



TECHNICAL BRIEF
MAY 2019

Rights-based HIV Prevention and Treatment for Key Populations in Mozambique

Key populations—people who have been pushed to the margins of society by discriminatory laws, policies, and social stigma—are defined by UNAIDS as key to a country's HIV epidemic, and key to its response. In Mozambique, these populations include female sex workers, men who have sex with men, incarcerated individuals, and people who inject drugs. While Mozambique has reduced the number of new HIV infections over the past decade, HIV prevalence among Mozambique's key populations is disproportionately high, when compared to the general population. The U.S. Centers for Disease Control and Prevention- and Anadarko-funded Increasing Access to HIV Prevention, Care, and Treatment for Key Populations in Mozambique project (2015-2018), led by Pathfinder International, contributed to a reduction in HIV incidence by increasing access to clinical and community services that protect and respect the human rights of key populations. This technical brief explores implementation of Pathfinder's rights-based approach in the context of VIDAS II project.



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Alice da Hortencia Racibo nurse counseling Fernanda, a sex worker in Nampula.

MOZAMBIQUE: Maren Vespi, 2017

Context

The global community has committed to ending the AIDS epidemic by 2030¹ and remarkable progress has been made towards this goal: the global incidence of HIV has declined² and approximately 17 million people living with HIV (PLWH) are currently on antiretroviral therapy.³ Crucial to ending the epidemic is reducing the number of new HIV infections.⁴ In 2017, 47 percent of new infections came from “key populations.”⁵ UNAIDS defines these populations as both key to the epidemic and key to its response. While the composition of these populations will differ by social, cultural, and economic contexts, they often comprise people who have been pushed to the margins of society by discriminatory laws, policies, and social stigma. As a result, they are disproportionately affected by HIV and often face significant barriers to treatment and services.⁶

Health and development communities—and government bodies—have a public health and an ethical obligation to key populations. Human rights are universal. Every human has the right to the highest attainable standard of health—a fundamental right, necessary for the enjoyment of all other rights. Ending

the epidemic and ensuring that human rights of key populations are respected, protected, and fulfilled requires a comprehensive approach that addresses barriers, stigma, and discrimination in both the health system and in individual communities and ensures key populations flow through the entire continuum of HIV services.

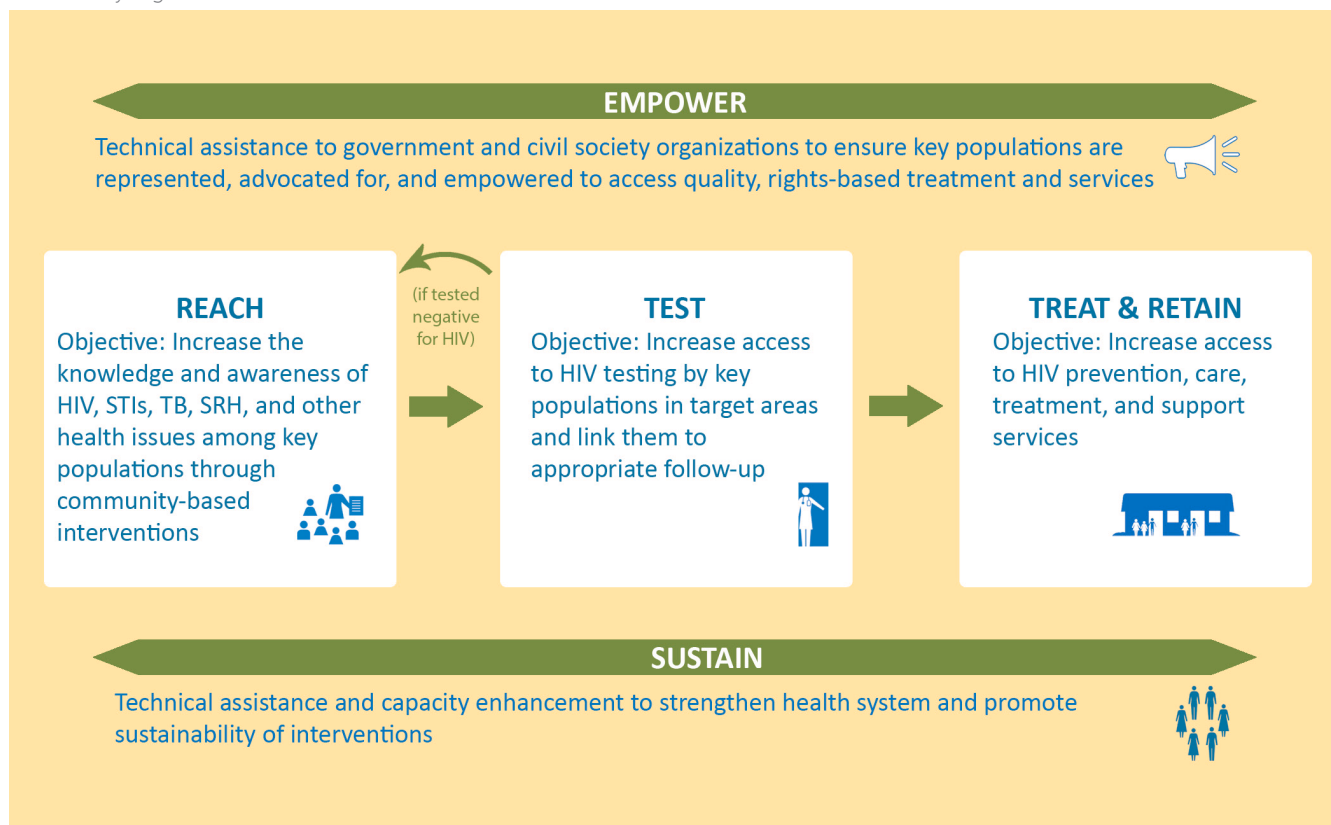
Between 2007 and 2017, Mozambique reduced new HIV infections among all ages from 170,000

Table 1. HIV prevalence by population in Mozambique.

Key populations (FSW, MSM, and prisoners) are disproportionately impacted by HIV in Mozambique.

Population	HIV Prevalence %
General population, ages 15 to 49	13.2 (overall), 15.4 (women), 10.1 (men) ⁹
FSW, ages 15 and older	31.2 (Maputo Province), 23.6 (Beira Province), 17.8 (Nampula Province) ¹⁰
MSM, ages 18 and older	8.2 (Maputo), 9.1 (Beira), 3.7 (Nampula) ¹¹
Prisoners, ages 16 and older	24 ¹²

Figure 1. The project's REACH-TEST-TREAT & RETAIN-SUSTAIN-EMPOWER strategy. The REACH-TEST-TREAT & RETAIN continuum implements a combination approach to address behavioral and biomedical needs of key populations. The SUSTAIN-EMPOWER framework supports an enabling environment of social, structural, and policy interventions led by the government and civil society organizations.



new infections to 130,000.⁷ However, there are an estimated 2.1 million PLWH currently in Mozambique⁸ and HIV remains a major public health concern in the country. Mozambique's primary key populations are female sex workers (FSW), men who have sex with men (MSM), people who inject drugs (PWIDs),ⁱ and incarcerated individuals (see Table 1).

Strategy

Between 2015 and 2018, Pathfinder, in partnership with the Mozambican Association for Sexual Minorities Rights (Lambda), led the U.S. Centers for Disease Control and Prevention- and Andarko-funded VIDAS II: Increasing Access to HIV Prevention, Care, and Treatment for Key Populations in Mozambique project (2015-2018). This project contributed to a reduction in HIV incidence by increasing access to clinical and community services that protect and respect the human rights of key populations.

VIDAS II aimed to achieve its goals by applying a rights-based approach to the services along the

HIV continuum of care.ⁱⁱ Pathfinder believes that a rights-based approach to programs is one that intentionally and consistently promotes and upholds the human rights of all through program goals, design, implementation, monitoring, and evaluation. Pathfinder's rights-based approach rests on the beliefs that sexual and reproductive rights are human rights, interventions should do no harm, and there must be respect for individual and collective agency. There are six guiding principles to Pathfinder's rights-based approach: equity and non-discrimination; autonomy and bodily integrity; confidentiality and privacy; participation and inclusion; availability and accessibility; and quality. As a result of this approach, the VIDAS II strategy involves behavioral, biomedical, and structural interventions at each stage of the HIV care continuum and necessarily places this continuum within a SUSTAIN and EMPOWER framework (see Figures 1 and 2).

ⁱ While people who inject drugs are among Mozambique's key populations, the VIDAS II project did not focus on this population.

ⁱⁱ The HIV continuum of care is a series of steps from positive HIV diagnosis to sustained viral suppression. These steps include: diagnosis, links to care, retention in care, initiation of treatment, and viral suppression. This series of steps or model can be used by health professionals to monitor HIV programs and to identify and address existing gaps or challenges. (<https://hab.hrsa.gov/about-ryan-white-hiv-aids-program/hiv-care-continuum>, <https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum>, <https://aidsinfo.nih.gov/understanding-hiv-aids/glossary/4680/hiv-continuum-of-care>)

Figure 2 . A rights-based approach to programming in VIDAS. *The project developed interventions at each stage along the REACH-TEST-TREAT & RETAIN-SUSTAIN-EMPOWER strategy that met different principles of a rights-based approach to programming.*



Implementation

The project began in April 2015, with implementation in 13 districts and 10 prisons. At project close in December 2018, activities were implemented in 36 districts in four provinces and 18 prisons across eight provinces.

The project recruited peer educators from each target population with the potential to increase knowledge and awareness and to act as a critical link between the formal health system and individual communities.

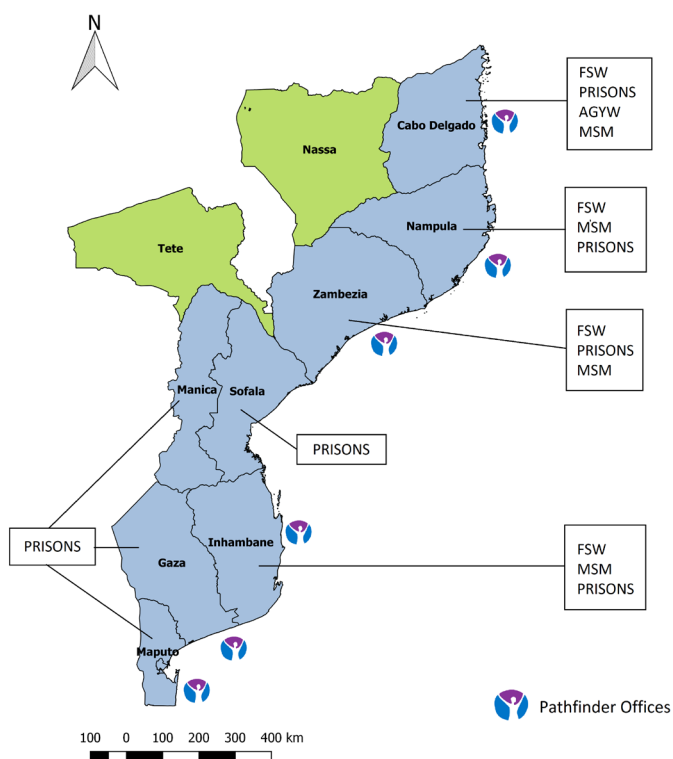
Reach

At the foundation of this project were tailored interventions to reach specific key populations. Through a mix of peer educators, behavior change activities, and digital health, the project aimed to increase its reach among key populations with knowledge and awareness of HIV and sexual and reproductive health (SRH) and to generate demand for HIV and SRH services. The project recruited peer educators from each target population with the potential to increase knowledge and awareness and to act as a critical link between the formal health system and individual communities.¹³ By selecting peer educators from these populations, the project was able to access key population socialization spaces and social networks. Peer educators were trained on counseling and referral protocols, quality health standards, and participated in self and collective reflection sessions to identify gender-related perceptions, attitudes, and sociocultural norms that hinder access to HIV services.

Peer educators were supported by innovative behavior change materials, such as Pathfinder's Pathways to Changeⁱⁱⁱ and Reflection and Action for Change activities. Peer educators were also supported by a mobile-based digital health application, created by Pathfinder. This app supported counseling with audio and video clips, and algorithms to assess risk during HIV, sexually transmitted infections (STI), tuberculosis (TB), gender-based violence (GBV), and drug and

ⁱⁱⁱ Pathways to Change is a tool based on the premise that people's perceptions and understandings from both supply and demand sides of health services are central to behavior change. This is a participatory approach to behavior change and is critically important in avoiding imposing beliefs and practices on a target population. The tool generates ideas and narratives from target populations that can then be used to develop IEC materials.

Figure 3. Map of project sites



Special Focus on Adolescent Girls

The project targeted adolescent girls (ages 10 to 19) with efforts to prevent HIV infection and gender-based violence, as well as to promote health-seeking behaviors. At nine primary and two secondary schools in Mocimboa da Praia and Palma districts in the Cabo Delgado province, the project showed educational films, educational dramas, hosted public talks, and trained teachers and peers to lead girls group discussion and boys group discussions. Additionally, and based on success in other projects, mCenas*, a mobile-based SRH education program, was implemented for secondary school students.

**For more information on mCenas, please see mHealth as a tool for integrated systems strengthening in sexual and reproductive health at <https://www.pathfinder.org/wp-content/uploads/2016/09/mHealth-as-a-Tool-for-Integrated-Systems-Strengthening-in-SRH.pdf>*

alcohol use screening. In addition, the app enabled peer educators to register clients, refer them for services at project-supported facilities, and track their progress through the HIV continuum.

Test

To support increased access to HIV testing, the project collaborated with the Mozambican Ministry of Health to support facility-, community-, and prison-based HIV testing and counseling (HTC) services. The project and Ministry of Health revised national clinical HTC guidelines and training materials to include key population specifications. The project also supported training to facility providers to screen clients for STIs, TB, and GBV, and on how to respond to self-identified cases of GBV among key populations.

At the community level, the project implemented activities to respond to barriers key populations face in reaching health facilities. Lay counselors were recruited from key population communities and trained to provide counseling, testing, and to

coordinate with and support peer educators. Lay counselors were supervised and mentored by clinical officers to ensure quality. Lay counselors provided services at health fairs, during outreach activities, at drop-in centers, and at key population hotspots. Similar to peer educators, lay counselors were supported by a mobile app to register and counsel clients, assess risk, refer clients for services, and see where clients were along the HIV continuum.

In addition, peer educators worked in prison settings and referred clients for HTC at prison clinics, or at health fairs.

Treat & Retain

To retain key populations in the HIV continuum, the project needed to ensure a safe, friendly, and accessible environment for seeking health care and treatment. To ensure such an environment, the project worked with the Ministry of Health technical working group on key populations to develop national facility certification criteria for key population-friendly

Education through theatre inside a prison in Nampula





Peer educator providing counseling in Nampula.

MOZAMBIQUE: Maren Vespi, 2017

services. Certification signaled to potential clients that facilities had skilled health personnel; collected and used data on key populations; had and followed non-discrimination policies and reporting mechanisms; and offered a comprehensive, integrated, and tailored package of HIV and primary health services for these populations. In addition, the project supported staff-wide trainings on integrated, key population-friendly care for 26 facilities in 22 districts in Nampula, Cabo Delgado, and Inhambane. Along with the trainings, the project implemented regular technical updates and mentoring for providers and staff.

At prisons, the project supported the ministries of health and justice to create systems to ensure continuity of treatment for released inmates and advocated for availability of prevention commodities and services (such as gender-based violence, post-exposure prophylaxis, and renovations to ensure private spaces for services and counseling).

Finally, the project supported antiretroviral therapy (ART) staff to connect clients with other legal and social support services to ensure retention in

treatment and implemented the national strategy on community support groups for adherence.

Sustain

The project implemented several interventions to strengthen the health system to ensure sustainability of these efforts. First, the project provided technical assistance to the Ministry of Health to finalize and implement training protocols, policies, and guidelines pertaining to key populations. At the province level, VIDAS II collaborated with provincial departments of health to design approaches and standards for mentoring health facility providers and staff to provide key population-friendly services. This collaboration included representation from working groups and civil societies. The project also supported the Ministry

The project work with the Ministry of Health Technical Working Group to ensure a safe, friendly, and accessible environment for key populations seeking health care and treatment.



Peer educators routinely met with project officers.

MOZAMBIQUE: Maren Vespia, 2017

of Health to develop and implement a surveillance system to capture key biomedical and behavioral information about key populations related to HIV, STIs, and risky behavior. Implementing this system also required training health providers and district data clerks to conduct routine data quality checks.

Finally, the project supported monthly coordination meetings between peer educators, lay counselors, facilities, and health authorities to ensure harmonization of activities, maximize use of resources, and minimize duplication. These coordination meetings also served as opportunities to identify challenges, successes, and to engage in collaborative problem-solving.

Empower

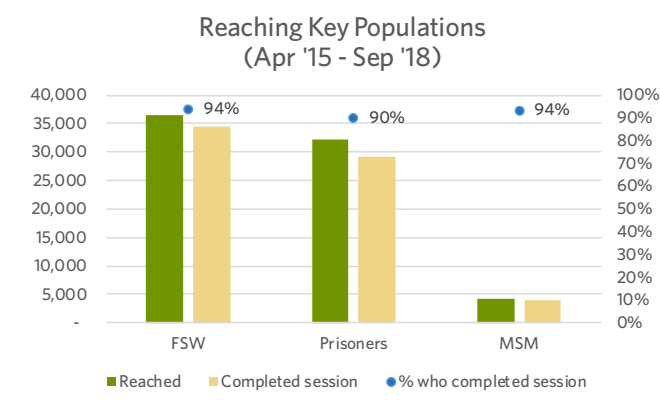
Activities under “Empower” supported the integration of strengthened systems—health systems with the capacity to deliver quality services; community systems that access these services and generate demand for services; and health and community systems that together engage in dialogue, shared responsibility, and mutual accountability for health.

VIDAS II enhanced health system capacity through supporting the National AIDS Council in its

development of national guidelines for HIV prevention activities, training packages, and information, education, and communication materials. In addition, the project supported the Ministry of Justice to develop the National Framework for Health in Prisons and regional workshops to roll out the framework and develop tailored action plans. The project also supported local and civil society organizations through organizational capacity building and capacity building specifically for advocacy. Initially, the project conducted an assessment of each organization’s technical and organizational capacity. Results from these assessments informed the joint development of institutional strategic plans to build capacity. With regard to advocacy, the project used Pathfinder’s Straight to the Point advocacy tools to update advocacy action plans. The project also supported partners to advocate for commodities and policies to support rights-based HIV care for key populations, such as: inclusion of condom-compatible lubricants on national commodities procurement list, hepatitis B vaccine for key populations, availability of condoms in prisons; national policy on community needle and syringe exchange; updated GBV policy and guidelines, including MSM, transgender people, and prisoners as survivors of violence; and post-exposure prophylaxis guidelines for key populations.

Graph 1. Number of individuals reached by the project by key population, and percentage of those reached who completed at least one counseling or information session.

Nearly all of those reached attended at least one counseling or information session.



Over the life of the project, 36,496 FSW, 4,340 MSM, and 32,203 prisoners were reached.

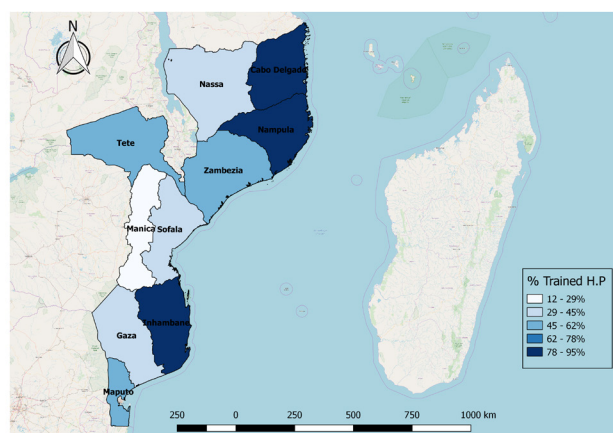
Project Results

Data collected by peer educators was aggregated and collected by monitoring and evaluation and clinical officers on a monthly basis. These officers validated peer educator data and submitted it to CommCare, where it can be accessed by multiple project and government stakeholders and visualized digitally.

Reach

Over the life of the project, 36,496 FSW, 4,340 MSM, and 32,203 prisoners were reached. Of those reached, nearly all completed at least one counseling and information session with project-supported staff (e.g., peer educators) (see Graph 1). The number of FSW, MSM, and prisoners reached by the project increased over time (see Graph 2). This increase is due, in part, to the expansion in project coverage. At project start, 13 districts were covered. By the end of the project, 21 districts were supported by the project. In addition, implementers suggest that measures taken to support peer educators had a positive impact on the project's reach and on key populations' participation in group sessions. Initially, peer educators struggled to maintain participation in group discussions and showed better results from their one-on-one interactions. In response, the project dedicated lay counselors to

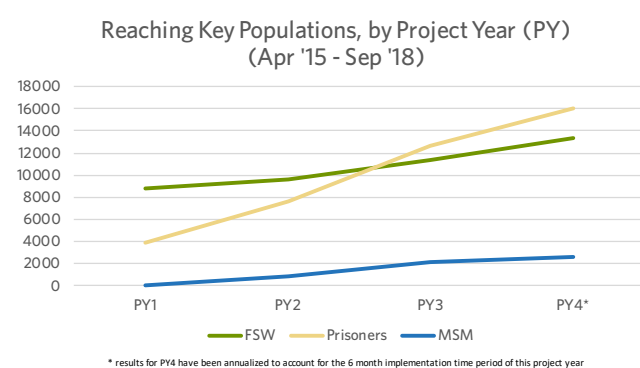
Figure 4. Percent of health facility-based professionals trained



supervise group discussions on a weekly basis, and, on a monthly basis, community engagement officers provided peer educators with technical support. Additionally, the project created a job aid with methodologies for group management to support peer educators. Finally, peer educators received additional support through a digital app that provided technical content and quizzes to support and measure peer educators' technical knowledge.

Implementers also report challenges in reaching key populations. For example, despite project efforts, fear of stigma remains deeply ingrained. Female sex worker participants occasionally provided false identities, making it difficult to track them. Project implementers also reported challenges with the mobility of key populations. Ideally, participation in group sessions would continue over time to foster building social support and cohesion. However, FSW often traveled to where potential clients were located, making sustained participation in group discussions challenging. In addition, prisoners' sustained participation in

Graph 2: Number of key populations reached by project year. Over the duration of the project, the number of key populations reached increased.



group discussions was threatened by transfers and releases and, further, holding group discussions at all often depended on the availability of prison staff to monitor the movement of inmates attending these discussions.

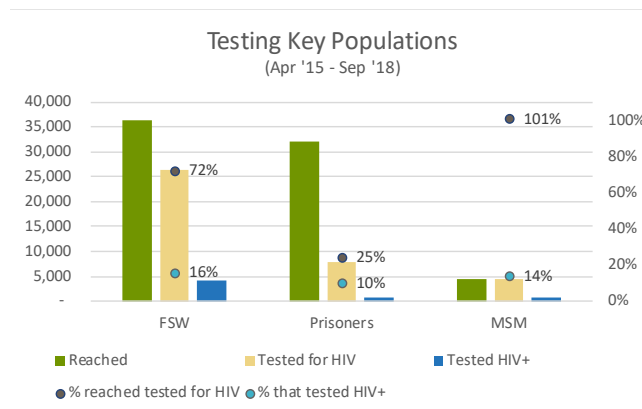
Test

Of the FSW reached, 72 percent were tested for HIV. Of prisoners reached, 25 percent were tested. Finally, of MSM reached, 101 percent^{iv} were tested for HIV (See Graph 3). Project implementers posit fewer prisoners who were reached got tested when compared to FSW and MSM—for a few reasons. First, the project began combining REACH and TEST activities in the second year by offering HIV testing and counseling (HTC) at group discussion sites, which increased the number of people tested. Further, during the project's first two years, HTC was provided to the prison population at health fairs on a monthly basis. In the project's third year, one lay counselor per province was dedicated to HTC in prisons.

In addition, planning and coordination meetings for frontline implementers (e.g., peer educators and lay counselors) were held on a weekly basis. In these meetings, peer educators and lay counselors identified and addressed HTC challenges. Finally, in Inhambane, lay counselors attended health committee meetings that focused on antiretroviral therapy and humanization of services. Through these meetings, lay counselors were exposed to more knowledge on how to identify PLWH, and with regard to who had already enrolled in services, enabling lay counselors to better target their efforts.

Initial anecdotal reports suggest MSM were challenging to reach with HTC services. At project start, implementers used peers (other MSM) as lay counselors for HTC provision because they hypothesized that peer HTC providers would be more easily trusted and would create a comfortable atmosphere for MSM. However, feedback from clients indicated that the opposite was true. In fact, MSM complained about lack of confidentiality and the discomfort they experienced receiving HTC from peers. In addition, more MSM accessed facility-based HTC than community-based HTC. In the project's third year, it adapted by using health officers as lay

Graph 3. Percentage of key populations reached that sought HIV status through testing. *Of those reached, a larger percentage of MSM and FSW sought testing services when compared to prisoners.*



counselors and provided HTC in fixed locations that were accessible to MSM with and without referrals.

Treat & Retain

Results indicate that of key populations who tested positive, a higher percentage of prisoners (72 percent) initiated treatment when compared to FSW (54 percent) and MSM (43 percent). Implementers posit that a lower percentage of FSW and MSM who tested positive initiated treatment because of persisting stigma and mobility. After testing positive, FSW and MSM clients receive referrals to visit health facilities at which they wait and interact with the general population, where they have more of a chance of encountering discriminatory attitudes or behaviors. Further, referral facilities may be more difficult to access—particularly in comparison to facilities for prisoners, which are located within the same property—due to geographic distance, time, or financial resources. Finally, facility staff in Zambezia report that a portion of their FSW clients were Malawi nationals who preferred to return home to seek treatment, at which point they were no longer followed by the project.

Sustain and Empower

To support the sustainability of an integrated and strengthened system for service delivery for key populations—in which the health system delivers quality services, the community can access and generate demand for these services, and the two engage in dialogue, shared responsibility, and mutual accountability for health—VIDAS II supported

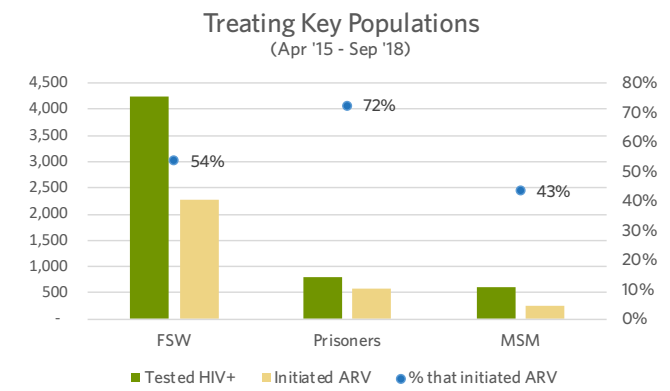
^{iv} The percent of MSM reached who tested for HIV exceeds 100 percent partly because some MSM do not want to disclose their HIV status or sexual orientation to peer educators. Instead, they seek testing at facilities, but without a referral from peer educators. Once at the facilities, they are registered as MSM, but they have no referral cards, so they are not identified as MSM who were reached, but they are identified as MSM who were tested.

continuing education and performance monitoring for peer educators (through digital health, supervision, and technical meetings); worked with the Ministry of Health for approval on guidelines for the provision of quality, rights-based services for key populations; and trained providers through in-service training and routine technical updates on these guidelines to ensure quality, rights-based service delivery. In 2018, the Ministry of Health hired an external consultant to evaluate the national implementation of these guidelines (as indicated by percent of providers trained on guidelines). Results suggested that the project-supported provinces demonstrated more successful implementation of the guidelines when compared to provinces that the project was not supporting (see Graph 4 for the percentage of providers trained in these guidelines across project districts). In addition, the project supported capacity-building and increased participation in local and civil society organizations that support key populations. Eight groups of FSW in Inhambane and Nampula were developed to focus on income management and savings. These groups established codes of conduct for participation and collaboratively made decisions on how to invest their savings. Finally, the project engaged the police to increase awareness of vulnerabilities of key populations and to develop a safe and non-discriminatory environment for FSW. This collaboration resulted in the establishment of police focal points at each station for cases of violence and a procedure guide to support interactions between FSW, MSM, and police was developed. This guide, the first national instrument to be instituted by the Ministry of the Interior that focused on rights-based and key population-friendly interactions between key populations and the police, was implemented.

Conclusion

Results from the VIDAS II project shed light on some of the persisting challenges as well as the opportunities that exist for reaching key populations and retaining them in HIV treatment programs. For example, while the three key populations targeted by this project all present challenges based on their mobility and hidden nature, results suggest that peer education and outreach programs can work, even in the prison system. The importance of going to key populations, meeting them where they are, cannot be overemphasized. Through its ability to meet key populations in their own communities, this project showed the importance of operating in a fluid

Graph 4. Percentage of key populations that tested positive for HIV that initiated treatment. *In comparison to FSW and MSM, a higher percentage of prisoners tested for HIV initiated treatment.*



manner, seamlessly connecting demand creation to the continuum of care. Around the world, the health and rights of key populations—particularly FSW, MSM, and prisoners—continue to face significant threats. Continuous advocacy, constructive dialogue, technical assistance, and funding are required to support interventions that strengthen community and health system linkages and rights-based approaches to quality services for key populations. The VIDAS II project has attempted to show what is possible by bringing in these populations as integral and active agents of change.

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ABOUT THE PROJECT

Funded by the U.S. Centers for Disease Control and Prevention and Anadarko, the VIDAS project (2015 – 2018) was designed to reduce structural barriers to accessing quality health services and to generate demand for HIV services among highly marginalized and vulnerable populations in Mozambique. The project targeted female sex workers, men who have sex with men, and prisoners across eight provinces—Cabo Delgado, Nampula, Zambézia, Sofala, Manica, Inhambane, Gaza, and Maputo.

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COVER PHOTO: Peer educators at a prison in Nampula. Credit: Sala Lewis, 2013.