority of the respondents had basic awareness of the key symptoms of common STIs and even though people complained about long waiting times and drug shortages, public health services were still the first choice for treatment of STIs.

As the Port of Beira expands in the next decade the number of people living and working in city will increase, and therefore increase stress on the health system. Leveraging resources from the private sector and revenue from the port and railways will be essential to improve the quality of care and ensure minimum services for communicable disease. Opening discussions around health care financing are critical for the city that will continue to expand and play host to both migrant and mobile populations.

CHAPTER 10

RECOMMENDATIONS

10.1 Municipal economic and social service planning

Leverage national and SADC wide investment portfolios in the Beira ports and railways (and the Beira corridor initiative) to develop strategies for the positive engagement of the populations of Munhava in developing the area, including investment in inclusive basic service planning (water and sanitation, solid waste management); economic stimuli targeting youth through educational and training opportunities (police cadets, nursing, teachers, vocational training).

10.2 Combat paedophilia in Beira

Start on the street and make Beira a city free of minors involved in sex work by: enforcing the laws on the sale of alcohol and presence of underage girls in bars and clubs (fines for bar owners); hard hitting campaigns to name and shame national and foreign clients of child sex workers; naming and shaming bars and hotels that allow child sexual abuse; close down hotels and guesthouses that permit the use of rooms for sexual abuse of girls; carry out mass media campaign to advise clients of the illegality of their acts and potential punishment; carry out sweeps to detain clients engaging in transactional sex with minors.

10.3 Health care provision

Leverage private sector and municipal funds for decentralised support to the health sector³¹. Concretely: Guarantee essential ART and drugs supplies, promote outreach clinics, fund ‘testing and counseling’ road-shows and support community initiatives on prevention; boost youth services in the municipality; family planning, treatment, and HIV testing; develop a municipal forum for sharing of good HIV and AIDS workplace policies in the private sector (e.g. Cornelder and CFM).

10.4 Health campaigning and information dissemination

Tailor dissemination campaigns to the urban context, including: Twice yearly sponsored entertainment road-shows in Munhava with counseling and testing, and treatment side shows; leverage local T.V and radio coverage for HIV and STI programming – interactive talk back shows. Target key issues arising from the research: multiple concurrent stable sexual relationships; the ‘married’ person dilemma; safe sex exchange;

³¹ There is a precedent for this with the use of Municipal Money for the provision of ambulances to the health facilities.

condom use YES, consistent condom use EVEN BETTER; ART and STI treatment – challenges for ‘youth’, and ‘mobile populations.’

10.5. Develop a comprehensive programme steam concentrating on ‘trust’ relationships in Mozambique

‘Trust’, relationships and HIV transmission. What is the message? Promote a forum to share SADC wide experiences on multiple concurrent stable relationships ‘Trust’, relationship and programming successes. Leverage funds for pilot experiences and ‘learning by doing’ research.

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