MOZAMBIQUE

Baseline report on young key populations and sexual and reproductive health and rights
## Contents

Contents .................................................................................................................................................. 1

executive summary .................................................................................................................................. 2

abbreviations .......................................................................................................................................... 5

introduction ............................................................................................................................................ 7

baseline findings .................................................................................................................................... 8

conclusions and areas for further research ........................................................................................... 20

references ............................................................................................................................................... 23
EXECUTIVE SUMMARY

Securing the SRHR of young people has become an urgent priority, both as a goal and a driver, for sustainable development across Africa. There is also increasing recognition that certain subsets of young people may require specific attention in policy and programming as a result of heightened levels of risk and vulnerability and who are considered ‘key populations’ (KPs) in the HIV response. KPs include sex workers, lesbians, gays, bisexuals, transgender and intersex (LGBTI) people, people who inject drugs (PWID) and prisoners. This collective of what are rather distinct groups are disproportionally affected by the HIV epidemic and faced with repressive legislation and societal antipathy following their identity and/or behavior(s). Very few studies have investigated the dynamics, vulnerabilities and needs of young KPs, in part due to the ethical and methodological difficulties of including them in research. An extensive desk review supported by semi-structured interviews with 38 key actors in Maputo, Beira and Nampula aimed to capture the legislative, socioeconomic and environmental issues that affect the SRHR of young KP and to identify current knowledge gaps which would warrant further investigation in each group.

The key findings of the baseline enquiry are:

- A lack of research on the SRHR of young KP leaves a large void in our understanding of health-seeking behaviour and how their needs and circumstances differ from adolescents and young people in general in Mozambique, who mature in a context of severe poverty, unemployment and cultural practices that encourage sexual debut and marriage at an early age. Hence, the overlapping vulnerabilities of being an adolescent as well as a member of a key population are yet to be fully understood in order to relate them to SRH outcomes; outcomes which remain largely obscured in general population data.

- KP-specific data is available for HIV and reveal a rapid increase of transmission risk on entering adulthood. This has provided the rationale for interventions and funding to prioritize HIV prevention, testing and treatment among female sex workers, men who have sex with men, people who inject drugs and prisoners. Out of these groups, most attention is being directed toward adult female sex workers and men who have sex with men.

- Important legal reforms in the past five years, which decriminalised sex work and homosexuality and allowed for alternative measures to imprisonment, have been followed by the development of KP-specific policies and strategies aimed at increasing the uptake of services and removing health service barriers for KPs. The proposed package broadens the service focus on HIV control to also offer screening and treatment of other STDs and tuberculosis, family planning, cervical and prostate cancer screening and attend to issues of SGBV.

- The willingness to reach adolescent and young KP with these efforts is less apparent. The country’s legal frame for minors coupled with the sensitivities attached to the practices or identities of the different KP groups make it very difficult for governmental and non-governmental providers to work in this space. Current legislation and age limits set to protect them appear ineffective in practice and, at times, counterproductive.
As a result, young KP members below the age of 18 are vulnerable to situations of harm and exploitation whilst health, social and legal support are not available to them in the same degree as for their adult peers.

- There is a sharp contrast between the normative views on sex work as a prohibited and immoral activity, and some traditional customs which intertwine with practices of transactional and intergenerational sex in Mozambique. The realities of a widespread occurrence of some form of sex work and the need to intervene, particularly in the underage bracket, are a prompt for the legislators to start regulating the sex industry. Existing HIV/SRH initiatives tend to concentrate on hot-spots where certain types of sex workers operate. Further work will be needed to unpack the full diversity in sex work (incl. male SW), and possible differences in SRH risks and needs as to inform the design of more inclusive SRH related information and services.

- Societal views on LGBTI people, particularly in urban settings, are said to be tolerant. However, disclosure or living openly as a homosexual or transgender remains a challenge in the face of prevailing religious and cultural norms and pressures to establish a family. There is limited knowledge of how young people manage the pressure to conform, if and where they seek support for questions around sexual and gender identities. Provision of SRH services as well as research on LGBTI primarily evolves around the group of adult MSM, leaving large gaps in our understanding of SHR outcomes and needs of lesbians, bisexual women and intersex people.

- The legislation criminalises people who inject drugs but at the same time also assumes active responsibility for their protection and rehabilitation. Current reality is that PWID are not benefiting from this stipulation. The Ministry of Health - largely responsible for enactment – is confronted with resource constraints to create rehabilitation centres, knowledge gaps in size and whereabouts of PWID as well as reputational risk considerations in mounting harm reduction programmes for a group which society considers as ‘marginals’. There is a weak constituency base representing the voice of PWID in policy and funding decisions and very few NGO-led support initiatives targeting this specific group.

- There is very little insight into the realities and exposure of young prisoners to risk situations in a setting where constitutional rights such as right to health, dignified living conditions and public trial are under pressure and age-based separation is not enacted throughout the prison system. There are considerable access barriers for prisoners to receive health services, incl. life-saving treatment. Provision of condoms and lubricants to prisoners continues to be a highly contentious issue and measures of prevention are confined to education and training, and where available counselling and testing. Only a few NGOs operate inside the prison on issues of health and reintegration.

- For all young KP groups, there is need for more precise knowledge on the types of (social) support and services that young people need and apply in order to mitigate SRH risk and exercise their rights within the broader, challenging context of being an adolescent in Mozambique. This enquiry should move beyond the current, narrow focus on HIV, which seems to have been driving the country’s key population response to date.
Further operational research is recommended which will deconstruct the different young key population groups and capture the diversity in expression, identities and SRHR needs; corroborate societal perceptions of young key populations with the lived experiences of each of these groups; produce knowledge on those groups that have so far remained invisible in research, policy and programming; and research which will identify the coping strategies and support systems applied by and available to young key populations in Mozambique. The report contains suggestions for specific research questions, based on our current understandings of each key population group.
<table>
<thead>
<tr>
<th>ABBREVIATIONS</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immune-deficiency syndrome</td>
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<tr>
<td>ARISO</td>
<td>Association for Rehabilitation and Social Integration</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-Retroviral Treatment</td>
</tr>
<tr>
<td>FSW</td>
<td>Female Sex Worker</td>
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<td>HCT</td>
<td>HIV Counselling and Testing</td>
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<tr>
<td>HEARD</td>
<td>Health Economics and HV/AIDS Research Division</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>IBBS</td>
<td>Integrated Biological and Behavioral Survey</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<tr>
<td>ICRH</td>
<td>International Centre for Reproductive Health</td>
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<tr>
<td>KP</td>
<td>Key Population</td>
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<tr>
<td>LAMBDA</td>
<td>Associação de Defesa das Minorias Sexuais / Association for Sexual Minority Rights</td>
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<tr>
<td>LGBTI</td>
<td>Lesbian, gay, bi-sexual, transgender and intersex</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health / Ministério da Saúde (MISAU)</td>
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<tr>
<td>MSF</td>
<td>Médecines Sans Frontières / Doctors without Borders</td>
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<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
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<tr>
<td>MSW</td>
<td>Male Sex Worker</td>
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<tr>
<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People/person living with HIV</td>
</tr>
<tr>
<td>PWID</td>
<td>Person who injects drugs</td>
</tr>
<tr>
<td>REMAR</td>
<td>Rehabilitation of People on the Margin of Society</td>
</tr>
<tr>
<td>SAAJ</td>
<td>Serviços Amigos de Adolescentes e Jovens / Youth Friendly Services</td>
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<tr>
<td>SGBV</td>
<td>Sexual and Gender Based Violence</td>
</tr>
<tr>
<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
</tbody>
</table>
SW  Sex Worker
UEM  Universidade Eduardo Mondlane / University of Eduardo Mondlane
UNDP  United Nations Development Programme
UNIDOS  Rede Nacional Contra Droga / National network against Drugs
YKP  Young Key Population
INTRODUCTION

Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters related to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when and how often to do so. The assertion of individual choice and control in matters that involve, at minimum, two individuals has proven problematic as sexual and reproductive choices are subjected to a range of socio-cultural, traditional, religious and gender norms that cannot easily be dismissed. The broader socio-economic and political context can also offset the infringement of individual autonomy when a State or society imposes legal barriers to exercising sexual and reproductive rights (SRHR) or fails to protect those vulnerable to sexual exploitation or harmful practices such as early marriage. Hence, SRHR choices are not just shaped by a person’s disposition; they are also strongly determined by the social context in which these choices take place. The social context can be particularly defining for young people. As young people transition from child to adulthood, tensions emerge when their sexual exploration evokes normative judgement and steering from parents, peers, teachers and community leaders. Their access to sexual and reproductive health information and services can be challenging in the face of third-party consent requirements or social barriers and subsequently place them at a disadvantage to avoid/redress risk behaviour. At the same time, young people may also experience benefits from their immediate social environment in the form of support to coping with the stressors of adolescence and keeping them out of harm’s way. As the state of one’s sexual and reproductive health during adolescence is a strong predictor of sexual and reproductive outcomes later in life, it is important to understand what shapes young people’s SRH in a period characterised by multiple pressures and challenges and which opportunities exist to prevent or mitigate negative SRH outcomes.

Attention to the young people’s vulnerabilities and risk mitigation is particularly critical for the African continent, where about two fifths of the population is within the 0-14 age bracket (approximately 486 million children) and nearly one fifth in the 15-24 age bracket (approximately 230 million young people) (UNECA, 2015). Securing the SRHR of young people has become an urgent priority, both as a goal and a driver, for sustainable development across Africa. There is also increasing recognition that certain subsets of young people may require specific attention in policy and programming as a result of heightened levels of risk and vulnerability and who are considered ‘key populations’ (KPs) in the HIV response. KPs include sex workers, lesbians, gays, bisexuals, transgender and intersex (LGBTI) people, injecting drug users and prisoners. This collective of what are rather distinct groups are disproportionally affected by the HIV epidemic and faced with societal disapproval, discrimination, marginalization, even criminalization based on their identity and/or behavior(s). Very few studies have attempted to capture the dynamics, vulnerabilities and (SRH) needs of young KPs, in part due to the ethical and methodological difficulties of including them (especially those below the age of eighteen) in research.
However, an in-depth understanding of the key legislative, socio-economic and environmental issues that affect the SRHR of KPs, and the enquiry into possible differences between adult and young key population issues is necessary to guide future SRH country policies and strategies. Findings from Mozambique suggest there are additional complexities within this age bracket which require critical attention as they directly affect the scope and availability of services for these groups. The following sections discuss the broader legislative, political, socio-economic and cultural context, prior to specifying what is currently known of the SRHR situation in each key population group and which knowledge gaps remain. It concludes with areas and questions for further research on YKPs in Mozambique.

**BASELINE FINDINGS**

*Legislative and political context*

A collection of laws, policies and guidelines are framing the sexual and reproductive health rights of Mozambique’s citizens, including those belonging to key populations. The country’s core legislative piece, the Constitution (2004), affirms their fundamental right to health and obliges the State to ‘promote the extension of medical and health care and equal access of all citizens to the enjoyment of this right’. Moreover, the Constitution emphasises social justice, quality of life and the promotion of human rights and equality regardless of colour, race, sex, ethnicity, place of birth, religion, educational level, social status, marital status, profession, and political orientation. Further commitments for the social inclusion, protection and care of vulnerable and marginalised groups in society are anchored within the Social Welfare policy (1998), and specifically for children, in the Law for the Promotion and Protection of Child Rights (2008).

A National SRH Policy (2011) guides the operationalisation of the right to sexual and reproductive health in Mozambique. The document defines seven areas that mark the country’s focus in SRH service provision: gender and sexuality, physical and sexual violence; family planning; infertility and sexual dysfunction; STDs and HIV; safe motherhood; abortion; and non-infectious conditions of the reproductive system, including cancers. The SRHR of young people is prioritized, with an emphasis on information, education and communication (IEC) and preventive services to mitigate the specific SRH problems in this age bracket. These are early and unwanted pregnancies, unsafe abortion, STDs and HIV, inadequate nutrition, substance abuse and physical and sexual violence.

Specific attention to the sexual and reproductive health and rights of key populations is to a large extent espoused by the country’s strategies and guidelines which focus on HIV. The National Strategic Plan for HIV and AIDS (2014-2019) distinguishes four key population groups requiring targeted interventions, notably female sex workers (FSW) and their clients, men who have sex with men (MSM), people who inject drugs (PWID) and prisoners, while adolescent girls and young women are identified as a vulnerable group (table 1).
### Table 1. Key and vulnerable populations in Mozambique (source: CNCS, 2015).

<table>
<thead>
<tr>
<th>Key populations</th>
<th>Vulnerable populations</th>
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<tbody>
<tr>
<td>Female sex workers and their clients</td>
<td>PLHIV</td>
</tr>
<tr>
<td>Men who have sex with men</td>
<td>Mobile and migrant workers</td>
</tr>
<tr>
<td>People who inject drugs</td>
<td>Adolescent girls and young women</td>
</tr>
<tr>
<td>Prisoners</td>
<td>Orphans and vulnerable street children</td>
</tr>
<tr>
<td></td>
<td>People with disabilities</td>
</tr>
</tbody>
</table>

The updated National Guidelines (2016) for the implementation of HIV Counselling and Testing (HCT) highly recommend HCT among vulnerable and key populations. It stipulates that HIV counselling and testing strategies must be adapted to their specificities and needs. Cognisant of the sensitivities around service acceptability and access for these groups, it recommends a combination and integration of various services, both within as well as outside the health facility. According to the guidelines, testing restrictions apply for adolescents below the age of 15. At the youth-friendly health service points, called the SAAJ\(^1\), adolescents between the age of 12-15 need to be accompanied by a trusted person of 18 years or above to be able to obtain a HIV test. Adolescents and young people aged 15 or above do not require a third party consent.

The need for integrated services and removal of service barriers for KPs in particular is further underscored in the Guideline for Integration of HIV/AIDS Prevention, Care, and Treatment for key populations (2016), aged 18 and above. The guidelines are situated within the ambitious roll-out of the Test and Treat approach to control HIV as well as a broader drive by the Ministry of Health to ‘humanize’ the health services, in which user-friendliness, a stigma and discrimination-free environment, and service coverage are key elements. The implementation of the guideline is accompanied by targeted interventions among health care personnel to increase their competence and address the issue of judgemental attitudes and unethical behavioural conduct towards KP in need of health services.

Prior to the guidelines, Mozambique made important revisions to its Penal Code (2015) through which the legal context for some key population groups improved. The provisions that previously criminalised homosexuality and commercial sex work were removed, whilst provisions were made for alternatives to imprisonment, such as community service, for juveniles and small offenders. The new Penal code continues to consider drug use a criminal offense, and the act of ‘facilitating’ sex work, forced sex work or forced sexual acts, sexual violence and violence against another person remain illegal. The grounds for discrimination were also not extended to include sexual orientation and/or gender identity.

The observed legal advances, which have allowed for a more enabling environment to address the SRHR needs of key populations, are the result of a positive, political climate in Mozambique in which these issues can be debated.

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\(^1\) SAAJ is the abbreviation of Serviços Amigos de Adolescents e Jovens which are units or corners established within health facilities. There are approximately 287 SAAJ across Mozambique, with an overrepresentation in urban areas.
Dialogue and collaboration among government ministries and between them and civil society and international partners, coupled with external funding for KP interventions, have raised the profile of work and led to the formation of several working groups in this domain. The government at various levels has tolerated the existence of key populations in such a way that organisations led by these groups or working to support them have not been facing reprisals or recriminations. The willingness to expand the KP focus to include adolescent and young KP, however, is less apparent. The country’s legal frame for minors\(^2\) coupled with the sensitivities attached to the practices or identities of the different KP groups make it very difficult to work in this space. As a result, there are considerable gaps in attending to the specific needs and vulnerabilities of YKP. We will elaborate on the legislative context and implementation gaps in more detail and as they pertain to specific groups in the next sections. In order to place the needs and vulnerabilities of YKP into context, we first highlight some of the socio-economic and socio-cultural issues that influence the health and wellbeing of adolescents and young people in general.

*Socio-economic and cultural context*

Young people aged 15-24 years constitute 20% of the country’s population, which translates into 5.6 million young people (UNESCO, 2015). They are Mozambique’s post-war generation raised during the aftermath and recovery from a brutal civil conflict which disadvantaged them from an early age. Multiple adverse exposures, such as poor living conditions, poor nutrition and restricted access to health care and education - as systems were rebuilt – occurred during their childhood. Particularly girls were caught in the self-perpetuating cycle in which poor, uneducated households do not see value in schooling and deny this opportunity to their children (Roby et al, 2009). The effects are felt today. The majority of young people in Mozambique have no access to formal employment, nor the prospect that this will change in the near future. With an estimated 300,000 young people newly entering the labour market every year, competition is fierce. And as skill sets are low, young people have not much option than to accept employment in the informal sector (ADB, 2012). Young people’s inability to enter the labour market and secure a stable and salaried job is vividly articulated as ‘waithood’ (Dhillon et al, 2009). Their continued dependence on parents or other relatives for livelihood effectively blocks their transition to adulthood which includes a self-supporting household. It is not a phenomenon unique to Mozambique, but witnessed across the continent as a result of the youth bulge. The potential acceleration of economic growth and elimination of poverty, driven by this bulge (African Union, 2011), will require active labour market policies, further investments in higher education as well as political vision. Meanwhile, almost three quarters of the country’s population (69%) live on less than U$1.90 per day; a situation which has not changed significantly in the past two decades (WB, 2016).

\(^2\) Young people formally reach adulthood by the age of 21. Under the age of 21 (and in some particular cases 18), young people do not have full autonomy on their decisions and may require parental consent.
There is considerable social pressure on young people to establish a family, even if they lack the necessary social, material and professional conditions to do so (Macia et al, 2013). Teaching on family values and normative behaviours starts from early childhood with the aim to facilitate young people’s integration in the community and acceptance as an adult. Initiation into sexuality is a critical part of this passage. In the Sena and Makua cultures in Central and Northern Mozambique, initiation can start as early as eight years for girls. During the rites, gender roles are reinforced with differences noted between ethnicities, whereby male superiority is emphasized by the Shangaan culture (Southern Mozambique) and part of the Sena and respect for women in the Makua culture (Kotanyi, 2009). While girls are generally taught not to refuse sex to their husbands, their induction is not one of submission or procreation bound. Expressions of female sexual agency as well as practices to increase sexual pleasure for both partners are part of a cultural tradition that preceded the permeation of religious connotations during colonial and post-colonial periods (Arnfred, 2015).

Mozambique’s cultural traditions, encouraging early sexual debut and marriage for girls, are reflected in the statistics, whereby almost half of the girls have their first pregnancy between the age of 15-19 and the contraceptive uptake in this age bracket is low (IMISIDA, 2016; see also table 2).

Table 2. Selected SRH indicators (source: IMISIDA, 2016;2017)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Urban 15-49</th>
<th>Rural 15-49</th>
<th>15-19 years</th>
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<tbody>
<tr>
<td>Ever pregnant</td>
<td>-</td>
<td>-</td>
<td>46% overall</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>35% urban</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>54% rural</td>
</tr>
<tr>
<td>Modern contraceptive use</td>
<td>34%</td>
<td>21%</td>
<td>14%</td>
</tr>
<tr>
<td>Ever tested for HIV</td>
<td>72% (f) 50% (m)</td>
<td>41% (f) 29% (m)</td>
<td>40% (f) 18% (m)</td>
</tr>
<tr>
<td>Male circumcision</td>
<td>68%</td>
<td>58%</td>
<td>68%</td>
</tr>
<tr>
<td>HIV prevalence</td>
<td>20.5% (f) 12.3% (m)</td>
<td>12.6% (f) 8.6% (m)</td>
<td>6.5% (f) 1.5% (m)</td>
</tr>
</tbody>
</table>

Child marriage is officially prohibited but the law as a singular instrument has not been able to remove the social pressure on (mostly rural) girls to marry and relieve their dependency on the family as well as prevent risks associated with adolescent pregnancies, such as pre-term delivery, low birth weight or neonatal death. There is a national strategy to prevent child marriage (2016-2019) which is expected to bring more substantive change through its focus on community mobilisation, greater access for girls to education and health services as well as a reform of the legal framework. Though urban girls are less exposed to the practice of early marriage, the difference does not translate in a much lower adolescent pregnancy rate. The relatively high occurrence of pregnancies out of wedlock give rise to other forms of vulnerability for the urban adolescent, resulting from an increased dependency and stigma around their social position.

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3 Marriage under the age of 18 is prohibited under the Family Law 2004, art. 30. Exceptions are made from 16 years onwards upon parental consent. Reforms proposed under the national strategy are to remove this exception.
Whilst nation-wide educational, clinical and community interventions appear to have been effective in increasing SRH knowledge and service uptake among young people, they were less successful in addressing the social norms that render them vulnerable to poor SRH outcomes (Chandra-Mouli, et al, 2015). This is also illustrated by the national HIV prevalence data which starts to climb steeply when girls and boys enter early adulthood (figure 1).

Figure 1. HIV prevalence by age and sex (source: IMISIDA, 2017)

![HIV prevalence by age and sex](image)

The vulnerable position of girls, both biological and social, is apparent with a 3 to 4 times higher odds to acquiring HIV than boys (IMISIDA, 2017). Early exposure to SRH risk situations warrants a strong focus on girls’ sexual and reproductive health, encouraging prevention from as young as 10 years old (National HIV and AIDS strategic plan) and service access from 12 years old (National SRH policy). The SAAJ are considered the prime provider of such services. However, key informants working on adolescent SRH noted that service coverage remains limited due to a general reluctance among adolescents to seek services as well as the urban-rural disparities in service availability (which is a larger and systemic problem of the country’s health system). Current plans are, additional to the SAAJ, to start locating SRH services in school settings as part of a larger school health programme targeting 12-18 year old in-school youth.

Adolescent and young members of key population groups are expected to visit the SAAJ for their SRH needs and concerns. However, as we will discuss in the next section, there are formidable legal barriers as well as social barriers for them to present as a YKP to the service. Coupled with a lack of research on the SRH of KP in this age bracket, there is currently a large void in our understanding of health-seeking behaviours in these groups and how their needs and circumstances differ from adolescents and young people in general in Mozambique.

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4 Only 7% of Mozambique’s GDP is allocated to health (WHO, 2014). Over 50% of the population lives more than 60 minutes by foot from the nearest primary health care facility (WB, 2016). The government is the main provider of health services. HIV and STI screening services are free of charge in the public sector. Private providers are mostly found in the urban areas and charge fees that are beyond the means of most of the population.

5 The ‘health corners’ will be staffed for one day a week by a nurse and the remaining days by peer educators who were trained under the national programme on young people’s access to SRH named Geração Biz.
We elaborate on the legislative and societal context, service and knowledge gaps for each of the KP groups covered under this research project, notably sex workers, LGBTI, injecting drugs users and prisoners.

Key SRHR issues per (young) key population group

Sex workers

While the act of sex work *per se* is no longer considered a crime in Mozambique, the inducement or promotion of transactional sex or sex work is, according to the Penal Code (2015). This second part leaves space for subjective interpretations as to who may be punishable under this law. There is no clear demarcation between the practice of sex work and its promotion, giving rise to uncertainties whether sex workers’ clients or the organisations that support sex workers would fall into the category of inducers. Sex worker-led organisations express concern over this grey area and of their legal status if their rights are violated. Moreover, there are doubts that individuals within their constituency have full knowledge of the law and that their sexual transactions are not punishable. The law does not apply to sex workers below the age of 18 and transactional sexual activities with minors are punishable. The rationale provided by the Ministry of Justice on this age distinction is that women or men above the age of 18 can make an informed decision to engage in sex work. Further reference is made to the Labour Law (2007), permitting employment from the age of 18. The dilemma of the Ministry in charge is how to effect the law without marginalising this vulnerable group which evidently exists; between a third to half of surveyed female sex workers (FSW) in Maputo, Beira and Nampula had their first paid sexual encounter under the age of 18 (MISAU, 2011-2012).

There is a sharp contrast between the normative views on sex work as a prohibited and immoral activity, and some of the traditional customs in Mozambique which intertwine with practices of transactional and intergenerational sex, in part induced by the severe economic constraints of families. The realities of a widespread occurrence of some form of sex work and the need to intervene, particularly on the part of those who are underage, are on the radar of the Ministry of Justice who is seeking to regulate the sex industry. What shape or form this will take is still unclear. Meanwhile, the issues around the safety and risk exposures in children are pressing (IOM, 2014; Lafort et al, 2010) as the police as well as Municipal authorities do not have the tools neither the resources to protect them or sanction those who exploit them.

The large diversity within this key population, as a cross-cut of society strata, challenges the ability of governmental and non-governmental providers to reach the full range of sex workers with SRH related information and services that is also seen to be responsiveness to the specific needs of each subgroup. While further work will be needed to unpack these groups, there is a large group of street sex workers which are more visible than the group of ‘elite sex workers’ who tend to operate away from public spaces. Another group are those who intermittently engage in transactional sex to complement their income or use it to buy ‘luxury’ goods but who do not consider themselves to be sex workers (Groes-Green, 2013).
This group may overlap with, what is believed to be, a sizeable group of students who sell sex to meet their educational and basic expenses (Inguane et al, 2015). And, there is a growing group of boys and young men who engage in male to male sex activities in exchange for money or other incentives and who not necessarily identify as a homosexual or bisexual.

The ‘default’ target group in the existing initiatives for sex workers are the women above the age of 18 who operate on the street and in known venues. In the major cities, particularly in Maputo, hot spots have been identified where female sex workers live and work. Health centres covering those catchment areas have been assigned as priority assistance centres for FSW, with HIV/STD counselling and testing as their main activity, as well as condom distribution and sexual health education. Some of the centres have extended opening times at the convenience of FSW. In some locations, such as Tete, there are also night clinics which exclusively provide oral and injectable contraceptives, HCT, male condoms, STI care and syphilis screening to FSW. NGOs, such as ICRH, MSF and FHI360, run FSW outreach programmes. Peer educators operate in the hotspots, with the role of identifying, advising, referring FSW to health facilities. Previously, the Ministry of Health had twenty-two designated ‘KP health facilities’. This has since grown to approximately 86 health facilities (mostly in Provincial capitals), which are implementing the KP Guidelines for Integration of HIV/AIDS Prevention, Care, and Treatment. It is the MoH’s ambition to scale-up to national coverage, using external funding. The service package for FSW currently includes HCT, counselling on safe sexual practices, STI, TB and cervical cancer screening, provision of PEP, condoms and lubricants, attention to SGBV, partner notification and universal test and treat (anti-retroviral treatment). Accelerated efforts are in response to the low service uptake and high levels of unawareness of HIV serostatus (approx. 50%) that was uncovered by various pieces of research despite FSW’ knowledge on where to obtain services (Inguane et al, 2015; IOM, 2014). Special health worker trainings, though currently one-off and not part of curricula, are intended to counter unprofessional behaviour and establish a better rapport between providers and FSW. Service bottlenecks pertain to stock-outs of female condoms, at times anti-retroviral treatment, and a lack of equipment for cervical examinations within health facilities. Subsequently, STI tend to be treated on the basis of syndromic management. A specific need, emerging from the experiences with HIV-positive sex workers in the hot-spots initiatives, is the need for flexible arrangements in the provision of anti-retroviral treatment. The high mobility of this KP compromises their ART retention as there is no system in place which facilitates the treatment uptake of one person from various locations.

There is evidence that prevention services, such as peer interventions, are far less likely to reach the underaged (Inguane et al, 2015) who are not considered sex workers in the legal sense. This frame also positions the work of sex worker associations, such as Tiyane Vavassate, who support SW from the age of 18 onwards. Similarly, there have been reports of underage FSW being refused critical SRH services, such as contraception, because providers considered them too young (Inguane et al, 2015).
The negotiating power in propositions for risky sexual acts such as anal or condomless sex is found to be weaker in this group (IOM, 2014) and significant differences between underage and adult FSWs in their reports of unprotected sex and symptoms of sexually transmitted diseases (STIs) point at a heightened levels of vulnerability (MISAU, 2013). HIV infection rates rise exponentially with age (table 3).

**Table 3.** HIV prevalence rates in FSW per age group (source: MISAU, 2013).

<table>
<thead>
<tr>
<th>City</th>
<th>Age 15-17</th>
<th>Age 18-19</th>
<th>Age 20-24</th>
<th>Age 25-29</th>
<th>Age ≥ 30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maputo</td>
<td>0%</td>
<td>14.1%</td>
<td>25.1%</td>
<td>63.7%</td>
<td>56.7%</td>
</tr>
<tr>
<td>Beira</td>
<td>5.1%</td>
<td>6.8%</td>
<td>31.9%</td>
<td>42.9%</td>
<td>54.1%</td>
</tr>
<tr>
<td>Nampula</td>
<td>0.5%</td>
<td>3.5%</td>
<td>20.3%</td>
<td>45.3%</td>
<td>54.4%</td>
</tr>
</tbody>
</table>

There is a complete gap in knowledge on male sex workers, apart from some data in the Integrated Biological and Behavioral Survey (IBBS) among MSM which reported that approximately 40% of the surveyed men had transactional sex with a male and approximately 20% with a female in the past twelve months (Horth et al, 2015). It is also unclear to what extent male sex workers are reached by services targeting MSM, whether services are considered appropriate and if not, where male sex workers otherwise seek SRH-related services.

**Lesbian, Gay, Bisexual, Transgender and Intersex people**

Similar to the legislation on sex work, the law neither legalises nor criminalizes same-sex relations. Its protective value, however, remains limited, according to the main LGBTI organization in Mozambique; LAMBDA. The omission of sexual orientation and gender identity as grounds for discrimination in the Penal Code (2015) and citizen equality in the Constitution (2004) leaves LGBTI people vulnerable to discriminatory practices and exclusion from employment or services. An ambiguity, as the Labour Law (2007) does include sexual orientation as an unlawful ground for dismissal or refusal of employment. The country’s Family Law (2004) excludes couples from the same-sex from the possibility to form a union nor does it recognise a family unit with parents of the same sex. A new round of reforms of the Penal Code are expected soon in which LGBTI activists are determined to, once more, lobby for the inclusion of sexual orientation and gender identity in this piece of legislation.

In the past decade, considerable progress has been made to bring the taboo subjects of sexual and gender diversity into the public debate. There is regular coverage and openness of these issues on national radio, television and social media. Key informants describe the current situation in Mozambique as one where there is tolerance but not (yet) an acceptance of LGBTI people. Some segments of society continue to actively condemn LGBTI and consider these groups as perpetrators of practices which are in shock with the cultural reality. Religious groups reportedly form the strongest opponents. Disclosure or living openly as a homosexual or transgender remains a challenge in the face of prevailing religious and cultural norms and the pressure to establish a family.
There is limited knowledge of how young people, particularly adolescents, manage the pressure to conform, if and where they seek support for questions around sexual and gender identities. Safe spaces to discuss issues of self-identity, family, health and wellbeing are available in the cities of Maputo, Nampula and Beira from the age of eighteen. Working with young people on LGBTI-related issues is sensitive and there is considerable reluctance to start providing services to individuals people below this age.

The provision of SRH services for LGBTI people primarily concentrates on the group of adult men who have sex with men (MSM). This focus is derivative of the priority groups in the National HIV and AIDS Strategy and the allocation of KP funding. In addition, some key stakeholders expressed the view that within the LGBTI ‘cluster’ MSM are the most at risk for HIV. According to the available epidemiological data in MSM, infection rates rise after the age of 25 (table 4).

Table 4. HIV prevalence rates in MSM per age group (source: Nalá et al, 2015).

<table>
<thead>
<tr>
<th>City</th>
<th>Age 18-24 (%)</th>
<th>Age ≥ 25 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maputo</td>
<td>2.4%</td>
<td>33.8%</td>
</tr>
<tr>
<td>Beira</td>
<td>2.8%</td>
<td>32.1%</td>
</tr>
<tr>
<td>Nampula</td>
<td>2.7%</td>
<td>10.3%</td>
</tr>
</tbody>
</table>

Research thus far has equally singled out MSM, leaving large gaps in our understanding of SRH outcomes and needs of lesbians, bisexual women and intersex people in Mozambique. Information that could also not easily be solicited from key informants.

Between 30-50% of surveyed men in the IBBS on MSM indicate to also have sexual relations with women and were classified as bisexual (Nalá et al, 2015). The extent to which transgender women or men may have formed part of this research is difficult to establish as the data did not present this information. An enquiry into MSM behaviours in terms of their engagement in transactional sex or drug use demonstrates there is overlap with other KP groups (Nalá et al, 2015; INS et al, 2011). The various fluidities may lead us to question whether current understandings of MSM in the context of Mozambique are sufficient to adequately respond to their service needs.

The service package for MSM currently includes HCT, counselling on safe sexual practices, STI, TB and prostate cancer screening, provision of PEP, condoms and lubricants, attention to SGBV, partner notification and universal test and treat. This package is provided by the MoH health facilities, which implement the KP Guidelines. LAMBDA also provides HCT in designated offices in the country as well as psycho-social and legal support to MSM aged 18 and above. The same approach of peer educators is used to identify and assist MSM with navigating the health service, with some locations also employing transgender peer educators. This approach has reportedly helped to reduce the level of discrimination which MSM experience while seeking services and which kept them from disclosing their sexual orientation to a provider. Service bottlenecks pertain to stock-outs of lubricants, at times ART and an absence of equipment for anal STD screening within health facilities.
Depending how people may choose to disclose their identity, the KP guidelines do not specifically target lesbians, bisexual and intersex people. There appears to be an implicit expectation that they will visit the general health services, and - articulated in particular for lesbian women - are not considered a high risk group.

People who inject drugs

The legislation on drug use distinguishes itself from the legislation on sex work and homosexuality in that it does criminalise this specific behaviour but at the same time also assumes active responsibility for the protection of this group, which is not the case with the before mentioned KP groups.

The law on drugs (1997) penalises those engaged in the preparation, drug-smuggling, selling and possession of narcotic drugs, psychotropic substances, precursors or other substances of similar effect. The sentence typically comprises of one to two years imprisonment and a fine. According to the law, individuals who have not reached the age of maturity are exempt from this punishment. According to a key informant legislator, adolescent and young drug users are increasingly aware of this clause to the extent that their impunity leads them to knowingly use, sell, and possess of drugs (whether this is out of free will remains unknown). Further exemptions are made for those who are not recurrent offenders, and for those who declare to be a drug addict but pledge not to resume their behaviour and to accept medical treatment. Those who initiate seeking health care, particularly minors accompanied by their legal guardians, will be guaranteed anonymity. The MoH is responsible to adequately respond to these patients.

An important loophole in the law may still lead to the arrest of adolescent and young people who inject drugs (PWID). It concerns the reference to the age of maturity, which is not further quantified and hence subjective to misinterpretation, depending on the law that is used to penalise the individual. Whereas the age of 21 is generally regarded as signifying maturity in Mozambique, the Law on Children in conflict with the law applies other age limits. 6 Authorities, such as the police, may enforce the available laws differently. Another issue is the unclarity on whether the possession of a small quantity of drugs for personal use warrants an arrest or not. The law appears to permit personal use, but there is anecdotal evidence that, in practice, this clause is being disregarded.

The guiding document which governs interventions to prevent and combat drug use is the National Policy and Strategy for Combating Drugs (2003). The policy acknowledges that the use of drugs in general, and injectable drugs in particular, has serious consequences for the family and work environment and is a driver of HIV transmission and crime. At the same time, the document also regards the actual dependence of drug users ‘as a misdirection of conduct’.

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6 There is impunity for children who are in conflict with the law and under the age of 15. Between the ages of 16-18, children will be subjected to alternatives sentences instead of imprisonment. Between the ages of 18-21 the law is less clear. While they are still considered minors by this law, this is only applicable to certain crimes and cases.
In preservation of human dignity, it is the State’s duty to guarantee the health of drug addicts and combat their social exclusion, without foregoing his/her individual responsibility. The policy calls for putting in place the conditions that enable drug addicts to access treatment and other health services; to adopt harm reduction policies; to promote and encourage their reintegration in family and work environments; and to assure that providers of psycho-social care and social reintegration services operate with at least the minimum standard of quality.

While the legal and policy environment may be in place, the reality is that PWID as a KP are not receiving the necessary attention nor services, apart from some scattered interventions led by a handful of civil society organisations such as REMAR and UNIDOS. On the one hand, the lack of knowledge on the magnitude of the problem, size and whereabouts of this group (Sathane et al, 2015) seems to inhibit further action. On the other hand, a large share of the responsibility seems to rest with one sector which, until recent, did not have a substantive involvement or direction in supporting this key population group. The mental health department is responsible for effecting the policy on behalf of the MoH. The department is currently developing Harm Reduction Guidelines, in which a methadone programme is expected to feature. It is still unclear to what extent the Guidelines will also be permissive to the distribution of clean needles and syringes. The methadone programme will be piloted in a reference health centre in Mafalala, Maputo, where the MoH, together with MSF already provides Hepatitis screening and treatment for Hepatitis C. The area is one of the ‘hotspots’ for PWID in the capital. The construction of treatment and rehabilitation centres is not currently being planned for but the vision is that these sites will be placed within general hospitals. At present, there is only one treatment site in the country which is situated in the psychiatric hospital in Maputo. Key informants revealed that PWIDs who sign up for this programme often leave prematurely as they are hospitalised together with psychiatric patients and alcoholics and find it difficult to cope in such environment.

A first (and only) survey on PWID in Maputo and Nampula/Nacala revealed that they are a relatively small group in society and predominantly male and young, with mean ages of 22 and 28 respectively (Sema-Baltazar et al, 2015). A very high burden of HIV infection was found within this group from the age of 25 and onwards (table 5) and an alarming 85% of HIV-positive PWIDs from Nampula/Nacala was not aware of their serostatus.

Table 5. HIV prevalence rates in PWID per age group (source: Sema-Baltazar et al, 2015).

<table>
<thead>
<tr>
<th>City</th>
<th>Age 18-24</th>
<th>Age 25-34</th>
<th>Age ≥ 35</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maputo</td>
<td>29.6%</td>
<td>45.9%</td>
<td>50.3%</td>
</tr>
</tbody>
</table>
| Nampula/Nacala  | 8.3%      | 47.7%     | 73.1%    

REMAR is a religious-based organisation which provides rehabilitative services for PWIDs. UNIDOS, which is a network of organisations, does not have an exclusively focus on PWID but may include them as a target group, depending on their activities and funding.
The society regards PWIDs as ‘marginals’. This underlies part of the reason that the MoH is reluctant to incorporate needle exchange into its harm reduction programme, risking to be seen as ‘supporters of drug users’. There is also an inhibition to allocate a share of the country’s health resources to this population.

Interventions which have a larger support base are those that focus on prevention, such as workplace-based and school-based interventions led by the Cabinet to combat drugs at Provincial levels. There seems to be some interest from the side of practitioners to open up the debate around the repression of drug dependent individuals, and as a first step, reconsidering the penalties for personal use and differentiate according to type of drugs in possession. However, the current capacity and voice to defend the interest of PWIDs is not as strong as observed in MSM and FSW.

**Prisoners**

Prison policy (2002) establishes that prisoners under the custody of the penitentiary services retain all their rights, except for those explicitly restricted or removed by the sentence they must comply to. The policy also states that inmates will receive health care during their imprisonment, will be provided with periodic HIV testing and information on prevention and that, prisoners infected with HIV will be monitored and receive treatment. The Law on Children in Conflict with the Law (2008) further states that young prisoners, aged 18-21 years, are to be separated from adults and be permitted regular visits from their parents. Reforms initiated in 2006, aimed at changing from a retributive to a restorative justice system, allowed for alternative measures to imprisonment (such as community work) for minors between the ages of 16-18 and to those receiving sentences below two years. Offenders below the age of 15 cannot be sentenced. As a consequence, there are children which are being exploited to perform criminal acts for adult criminals. In reality, prisoners do not retain all their rights, e.g. the right to vote. Other constitutional rights, such as right to health, dignified living conditions, and a public trial are under pressure. There are considerable access barriers for prisoners to receive health services, poor hygienic circumstances, overcrowding and a high proportion of prisoners (33%) are in pre-trial detention.

Mozambique’s prison population is predominantly male and under 30 years of age. There continues to be a big controversy around the issue of condom provision in the prison. Whilst the directors of these institutions recognise that sexual relations between inmates may happen, few will openly admit this, according to key informants. As a consequence, condoms and lubricants are not made available to prisoners. The SRH and HIV-related interventions within prisons are limited to education and training, and where available, HCT. The trainings are universal, covering all age groups. Pathfinder and ARISO, which are non-governmental organisations, provide such level of support in prisons. Prisoners may access SRH services at a health post within the prison establishment, of which the range and quality is reportedly limited, or in some cases absent. Alternatively, prisoners may seek services from a public health facility, where there is little privacy to discuss issues of SRH as they are under the supervision of prison staff at all times. Despite the entitlements mentioned in the Prison Policy, the IBBS found that prisoners were faced with the discontinuation of lifesaving treatment for HIV, TB and Hepatitis C (INS, 2013).
No further details were provided of the reasons and length of discontinuation in the study report. According to the MoH, anti-retroviral treatment is provided in the health posts within prisons or at a nearby health facility.

There is recognition of the vulnerability of young inmates to psychological, physical and sexual forms of violence, particularly from older prisoners. Where possible, prison centers separate juveniles from adult prisoners. The only data source available on sexual relations within prisoners is the IBBS in which 6.5% of prisoners below the age of 21 and 12.3% aged 21 to 25 years reported to have had experiences with forced sex. Experiences with consensual sex was 3.8% and 6.1% resp. (INS, 2013). The survey results on HIV and syphilis prevalence are provided in table 6.

Table 6. National prevalence of HIV and syphilis in prisoners per age group (source: INS, 2013).

<table>
<thead>
<tr>
<th>Infection</th>
<th>Age &lt;21</th>
<th>Age 21-25</th>
<th>Age 26-30</th>
<th>Age 31-35</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>10.6%</td>
<td>20.4%</td>
<td>29.4%</td>
<td>35.1%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>10%</td>
<td>14.6%</td>
<td>15.4%</td>
<td>18.2%</td>
</tr>
</tbody>
</table>

Apart from the IBBS, there are is no other data which helps further our understanding of the magnitude of vulnerability in young people inside prisons in Mozambique. The survey results leave many open-ended questions around the actual access to SRH services for prisoners, their specific needs, coping mechanisms and ability to seek redress when they find themselves in harm’s way.

CONCLUSIONS AND AREAS FOR FURTHER RESEARCH

The baseline findings illustrate the complexities of improving the SRHR of young key populations. There are the structural determinants which affect Mozambique’s growing group of young people, such as lack of active labour market policies and harmful cultural practices, and those that affect young key populations in particular such as the ambiguities within and between laws and policies and the societal disapproval of certain identities and practices. The intersections between the different vulnerabilities of adolescent and young Mozambicans and the repression faced by young key populations are yet to be fully understood in order to relate them to the SRH outcomes in these groups. Outcomes which, for a large part, remain obscured in the data on the general population. KP-specific data is available for HIV, suggesting a rapid increase of HIV risk on entering (early) adulthood, which has provided the rationale for targeted interventions, particularly aimed at adult MSM and FSW.

While there is a larger body of knowledge on MSM and FSW compared to the other KPs in Mozambique, there is insufficient depth in understanding the heterogeneity within these populations. A deconstruction of these groups that captures the diversity in expression, identities, practices and SRH needs may help inform and strengthen the effectiveness of current approaches and messaging, possibly locating subgroups who have so far remained invisible to programmers and practitioners.
Findings point at a level of openness and tolerance towards homosexuality, with the decriminalisation signifying an important change in the legal position of young gays and lesbians in Mozambique. However, there have been very few enquiries into the societal discourse on same-sex relations. Expressions of a non-conforming sexual orientation or identity are likely to be suppressed in a context in which young people are family-dependent, socialised according to their gender and steered towards unions with the opposite sex. But these narratives remain largely anecdotal and there is an absence of young people’s experiences. How do young people manage social pressure, situations of stress or sexual risk, and where do they seek support and services for their SRHR?

We know that the current space for working with young LGBTI is contentious and that the SAAJ – currently considered as the first point of call - are not (yet) sufficiently equipped to respond to their needs and concerns. We also have some insight into the reasons (e.g. reputational risk, a patchwork of legislation that is unable to produce a coherent legal stance) that contribute to this gap in attention to young LGBTI and to young SW, PWIDs and prisoners. In view of the sensitivities and legal barriers of attending to YKP in Mozambique, there is need for further investigations into the societal perceptions of these different groups, and corroborated by young people’s narratives, with a view to identifying which opportunities/space exist to respond to their SRHR needs given this knowledge.

Current legislation and age limits set to protect YKP appear ineffective in practice and, at times, counterproductive. A combination of factors appear to inhibit law enforcement, among which limited tools and legal knowledge among responsible authorities. This situation is further compounded by a deep societal antipathy towards behaviours that are linked to drug use, crime and prostitution which situates young addicts, prisoners and sex workers at the margins of society. The extent of marginalisation and deprival of constitutional rights, and how this in turn shapes the SRHR of young PWIDs and prisoners is unknown. Apart from HIV epidemiology, both groups have so far largely been invisible in research. Findings also show there is a very limited support base available to PWIDs and prisoners as well as constituency base which can represent their voice in policy and funding decisions.

For all YKP groups, there is need for more precise knowledge on the types of (social) support and services that young people need and apply in order to mitigate SRH risk and exercise their rights within the broader, challenging context of being an adolescent in Mozambique. This enquiry should move beyond the current, narrow focus on HIV, which seems to have been driving the country’s KP response to date, with an aim to deconstruct YKP groups and capture the diversity in expression, identities and SRHR needs; to corroborate societal perceptions of YKP with the lived experiences of YKP; to produce knowledge on those groups which have largely been invisible in research, policy and programming, and; to identify coping strategies and support systems applied by and available to YKP in Mozambique.

Possible research questions that could be pursued on the basis of our current understandings include:

- Which local definitions and classifications of young sex workers exist in Mozambique?
What are their SRHR needs and how may these differ across local definitions and classifications within these groups?

How do these needs differ from the needs of adult sex workers and of young people in general?

In which ways are existing services and programmes responsive to the needs of these groups?

What are the bottlenecks as well as opportunities in responding to these needs?

What are the local understandings, expressions of and views on bisexual women and men and lesbians?

What are the SRHR needs of young lesbians and bisexual men and women?

How do these needs differ from the needs of adult lesbians, bisexual men and women and of young people in general?

In which ways are existing services and programmes responsive to the needs of these groups?

What are the bottlenecks as well as opportunities in responding to these needs?

What are the societal perceptions and attitudes towards young people and how may these differ from the perceptions and attitudes towards young key populations, according to opinion leaders?

Which forms of social support are being used by YKP to address their concerns and needs about their SRHR?

In which ways are young PWID experiencing marginalisation from different actors in society? (family, peers, providers, authorities)

How do young PWID manage SRHR risk situations and which coping strategies can be identified in this group?

To whom and where do they reach out for support and services?

In which ways are young prisoners experiencing marginalisation within closed settings?

How do young prisoners manage SRHR risk situations and which coping strategies can be identified in this group?

To whom and where do they reach out for support and services?

How does the prison system protect young prisoners from SRHR risk situations?
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