PH.D. THESIS

Everyday struggles with HIV/AIDS in Mafalala, Maputo (Mozambique)

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SCHOOL OF GLOBAL STUDIES

UNIVERSITY OF GOTHENBURG

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To Sousa and Gina

Abstract

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The HIV/AIDS epidemic is a huge problem in Mozambique. The aim of this thesis is to inquire into how some of the most vulnerable people in Mozambique, the urban poor, experience and understand the epidemic and the government's efforts to address it. The study is based on extensive anthropological fieldwork, including participant observation and a number of interviews in the urban area *Mafalala*, Maputo, and it seeks to understand and discuss how the HIV/AIDS epidemic in urban Mozambique relates to people's own voices, experiences, and understandings. By using a people-centered approach, where the needs and care of the people in the local context is in focus rather than specific illnesses, the study explores people's socio-cultural practices, ideas, and living conditions related to HIV/AIDS. With this approach, the healthcare delivery can only be improved and made more effective by being sensitive to both individual and social needs.

The theoretical framework is based on anthropological perspectives on global health and applied medical anthropology, emphasizing concepts such as social suffering, stigma, structural violence, gender values, and people-centered health delivery. The thesis shows that the HIV/AIDS epidemic in *Mafalala* is closely related to a situation of deep poverty, an everyday struggle for the most basic necessities, a patronizing and insensitive health sector, stigma, cultural perceptions, and gender values. Moreover, the study demonstrates that understandings, treatments, and local prevention efforts concerning HIV/AIDS are related to religious, spiritual, and ethnomedical practices, and it argues for an integrative approach where socio-cultural and medical approaches should be applied together in combatting what one informant has called "the illness of the century."

Key words: Mozambique, HIV/AIDS, Applied Medical Anthropology, Global Health, Social Suffering, Stigma.

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AMETRAMO	Associação dos Médicos Tradicionais de Moçambique [Association of Traditional Healers of Mozambique]
AMODEFA	Associação Moçambicana para o Desenvolvimento da Família [The Mozambican Association for the Development of the Family]
ART	Antiretroviral Therapy
CNCS	Conselho Nacional de Combate ao HIV/SIDA [National Council to fight HIV/AIDS
FRELIMO	Frente de Libertação de Moçambique [Mozambique Liberation Front]
HIV	Human Immunodeficiency Virus
INE	Instituto Nacional de Estatísticas [National Institute of Statistics]
INSIDA	Inquérito Nacional de Prevalência, Riscos, Comportamentos e Informação sobre HIV e SIDA em Moçambique [National inquiry on Prevalence, Risks, Behavior and Information about HIV/AIDS in Mozambique]
MGCAS	Ministério do Género, Criança e Acção Social [Ministry of Gender, Children and Social Action]
MISAU	Ministério de Saúde [Ministry of Health]
MMAS	Ministério da Mulher e Acção Social [Ministry of Women and Social Action]
ONG	Organizaçõ Não Governamental [Non-Governmental Organization]
PLWHA	People Living With HIV/AIDS
PSI	Population Services International
PEN	Plano Estratégico Nacional [National Strategic Plan]
PNC	Programa Nacional de Combate ao HIV/SIDA [National Program to Fight HIV/AIDS]
SIDA	Syndrome Imunedificence Adquirida [Acquired Immunodeficiency Syndrome]
SIDA	Swedish International Development Agency
STI	Sexually Transmitted Infections
TV	Television
UNAIDS	United Nation's Program on HIV/AIDS
WHO	World Health Organization
WLSA	Women and Law in Southern Africa

Glossary

Andar fora	Literally “walk on the outside”; adultery or extramarital relationship
Bairro	Neighborhood
Barraca	Tent
Bichinho	Little bug
Biscato	Temporary job that gives immediate cash
Biscateira	Woman doing temporary jobs, often applied to women who have sex with men in exchange for money
Boss	Cheap alcoholic drink sold in a small plastic packet
Caçadores	Literally “hunters”; men who have more than one sexual partner
Cantinho	Corner
Capulana	A piece of clothing that women wrap around them in various ways
Carne a carne	Literally “meat to meat”; sexual relations without using a condom
Caril	Stew
Casamento	Wedding
Célula	Section (e.g., of Mafalala)
Cidália	Portuguese female name; SIDA is Portuguese for AIDS and “Cidalia” is a pejorative name for people living with HIV/AIDS
Chefe de dez casas	Ten houses chief
Chefe de quarteirão	Block chief
Chefe do posto	Administrative chief administrativo
Comida saudavel	Healthy food
Comprimidos	“Medicine”; often used for ART medication
Congeleta	Blessing (Changana)
Curandeiro/a	Male or female traditional healer
Curtidora	Courtesan, young woman who enjoys life without plans for the future
Dema la kutxuca	Root decoction used by healers to deal with opportunistic illnesses related to HIV/AIDS (Changana)
Desabafar	To talk freely with somebody about everything; let off steam
Dormir	Literally “sleep”; sexual intercourse
Estragado	Damaged
Essa doença	Literally “that disease”; euphemism for HIV/AIDS in Mafalala
Fajardo	Informal market in Maputo city

Feitiçeiro	Witch
Jeito	Brand of male condom
Geração Biz	"Busy generation"; association for young people working with sexual reproductive health and HIV/AIDS
Gigolô	A man who has sex with women in exchange for money
Guevar	To buy cheap products to resell
Hospitais dias	Day hospitals
Kutivikela	Prevention (Changana)
Machaka	Family (Changana)
Machamba	Plot of land
Malhanganisso	Mixture of roots used to treat opportunistic illnesses related to AIDS
Mulher de fora	Literally "woman from outside"; extramarital female partner
Mulher de má vida	Literally "woman of bad life"; female sex worker
Mulhiwa	Bad spirit
Namorado/a	Male/female long-term partner
Onze	Two small cuttings that healers make with a razor in their client's body
Pisou mina	Literally "stepped on a mine"; pejorative term for a person living with HIV/AIDS
Podre	Rotten
Preservativo	Male and female condom
Publicidade	Advertisement
Quarteirões	Blocks
Sacar cena	"Play out"; dating without commitment
Supiana	Bad water spirit that comes close to the houses during the night
Seroprevalência	Seroprevalence
Tindjolo	Divination with animal bones and stones
Xima	Maize porridge
Xipamanine	Big market in Maputo city with cheap products
Xitique	Rotating savings and credit scheme

1
Introduction

In order to capture the topic of this study, the HIV/AIDS crisis in Mozambique, I begin with a story describing a young, single, mother infected with HIV, to whom I give the anonymous name Jota. I encountered her during my fieldwork in *Mafalala*, Maputo. Her story is one of many about the everyday experiences of living with HIV/AIDS. Jota struggles to keep herself on the Antiretroviral Therapy (ART) and tries to take her medication on time every day. Jota was told that she had to eat well while on the ART medications. This has become difficult, as she often cannot afford to buy the kind of "healthy" and protein-rich foods that she has been told to eat by those at the health center. Jota has moved back to her parents' house, comprised of two sparsely furnished rooms in the interior of the neighborhood, where houses are small and built with cheap wood and zinc. Many who live there are extremely poor. Jota moved to her parents' house when she realized that she did not have the strength to keep her small business going. She used to sell sweets and popcorn in front of a primary school near her house. Her parents are poor; they do not have a formal job, and they sell some vegetables in a small street close to their house. To have food every day, the family depends on the money they get from the vegetables they sell. With the money, they buy bread, maize, and small fresh fish. When vegetables are not sold, they do not make any money; then, they only eat lettuce and tomatoes. Sometimes neighbors invite them to eat with them.

Jota told me that when she began losing weight, her parents met with other members of the family and they decided to take her to various traditional healers to seek help. One of the healers performed a divination and discovered that a close member of her family had caused her illness. This family member was said to have bought a bad spirit from a healer and thrown it on Jota. Another healer whom they consulted gave her a purification bath and advised her family to take her to the health center. At the health center, she received soya flour, which she ate twice

a day together with other food. After a month, she regained her weight, but then suddenly decided to stop taking her antiretroviral medication. She said that she felt well, was tired of following the medication schedule, eating a special diet, and abstaining from nightlife. When her parents noticed this, they discussed it within the family and finally persuaded her to restart her ART medications.

The struggle experienced by this young woman is not unique. It is not only an individual struggle; rather, it has an impact on all members of the infected person's family, sometimes even involving neighbors and other members of the local community. Moreover, it involves various forms of healers and medical institutions, both western and non-western. The story is one example of how people live with HIV/AIDS (PLWHA) and, in this case, have difficulties in taking their antiretroviral medications. Many in *Mafalala* have similar stories to tell. They may lack money to buy food. They can have difficulties taking their medication on time, and they often face stigma, social exclusion, unemployment, and deep poverty. Some even stop taking the drugs because of despair and hopelessness.

The aim of this thesis is to enquire about how some of the most vulnerable people in Mozambique, the urban poor, experience and understand the AIDS epidemic and the government's efforts to address it. Empirically, the study is an example of, and a contribution to, the field of research that focuses on how the urban poor experience and live with HIV/AIDS in southern Africa in general and in Mozambique in particular. On a more theoretical level, it seeks to contribute to research on medical anthropology, and especially applied medical anthropology, which takes into consideration both structural violence/structural inequalities and the role of cultural perceptions. Based on extensive fieldwork in a poor neighborhood, or *bairro*, in Maputo, known as *Mafalala*, and by using a people-centered approach, the study explores people's socio-cultural practices, ideas, and everyday living conditions. Hence, I am particularly interested in how ordinary people perceive that they contract HIV, how they think they become ill, how they treat AIDS, and how all of this interplays with the government's view on the epidemic.

In the thesis, it is argued that the HIV/AIDS epidemic in *Mafalala* is closely related to a situation of deep poverty, a daily struggle for the most basic necessities, a patronizing and insensitive health sector, stigmatization, and gender inequalities. Moreover, the study shows that understandings, treatments, and local prevention efforts concerning HIV/AIDS are related to religious, spiritual, and ethnomedical practices. The thesis explores why the disease continues to spread in *Mafalala* despite the fact that the HIV/AIDS campaigns provide information about HIV/AIDS for all the inhabitants.

The thesis focuses on the following research question:
How do people in *Mafalala* perceive that they contract HIV/AIDS, and how do they face and treat the affliction?

How is the stigma, in relation to HIV/AIDS, created in the family and within the community?
What is their understanding of prevention?
How do government policies and their implementation relate to the above questions?

Mafalala was chosen as the ethnographic case for this study. For many poor people in *Mafalala*, as well as in other poor urban areas in Mozambique and in southern Africa, sex is a way of making a living. Transactional sex is prevalent in *Mafalala;* moreover, many people, both men and women, earn all or part of their income from sexual activities. In Maputo, *Mafalala* is known as the place to go to, in order to find a sexual partner and engage in a temporary relationship. There is a joke illustrating this: "If your husband did not sleep at home, go to *Mafalala* and you will find him." By extension, this also means that many people in *Maputo* believe that *Mafalala* is a neighborhood where many people are HIV-positive. I also have personal reasons for engaging in this research. Specifically, I have seen friends and relatives suffering and dying because of AIDS and opportunistic diseases. Some of them did not feel comfortable to share their HIV/AIDS status with other people due to fear of being stigmatized. They also often lack knowledge about the epidemic, which would make their everyday lives somewhat smoother.

The analytical unit in this thesis is the household. In the household, the afflicted person frequently relies on other members in order to decide how to handle HIV/AIDS and how to plan their food requirements as well as other forms of support and necessities. Household members often remind the ill person to go to the health center for check ups and to get a supply of the antiretroviral medication. Household members also search for different ways of handling HIV/AIDS and understanding its origin. They may go to the public or private health institutions, and/or to healers, and they may use knowledge and practices they themselves have learnt to try to solve the health problem or alleviate the suffering. In this way, individuals' experiences of the illness depend on how the households approach the illness, where they decide to seek help, and what kind of support they feel confident to receive.

There are some aspects of HIV/AIDS in *Mafalala* that the thesis does not address. Specifically, it does not discuss different dimensions of ethnicity and its importance for socio-cultural understandings of HIV/AIDS. The reason for this is that ethnicity is sometimes used as a political tool for putting Mozambican people against each other. As an anthropologist, I do not want to contribute to this kind of problem and practices related to HIV/AIDS. Further, the study does not go into details concerning cases of elderly people that care for orphan children living with HIV/AIDS. It also does not look into how people relate homosexuality to the HIV/AIDS epidemic.

CHAPTER 1

Today, about 37 million people in the world live with the Human Immunodeficiency Virus (HIV). Southern Africa, which also includes Mozambique, is a region severely affected with HIV; furthermore, more new infections occur every day than in any other region in the world (see UNAIDS 2016a, 2016b). Having multiple partners has been said to be a main cause of the HIV infection in southern Africa (Leclerc-Madlala 2009), but the picture is more complicated and has many dimensions. Stigma, discrimination, exclusion, gender inequalities, and power relations are among the factors that continue to make women and young people, in particular, vulnerable to HIV. These factors may hinder access to HIV prevention, treatment, and care. Today, efforts are being made in the region, and interventions and many research projects are carried out. However, many of these efforts have limited effect, and they often lack sufficient understanding of people's living conditions, and of how their socio-cultural beliefs and practices relate to HIV/AIDS (Leclerc-Madlala 2009; cf. Monteiro 2012; Singer 2009).

Mozambique has suffered badly from the HIV/AIDS crisis. The country has a total population of approximately 30 million inhabitants (Worldometers 2017). The total HIV prevalence in Mozambique is around 11%. Among young women and women aged between 15-49, the HIV prevalence is about 13%, and the HIV prevalence among men is about 9%. Especially girls and young women between 15-24 years old have been shown to be vulnerable to contracting HIV (Conselho Nacional de Combate ao HIV/SIDA 2015). Moreover, there are important differences of HIV prevalence between the eleven provinces of the country. *Gaza* in the southern part of the country has the highest HIV prevalence of about 25%. The northern province of *Niassa* has the lowest HIV prevalence of about 4%. *Maputo*, the capital city of Mozambique located in the south, which is also the area of this study, has a HIV prevalence of 17%. These differences between the provinces have been explained by the impact of internal and international migration, circular migration between Mozambique, South Africa and Swaziland, the frequency of multiple sexual partners, and of men that have sex with men (Conselho Nacional de Combate ao HIV/SIDA 2015; INSIDA 2009).

Similar to the rest of southern Africa, in Mozambique many people are moving from rural to urban areas, and from urban to other urban areas where they search for jobs and for better socio-economic living conditions. Men migrate more than women. When they migrate, they leave their wives in the place of origin. In the new arrival area as well as back home, men and women are sometimes involved in new, sometimes multiple, sexual relations, which increases the risk of contracting HIV, especially if they do not use condoms consistently. The epidemic and the deaths that follow create breakdowns in the migrant families, with a negative impact, particularly on the children and the young people. Many poor families cannot earn enough income to pay for food and school fees, children end up in the streets, and young people are lured into sexual relations. Moreover, in Mozambique, many

young people lack knowledge about condoms, or they do not have the capability or power to negotiate the use of condoms (see Arnaldo 2004; Casimiro and Andrade 2002; Raimundo 2011).

As a response to the crisis, the Mozambican Government has tried to act in different ways. The fight against HIV/AIDS has been ongoing since 1988. Up to the present, more than eighty HIV/AIDS programs have been launched by the government and by international and national non-governmental organizations (NGOs). At the beginning, the HIV/AIDS campaigns often relied on surveys to assess the individual's sexual behavior and the risk of contracting HIV. The HIV/AIDS campaigns in Mozambique have mainly targeted individual behavior change and focused on the physical body. The campaigns on behavioral change have advocated abstinence from sex before marriage, being "faithful to one sexual partner," "reducing the number of sexual partners to a single partner," "delay in the sexual debut for young people," and "male and female condom use" (INSIDA 2009: 6).

HIV/AIDS continues to be a great problem in Mozambique despite efforts made by governmental institutions and NGOs to make people aware of the epidemic and the ways in which people should prevent it. Many HIV/AIDS campaigns have been launched to target heterosexual populations at risk of contracting HIV, such as young people in urban areas, sex workers, and long haul drivers. The campaigns mainly work on the basis that people will change their behavior if they have the right information about HIV/AIDS and if they know where to undergo HIV testing and to get AIDS treatment. This means that the so-called ABC model (Abstain, Be Faithful, and Condomise) has been used in many HIV/AIDS campaigns in the country (Monteiro 2012). However, as I will show, the campaigns show little sensitivity to the socio-economic realities and cultural practices and what may affect people to care, or not care, about the risks and issues associated with HIV/AIDS.

1.1. Research framework

This thesis builds upon medical anthropology and medical anthropological perspectives on global health (Drobac et al., 2013; Ember and Ember 2004; Joralemon 2017; Kiefer 2007; Kleinman 2010) and its applied aspects (Trotter 2011; Winkelman 2009). Of importance here is the cultural construction of health and illness in various contexts, but also the socio-economic issues and power relations, as well as the unequal distribution of resources that negatively affects people's health and access to healthcare. Of special importance here is how the socio-cultural factors are related to values and practices and how these, in turn, are related to health, illness, and healthcare (Drobac et al., 2013).

When applied, medical anthropology focuses on connections and interrelationships between the local, community, national, as well as the international level of

healthcare. In healthcare projects, and when implementing and supporting access to healthcare, programs and activities informed by this approach especially focus on cultural values, socio-economic factors, and structural constrains to bridge the gap between the local populations and the biomedical personnel, such as medical doctors, nurses, and other healthcare professionals (Kim et al., 2013; Kleinman and Benson 2006). This also implies that socio-culturally informed techniques and approaches are present (Joralemon 2017).

1.1.1. The disease model and the socio-cultural model

Medical anthropologists commonly distinguish between two overarching healthcare models or perspectives: *the disease model,* which is the biomedical or western medical perspective that mainly focuses on the individual patient's symptoms and physical alteration of the patients' body, and *the social perspective on health*, which refers to the individuals and family's experience of the illness, health, and healing (Kiefer 2007). The disease model has its origin in laboratory science and statistics. It is used to get particular knowledge on how individual bodies function and what causes disease. When this model is used in relation to the public health programs, it tends to be based on the same assumptions as the laboratory study of disease. "Using the disease model based on such laboratory-like studies, scientists can craft ingenious ways to discover subtle causes of illness in the body" (ibid: 9). However, the disease model should be used together with other socially informed models or perspectives that are not based on traditional laboratory techniques. The reason for this is that illnesses should be understood and dealt with in relation to both the physical malfunction of the body and the social environment that causes the ill health.

The social perspective on health focuses on the understanding of the influence of the whole environment in which the person or group lives. Within this perspective, a study or intervention could, for example, be based on observing social interaction and individual cases of the healing process, based on local perceptions and actions. Of importance here is not just the individual physical effects of the treatment, but also its effects on the rest of the patients' life, family, and community. In this thesis, I intend to use the social perspective on health to give an insight into, and understanding of, how especially the poor and powerless people's conditions, cultural beliefs, values, practices, and agency are related to the HIV/AIDS epidemic and the efforts to prevent it. This also implies how people's choices and actions are being limited and constrained by social stigma and by structural forces beyond their control (cf. Farmer 2004; Green 1994; Green et al., 1993).

The idea that individuals are vehicles for the spread (and control) of HIV/AIDS may undermine the broader socio-cultural perspective and socio-cultural factors. From the individual perspective, a key principle in fighting HIV/AIDS is that condom use, abstinence, and being faithful could reduce the spread of HIV/

AIDS. Hence, individuals are themselves responsible for their own actions. This simplistic view of individuality, focusing on the physical body and individual behavior, fails to offer an understanding of the complexity of life among people in different socio-cultural contexts (cf. Comaroff and Comaroff 2001; Kagitçibasi 1997; Panter-Brick 2014).

When illness is individualized, it is individual behavior and the individual that is addressed, not the family, neighborhood, or social network in all its complexities. Hence, in this perspective, one tends to downplay the fact that especially marginalized people, with limited agency and whose choices are constrained by poverty, often have limited possibilities and opportunities to make choices concerning, for example, the use of condoms, to decide to be faithful, or to abstain from extra-marital sexual relations. There may be socio-cultural perceptions in relation to people's choices of using or not using condoms, other than to protect themselves against an invisible enemy. These choices and actions may be influenced, and affected by, factors such as peer pressure, the media, religious beliefs, unequal macro-economic forces, the effect of migration, family structures, and the kinship system.

1.1.2. Social suffering, structural violence, and people-centered health delivery

In relation to the social perspective on health, the theory of social suffering is important (Farmer et al., 2013; Kleinman 2010; Kleinman et al., 1997). According to Kleinman et al. (1997: ix), "social suffering results from what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems." Accordingly, structural economic and political forces often contribute to create disease as, for example, "…the case with the structural violence of deep poverty creating the conditions for tuberculosis to flourish and for antibiotic resistance to develop" (Kleinman 2010: 1519). Social institutions can be inadequate for ill individuals that seek help therein, with little sensitivity for individual and social needs. Kleinman notes that healthcare bureaucracies developed to respond to suffering could even make suffering worse. Examples of this on a global scale are "hospital-based medical errors or the failure of the US Veterans Administration clinics to adequately diagnose and treat the psychiatric trauma among soldiers returning from current wars in Iraq and Afghanistan" (ibid: 1519).

The social suffering theory is also relevant in relation to the fact that pain and suffering from a disorder is not limited to the individual sufferer but also involves the sufferer's family and social network. The ways in which people handle and understand illness are important also when it comes to recovering and for getting family support. In addition, the individuals' illness can have a strong impact on the well-being of the rest of the family. In the case of Alzheimer's disease, for

example, the sufferer's cognitive impairment may cause his/her adult children to experience deep loss and frustration (Kleinman 2010). Healthcare interventions and programs, therefore, should also include the family and the sufferer's broader network. Social and health problems cannot be separated from each other, just as health policies cannot be separated from social policies. Accordingly:

> The theory of social suffering collapses historical distinctions between what is a social and health problem, by framing conditions that are both and that require both health and social policies, such as in urban slums and shantytowns where poverty, broken families, and high risk of violence are also the settings where depression, suicide, post-traumatic stress disorder, and drug misuse cluster (Kleinman 2010: 1519).

Kleinman's concept of social suffering is useful for understanding powerless individual's beliefs and practices related to HIV/AIDS in their own right and through their own voices, perceptions, and interactions. Of vital importance here is the individual's own experience of the illness, of values, and motivations concerning the HIV/AIDS epidemic, especially in relation to prevention, treatment, and healing. By emphasizing social suffering, this thesis strives to get an insiders perspective on how individuals and families explain the manner in which and why suffering occurs. The thesis also aims to understand where the family and the individual may turn to when facing ill health, the treatment received (e.g., at the health center and/or traditional healer), as well as how the sufferer and the family members feel they are treated and helped.

Social suffering is closely related to the concept of structural violence and its relation to any constraint of human potential caused by the economic or political structures (see also Galtung 1969; Moyer 2015; Panter-Brick 2014). According to Farmer (2004), the outcome of structural violence is the embodiment of marginalization, subjugation, stigmatization, and even psychological terror: "Structural violence is embodied as adverse events if what we study, as anthropologists, is the experience of people who live in poverty or are marginalized by racism, gender inequality, or a noxious mix of all of the above. The adverse events to be discussed here include epidemic disease, violations of human rights, and genocide" (ibid: 308). Accordingly, structural violence is related to limited agency as well as to the overarching structuring of society. A focus on agency is hereby a focus on how people respond to poverty and everyday problems and what matters to them in their everyday struggles for access to food, medicines, education, jobs, money, and so on. People with little agency often have fewer opportunities to make decisions in their lives due to structures beyond their control or influence. The empowerment of especially the poverty stricken, therefore, implies a concern with poverty,

powerlessness, social inequality, and stigma (see also Hardon and Moyer 2014; cf. Kleba and Wendausen 2009; Parker 2001; Schoepf 2001, 1992). In *Mafalala*, poor individual's choices are constrained by a situation of deep poverty but, as I will show in my thesis, HIV afflicted persons and their families do make decisions and take action concerning HIV/AIDS and related issues in their everyday lives. Among the people I met, in the day-to-day struggle, structural violence does not altogether exclude agency.

Social and cultural factors, including gender inequality and stigma, are particularly important when understanding how HIV/AIDS care is delivered and perceived on the local level. Stigma and prejudices may inhibit people who are affected by HIV/AIDS to seek help, treatment, and care. Therefore, healthcare providers should intensify their efforts and "…provide care with even greater confidentiality to gain the trust of patients" (Kim et al., 2013: 186). For a social perspective on health, therefore, how healthcare is delivered is relevant in relation to people-centered and participatory approaches. Marston et al. (2016: 377) argue that people-centered interactive approaches are "oriented around the needs and preferences of users rather than around disease… [and aimed at] strengthening efforts to build stronger relationships and dialogue between communities, institutions and service providers about the care required." Accordingly, participatory health interventions may thereby change the usual patient-provider dynamic and power relations: "Participatory approaches need to be embedded throughout the health system: internally (within health-care teams and between levels of health system), as well as externally (between services and communities)" (ibid: 379). Of importance here is that people-centered health delivery, if carried out with sensitivity and adapted to the local context, can be beneficial for both the people involved and for the health-care providers, as people share their concerns about health issues and can present solutions to their problems and paths to recovery, according to their socio-cultural practices, thoughts, and values (Drobac et al., 2013).

1.1.3. Medical Pluralism

The concept of medical pluralism is also highly relevant in this thesis. It defines a phenomenon where various healing and medical systems, both western and non-western, coexist and interact with one another. The relationships can be both cooperative and competitive and may involve physicians, nurses, social workers, spiritual and herbal healers, religious experts, and so on. Biomedicine (western medicine) is usually the dominant system and often seeks to absorb other medical/healing systems or restrict them and their practitioners. While "one medical system tends to exert, with the support of strategic elites, dominance over other medical systems, people are quite capable of dual use of distinct medical subsystems" (Baer 2004: 115). Frequently, family members and other relatives may intermediate and serve as brokers between the patient and the healer/medical specialist.

Family members may make decisions based on a perceived illness etiology, diagnosis, and the outcome of a divination session. In this process, a moral dimension is often present as a question of innocence or guilt, related to sorcery accusations and the social origin of afflictions, is raised (Brodwin 1996; Crandon-Malamud 1991; Geschiere 2013, 1997; Janzen and Arkinstall 1978; Wedel 2004).

1.2. Previous Research

Since the late 1980s, anthropologists have published extensively on HIV/AIDS, focusing on issues such as morality, behavior change, gender, sexuality, local practices, cultural beliefs, social and structural factors, poverty, and access to treatment, as well as culturally appropriate strategies for prevention. Several studies emphasize the indigenous understandings and issues surrounding morality (e.g., Brodwin 1996). The study developed by Farmer (1992) in Haiti distinguished between three kinds of narratives: The "scientific" narrative claiming that the epidemic was coming from homosexuals in the United States; the "rural" narrative saying that HIV/AIDS emerged because of *maji* (magic) and was viewed as the "jealousy sickness." Finally, the "conspiracy theory" claiming that HIV/AIDS was created and released by the United States or "white folks" to reduce the growing number of Haitians and Africans. There have been several studies concerning scientific explanations versus indigenous explanations of HIV/AIDS and risk behavior (Ayikukwei et al., 2008; Gausset 2001; Nkwi 2005).

Treichler (1999) claimed that it is important to understand how poor people themselves reason and understand a high-risk behavior. In a similar vein, Green (2011) showed that having concurrent sexual partners was the vehicle for HIV transmission and argued that fidelity, male circumcision, and ART would reduce the number of HIV infections. Other studies on morality and behavior (Colson 2010; Quaranta 2010; Smith 2014, 2003; Talle 2010) discussed how people understood they contracted HIV/AIDS and whom they blamed for bringing HIV/AIDS to their country. In her study of HIV/AIDS in Gwenbe Valley, Zambia, Colson (2010) showed how people in the beginning of the epidemic treated it through a series of responses. Denial was a response that also included a refusal to give up hope of a cure and an ongoing search for a cure. People in Gwembe refused to acknowledge the epidemic within their family and in their neighborhood. As people were told that the epidemic was spreading through sexual relations, infected people were blamed for having had illicit sex. Similarly, Talle (2010) showed that people in East Africa thought that HIV/AIDS came from Europe by wealthy men and that it spread all over the region. Migrants and wealthy business persons were viewed as the main transmitters of HIV.

Gausset (2001), Nkwi (2005), Sovran (2013), and Whelehan (2009) discuss how local practices and perceptions led to the risk of people becoming infected

with HIV. Exploring young people's experiences of responses to HIV/AIDS, a study among students at the University of KwaZulu-Natal, South Africa, showed that sexual desire and appearance contributed to risk-behavior and that there is a need for education. The authors explain that "most of the students' responses demonstrated that biological factors play a significant role in influencing their sexual taking behaviour" (Mutinta et al., 2014: 327). Similarly, local practices and local knowledge, in relation to cultural beliefs, are discussed by a number of authors. Leclerc-Madlala (1997), Moyer (2015), Tenkorang et al. (2011), and Thomas (2007) focused on how people attributed HIV/AIDS to supernatural causes and "evil spirits." A study in rural Tanzania showed that people distinguish between spiritual and "natural" ways of contracting HIV and relate HIV contraction to evil spirits (*majini*), witchcraft accusations, envy, and the breaking of taboos and family norms (Mshana et al., 2006). Whyte (1997) focused on uncertainty and divination in relation to HIV/AIDS.

Studies on the relation between indigenous knowledge and biomedicine (Audet et al., 2012; Green 1994; Green et al., 1993; Moyer 2015; Wreford 2007) call for an understanding of indigenous knowledge and its relevance when collaborating with biomedicine. Based on an indigenous knowledge perspective, Green et al. (2009) argue for a need to mobilize indigenous resources to prevent HIV and thereby change behavior. The authors used the so-called PEN-3 framework for health education as "a model, which utilizes a culturally tailored and appropriate approach in which African identity and indigenous knowledge are fully taken into account" (ibid: 390). In this process, cultural resources such as rites of passage, chiefs' council, and traditional courts were seen as cultural platforms useful to influence individuals to change their behavior. Behavior change has also been discussed in relation to gender. Some studies on sexuality (Arnfred 2011; Foucault 1984; Parker 2001; Thornton 2009, 2008) discuss different ways in which societies talk about sexuality, in relation to power and politics and to unequal gender relations where men are considered superior. Some gender studies have also focused on people's perceptions of the sexual practices that led to the spread of HIV, as well as health programs that failed to address socio-cultural factors (Leclerc-Madlala 2009; Susser and Mkhize 2009).

A number of studies have focused on HIV/AIDS treatment (Biehl 2008, 2007; Hardon and Dilger 2011; Mattes 2012, 2011; Moyer and Hardon 2014; Whyte 2014), directing their attention to how people think and react to the AIDS treatment, the consequences for the person infected and his/her family, as well as the side effects of the Antiretroviral treatment. Moyer (2015), Nguyen (2010), and WHO (2010) focused on aspects such as how poor people have access to antiretroviral medications at a low price, equal rights in relation to the treatment, criteria that the local and international NGOs use to include or exclude PLWHA (People Living With HIV/

AIDS) from treatment, and obstacles, such as the distance people had to walk to the health post, especially in rural areas.

Several studies have focused on culturally appropriate strategies for prevention (Airhihenbuwa and Webster 2004; Bolton and Singer 1992; Bolton 1989; Green 2003; Green et al., 2009; Gorman and Mallon 1989; Hardon and Moyer 2014). Tavory and Swidler (2009), who carried out a study in Malawi, argued that the use of condoms might interfere with people's socio-cultural beliefs and practices related to sexuality and reproduction. They showed that sex was considered as "sweet," condom use was related to less intimacy and pleasure, and the understanding that condoms spoil the semen and prevent reproduction. The authors concluded that there was a need for an understanding of local concepts and ideas in order to know why people may resist the use of condoms.

1.2.1. HIV/AIDS in Mozambique

Mozambique has been subject to a number of studies concerning HIV/AIDS. When the first cases of HIV/AIDS emerged in 1986, the country was in a crisis because of civil war, and it struggled with a structural adjustment program (Matsinhe 2005). In that period, the country did not have the required conditions to be able to diagnose the epidemic, and many national and international NGOs began their work. Based on neoliberal principles, they recruited many health professionals from the public sector (ibid.). In addition, several studies have focused on local practices, gender relations, sexuality, and the risk of contracting HIV. Bandali (2011), working in the *Cabo Delgado* province in northern Mozambique, showed that ideas concerning infidelity and gender differences were important in understanding how men and women perceived HIV/AIDS. Women were taught to be sexually available for their husbands and were not supposed to refuse sex. The study concluded that for financially dependent married women, it was difficult to negotiate the use of condoms. In contrast, financially independent married women found it easier to negotiate the use of condoms.

Exploring the social and cultural factors that lead to the spread of HIV, Monteiro (2012), who worked in *Dondo* and *Maringue* districts of central Mozambique, argued that the prevailing western biomedical approaches concerning HIV/AIDS interventions do not include socio-cultural definitions of health and health practices. Accordingly, they do not take into account the customary and indigenous meanings and practices among local people, which makes it less effective. The author suggests an approach concerning HIV/AIDS interventions that includes traditional values, local language, and local inhabitants' point of view in order to obtain results that are more effective. Similarly, Kotanyi and Krings-Ney (2009) argued that people learn about moral values and norms in initiation rituals, which could be important in prevention efforts and in avoiding sexual relations with multiple partners.

Several studies on gender, sexuality, and HIV/AIDS (Arnfred 2011; Bagnol and Mariano 2011; Loforte 2003; Paulo 2009) have investigated gendered expectations concerning sexual performance. In her study in northern Mozambique, Arnfred (2011) looked at female initiation and female sexual power, arguing that gender and sexuality need to be understood in relation to the local inhabitants' perceptions of gender. Bagnol and Mariano (2011) also discussed cultural practices in their study in central Mozambique. They argued that the elongation of the labia minora and so called "dry sex," relating to the inclusion of natural products in the vagina to make it "dry and "hot," are cultural practices that may lead to sexually transmitted infections and HIV contraction. They found that these practices were important for the constitution of women's identity, eroticism, and the experience of pleasure. The authors concluded that women are motivated to engage in these practices because they perceive that sex gives more pleasure when the vagina is dry and hot. The concepts such as closed and opened, heavy and light, life and death, and sweet and not sweet are here fundamental for the understanding of these practices.

In relation to studies on condom use, a number of authors discuss what people think and how they behave when it comes to condom use (Agha et al., 2001; Pffeifer 2004; Manuel 2005; Matsinhe 2005). Agha et al. (2001) studied condom use and showed that access to interventions programs and social marketing programs increased condom use between non-regular partners. Similarly, Matsinhe (2005) argued for the importance of cultural meanings in relation to condom use and showed that many men think that condoms are to be used with *mulheres de fora*, "women from the outside," not with the wife. Men viewed the use of condoms as having a *banho com capa*, "shower with a cape." A condom was considered strange in relation to the body, and it reduced pleasure and reproduction. Women, on the other hand, viewed condoms as causing discharge and infections. Another study among students at a secondary school of Maputo city showed that condom use was related to ideas concerning trust and love (Manuel 2005). In this study, young people used condoms when they had a *pito*/*a*, an occasional boyfriend or girlfriend. However, when they had a *namorado/a*, a stable boyfriend or girlfriend, they only occasionally used a condom. The study also showed that gender inequality and lack of information and education about HIV/AIDS are obstacles for condom use among young people.

Other studies have focused on biomedicine in relation to ethnomedicine (Mariano et al. 2010), traditional healers' services (Audet et al., 2012), the access to ART, and the experience of living with HIV/AIDS (Braga 2012; Høg 2008). In *Molocué* and *Zambézia* provinces, men were more satisfied than women with the traditional healers' services. Both men and women living far from urban areas first visited traditional healers to get a diagnosis before going to the health center (Audet et al., 2012).

With regard to the access to ART and the experience of living with HIV/AIDS, Høg (2008) discusses the relevance of human rights in access to treatment. The author argued that the human rights discourse in relation to ART in Mozambique is, to a certain extent, silenced. This silence could be understood in relation to a history where people are not encouraged to criticize governmental health policies, although access to treatment is a central concern for the civil society. According to Høg (2008), a hierarchical social order creates obstacles for the planning of ART accessibility and implementation. In a similar vein, Pfieffer (2013) discusses HIV/AIDS services in relation to the private sector and to healthcare delivery.

1.3. Methods

This section aims to present the methods used in this thesis, and it highlights three main themes. The first theme concerns the entrance in the field and how the contact with informants evolved. The second theme relates to fieldwork methods and to informants' attitudes in relation to talking about HIV/AIDS and sex. Finally, the third and last theme focuses on the exit from the field and ethical considerations.

1.3.1. The entrance in the field

The first time I visited *Mafalala* was in 1998 when I went there as a teacher, together with undergraduate students in social science from the University *Eduardo Mondlane*, *Maputo*, to conduct their first training in research methods. At this stage, I made contact with local leaders, traditional healers, and ordinary people, and I learned about the history of *Mafalala* from some experienced people in the neighborhood. After I became familiar with the *bairro,* I carried out some short- and long-term consultancies and assignments for national and international organizations working with development. Moreover, I built a network with ordinary people, which allowed me to perform these tasks.

Between January and March 2013, I carried out a pilot study for this thesis and started to work with a research assistant. The pilot study was planned to test the research questions that I had prepared to guide my interviews. I needed to work with an assistant for linguistic reasons. The main languages in *Mafalala* besides Portuguese are *Makwa*, *Changana*, *Xitswa,* and *Ronga*. The last three languages are closely related, and *Changana* is the dominant one. As I do not speak any of these three languages, I contacted an assistant to help me with the translation. During the pilot study, I worked together with a male assistant; however, people did not talk to us as we had expected. When we asked them why they did not talk to us, they replied that it was because they thought we were a couple and they did not want to interrupt our conversation.

During the main fieldwork between January and November 2014, I instead chose to work with a female assistant. She was born in *Mafalala* and still lived in the neighborhood. She had finished grade eleven, which according to Mozambican standards means that she is highly educated. Moreover, she was also able to contribute interesting reflections about the realities in *Mafalala*. She was married and had one child. In the field, the female assistant interpreted some interviews (with elders and traditional healers) from *Changana* (the local language spoken in southern Mozambique) to Portuguese. She also reported on what was happening in the *bairro* while I stayed away (from 6 p.m.-7 a.m.) for security reasons (risk of petty crime and theft in the narrow streets). My assistant walked together with me in the *bairro* during daytime and on those nights when there were events (jazz, dance, videos promoted by residents, among other relevant activities). The female assistant received 300 MT (about 8.3 USD) per day from the Swedish International Development Agency program in Mozambique, which she told me helped very much for her family's expenses.

The decision to have a local female assistant allowed people to talk spontaneously with me. People said that my assistant and I looked like mother and daughter. They invited us for breakfast, lunch, and snack and took the time to know more about our research. They often contributed with their experience on the topic. Sometimes people thought that we were members of some church that preached in the *bairro* because of how I dressed, with a long skirt, T-shirt, and cap. Seeing someone wearing clothes that covered most of their body was viewed as this joke. However, the reason for wearing such clothes had to do with the fact that I wanted to demonstrate respectability, which was especially important, as I asked many sensitive questions about sexuality. With regard to socio-economic differences, it was important that I wore plain clothes and walked in the *bairro,* thus, showing closeness to the inhabitants. I myself am a middle class woman, and I wanted to avoid people asking me for expensive gifts that I could not afford to give to everyone. I also explained that I was an assistant lecturer at the University and that I was collecting data to write my dissertation.

1.3.2. Informants and key households

Following, I will describe my informants as well as the twelve households where I carried out an important part of the long-term participant observation. Access to informants was partly possible using the snowball technique; in turn, informants indicated other people to talk to. Some individuals outside of my key informants' social network were included in order to avoid the data collection being biased by responses from a particular group of people. Sometimes I met people identified by the secretary of the *bairro*. According to the secretary, the identified individuals were in an especially vulnerable condition. Moreover, I met some of the infor-

mants that I got to know during my previous visits to *Mafalala* between 2000 and 2011, and I also had access to informants through my female assistant's network.

The majority of the informants were men and women between approximately 20 to 40 years of age. Some of them had never attended school, while others had gone through primary school but not continued with their studies for various reasons. The women often worked as domestic workers or resold small quantities of products such as salt, sugar, tomatoes, lettuce, and coconut that they had bought in the informal market. The men did *biscatos* (temporary work that gives immediate cash) such as carrying bags in the streets and in the market, helping out with construction work, and collecting garbage to sell to an enterprise. Some of the men and women living in the poor households engaged in transactional sex and sex work. Other informants were somewhat better off. They had finished secondary school and worked for the state or had opened their own businesses. These informants were primary school teachers, carpenters, nurses, HIV activists, healers, and politicians (e.g., local authorities).

Informants came from different ethnic groups. Some were HIV positive and others were HIV negative, while others were not certain about their HIV status. In the first two months of the fieldwork, I interviewed various people, local authorities, and people connected with the local association *Machaka* (meaning "family" in the *Changana* language spoken in Southern Mozambique). This association was founded by young people in *Mafalala* in order to raise an awareness among their peers about the need to prevent themselves from getting various illnesses, including HIV/AIDS. I observed how people talked and acted in relation to HIV/AIDS issues.

In the third month of fieldwork, I selected twelve households for long-term participant observation, and these households became central to my study. I tried to include various kinds of households. My selection was based on a number of criteria, such as the number of household members, age and gender of household members, HIV/AIDS status of household members, religious belonging, socioeconomic status, and their relationship to the different healthcare systems. In addition, I selected households from different sections of *Mafalala*. *Mafalala* is divided into sections A, B, and C, and there are some tendencies for ethnic divisions among the three sections. As I selected households from all three sections, I could reach people who spoke different languages. Section A originally had people that spoke *Makwa* from northern Mozambique, while sections B and C were dominated by people that spoke *Changana, Xitswa,* and *Ronga*, which are local languages from southern Mozambique. During our conversations, I was particularly interested in how both women and men felt about their illness, what was their understanding of HIV/AIDS counseling and testing, where they turned to when they were ill, the support they received from their social networks and religious congregations, and the kind of work they were involved in to economically sup-

port themselves and their families. An overview of the households is presented in the Appendix.

1.3.3. Ethnographic methods

On a normal day, I visited six households out of the twelve households in the morning and the rest of the households during the afternoon. The visits could be both short and long. With regard to the short visits, informants were often busy or worried about something that happened in their family, such as a death or an episode of illness. In these cases, I followed up on their concerns and asked them how they would solve the problem. Then, I often left so they could do what they needed to do. The long visits to the households occurred, for example, when the household prepared prayers for the ill person in the family and during the preparation of initiation rituals for girls. It could also be when people wanted to talk a lot about their concerns. Some female informants seemed to enjoy my visits because they saw us as friends. Based on these observation, I learnt about poor people's everyday lives, and I saw that they had many challenges and struggled with many difficulties. For example, l learnt that some poor households only had one meal per day, which many times was bread without any butter and tea or *xima* (maize porridge) and beans. I also observed some informants living with HIV/AIDS that interrupted taking their antiretroviral medication because they did not have food to eat. Besides the twelve households, I also observed and talked to other people, such as local authorities, nurses, HIV/AIDS activists, and religious leaders.

In the beginning of the fieldwork, it was difficult to start the observation in the households because people seemed to distrust my informant and me. People thought that we would only stay for a short period and leave, never to return. After they realized that we were going to stay in *Mafalala* for a long period, they started to invite us for soft drinks, breakfast or lunch, and they took the chance to question us about what we were doing. Most of the time, people understood that our investigation was important. Overall, participant observation allowed me to have a close relationship with the informants and closely relate to what informants did and did not do.

Participant observation and in-depth interviews helped me to understand what people said in relation to what they did. For example, one of informants said that he always used a condom during intercourse and took out a condom from his pocket and showed me. A few days after our meeting, however, his wife told me that he had had a child with another woman. Hence, because of participant observation, I could inquire about any discrepancies between what people said and what they actually did (see Berreman 2012; DeWalt 2011; Wengraf 2001).

Besides all the meetings and interactions with the informants, I also carried out participant observation at other places. I visited the main informal market in the *bairro* where residents from *Mafalala* and other neighborhoods shopped. Close to

the market, on several occasions, I observed activities at a small hotel where people sold sex. Other observation were carried out in one health center with some of the informants living with HIV/AIDS. The aim was to observe how the informants were treated in the health center, what kind of people living with HIV/AIDS went to the health center in terms of generation and age, and what types of information they received. I observed the two primary schools in *Mafalala* because they had a specific program to help students, teachers, and administrative staff living with HIV/AIDS. I observed activities in churches and mosques in *Mafalala,* as many of my informants were members of religious congregations. Some of the congregations were concerned about HIV/AIDS. They had specific activities related to HIV/AIDS such as talking about HIV/AIDS to their members, offering prayers for ill members and their family, and providing herbs to enhance the health of members living with HIV/AIDS.

I also observed the work of HIV/AIDS activists. I followed them when they walked around *Mafalala* and when they visited different households. My objective was to study how they interacted with people in the households, in what types of conditions they worked, and what procedures they used when counseling and doing HIV testing. I also observed healers when they prepared herbs to treat tuberculosis and HIV, but I could not be present when they performed divinations and treated people, as both healers and patients wanted to do that in privacy. I observed healers bringing herbs and bulbs from a market outside *Mafalala* called *Xipamanine* or from the bush outside of Maputo city. They dried the bulbs and herbs, and sometimes they asked me and other people in the house to help to select the best herbs and bulbs to store. This task was done under supervision of the healers.

I also used semi-structured interviews. I have carried out more than 30 interviews with ordinary men and women, teachers, nurses working in the public and private health services, informants who did HIV testing, informants living with HIV/AIDS, local authorities, coordinators of the associations working with HIV/AIDS in *Mafalala* such as *AMODEFA Associação Moçambicana para o Desenvolvimento da Família* (The Mozambican Association for the Development of the Family), *MozHope,* and *Machaca*. I also interviewed the coordinator of the *Departmento sócio-antropológico e etnobotânico* (The Social Anthropological and Ethnobotanical Department) at the Ministry of Health that works together with traditional healers to find ways to combine biomedicine and local healing knowledge and to improve the ways in which illnesses are treated. I also interviewed the coordinator of the *Conselho Nacional de Combate ao HIV/SIDA* (The National Council to Fight HIV/AIDS). This institution coordinates the discussion of *Planos Estratégicos de Combate ao HIV/SIDA*, or the strategic plans to fight HIV/AIDS. Overall, I found that semi-structure interviews led people to talk spontaneously about the topic (Wengraf 2001).

I took notes during the interviews, and at the end of the day I transcribed the interviews in my computer. In the field diary, I noted the date, week, place of the interview, who was present when I interviewed the person, atmosphere, duration of the interview, how I set up the interview, and my reflections about the interview and atmosphere. The next day, I discussed the interview with my assistant, and sometimes I went back to ask the informants follow-up questions. I frequently communicated with my informants in Portuguese, but when I met an older, local leader or new arrival in *Mafalala* who did not speak Portuguese, I asked my assistant to translate each question. Mostly, she translated between *Changana* and Portuguese as I understand *Changana* but cannot speak it well. Each interview took between forty minutes to one hour. The interviews worked better with men because they had plenty of leisure time at home, while the interviews with women were more difficult because women were always doing something while talking. I sometimes helped them to do their chores such as selecting beans to cook, crushing peanuts to mix with vegetables, so that we could talk without disturbing their daily activities.

The interviews were sometimes an act of balance as I interviewed informants pointed out by the local authorities, informants arranged through my assistant, and people indicated by different informants. The selection of interviewees was a challenge because I did not want to increase division among people in the *bairro*, especially because there was a perception that local authorities promoted informants that were part of their social network and ethnic group. However, I tried to work as transparent as possible.

I also conducted two focus group discussions in the beginning of the fieldwork. One focus group was composed of young men living in *Mafalala*, who were students at various universities in Maputo city. These young men belonged to a Muslim congregation, and they lived in a student resident house organized by members of certain mosques. Another focus group was composed of young female university students living in *Mafalala*. I decided to conduct these focus group discussions because I wanted to listen to young highly educated people's view on rumors about infected condoms and incorrect HIV test results, as well as other issues connected to HIV/AIDS. For the focus group discussion with the young men, I organized a team of three persons. My assistant took notes, one of the young men was the moderator, and I asked the questions. During the focus group discussion with the young women, my assistant took notes, one of the young women was a moderator, and I asked the questions.

The focus groups discussions created opportunities for young men and women to share their views about some specific themes that I wanted to explore. I selected informants for the focus group discussions according to age, generation, level of education, and the section of the *bairro* they lived in. In the focus groups, I asked informants to discuss what people said in private, e.g., about condoms being "in-

fected" to kill poor people, about ART causing hunger, and about herbs used to treat AIDS. In the focus group discussions, the participants tended to be influenced by each other's views, and they strived for some sort of consensus. I found focus group discussions to be important because they provided general ideas about what concerned people, and they helped to create a consensus in the selected groups (Hennink 2014). However, talking to a particular group did not mean that all voices and views in the *bairro* were represented.

After I finished the fieldwork, I organized the data in overarching themes, such as HIV testing and AIDS treatment and stigma toward people living with HIV/AIDS. I also identified a number of more minor empirical themes that were important because they had to do with topics that are less explored in previous research on HIV/AIDS. Examples of such themes are people living with HIV/AIDS organizing in groups to collect the antiretroviral medications at the health center and descriptions about the role of "small hotels" for transactional sex and sex work. After having organized the themes, I started writing, organizing, and reorganizing the ideas; furthermore, I included a review of relevant literature and the research framework in the text.

The fieldwork was combined with extensive reading of governmental documents, such as the *Planos Estratégicos de Combate ao HIV/SIDA,* issued by the government in collaboration with Conselho Nacional de Combate ao HIV/SIDA (2015, 2010, and 2004), and academic literature on HIV/AIDS in the world, southern Africa, and Mozambique, HIV/AIDS as well as relevant literature in anthropology and public health science.

1.3.4. Talking about HIV/AIDS and sex

The success of my fieldwork depended to a large extent on the fact that informants generally were willing to talk openly about sexuality and HIV/AIDS, or *essa doença* (lit. "that disease") as it is locally called. Generally, people in Mozambique engage in conversations about sex without feeling that it is a sensitive topic of conversation. Yet, informants sometimes wanted to talk about something they considered to be private. Some women had specific issues to share related to their health, and in some cases this helped me to build a relationship of trust. Some wanted to talk with me in private, e.g., in the backyard without the knowledge of other members of the household or neighbors. Commonly, they first asked me if I wanted to have a soft drink or some pastry that they had baked. Then, they started sharing their troubles. Often, it was related to pain or bleeding in a sensitive part of the body. They asked for advice, and I often suggested for them to go to the health center where they could get appropriate help. Sometimes I went with them.

People talked about sexuality, using words that they considered appropriate to use in public (e.g., *dormir com,* lit. "sleep with" meaning sexual intercourse, and

andar fora, lit. "walk on the outside" meaning adultery). Informants were also comfortable with music that referred to sex or sexual relations, and they would sometimes mimic the sexual act while listening to the music. The proximity of the houses in *Mafalala* also makes people become aware of what is happening in their neighbor's house. Because of this proximity, people would often know if a neighbor had committed adultery or if she/he had had intimate relations with someone.

1.3.5. Exit from the field and ethical considerations

From October 2014, I started to say farewell to the informants. I told them that I would leave *Mafalala* for a while and that I would come back with the thesis to share what I wrote about them. Some informants were unhappy about my leaving, but they accepted my explanation. Others were unhappy because they did not believe that I would return. They argued that many people go to *Mafalala* to get the information they want and then they never come back. After I definitively left *Mafalala* by the end of December 2014, some informants that had also become dear friends called me to ask when I was going to visit them. Sometimes I saw some of them in the street, and they stopped me to ask for a lift. Since I left the *bairro*, I sometimes cry remembering the people who died because of HIV/AIDS and those that are still suffering and struggling with the disease, with little possibility of changing their lives.

Ethics in anthropology highlights the importance of protecting informants when collecting data and writing. Anthropological ethics suggests that interviewees should be protected against possible harm by making them anonymous. To protect my informants, I use pseudonyms. Other ethical issues that I have observed are confidentiality and verbal informal consent. All interviewees accepted to share their experiences about HIV/AIDS and related issues after an explanation about the project and being told that they could withdraw from the project at any time. Thus, stipulated ethical codes within social sciences were followed (AAA 1996).

Before any interview, focus group, or observation, I explained the aim of the study to the informants and they gave verbal informal consent. Many were not familiar with the terms used in research. Therefore, I used local terms to make people understand what I was doing. For example, many people did not differentiate between HIV (virus) and AIDS (disease). Instead, people said *essa doença* when they talked about HIV/AIDS, so I used the same term.

My position as a woman, a teacher at the University Eduardo Mondlane in Maputo, and a Ph.D. student at the University of Gothenburg, Sweden, created expectations that maybe if people came close to me they would gain material benefits. I always explained that my study would not directly bring any material benefits, but if policy makers read my study they would maybe find ways to develop policies that will better meet the needs of people living in poverty. Some informants that had children in secondary school asked if I could give them

tips to prepare their children to apply for undergraduate studies. I provided some informants with past exams so that their children could use them to prepare. In conclusion, I believe that my attitude shaped the results of this study in a good way because people were willing to share their experiences and they asked me to visit them every day.

1.4. The structure of the thesis

This thesis is structured into eight chapters. Chapter two, "HIV/AIDS policy, associations and activists," takes a close look at the HIV/AIDS governmental policy in Mozambique and at the local implementation of this policy in *Mafalala*. It also presents the government's view on healers' spiritual prevention and the work developed by activists working with HIV/AIDS. The chapter ends with a presentation and discussion of the organizations and associations working with HIV/AIDS in *Mafalala*.

Chapter three, "Life in *Mafalala,*" provides a background into people's lives in *Mafalala,* and it is based on how the inhabitants perceive their neighborhood. The chapter begins with a presentation of the physical environment. Thereafter, it discusses the various ways that families and households may be composed; moreover, it presents the key social institutions in the *bairro*, i.e., the schools and the various religious congregations, and their work on HIV/AIDS. This is followed by a discussion on how people in *Mafalala* make a living and on the role of transactional sex and sex work for people's livelihoods.

Chapter four, "Contracting HIV," presents the different ways that poor people, who are the most vulnerable and at the greatest risk of contracting HIV, believe that they can contract HIV. The chapter shows that people perceive that they can get HIV by having sexual relations without a condom (*carne a carne* or "meat-to-meat"), through infected condoms, through sharing of cutting instruments, and by contracting HIV through evil spirits.

Chapter five, "Trying to treat HIV/AIDS," addresses how people understand and treat HIV/AIDS. It presents people's perceptions and experiences of HIV testing, and it shows how nurses may act toward patients in the health centers, which may create a lack of trust as well as misunderstandings. The chapter presents people's experiences of AIDS opportunistic illnesses, such as tuberculosis, and side effects of antiretroviral therapy. The chapter also discusses how people treat AIDS through ART and why some people continue with the treatment, while others withdraw from treatment or interrupt it. The chapter ends with a discussion about the different ethnomedical non-western ways of treating AIDS.

Chapter six, "Perceptions of stigma," discusses the governmental policies and healthcare practices related to HIV/AIDS and argues for the importance of avoiding the creation of stigma in relation to HIV/AIDS. The chapter also discusses the

creation of stigma in the family and community, as well as differences in how men and women living with HIV/AIDS are treated.

Chapter seven, "Understandings of prevention," focuses, in particular, on how people understand HIV/AIDS prevention. It explains why some people seem not to care about HIV/AIDS prevention while others do. The chapter also discusses people's non-biomedical and non-western understandings of prevention of HIV/AIDS and healers' treatments and spiritual "vaccinations."

Finally, chapter eight presents the thesis conclusions.

2
HIV/AIDS policy, associations, and activists

This chapter will discuss the national HIV/AIDS policy in Mozambique and the implementation of the policy by activists and associations working with HIV/AIDS issues in *Mafalala*. The objective of the chapter is to present a background for the policy setting and the different local actors that together shape the official attitude and activities, with regard to HIV/AIDS prevention in *Mafalala*. In addition, some ethnographic material is included in order to provide a picture of the ongoing HIV/AIDS campaigns in *Mafalala.*

2.1. Government policy

The Government of Mozambique, together with national and international NGOs, focus on HIV/AIDS in relation to two main issues: prevention and treatment. With regard to prevention, the government support, in particular, the following six key activities: counseling and HIV testing, promotion of condom use, reduction of HIV infection among health workers, reduction of sexually transmitted infections, promotion of increased knowledge about HIV/AIDS among adolescents and young people, and reduction of the transmission of HIV from mother to child. Concerning treatment, the strategic focus is to encourage PLWHA to start with ART as soon as they know their HIV positive status (Conselho Nacional de Combate ao HIV/SIDA 2015; cf. Pfeiffer 2013; Boletim da República Lei nº 5/2002). Below, I will briefly discuss the implementation of the key activities aiming at preventing the spread of HIV/AIDS and treating those who suffer from the disease.

In relation to HIV counseling and testing, the Mozambique Government started to create GATVs - *Gabinetes de Atendimento e Testagem Voluntária* (Offices

for Attendance and Voluntary Testing) in 2001. Later, the government closed down the GATVs because they contributed to increase the stigma against PLWHA, as they increased the public visibility of those who were suffering from HIV/AIDS. Instead, a program called *Aconselhamento e Testagem em Saúde,* ATS (Health Counseling and Testing), was launched at public health posts, health centers and hospitals, providing voluntary counseling and HIV testing.

Mozambique has a total of approximately 3,000 sanitary units, of which about 1,500 are health centers, 1,000 sanitary units, 49 district hospitals, and 4 central hospitals. According to, for example, the National Coordinator of HIV/AIDS in the workplace (Coordenadora Nacional de HIV/SIDA no Local de Trabalho) whom I interviewed, these sanitary units do not cover the healthcare needs of the people in Mozambique. ATSs exist in all hospitals, health centers and health posts, but they are often not equipped with adequate material and staff, which implies that they are unable to help people who seek treatment for the different symptoms.

In relation to the promotion of condom use, the government's strategic objective is that people who cannot abstain from sex should have the possibility to use "male" or "female" condoms. For many years, the government has promoted campaigns and interventions with the aim of influencing people to use condoms. As I will make clear in this thesis, however, these activities have often been far from successful.

With reference to the reduction of HIV infections among health workers, the Ministry of Health provide disposable needles and gloves to prevent health workers from becoming infected with HIV at their workplace. The government also offers HIV testing for health workers when there is a suspicion that they have been in contact with a patient's blood and fluids.

Regarding the reduction of sexually transmitted infections, the government works in collaboration with the international NGO Population Service International (PSI) to promote condom use, especially among young people, to prevent sexually transmitted infections such as syphilis and gonorrhea. It is important to fight sexually transmitted infections because they make people vulnerable to contracting HIV. It is also important for PLWHA to use condoms regularly, as this helps them to avoid reinfection since there are many different types of HIV.

Promotion of increased knowledge about HIV/AIDS among adolescents is also a priority. The government's objective is to implement actions in the families, communities, and schools. Adolescents are often included as activists in the organizations and associations, which disseminate information about HIV/AIDS. The rationale behind this is that the government hopes that young people will pay more attention to messages from their peers.

In relation to the reduction of HIV transmission from mother to child, the government strongly recommends that all pregnant women in the fourth month of pregnancy undergo HIV testing and counseling. If the HIV testing of the pregnant

woman is positive, she receives the antiretroviral medication *ziduvudina*, possibly also with other antiretroviral therapies, during labor to prevent infecting the unborn child. After the child is born, he or she receives some drops of syrup and the mother is not allowed to breastfeed.

Finally, regarding treatment, the government has been providing free ART for all PLWHA since 2002 in the public health centers and hospitals. PLWHA go to the public health center or hospitals to pick up their antiretroviral medication because the private health centers do not offer ART.

The rational underlying the six points emphasized by the government regarding the HIV/AIDS prevention is threefold. It is assumed that: i) people will change their behavior when they are given the right information about HIV/AIDS, ii) people will undergo HIV testing when they know where to go to get counseling and HIV testing, and iii) PLWHA will improve their lives when they have access to ART. This approach targets mainly individuals and individual behavior, and pays less attention to the cultural and social understandings of risk and prevention. As I will show, however, there are signs of change in the latest policy documents.

2.1.1. National strategic plans

Since 2000, the Mozambican Government has set up strategic plans in order to try to prevent the spread of HIV/AIDS. Over the years, four *Plano Estratégico Nacional de Cambate ao HIV/SIDA* (National Strategic Plans to fight HIV/AIDS) have been developed, namely, PEN IV 2015-2019, PEN III 2010-2014, PEN II 2005-2009, and PEN I 2000-2002 (*Conselho Nacional de Combate ao HIV/SIDA,* 2015, 2010, 2004, 2000). Following, I will discuss the development of these plans.

In PEN I and PEN II, little emphasis was placed on HIV/AIDS prevention. Focus was on information about HIV/AIDS for some target groups (e.g., long distance drivers and sex workers). The disease model (Kiefer 2007) was emphasized, and the idea was that people will change their behavior if they have the right information about HIV/AIDS. In PEN III and PEN IV, the emphasis was on prevention, and the government expected that the communities, the families, and NGOs would work together to reduce the number of people infected with HIV, especially the young people. Particular attention was paid to children from 10 years of age because the results of the national health inquiry showed that young people between 15-24 years old were more infected with HIV than other groups in Mozambique (INSIDA 2009). The government emphasizes community and family collaboration, based on the assumption that people will react in a positive way when they hear from their family and community members about HIV/AIDS prevention.

Another development has to do with the shift from the ABC model to the so-called "combined prevention (*prevenção combinada*). From PEN I to PEN III, the strategy was mainly based on individual behavior change through the ABC model (Abstain, Be faithful, or Condomise). In these strategies, the government

promoted condom distribution and the provision of educative information for behavior change, in particular, behavior in relation to sexuality. In PEN IV, the government's strategy is a combined prevention, which includes a mixture of the individual approach (promotion of safe sex for those who cannot abstain) and community and family focus on elimination of multiple partners, reduction of stigma toward PLWHA, and dissemination of knowledge pertaining to the PLWHA human rights. In PEN IV, the government also emphasizes the distribution and promotion of both male and female condoms, counseling, health testing, and voluntary masculine circumcision. The government expects that these activities will be carried out in collaboration with the national/ international organizations, communities, and families in both rural and urban Mozambique. This strategy is seemingly more promising, with regard to the possibility of having a sustainable impact on the reduction of new infections. Furthermore, PEN IV includes socio-cultural practices and meanings (cf. Kiefer 2007) related to HIV/AIDS and contributes in a more socio-culturally informed way to the prevention of new infections. However, the plan includes many different and complex activities, and it remains to be seen whether all of these will be implemented in an efficient and sustainable way.

2.1.2. Government policy and traditional healers

The Ministry of Health is aware of the fact that people from different parts of Mozambique use spiritual prevention methods for various illnesses, including AIDS. The *Instituto de Medicina Tradicional* (Institute for Traditional Medicine) located at the Ministry of Health is a government institution that collaborates with non-western, traditional healers. The institute trains the healers on prevention from a biomedical perspective and supports traditional healers to recognize symptoms of frequent illnesses among their clients. The institute also encourages healers to send their clients to the health services when they observe symptoms related to illnesses such as malaria, tuberculosis, and AIDS. The Ministry of Health does not hinder healers to spiritually prevent their clients from contracting HIV, but they are also advised to send their clients to the biomedical health services, especially if they observe that their clients have symptoms of AIDS, such as a strong cough, permanent diarrhea, and/or a rapid weight loss.

All healers who are members of the *AMETRAMO - Associação dos Médicos Tradicionais de Moçambique*) (Association of Traditional Healers of Mozambique) receive information and training from the Ministry of Health about frequent illnesses and HIV/AIDS prevention in Mozambique. For instance, the regional branches of the Ministry of Health train traditional healers to make changes in the way they use cutting instruments when they spiritually "vaccinate" their clients. Instead of using one razor for various clients, healers are trained to ask their clients to bring their own razor in case they need a spiritual "vaccination" (see Gune 2001). The efficiency of this training is limited because many healers are not affiliated with

the healers' association, which is the case in *Mafalala*. In particular, healers who recently had moved to *Mafalala* did not know about the healers' association.

2.2. Activists and associations working with HIV/AIDS in *Mafalala*

In *Mafalala,* there were many activists working either for the Ministry of Health or for NGOs working with HIV/AIDS. These activists played a key role in the implementation of the government's HIV/AIDS policies.

2.2.1. Activists from the Ministry of Health

During my fieldwork in 2014, four activists from the Ministry of Health performed voluntary counseling and HIV testing in *Mafalala*. The idea was that people who were not able to go to the health center for some reason should get counseling and testing at home. The activists worked in the *bairro* from 8 a.m. to 15:30 p.m., dressed in a yellow T-shirt and a cap with the text "Ministry of Health, Voluntary Counseling and Testing," so that everyone could recognize them. They walked in pairs because they had to carry material, but also because they wanted to feel secure in the *bairro*. The activists stopped by in the houses where people called them, where they provided counseling and HIV testing. Thus, the initiative of the door-to-door contacts was in the hands of the *Mafalala* inhabitants.

When visiting houses, the activists sometimes stayed in the yard, where other people from the family and sometimes neighbors could follow the counseling and HIV testing. This made the issue of anonymity uncertain because other people could easily understand the HIV status of the person through his or her facial expression when the result of the test was communicated. Moreover, only those who had a negative HIV test received condoms from the activist. When I approached the Ministry of Health activists to understand how they worked, they received me with some resistance and distrust. They provided me with their mobile phone number, but when I called them, they always said they were very busy. When I met them, they said that they were not allowed to talk and that I should instead talk to the person in charge at the Ministry of Health. It seemed like the activists were reluctant to talk to me because of the confidentiality uncertainties surrounding HIV testing. As I will show below, the lack of anonymity and disclosure may increase the possibility of individuals being stigmatized (see French et al., 2015 and Greeff 2013) by the family and the community. This is how health institutions contribute to increase the social suffering (Kleinman 2010).

Another problem is that the activists working for the government and activists working for NGOs do not get the same kind of training (Conselho Nacional de Combate ao HIV/SIDA 2010). Consequently, they do not deliver the same advice and information, which may confuse people (cf. Pfeiffer 2013). In the following, I

will present the different activities carried out by the non-governmental organizations working with HIV/AIDS prevention in *Mafalala*.

2.2.2. Non-governmental organizations

There were three main organizations working specifically with HIV/AIDS prevention in *Mafalala* during my fieldwork, namely, PSI, *AMODEFA,* and MozHope. In addition, there was also the organization *Geração Biz,* a young people's association working on HIV/AIDS issues, but they did not have regular activities in *Mafalala* during 2014. PSI, *AMODEFA,* and MozHope worked with the local government institutions in *Mafalala* and with a community based organization called *Machaka. Machaka* was created in *Mafalala* in 1995 with the objective of providing young people with information about various issues such as the environment, health, and education. The organizations working with HIV/AIDS prevention did not have an office in the *bairro,* which made them sometimes lose track of what was going on between the HIV/AIDS activists they employed and the people in *Mafalala*. The above-mentioned associations/organizations collaborated with the Ministry of Health of Mozambique and received financial support and technical training to carry out the HIV/AIDS campaign (c.f. Pfeiffer 2004a).

All NGOs and associations working with HIV/AIDS and other topics in *Mafalala* are granted permission from the secretary of the neighborhood through a stamp that is placed in a document. In this document, the organization states the aim of its work in *Mafalala* and the benefit the project will bring to the local people. The neighborhood administrative chief suggests local people that should be involved in the project. The aim of involving local people is that the project shall continue even after the NGOs and associations have left. Often, the *Mafalala* residents involved in the project receive some monetary rewards, certificates, and/or training from the organizations.

Involving local people in the NGOs activities is one way for the local authorities to actively participate in *Mafalala*'s development.[1] *Mafalala* residents involved in the projects inform the local authorities if something is not working well with the organizations, and they also dissipate any misunderstandings occurring in relation to the activities of these organizations. The *Mafalala* residents I met cared about and observed what the NGOs, researchers, and other people do and do not do in their neighborhood. It happened that the *Mafalala* residents complained about the activists providing inadequate information about HIV/AIDS prevention.

1 There are other forms of communal labor supported by the municipality and the administrative post of Mafalala, such as collection and recycling of garbage. Some poor people sell the garbage and manage to help themselves and their families through this activity.

PSI

The Population Service International Mozambique is a non-profit international NGO, which was converted into a national NGO in Mozambique in the 1990s. PSI works in sixty different countries and aims to use social marketing "to make it easier for people in the developing world to lead healthier lives and plan the families they desire" (PSI 2002a:10). PSI was hired in 1994 by the Ministry of Health of Mozambique to disseminate messages about reproductive health and HIV/AIDS prevention, mainly using the ABC-model (Abstain, Be Faithful, or Condomise). The PSI also provides technical and administrative support to the Ministry of Health with voluntary counseling and HIV testing and with regard to how to prevent the transmission of HIV from mother to child. The PSI implements activities related to HIV/AIDS prevention approved in the National Strategic Plans to Fight HIV/AIDS (the PEN).

From 1994, PSI has promoted condom use in Mozambique; at the time, PSI was the only NGO promoting condoms in the country. The PSI focused on communication and education using various media to circulate messages about condom use. The PSI directed their message to people engaged in high-risk behavior, such as sex workers, long distance drivers, young people in selected places like discotheques, PLWHA, *gigolôs* (men that have sex with women in exchange for money/goods) and *biscateiras* (women that have sex with men in exchange for money/goods). As I will discuss later, studies realized by the PSI (2002b, 2001) showed that many people in Mozambique did not use the free condoms because they suspected that free condoms were infected with the HIV virus. It was due to the results of these studies that PSI started selling condoms for a price of 10 MT (about 0.2 USD) each.

Today, the PSI supports HIV/AIDS prevention campaigns based on counseling and condom promotion in order to convince young people to use condoms if they do not abstain from sex. In *Mafalala*, the HIV/AIDS campaign supported by the PSI takes place in the crowded areas of the *bairro* such as the *Adelina* market, the principal streets, the primary schools, and the football field, and they attract the attention of young people, in particular. PSI works with young activists from *AMODEFA* who are recruited by *Machaka*. PSI trains the activists recruited by *AMODEFA*, and provides material and written information for activists to use in their work. The campaign shall target boys and girls separately and explain the relevance of using the "male" condom. There is also a "female" condom, but it is advertised to a lesser extent compared to the male condom. The PSI campaign assumes that young people will change their behavior if they are informed about condom use and if they know where to go to receive counseling and HIV testing.

AMODEFA

AMODEFA - Associação Moçambicana para o Desenvolvolvimento da Família (Mozambican Association for the Development of the Family) is a national association created in 1989 as a result of an invitation from the UK-based International Planned Parenthood Federation (IPPF), which is concerned with women's rights to control their own fertility. Since its foundation, *AMODEFA* has had three aims: to train women and young women in relation to reproductive health and sexuality, to promote the development of community projects, and to empower women in relation to their reproductive rights. In *Mafalala*, *AMODEFA* worked in collaboration with PSI to promote reproductive health, family planning, and HIV/AIDS prevention. *AMODEFA* only worked with young female activists. While working in *Mafalala*, these young activists received up to 50 USD per month for transportation expenses and snacks, depending on how much they worked. However, they did not receive a salary. This was viewed by some of the activists as one of the reasons explaining their lack of motivation to work. During my fieldwork in 2014, many young activists from *AMODEFA* abandoned the HIV/AIDS activism because they were not satisfied with the incentives they received.

*AMODEFA*s activists often made a negative impression on the *Mafalala* residents I met. Some people mentioned that the *AMODEFA* activists were dressed like "swaggers" (i.e., wearing tight and colored clothes) and that they drank alcohol when they were in the neighborhood. Unfortunately, because the *AMODEFA* activists appeared quite randomly in *Mafalala*, I did not have an opportunity to meet them and hear their version of how they worked. However, the conversation with *AMODEFA*s supervisor for *Mafalala* revealed that she knew that there were problems with the activists. She apologized for not being able to supervise the HIV/AIDS activists properly as she was busy working and studying at the same time. This lack of supervision was another reason why young HIV/AIDS activists abandoned the organization while working in *Mafalala*.

The young activists from *AMODEFA* were trained by PSI in three areas, namely, HIV/AIDS prevention, family planning, and reproductive health. In relation to HIV/AIDS prevention, young activists were trained to explain what HIV is, what AIDS is, how HIV is transmitted, how HIV is not transmitted, how people know they are infected, how to prevent HIV, and the importance of HIV testing. The key message in the young activists' training was that when people do HIV testing early, have only one partner, and use condoms regularly, it is positive for their health and well-being.

The young activists worked during different times of the day because many of them were secondary schools students. Thus, activists that studied in the morning did HIV/AIDS activism in the afternoon and vice versa. The activists arrived in the *bairro* and went to the local association called *Machaka* to sign their names on a list and to collect their materials. Materials included condoms, instruments to

show young people how to use a condom, a list of houses they should visit during the day according to the authorization given by the *chefe do quarteirão* (block chief). After receiving the materials, the activists had a brief conversation with the *Machaka* members to become aware of what was going on in the *bairro* on that particular day.

Despite having official permission to work in the houses they visited, the activists always checked with each family if they wanted to talk. Young activists only worked in the houses where people agreed to talk with them, despite the fact that the secretary of the *bairro* had authorized them to go and meet everyone. When activists arrived in a house, they greeted everybody they met; people in the house found them a comfortable place to sit, often outside of the house. Activists presented the aim of their visit and asked to talk with the young people in the house. If they met the young people in the house, they asked them if they knew about HIV/AIDS prevention. Sometimes there were also young people present who were not part of the household.

Sometimes *AMODEFA* brought a car with a loudspeaker playing music, especially during the weekend in order to attract young people to the place where they would carry out a campaign. In that place, *AMODEFA* presented games and quizzes. These included checking if young people know about HIV/AIDS, about how they can contract HIV, and about how they can prevent themselves from contracting HIV/AIDS. I participated in one event that *AMODEFA* organized during the weekend in which only a few young people were present, mainly because it was very early, around 8 o'clock in the morning. This was unfortunate as many young people in *Mafalala* enjoy nocturnal life and like to sleep in during the weekends.

During my fieldwork, I often witnessed how young activists struggled to pass knowledge about HIV/AIDS prevention to other young people in *Mafalala*. The struggle can be illustrated in the following quote in which a young activist had a dialogue with a young woman in *Mafalala*.

> Young activist (YA): HIV is a *bichinho* (little bug) that enters in our body. If our body is weak, we can develop AIDS.
> Young woman (YW): What kind of *bichinho* is it?
> YA: Silence… I really do not know what kind of *bichinho* it is, but I will ask my supervisor and I will tell you next time.

The young activist said *bichinho* instead of saying virus because she believed that the recipient of the message would better understand that concept. Generally, young activists received instructions in their training to use their own words when they shared HIV/AIDS prevention messages with people. During my fieldwork, young activists from *AMODEFA* worked without supervision, which made it difficult for them to immediately dissipate people's doubts. Young activists tried to

pass on the right information about HIV/AIDS, but frequently they had received too limited training to be able to substitute the technical language with a language that ordinary people could understand.

MozHope

MozHope is an international humanitarian Christian organization working in Mozambique since 2006 and officially registered in 2008. *MozHope* works in the *KaMaxaquene* district, which includes the neighborhood of *Mafalala.* Since 2008, *MozHope* supports vulnerable groups, such as orphans whose parents died of AIDS and the caretakers of these children. *MozHope* offers nutritional and psychological support to the AIDS orphans and their caretakers. *MozHope* works together with the *bairro* authorities in the selection of children who need nutritional and psychological support.

The work of *MozHope* builds on the idea that people engage in high-risk behavior because they do not have the means to act in other ways. From this point of departure, *MozHope* has started four programs and projects to help vulnerable groups, including vulnerable orphans and their caretakers to earn money in order to avoid high-risk behavior. The four programs and projects are the so-called: Anchor program, a pilot project to earn a living from selling Coca Cola; a project funded by Australia called the AusAID project; and the distribution of baskets with basic foodstuff.

The *MozHope* manager in Mozambique explained that the Anchor program provided nutritional support to orphan children and vulnerable families with members living with HIV/AIDS. In *Mafalala,* they supported about a dozen families who took care of orphans. The pilot project Coca Cola benefited 28 vulnerable families. The project lends boxes of Coca Cola to vulnerable families to sell. Once sold, the families receive about 100 USD, depending on how much Coca Cola they have sold. The AusAID project supported vulnerable children in *Mafalala* with birthday parties, cultural activities such as dances and plastic art and integration of young people in technical training.

During fieldwork, I had the opportunity to participate in a meeting where *MozHope* gave thirty basic baskets to the most vulnerable orphans of AIDS victims and their caretakers. The meeting occurred in the yard of the Administrative Post of *Mafalala. MozHope* had received a list of orphan children and their caretakers from the local authorities in *Mafalala*. In the meeting, there were many elders who were the children's caretakers. The elders wore dirty clothes and some of them used a stick to walk, indicating that they did not have good health. The meeting was organized by a *MozHope* activist who spoke Portuguese and a translator who translated the speech from Portuguese to *Changana*.

Before *MozHope* offered the basic basket, the activist explained to the caretaker that the basic basket was to complement what they had at home, and that they

should not only wait for *MozHope* to bring them food. The *MozHope* activist said that the caretakers should continue with their small economic activities in order to support themselves and the children. This is because *MozHope* wanted to avoid people becoming dependent on their programs and projects. In the meeting I observed, the elders were happy when they received the basic basket although some of them complained that "the food will not last for the whole month."

2.3. Summary

This chapter discussed the HIV/AIDS policy in Mozambique and the implementation of the policy by activists and organizations working with HIV/AIDS issues in *Mafalala*. The chapter showed that HIV/AIDS policies in Mozambique have been focusing on creating a basic infrastructure in health institutions. Yet, this infrastructure is not enough to help all PLWHA and those who need to undergo HIV testing. The various information campaigns have mainly been targeting individuals, emphasizing the individuals' responsibility to fight against HIV/AIDS. Up until recently, the national strategic plans (the PENs) did not include the role of the family and the community in the fight against HIV/AIDS.

In the various PENs, four aspects have been emphasized, namely, counseling, HIV testing, treatment, and prevention. The challenge here is to make sure that these strategies are translated into something people find relevant and useful in their everyday lives. As shown throughout this thesis, there is often a discrepancy between the information campaigns and poor people's acute needs, concerns, and ideas. In relation to counseling and prevention, the government has tried to collaborate with healers through the Institute for Traditional Medicine, but it is uncertain whether this training has been sufficiently tailored to meet the needs, competencies, and illness explanations of the healers. Moreover, many healers have not participated in the training.

Generally speaking, various national and international NGOs have implemented a HIV/AIDS program in *Mafalala*, but their activities have not been sufficiently coordinated; furthermore, many activists have insufficient training to help people understand HIV/AIDS, including what to do after testing HIV positive, and upon becoming ill. Moreover, the organizations and their activists often use a technical or obscure language that does not help to bridge the gap between local understandings and biomedical information.

3
Life in *Mafalala*

This chapter aims to provide an overview of life in *Mafalala.* The chapter starts with a brief background of the history of Mafalala and a physical characterization of the neighborhood. This is followed by a presentation of the local authorities, the inhabitants' access to infrastructure, and the importance of some key places in the *bairro*. Thereafter, follows a discussion of variations in the organization of families and households and a presentation of key social institutions, such as schools and religious congregations and how these deal with HIV/AIDS. The chapter also addresses how people make a living, including through sex work and transactional sex. Finally, the chapter presents some of the inhabitants who also have acted as informants. The objective of this presentation is to provide an insider's or emic picture of some individuals living in *Mafalala*. The ambition throughout the chapter is to describe the neighborhood in a way that is close to how the inhabitants of *Mafalala* understand the environment they live in.

3.1. The neighborhood of *Mafalala*

During colonial times, *Mafalala* was categorized as an "área indígena" (indigenous area). People from different parts of Mozambique moved there in order to work in the railway sector, at the harbor, and in industry. In addition, *Mafalala* was a place where seamen coming from e.g., northern Mozambique, Madagascar, and the Comoro Island used to stay and rest before continuing their voyages. Contract laborers from other parts of the Portuguese African Empire also lived in *Mafalala*. After the Mozambican independence in 1975, people from all over Mozambique continued to move to the neighborhood. Often, they arrived through invitation from members of their families, relatives, and friends who already lived in the *bairro*. Many people moved to *Mafalala* to be close to the city center, where they

could find jobs to improve their own lives as well as the lives of their families back home.

This history of mobility implies that *Mafalala* of today is a mixed neighborhood. People from different parts of Mozambique live together in *Mafalala*, and there are some discernible cultural differences between them. These differences may have to do with the religion they practice, the language they speak, the rituals they perform in various moments of their lives, the kind of clothes they wear, and their preferences of food. People from other countries, such as the Democratic Republic of Congo, Nigeria, Bangladesh, and India also live in *Mafalala*. These people are mainly men that frequently come alone. After they have settled in the *bairro,* they sometimes bring their wives. Some of them marry a Mozambican woman and have children with her. The majority of the foreigners in *Mafalala* develop activities in the informal sector, such as the selling of basic products, second-hand clothes, and plastic bowls. Other foreigners are healers, and some are said to be sorcerers.

Geographically, the *Mafalala bairro* is located in the Urban District Number Three of *Maputo* City. Its total population is about 21,000 inhabitants (INE 2007). Because of the proximity to the central Urban District Number One, the *bairro* benefits from many services, particularly public services. The *barrio* itself is bounded by the market *Adelina* to the north, *Mariah Ngoabi* Avenue to the south, *Acordos de Lusaka* Avenue to the west, and *Angola* Avenue to the east. There is a local perception that the *barrio* is composed of three *células* (sections) – A, B, and C, and it is subdivided into fifty-seven *quarteirões* (blocks). The smallest administrative unit is composed of ten houses. A block was originally composed of forty houses. The block's composition changed after the end of the Civil War in 1992, when many new residents arrived and built houses in places that before were used for entertainment, such as the football field and some green areas. Actually, these new blocks include more than forty houses. Some blocks in the interior of the *bairro* are overpopulated. These blocks have approximately sixty houses. The blocks close to the main streets, such as *Rua de Goa* and *Rua de Guiné* have more space, and the houses are well organized. In the interior of the *bairro*, the houses are small and there is a lack of infrastructure; people commonly throw dirty water and garbage in the street outside of the house.

3.1.1. Local authorities

The *bairro* has four representatives of the governmental authorities, namely, the *secretário do bairro* (secretary of the neighborhood), the *chefe do posto administrativo* (administrative chief), the *chefe do quarteirão* (block chief), and *the chefe de dez casas* (ten houses chief). These local authorities work together with issues that concern residents, such as security, provision of food for people living with HIV/AIDS, among others. Local authorities go to each household that has a mem-

ber living with HIV/AIDS and sometimes interview members of the household to decide if they should be entitled to receive food from the state. Governmental authorities also give permission to researchers and national and international Non-Governmental Organizations working in different areas to perform activities in the *bairro*.

According to the secretary of the *bairro,* the administrative organization was created after independence to control and organize the population. The administrative organization should inform government authorities about people's concerns in relation to drainage, water, and electricity, for instance. The local authorities in *Mafalala* are responsible for reporting social problems to the central authorities and pointing out which parts of the *bairro* they should focus on if there are some problems. For example, the *bairro* secretary would report to the former *Ministério da Mulher e Acção Social* (Ministry of Women and Social Action), now *Ministério do Género, Criança e Acção Social* (Ministry of Gender, Children and Social Action), about people who are ill and who do not have support from their social networks. Poor people can get a small sum of money every month, and orphans can receive school material and basic healthcare for free.

Figure 1 Map of Mafalala

3.1.2. The inhabitants' access to infrastructure

As mentioned, *Mafalala* residents live in three separate areas: A, B, and C, but they meet for different purposes in different places such as churches and mosques, markets, and streets. The south-eastern area of the *bairro* is the part that is best served with infrastructure. There is easy access to the rest of the city, including the downtown areas, the commercial center, and the industrial areas. The *bairro* is supplied with piped water, electricity, and a telephone network, although not all households are connected to those facilities (cf. Tivane 2002). The poorer parts

of *Mafalala* lack access to infrastructures such as electricity. Moreover, people throw water in the streets, and the houses have no latrine or a badly functioning one, which creates an unhealthy environment. People who have a steady job and income commonly have access to water and electricity because they pay a monthly fee to the public companies called *Eletricidade de Moçambique (Mozambique Electricity) and Água da Região de Maputo (Water for Maputo Region)*.

The monthly fee for water and electricity varies depending on how much water and electricity a household uses. Since many households did not pay for the electricity, the Mozambique electricity company introduced a system of pre-paid electricity to all people that signed a contract. Poor people do not sign a contract with Mozambique Electricity because they do not have a permanent job that allows them to pay for the electricity they need. Moreover, many poor people do not know how to read and write in order to sign a contract. Some poor households temporarily buy water and electricity from other households who have a contract with *Maputo* Water Regional and Mozambique Electricity.

The lack of electricity is a problem, not only inside the houses but also in the streets, especially during the night, when the darkness makes people's movements more restricted. Poor people use carbon and wood to cook vegetables, beans, maize, rice, and other kinds of food they manage to buy. Poor households without electricity do not have a fridge although they need a fridge where they can store food, as they do not have money every day to buy food. This means that when poor households without a fridge cook food, they have to finish eating all the food the same day or the food will become rotten. Moreover, poor people cannot watch soap operas on the television as more affluent households do. Soap operas are socially important for people because everyday conversations often focus on what happened in some scenes of the soap opera, and many people discuss the way in which soap opera actors dress, talk, and act. Poor people try to find a house that has a TV and stand outside and watch the soap opera. Especially for young people, it is hard to be unable to contribute to the conversation about the latest soap opera because their parents and relatives do not have electricity and/or TV.

In the rainy season between January and March, many houses in the interior of the *bairro* are flooded for days or weeks. Houses located in the interior of the *bairro* are more vulnerable to flooding because the sewage is often full of garbage, which blocks the water from running freely. People try to remove water inside the houses with buckets, but the water comes back again from underground because the soil is impermeable. When there is flooding, it is difficult to cook, do temporary work, and trade because there is water all over the place. Sometimes people lose products they have guarded in their houses to sell because of the flooding. In the rainy season, many poor households face difficulties because household members have fewer possibilities to do temporary work. Because of such economical

vulnerabilities, many poor people are left with few choices, and some are forced into sex work or other illicit activities, at least temporarily.

3.1.3. Key places in *Mafalala*

Adelina market, mentioned earlier, is one of *Mafalala*'s central places, together with the football field. In *Adelina* market, there is always movement of men and women, young people, and children who shop or look for something. Many men spend their time in the market drinking and eating, but women also have food and alcoholic drinks there. Rich and poor people buy bread, sugar, rice, maize, and vegetables, among other things. There is always rubbish in the market. Some people try to clean the market, but the cleaning does not last long because people throw garbage anywhere. There are women selling vegetables and other products on the floor, in a tent or in a stall.

Mafalala residents and residents from other *bairros* in *Maputo* city shop in the *Adelina* market because it is one of the cheapest markets in the city. The market is composed of several tents and stalls. The people in the tents and stalls sell basic consumption items such as rice, maize, and fish from Angola and Namibia, oil, salt, sugar, condoms, and paracetamol. Some people in the tents and stalls also sell pre-cooked food for those who have a job and income, but who do not have enough money to eat in a restaurant. Other people sell alcoholic drinks, such as beer, spirits, and whisky at low prices. The products in the *Adelina* market are cheap because some men and women travel to South Africa and Swaziland to buy products and then they resell these in the *Adelina* market and other markets in the country.

Some people find a sexual partner in the tents in the market, especially when they are drunk. Both older and younger men and women have sex in exchange for money, goods, or for pleasure. Men sit in the tents, drink and eat, and they call women of all ages to join them in sharing the drink and the food. If a woman accepts the invitation, it is often interpreted as she accepts sex for pleasure, money, or goods. Rich women also invite men for sex in exchange for money or goods. These rich women tend to arrive by car, call a man and pretend to ask for something. The man will then get into the car. They will drive outside the *bairro* or they may go to a small hotel. Men and women who repeatedly return to the tents for sex normally always look for a new companion. A woman living in *Mafalala* who knows the market well said:

> You can expect anything when you go to the *barracas* [tents]. You can drink and if you want, you can get a boyfriend for the day. If you find the same boyfriend in the street, you pretend that you do not know him. Next time, you can have him again or you find another boyfriend. In this relationship, money can be involved or not. It depends on what couples agree upon.

The football field is another place where many social and cultural activities occur. Traders advertise new products, organizations disseminate ideas about themselves, teams from inside and outside *Mafalala* play football, and representatives for political parties make speeches and meet with people during the election campaign. There are also performances of music, HIV/AIDS campaigns, and Muslim prayers during the Islamic festive day. The football field is also used as the meeting point for people from inside and outside *Mafalala* who search for sexual partners. The difference between the market and the football field is that the market is located in the interior of the *bairro,* while the football field is located close to one of the main streets where many people circulate. This means that one can reach the football field by car. Hence, richer people sometimes prefer to pick up a partner close to the football field rather than in the market.

3.2. The family and the household

The objective of this section is to give an idea of the different kinds of families and households that exist in the neighborhood. This overview of the composition of families and households aims to contribute to the understanding of the complexity of HIV/AIDS issues in *Mafalala*. The section begins with a discussion of the notion of the family. It will also describe some types of households that are to be found in *Mafalala.*

The definition of family is not universal. Understandings of the concept vary from society to society. Åkesson (2004) and Russell (2003) provide discussions on the family, where they show the differences between the western nuclear family and the non-western family. Åkesson (2004) states in her study on Cape Verde that, "the Cape Verdean family should not be confused with Western nuclear family. In São Vicente, the concept of *família* is used in two ways. It can either indicate kinship relation in general – we are *família* (related), or it can signify 'kin group' or 'personal kin.'" This view of the family as a kin group is similar to what Russell (2003) found in South Africa, where the black family is composed of a man, a woman, their children, cousins, nephews, in-laws, and grandparents. In general, the same kind of extended family is found in Mozambique, with the exception of the middle class urban areas where there are some nuclear families (see Arnfred 2000).

In rural areas in Mozambique, there are two kinship systems, namely, patrilineal kinship system and matrilineal kinship system. The patrilineal kinship system is most common in southern and central Mozambique, where men bring their wives to their family house. The children belong to the man's family. In the matrilineal kinship system, which is found in northern Mozambique, men marry and live in the house of the woman's family, and the children belong to the woman's family (cf. Geffray 2000; Junod 1996). In *Mafalala,* these systems have little rele-

vance because people tend to adapt their lives according to the social system in *Maputo*, where kinship is bilateral.

There are many different kinds of households in *Mafalala*; here, I will describe some of the most common types of households. Firstly, there are matrifocal households that are headed by a senior woman and composed of her children, her daughters' children, and maybe also other children who are related to her. The senior woman is socially and economically responsible for the family and if she has a partner, he is regularly absent. She performs most of economic activities for the household, but if there are other adult members she will expect them to contribute economically to the household (cf. Åkesson 2004). Secondly, there are households with only children because they lost their parents, mostly as victims of HIV/AIDS. These households are often supported by the state and/or non-governmental organizations (such as *Mozhope* described in Chapter 2). Thirdly, there are also household composed of a nuclear family, and they mainly belong to the middle class. Members of these households often work for the state or have their own business. The children from these households attend schools outside *Mafalala*. These households have little contact with other households in *Mafalala*. Fourthly, there are households composed of elderly people living alone. Many of these elderly have children, but their children do not care about them. The state and/or some non-governmental organizations provide them with some hygiene products and food.

3.3. Education and religion

This section will discuss education and religious institutions, which are fundamental in shaping people's idea about prevention.

3.3.1. Schools and their work on HIV/AIDS

School is obligatory and free until grade seven in Mozambique. The *bairro* has two public schools, namely, *Escola Primária 25 de Setembro* (Primary School 25 of September) and *Escola Primária Unidade 22* (Primary School Unit 22)*,* which both provide schooling from grades one to four. After grade four, pupils may go to *Escola Primária da Munhuana* (Primary School of Munhuana)*, Escola Primária Estrela Vermelha* (Primary School Red Star), and *Escola Primária Noroeste* 2 (Primary School Northwest 2). These schools are located within two kilometers from the *bairro*. A "normal" class in the public schools accommodates between forty to sixty students. Because of the high number of students in the public school classes, many *Mafalala* residents as well as people in other parts of the country have doubts about the quality of education in these schools. Children that belong to the poor households outside *Mafalala*, such as *Xipamanine*, *Micadjuíne,* and *Alto Maé* also sometimes go to *Mafalala*'s primary schools. Children from house-

holds who can afford it go to the private schools outside *Mafalala*. In the private school classes, there are between 10-15 students and they have the opportunity to get help from teacher when needed. Many people who can afford this believe that in the private schools students can access good quality education.

In the national education system of Mozambique, there is a subject called *educação moral e cívica* (moral and civic education) taught to students from grade seven in the public primary schools, which means that the students are from twelve years old. In this subject, teachers talk about the body and its functions, reproductive health, and HIV/AIDS prevention. Not all parents welcome this, as a teacher from *Escola Primária 25 de Setembro* explained:

> We teach students to call organs with their proper names. When they go home they tell their parents what they learnt. Parents come to school to claim that their children are too young to learn about sex.

At schools, teachers explain to the students how male and female bodies are composed and how the body functions. Teachers also tell the children and adolescents that they should not engage in sex early because their body is not adapted to it. However, teachers normally do not have a clear idea about what kinds of values, customs, and practices in relation to reproductive health and HIV/AIDS their pupils share in their social networks, with family, relatives, and friends. There is a gap between family education and school instruction (cf. Visser 2002; Mazula 1995).

All public schools of Mozambique should have a *cantinho* (corner) where a team of teachers and administrative staff support students, teachers, and administrative workers living with HIV/AIDS. However, the corner team is not present in all public schools because of the lack of human capacity and financial constraints. These corner teams were created by the former Ministry of Women and Social Action, now Ministry of Gender, Children and Social Action. The corner teams were expected to provide information and moral support to the teachers, students, and administrative workers when they tested HIV positive. The corner teams were supposed to advise people to continue with their lives, as the antiretroviral therapy provides them with the possibility to do so. The idea is also that the corner teams should help students, teachers, and administrative workers living with HIV/AIDS with food and other things if they become very sick and are unable to get out of bed.

There is one public school with a corner team in *Mafalala*. During fieldwork, I could not follow their activities because the corner team wanted to protect the anonymity of the PLWHA. Instead, I interviewed the coordinator of the corner team who told me that when people test positive for HIV/AIDS, they need to start with ART and they must live according to their new HIV status. The corner team gives similar advice as the public health service. They recommend that PLWHA should

eat healthy and protein-rich food such as fruit, eggs, meat and milk; get plenty of rest; and avoid alcohol. The corner team reminds people to have only one partner, to use a condom in order to avoid pregnancy and infecting others with HIV, and they advise young people to delay their sexual debut.

The main difference between being helped in the public health services and by the corner team is said to be that in the *cantinho* there is a kind of trust. Students, teachers, and administrative workers believe that the corner team will not tell other people about their HIV/AIDS status. The corner team follows the PLWHA to their households and tries to build confidence between the ill person and his or her family. Largely, the corner team focuses more on the social perspective (Kiefer 2007).

The corner team faces the challenge of convincing people to continue with the antiretroviral medication because many people claim that they do not have healthy food in their houses, and it is widely believed that ART must be combined with such food. Many times, the corner team buys food and second hand clothes to help the teachers, students, and administrative workers living with HIV/AIDS. The corner team claims that they do not have enough money to continue to help people because they do not receive financial and material help from the government and NGOs working in *Mafalala*. A teacher stated, "Many times, we use our own money and goods to help our colleagues living with *essa doença.* Sometimes we cannot help with material goods because we do not have them."

The minimum salary for a primary school teacher could be less than 200 USD per month. Some poor students living with HIV/AIDS sell small quantities of different products such as donuts, sweets, bananas, and oranges in the market or in the streets to be able to buy things they need. These poor students live with relatives and/or friends because their parents have died from AIDS.

3.3.2. Religious congregations and their work with HIV/AIDS

With reference to religion, most people in *Mafalala* are either Christians or Muslims. The Christian churches include the protestant Methodist Wesleyan Church in Mozambique (originally from South Africa), the Universal Kingdom of God (originally from Brazil), Old Apostles, Zione Church*,* and the Twelve Apostles Church. The Catholic Church is not represented inside *Mafalala,* but there is a parish in Maputo called *Santa Ana da Munhuana* that members of the Catholic Church from *Mafalala* attend.

Two churches in *Mafalala* work with HIV/AIDS prevention and treatment. These churches are the Methodist Wesleyan Church and the Zione Church. I will start with the Methodist Wesleyan Church that works in partnership with the Methodist Church of Southern Africa on HIV/AIDS prevention. The partnership aims to make members of the Wesleyan Church aware of HIV/AIDS prevention and contraction. Thus, every December 1st, the Methodist Wesleyan Church hangs up pamphlets in front of the church with the following text in English: "The

Church has AIDS. When one part of the body is affected, the whole body suffers. We Care (1 Corinthians 12: 26).” The quote from the pamphlet means that when one member of the church is infected with HIV, all members of the church and the member’s social network suffer. However, the majority of the members of the Methodist Wesleyan Church in *Mafalala* do not speak and read English.

In my conversations with some Methodist Church members about the pamphlet, they said that it is only on December 1st that the church has special activities on HIV/AIDS prevention. One woman stated: “It is not easy to talk about HIV/AIDS in the church. It [HIV/AIDS] brings shame because many people contract HIV/AIDS when they play with sex.” According to this Methodist Church member, the church periodically informs its members about HIV/AIDS prevention. Many people are ashamed of disclosing their HIV status to other members of the church. They want to avoid the shame of being blamed for their promiscuous behavior. As a woman in her 30s who is a member of the church expressed:

> People are ashamed to disclose their HIV status because other people stigmatize people that have *essa doença*. People use words like: *estragado* [destroyed] or *podre* [rotten], *pisou mina* [stepped on a mine] and *Cidália,*[2] among other pejorative words.

The Zione Church helps their members living with HIV/AIDS with prayers and herbs, and they preach that members should either be faithful to one partner or abstain from sex. This religious congregation does not have a large building in *Mafalala*. During the weekdays, members of the Zione Church meet in the houses of selected members to pray and support each other. In the houses where Zione members meet, there is a red and white flag in the yard. It is easy to notice the Zione Church members in the *bairro* because they beat drums before they start praying. During the weekend, members of the Zione Church from *Mafalala* meet in *Albasine*, a *bairro* that is about half an hour away from *Mafalala* by *Chapa 100* (a private small bus). In *Albasine,* there is a big Zione Church where members of *Mafalala* and other *bairros* go to attend services.

There are also four mosques in *Mafalala*: *Braza*, *Cadria*, *Chadulia,* and *Camararia.* According to the inhabitants, these names of the mosques are a mixture of *Makwa* and Arab languages. Each name of the mosques has its own meaning: *Braza* means “the place for entertainment.” *Cadria* was a follower of Muhammad, and means “the way to power.” *Chadulia* is named after another disciple, Ahmed Chadulia, and lastly *Camararia* means “stone.” The *Camararia* Mosque was later designated *Itifaque,* which means “agreement.” *Chadulia* is the largest mosque in the *bairro*. In this mosque, weddings and burial ceremonies are performed.

2 Cidália is a female Portuguese name. In Portuguese, AIDS is called SIDA, which explains why some people in Mafalala use the name Cidália for people living with HIV/AIDS.

Some *Mafalala* residents claim that people from northern Mozambique founded *Chadulia,* while Muslims from Zanzibar, Comoro Island, and Tanzania created the *Braza*, *Cadria,* and *Camararia* Mosques (Laranjeira 2016; Lemos 1988). However, today, the mosques mainly attract people who have moved to *Maputo* from other parts of the country or from a neighboring country.

The mosques have activities that attract a considerable number of people. Poor and rich people use the mosques for various purposes. Poor people receive food and clothes from the mosques. Atheist people who do not have family/relatives can be buried when they die with the help of the mosques' members. Migrants that cannot afford to visit their family back home can get help from the mosques to solve their everyday problems, and they can visit the mosque. In the mosques, residents meet with people from their birthplace, they have opportunities to find a job or/and a partner with the help of the people that arrived before them in *Mafalala*. In the mosques, migrants talk about their land, they share food and they remember their "home" (Paulo 2004).

Out of all the mosques, only *Braza* has a HIV/AIDS prevention program. The *Braza* leader, a religious teacher, was born in *Mafalala*, but he has lived and worked in a car garage in South Africa for twenty years. In South Africa, the religious teacher had some experience with HIV/ADS prevention, which he shares with his members in the *Braza* mosque. The religious teacher said:

> We have speeches about HIV/AIDS every second Friday [in the mosque]. In the speech, we emphasize the need for a healthy family in the society and the need to prevent HIV/AIDS by having only one partner.

The religious teacher's claims contradict some Muslim members' practice in *Mafalala* who have more than one wife. There is no statistics that compare the number of HIV/AIDS cases between Muslim and non-Muslim members. As all mosques are close to each other, it is possible that members from other mosques listen to the *Braza*'s religious teacher's speech about HIV/AIDS prevention. Members in one mosque are allowed to pray and participate in other mosques' activities.

3.4. Making a living

This sub-section focuses on how people make a living, the history of sex work in *Mafalala*, how sex work is organized, and sex in social networks. People in *Mafalala* make a living in different ways. After independence in 1975, many developed informal economic activities, such as carpentry or selling of second-hand clothes or coal. Some people opened tents and stalls inside or outside *Mafalala* and sold basic products or pre-cooked food. Some people managed to find a formal job as a teacher, nurse, or police. *Biscatos* (temporary jobs that give immediate cash)

is the activity that poor people often do. Young, poor men carry packages in the railway station and at the harbor, repair houses, and collect garbage. Young, poor women do domestic activities such as washing clothes, cleaning houses, baby-sitting, and carrying water. Some poor households buy or produce small quantities of vegetables somewhere outside the *bairro* and sell the products in *Mafalala*'s markets or in the *Maputo* city center. Some poor people collect garbage and sell to associations or they sell to people who want to reuse some objects, such as bottles and plastic bags. Those who have a job and an income may also do *biscatos* to complement their income. For example, a teacher with a contract in a public school can also do extra work in a private school.

Xitique is a rotating savings and credit scheme that helps those who have an income to solve specific economic needs. *Xitique* occurs in a group of between two to ten people who trust each other. Trust is an important thing to consider in *xitique* because of the risk that somebody may not return the money they have received from others. In case a person does not return the money to others, s/he is requested to leave the *xitique* group. Everybody who has money can participate in *xitique*. There are different kinds of *xitique*: daily *xitique* for people who do *biscatos*, weekly *xitique* for people who work in informal activities and in the market, and monthly *xitique* for those who have a formal job and income. *Xitique* meetings are also a kind of entertainment, where people exchange information, eat together, and maybe have a party where they dance (Trindade 2011; Caifaz 2005; Lundin 1987).

3.4.1. The history of sex work in *Mafalala*

According to Espling, during colonial times "... Mafalala used to be a centre for prostitution and the Portuguese traders who had shops (cantinas) often had houses in the back yards for the prostitutes" (1999: 115). The author says that the view of *Mafalala* as a place for prostitution "ended with independency," although that seems not to be true today. In the next paragraphs, two versions of the history of sex work in *colonial Mafalala* are told by an elderly person and a female trader in *Mafalala*. The elderly person explained:

> There was a place where *mulheres de má vida* [sex workers] coming from *Sofala*, *Gaza* and *Nampula* provinces had sex in exchange for money and goods. The sex workers came from poor families, and they expected to make and save money in *Lourenço Marques* [*Maputo*] to help their family and relatives back home.

The elderly person argued that sex work started with poor women who wanted to improve their family's life in rural areas. The elderly person also stated that *Mafalala* is a place that received migrants from different parts of the country. The second version of the history of sex work is told by a woman trader in *Mafalala*.

The woman said: "In the colonial period, there were houses called *matxotxomana* [a *Changana* word for a place where people sell sex]. Sometimes, men sent their wives to *matxotxomana* when they did not behave well in the house." The female trader's account about men forcing their wives to become sex workers is shared by many *Mafalala* residents. These houses were known in *Mafalala* and outside the *bairro* and anybody who wanted to meet a sexual partner would go to them. According to the female trader, in the colonial period, many women could not do anything without men's permission. If a married woman disagreed with her husband, he could send her to the place for sex. Today, the houses where sex selling occurs are inhabited by *Mafalala* residents.

3.4.2. Sex work in contemporary *Mafalala*

Some people continued with the practice of having sex in exchange for money and goods in the post-colonial period. The practice of having sex in exchange for money is sometimes passed on to young people when parents or other relatives tell young people to start *desenrascar* (to do something in order to make a living). In general, for many people in *Mafalala,* sex is a way of making a living. Transactional sex is very common, and many people of both sexes get part or all of their income from sexual activities. Some people make a living by running a *motel* (small hotel). The small hotels have music, dance, and offer different kinds of alcoholic drinks, cool drinks, and rooms to rent. The small hotel is an attraction for tourists and foreigners who want to experience the "wild life." Some men and women go to the small hotels to search for sexual partners and to entertain themselves. The following paragraphs will describe a small hotel and our meeting with a man who was employed to take care of the small hotel.

It was raining when my assistant and I arrived at the small hotel. The floor was wet, and a man was cleaning the floor. We greeted each other, and he asked us if we wanted to go inside with him. We were embarrassed about visiting this place where people sell sex. We asked the man to talk about the place, and he immediately accepted the request and we started talking about the place and the people who go to the small hotel. The man said that the prices of the room vary between 150-200 MT (*Meticais*, about 3-4 USD) per hour depending on the size of the room and if the room has air conditioning. The man said that the small hotel opened twenty years ago, and it receives both poor people and those who have a job and income, and that the visitors come from various *bairros* in *Maputo* city.

The hotel caretaker explained that many *biscateiras* (women who have sex with men in exchange for money or goods) and *gigolôs* (men who have sex with women in exchange for money or goods) go to the small hotel because it is one of the cheapest and most centrally located places to go. The man affirmed that many men and women who search for *biscateiras* and *gigolôs* are married, and they search for *biscateiras* and *gigolôs* because they want to find a partner to *desaba-*

far, meaning to talk to someone about everything they cannot talk about with their husbands or wives, including having sex without a condom.

This small hotel is located where many poor people live. Some poor households complain about the small hotel's proximity to their houses because they fear that their children will have sex early. The hotel caretaker said: "some young people go to the small hotel to make some money for their needs." He mentioned that people argue that the proximity between the small hotel and the poor households creates a negative impact. The man also explained that when a newborn becomes ill (with diarrhea, fever, tuberculosis), poor people attribute the illness to the parents who have "polluted" themselves at the small hotel.

The man further explained that some men and women walk into the small hotel alone and then they meet there: "men and women walk in and out of the small hotel separately because they want to make sure that someone they know will not see them together in the small hotel." This statement showed that some people in *Mafalala* do not turn a blind eye to people that go to the small hotel as it is believed that people have multiple sexual partners in these small hotels. They are also concerned that people who go to small hotels are a bad example for young people in the neighborhood. The man added: "Some married women use Muslim clothes to cover their body and faces when they go to the small hotel but *biscateiras* and *gigolôs* walk in and out of the small hotel relaxed." Generally, people tolerate that men but not women go to the small hotels. *Biscateiras* and *gigolôs* do not cover their bodies modestly when they go to the small hotels, as they generally do not care what people say about them.

The idea of letting out rooms for sexual encounters was also adopted by some *Mafalala* residents. Some poor households let out rooms for between 50-100 MT (about 1.25-2.5 USD) per hour, which is cheaper than in the small hotel. With this money, poor households can manage to buy food or water and electricity. Sometimes there is a disagreement inside the poor households because some members do not like this way of making money and there may be disagreements concerning how this illicit money should be spent. In some cases, there is a discussion in the households because senior members do not share the money with junior members of the household.

3.4.3. The organization of sex work

Sex is sold in many ways in *Mafalala*. *Gigolôs* and *biscateiras* find sexual partners inside and outside the *bairro,* and the small hotels as well as the market are examples of places where they meet sexual partners. Some poor people have contact with the small hotels that arrange for them to have meetings with clients because then they will rent a room. Or people circulate information that there are rooms in the poor people's household to interested persons who search for a place to have sex. As I will make clear below, some *gigolôs* and *biscateiras* are involved in sex

networks that stretch far away, and they sometimes travel abroad to meet their clients.

This sub-section will present an event that shows how a sexual network is set up in one of *Mafalala*'s street, and how it also incorporates people in other places. The two women Abiba and Bela were talking about sexual networks that allowed them to find sexual partners. The two women greeted each other and Bela asked Abiba "what did you bring from South Africa?" Abiba answered, "I brought my vagina." Bela kept quiet. Abiba started talking about being upset with Bela's mother because Bela's mother forbids Bela to travel with Abiba to South Africa. Abiba said, "I had a client for you and I became embarrassed for not bringing you to South Africa."

Bela replied to Abiba that she stayed in *Mafalala* with a client that gave her 3000 MT (about 80 USD) to stay with him in a small hotel for three days. The client wanted to stay in Bela's house. Bela declined the request because she did not want her mother and daughters to know what she does. Bela advised her client to go to the small hotel. They stayed for two days in the small hotel, and the third day a rich woman arrived and paid Bela's client to have sex with her. Bela knew what happened and she quarreled with her client. Bela told Abiba that the woman who had sex with her client has *essa doença*. But she was not going to tell her client that the woman has HIV/AIDS because he betrayed Bela.

Abiba listened to Bela's narrative and she insisted on telling Bela to be careful with her mother because "she doesn't want Bela to be happy." Bela answered, "I understand my mother and I can't do anything because she's my mother." Abiba told Bela that her mother was using magic to make Bela give her everything she receives from her boyfriends. Abiba told Bela that all her girlfriends are rich and only Bela is poor. Abiba said to Bela "you should think about your life because you have daughters and you need to have your own house." Bela answered, "In the name of Allah, I will have my own house and I will leave my mother. But I can't fight her because she's my mother."

Bela said, "it's not all lost because my boyfriend that lives in Angola called and told me to get ready to travel with him to Angola." Bela said that she already had a passport and that she was going to tell her mother that she should not interfere in her decision to go to Angola. After few minutes, Abiba said goodbye to Bela and they continued walking in different directions. It is interesting how the two women were talking about sexual networks in the street while many people like us were listening. Abiba and Bela were proud of being able to have sex in exchange for money and goods abroad. This shows that they are at different levels than the *biscateiras* who sell sex only in the *bairro,* as Thornton (2009, 2008) showed in a similar case in South Africa.

3.5. A presentation of some inhabitants

In this last section, I will present some inhabitants in *Mafalala* whom I got to know, and who provided me with a lot of information. All these individuals live in the twelve households that were introduced in section 1.3.2. They were all good and reliable informants because they gave detailed information on the topics we discussed; they were open to share their stories and they consented to have their stories written down. I present these persons in some detail, as this provides a good contextual background to the social setting of the thesis.

Bela who is quoted in the above conversation is in her 30s. She likes wearing *capulanas* (a piece of cloth that women wrap around them in various ways). In everything she does, she mentions Allah's name. She lives in her parent's house comprised of two rooms, with her three daughters and five sisters. She likes greeting people in the streets with words such as "good morning brothers and sisters." She speaks loudly because she likes to call people's attention. It is common to find Bela talking loudly with somebody in the street. She is single and has three daughters. She is a *biscateira*, but she affirms that she will never bring her boyfriends to her home because she does not want her daughters to become *biscateiras*. She likes to be together with married man because she thinks they will not demand a lot of work such as cleaning their clothes and cooking. Bela would like to stop being a *biscateira* and find an ordinary job. She says that she is getting too old which means that the clients will pay her less.

Bela's friend Abiba is in her 20s. She was born in the Democratic Republic of Congo, and she has lived in *Mafalala* for more than ten years. She is short and likes wearing high-healed shoes. She is married, but she is also a *biscateira*. She frequently travels to South Africa, Angola, and Brazil to meet her boyfriends. Abiba's friends say that Abiba's husband knows that Abiba is a *biscateira,* but he does not mind because he is unemployed and he lives on the money Abiba brings home. Abiba has a hairdresser salon where she does braiding for women and offers other beauty services. Some people in *Mafalala* claim that Abiba has a group of women who sell sex and that she supports them to find sexual partners and then the women pay her a certain amount of money. According to these rumors, Abiba meets women who want to be *biscateiras* in her hairdresser salon. Abiba plans to open a restaurant in *Mafalala* with her husband and sell food cheaply.

Lola is in her 30s. She likes talking with everybody in the street while she is drinking a beer and smoking. She offers food and drinks to her friends. She does not like to go outside of *Mafalala* because she does not know the city very well. She likes wearing short skirts and T-shirts. She is HIV positive, but she sometimes has sex without a condom when her boyfriends request it. She said she contracted HIV from her former husband who is a drug user. She has multiple partners, but she has never mentioned to her boyfriend that she could be infected. Lola is a

biscateira. She said she became a *biscateira* because the lack of a formal education prevented her from getting an ordinary job. Lola studied only until grade six and as a result found it difficult to find a formal job and a stable income.

Shifa is a woman in her early 20s. She is married and has two children. She likes walking around with her girlfriends. She uses long hair extensions like some Mozambican musicians. She buys pre-cooked food in the food tents and says she does not cook very well. She always meets healers when she has to decide something important in her life. Shifa stopped studying because she became pregnant when she was twelve. She claimed that she did not know that she could become pregnant in only one coitus. She started dating early because many of her girlfriends had boyfriends. She lives in her mother-in-law's house together with her husband and two children. For many years, she was dependent on her husband's salary. Thereafter, she did *biscato* (temporary work that gives immediate cash), and she decided to do *xitique* with her friends, which is a form of money savings based on rotation schemes. Shifa is HIV positive. She had syphilis twice and she affirmed that she got it from her husband who had an extra marital relationship. He did not accept the idea of using a condom with Shifa.

Canaco was born in *Mafalala*. He is in his 70s but looks like he is in his 30s when he talks vividly with people. Before he retired, he worked in a garage in South Africa. Every day he sits in front of his house playing with the neighbors' children. He gives sweet, food, and clothes to poor children. When he is not playing with the children, he is walking around the *bairro* and he talks to everybody. He domesticates some animals like chickens, ducks, goats, pigeons, and rabbits. He has ten children, and they all live in their own houses. His children visit him when they can. He claims that the *bairro* has changed a lot because young people drink a lot of alcohol and consume drugs. Canaco says that with alcohol consumption, young people do whatever negative things they can. He blames the media for teaching young people to drink alcohol and to have sex at an early age.

Toni is Canaco's son. He is in his 30s. He is tall with black eyes and long hair. He was born and raised in *Mafalala*. Toni studied until grade six, and then he stopped because he did not like studying. Toni has been married three times, and he has three children. He is a long distance driver, and he also does temporary work in the harbor. Toni's family complains about him because he has girlfriends everywhere he goes. Toni is HIV positive. Toni's neighbors say that he contracted HIV because he has many girlfriends. He started with ART, but he does not take the medication regularly because he drinks alcohol often and forgets, he says. Toni has been in jail several times because he got drunk and drove a car. According to Toni, his neighbors, especially women, like him because he offers them money and goods.

Ivo was born in *Mafalala*. He is in his 20s. He does body building in the gym. Some of his neighbors said that Ivo builds muscles to attract women. He has a

small car that he bought on the Internet from Japan. He drives his car on the streets of *Mafalala* and he stops every time he meets somebody he knows. He wears a T-shirt without sleeves and shorts even when it is cold. His parents were born in the *Inhambane* province, in southern Mozambique. He stopped studying when he was fourteen because his parents did not have the money to keep him at school. Ivo said he was building a house with three bedrooms with the money he received from sex with women. Ivo said he uses a condom when his clients, who are all women, request it, but he does not use a condom if his clients do not want to. He is single and lives with his mother, brothers, and sisters. His father died many years ago. Ivo said that his extended family relies on his help.

Mico was born in northern Mozambique and is in his 30s. He looks strong. He wears a cap with different colors every day, together with T-shirt and jeans. He often supports his friends in the *bairro* to solve their problems. He has a small motorcycle, and he gives a lift to his girlfriends and lends it to his friends. He has lived in *Mafalala* for more than ten years. He is a teacher by profession, but he does not practice teaching since it does not allow him to earn enough money to sustain his family. He sells second-hand clothes on two main streets in the *bairro*. Some neighbors argue that he is involved with a group of people who steal second-hand clothes in different shops and then sell the clothes cheaply in the *bairro*. He is married and has two children. He has extra-marital relationships. His wife knows that he had a child with another woman, so his wife then decided to find a boyfriend to *desabafar*, which means to talk about everything she cannot talk to her husband about, including having sex.

3.6. Summary

Mafalala is one of the oldest *bairros* of *Maputo* city. The *bairro* is composed of people coming from different regions of Mozambique as well as abroad. *Mafalala* was created during the colonial period, and people came there because it was close to the downtown area. However, today, many of the inhabitants search for temporary work that gives immediate cash since there is a shortage of permanent jobs. *Mafalala* as well as other *bairros* of Maputo have local authorities that work with people to help ensure that they get the support they need. The majority of informants of this study have access to infrastructures such as electricity and drainage, but some of the poorest households do not have access to such infrastructures because of the expense.

In *Mafalala,* there are key places such as the football field, the *Adelina* market, and *Rua de Goa* where people gather and many socio-cultural and political activities occur. Households and families are organized in different ways, and they play important roles for people's understandings and actions in relation to the

HIV/AIDS epidemic. Institutions such as schools, churches, and mosques are also important for the creation of attitudes in relation to HIV/AIDS.

For many inhabitants in *Mafalala*, transactional sex and sex work are few of the ways to make a living. Many have a low educational level and live in deep poverty with few possibilities of finding a regular job and a secure income. This vicious circle of extreme poverty makes people vulnerable for contracting HIV/AIDS, which, in turn, makes it difficult to build a better future for themselves and their children.

4
Contracting HIV

This chapter aims to explore how poor people in *Mafalala*, who are exposed to structural challenges (Galtung 1969), perceive they contract HIV. Thus, the chapter investigates popular ideas related to HIV contraction. The chapter argues that many people in *Mafalala* are aware that they can contract HIV through sexual relations, and they are aware of the biomedical explanations regarding HIV/AIDS prevention. In addition, people also construct lay perceptions of how HIV is contracted, according to notions and ideas that are recurrent in their social environment. These are often intertwined with biomedical explanations. Before discussing this, the chapter starts with a representation of different kinds of sexual relations.

There are at least four common forms of extramarital sexual relationships in *Mafalala*, namely, *sacar sena* ("play out"), *namoro* (dating), relations with *curtidoras* (courtesans or young women who are said to enjoy life without plans for the future), and *andar fora* ("walk on the outside"). *Sacar sena* is an occasional relationship, where two persons of the opposite sex decide to stay together and have sexual relations without any future commitment. Single young people and adults are more likely to be in a *sacar sena* relationship. *Sacar sena* is a relationship, commonly found among young people who are not prepared for *namoro* because they are studying and/or they do not have an ordinary job to sustain a permanent relationship and maybe marry. In the *sacar sena* relationship, condoms are often expected to be used. In the *sacar sena* relationship, couples do not always know each other well, and they can have multiple partners. Therefore, people consider that those who are in a *sacar sena* relationship are vulnerable for contracting HIV if they do not use a condom. *Namoro* is a socially acknowledged relationship that could end up in marriage. Here, condoms are not expected to be used. In the *namoro* relationship, where couples and their extended families know each other well, the couple can be at risk of contracting HIV if they do not use a condom.

Even in a *namoro* relationship, one of the partners may be infected with HIV or have other relationships on the side. In addition, some women may feel that they do not have the possibility to negotiate the use of a condom due to financial constraints. Thus, both in the *sacar sena* and the *namoro* relationships, it is possible to contract STIs and HIV if couples do not use a condom regularly.

A study on transactional sex in *Maputo* city by Hawkins et al. (2009) showed the existence of different kinds of urban female identity. Among these women's identities, I recognized one called "*curtidoras,*" which is also performed in *Mafalala*. Hawkins et al. (2009) stated that "*curtidoras*" were at risk of contracting HIV because they had multiple partners. Groes-Green (2013) also studied transactional sex in *Maputo* and explained that some "*curtidoras*" had sex in exchange for money with European men. The author says that some of the European men did not understand that the relationship they had with "*curtidoras*" was only about money. The authors said that "*curtidoras*" had multiple partners, which provided something that "*curtidoras*" need, for example, food, clothes, and hair extensions. Many residents of *Mafalala* view "*Curtidoras*" as spreading the HIV infection because they have multiple partners, and people suspect that they do not always use a condom.

Andar fora is a relationship that married people, both men and women, have with other married men and women or single men and women. *Andar fora* may sometimes involve an exchange of money or consumer goods and cause an extra risk for contracting HIV. Many young women in such *andar fora* relationships claim that they want money to be "modern," for example, by using hair extensions, cellphones, and fashionable clothes. Young people who are part of *andar fora* relationships have sex in exchange for money or goods because they want to "follow fashion" and buy expensive clothes (cf. Leclerc-Madlala 2003). In this kind of relationship, young women and women are more likely to negotiate condom use when they receive money or goods. Some married men and women decide to engage in *andar fora* because they do not feel sexually or materially satisfied with their partner. Married men and women sometimes contribute with money or consumer goods in exchange for sex because they want to have sexual experiences that they do not have in their marriage. Sometimes they seek out young men and women who have sexual relations in exchange for cash, cars, flats, cellphones, clothes, and food, among other things, and often with multiple partners. Some poor married men and women also have sex in exchange for money to provide food and other necessities. Wreford (2007) studied HIV/AIDS in South Africa, in a similar socio-cultural environment as *Mafalala*, and showed that unemployment is one important reason as to why people engage in unprotected sex. Wreford (ibid.) also showed that without a formal job, poor men and women are more likely to have sex without protection, in exchange for money.

Sometimes those who *andar fora* go to sex workers, and there are two categories: *gigolôs* (young men that have sex with women in exchange for money) and *biscateiras* (young women who have sex with men in exchange for money). My informants blame *gigolôs* and *biscateiras* for spreading HIV in the *bairro* because they often have multiple partners, and people suspect that they often have sex without using a condom. It is commonly held that *gigolôs* and *biscateiras* often have unprotected sex because they need to receive immediate cash and they can be in situations where they may not be able to negotiate the use of a condom. It is not only gigolos and *biscateiras* who make their living selling sex; other people may also use transactional sex as a way to earn part or all of their living.

Some men and women start their adult life with the money they make from sex. Ivo, a young man, *gigolô,* in his 20s is an example. Ivo is building a big house with the money he saved from selling sex to women. Ivo claimed that, "it is not only *biscateiras* and *gigolôs* who disseminate *essa doença* (HIV) in *Mafalala.*" He affirmed that heterosexual couples also disseminate *essa doença* in *Mafalala* as well as in other parts of Mozambique. Ivo continued to say that some married men have *casa um e dois* (household one and two). Ivo laughed and said:

> I do not believe that a man in polygamous relationships can provide comfort for all his women, and it is very possible that in each of these houses the man does not leave enough money for groceries. These women can start hidden relationship (*andar fora*) to sustain themselves.

Ivo also told the story of his neighbor Mico. Ivo said:

> He was born in Northern Mozambique and has lived here [in the *bairro*] for many years. He asked his relatives to search for a woman in his village who he could marry. The family sent a woman, they married and now they have two children. After some time, he started to tell me that his wife changed. She did not cook nice food. She liked walking around in the *bairro* with her girlfriends. He decided to find an *amiga* [girlfriend] to *desabafar* [to talk about things he could not talk to his wife about and also to have unrestricted sex], and they ended up having a child. If Mico had a child with another woman, it is because they did not use a condom. His wife and everybody in the *bairro* knew what happened. His wife asked for a divorce. Mico refused because he is afraid to lose his mother-in-law's support. His mother-in-law gave him money to start his business. His wife found an *amigo* [boyfriend] to *desabafar*. Everybody in the *bairro* knows it, and I don't believe Mico doesn't know about it. Can you tell me what this is?

Ivo illustrated a relationship involving multiple partners that can lead to the spread of HIV. Ivo showed that it is not only *gigolôs* and *biscateiras* who spread HIV in *Mafalala.* Married heterosexual couples also disseminate HIV because they have multiple partners. There are many young people who marry or start cohabiting without having a job or any kind of activity that can help them earn money. Many extended poor families help young people to start their lives, but they often do not continue to help because they are also poor. Young people could stay single or cohabit without children to minimize costs. However, often, the extended family puts pressure on young people to start a family because it is when young people marry and have children that they are considered as adults. As such, they gain respect from the family, perpetuate the lineage, and maybe bring some money and other things to help their extended family (see Honwana 2013 and Paulo 2009).

4.1. Risk groups and the vulnerability of the poor

In the beginning of the HIV/AIDS prevention campaigns in Mozambique, the media presented images of risk groups. These groups were defined as heterosexual men and women with multiple relations, sex workers, and drug users, but homosexuals have not been viewed as a risk group to the present. As years passed, the media presented other risk groups, such as health personnel and healers. Slowly, it became clear that everybody is vulnerable for contracting HIV if they do not prevent it. People in *Mafalala* believe that HIV can be contracted by people from different classes and gender, as Shifa said:

> *Essa doença* is disseminated between rich and poor people who do not mind to have carne a carne [“meat to meat”] in exchange for money and goods. Sometimes, poor people know that some rich people have *essa doença*. They do not seem to mind because they have sex in exchange for money and goods.

Shifa affirmed that both rich and poor people can contract HIV, but poor people are more vulnerable for contracting HIV because they often cannot negotiate the use of a condom. Some poor people starve; others do illicit activities, such as sell sex, burglary, or drug dealing to have what they need. Many people who sell sex have learnt from the HIV/AIDS prevention campaigns that they run the risk of contracting the disease, but they are limited in their choices because of poverty. Poor people in urban areas do not have enough education to get an ordinary job. They do not have a *machamba* (plot of land) to produce food. Many poor people living in urban areas in Mozambique have a limited social network, which implies that they have little access to social support when a need arises (cf. Paulo et al., 2011, 2007).

Shifa's friend Lola is an example of how limited education and lack of family support can make someone end up as a *biscateira*. One early morning, Shifa was talking to Lola, a woman living with AIDS. We greeted each other and Shifa presented us to Lola. After a few days, I contacted Lola to talk about her illness. Lola came to know that she was HIV positive when Shifa convinced her to do the HIV testing. Lola suspected that she contracted HIV from her former husband who injects drugs and has multiple sexual partners. Lola started being a *biscateira* when she realized that she could not find an ordinary job. Lola has only studied up to grade six, and she did not continue her studies because her parents did not have the money to pay for school fees and uniforms for all their children. Her father worked as a security guard and her mother is a domestic servant. Sadly, Lola claimed, "I lost my son because of *essa doença.*" Lola's son was born HIV positive, and he did not survive because Lola frequently left him with her mother who paid little attention to the dates when she was supposed to take her grandson to the health center for control and ART medication.

Lola said that she did not go to the health center when she was pregnant because of the long queue she had to wait in to be seen. Lola explained that in order to be seen, she had to wake up at 4:30 a.m., prepare something to eat and to take with to the health center. Lola as well as many PLWHA whom I met claimed that they did not have enough food to take to the health center and at the same time leave food at home for other family members. This is one of the reasons why some people decide not to go to the health center and instead try to find alternative ways of treating their illness. Lola explained to me why she became a *biscateira*:

> I started my business [to have sex in exchange for money] to help my parents to buy things that we needed in the house. I make money for food, clothes, and *boss,* ["whisky" in a small plastic packet]."

Lola says that sex with a condom is cheap, and sex without condom is expensive. She states that she prefers sex without a condom because it is more pleasurable and she can also have more cash. Lola said that she sometimes receives between 500-1000 MT [about 13-27 USD] for sex without a condom and 20-200 MT [about 0.5-5 USD] for sex with a condom. Lola adds that her friends make more money, about 3000 MT [about 80 USD] per night for sex without a condom when they find rich partners in the *Avenida 10 de Novembro* in downtown *Maputo* city. Lola expressed that she is afraid of following her friends to that Avenue because she does not speak Portuguese well.

4.2. Popular beliefs about contracting HIV/AIDS

According to my informants, there are four ways that people can contract HIV. The first way is *carne a carne* (literally meat to meat). The second is through freely distributed condoms that some people believe are infected. The third way is through sharing of cutting instruments. The fourth way of contracting HIV, according to local beliefs, is through bad spirits.

4.2.1. Carne a carne, condoms, and extra-marital sex

Carne a carne (literally means meat to meat) is sexual relations without a condom. As I have shown, people may not use condoms in different kinds of relationships. People believe that they will have sexual pleasure and reproduce when they have sexual relations without using a condom. This may happen both among married couples, as well as in sexual relations outside of marriage. I will bring up the case of Shifa who cannot make her husband use a condom, despite his many extra-marital affairs. I will also show that some poor people often are lured into having sexual relations without a condom in exchange for money or goods, as will be shown in the case of Lola. *Meat to meat* was evident in the case of Shifa, a woman in her early 20s, who explained:

> I contracted *essa doença* from my husband. He does not accept to use a condom. I had syphilis twice. The nurse advised me to come with my husband to see if he was infected with HIV. My husband refused to go with me [to the health center].

Shifa argued that before she contracted HIV, she had syphilis twice. Shifa's argument demonstrates her conviction that she contracted HIV from her husband who had multiple partners and did not accept to use a condom with her. Shifa's husband refused to go to the health center together with her because he suspected that the nurse would claim that he was having extra-marital relationships. In *Mafalala* as well as in Mozambique, it is common that married women tolerate the fact that their husbands have extramarital relationships in order to be seen as a "good" and tolerant wife.

Similarly, Bandali (2011), who studied HIV/AIDS risk and risk reduction in *Cabo Delgado*, in northern Mozambique, showed that the different ways in how men and women are educated in the family has an influence in what men and women think and how they act in relation to HIV/AIDS. In many contexts, men are educated to show their virility, while women are less encouraged to show their sexual desires. Studying women's tolerance of men's infidelity in southern Africa, Leclerc-Madlala (2009) argues that male infidelity is culturally more accepted than female infidelity. This is because women are expected to tolerate their husband's

infidelity as a way of showing respect for his family. By not talking about her husband's infidelity, a women may be considered "good" and thus avoid physical and psychological violence. In the case of Shifa, her husband had multiple partners and did not use a condom with Shifa. She did not ask her husband to use a condom because she was economically dependent on him and she was also afraid that if she asked him he would suspect that she was having an extra-marital relationship.

The fact that a female nurse would have treated Shifa's husband is one of the reasons why he declined to go to the health center. Many poor men I met did not accept being treated by a female nurse when they contracted STIs. They feared that a female nurse would tell other people that they have an STI that is linked to HIV, which would make them less attractive as a sexual partner. Another reason why some men feel ashamed of being diagnosed by a female nurse is their lack of circumcision. Circumcision is viewed as important for boys and men to be considered adult, to be clean, and prevent HIV. Actually, PEN IV (2015-2019) in the public health system in Mozambique advises that boys and men should undergo a circumcision as a way to prevent HIV/AIDS, although there is no guarantee that being circumcised will prevent HIV/AIDS (Conselho Nacional de Combate ao HIV/SIDA 2015).

Accordingly, people are exposed to contracting HIV because of poverty, economic dependence, and little formal education. This is in line with Kleinman's (2010) observation that such conditions often contribute to create disease. Some poor young men and women tolerate their partners having sexual relations with multiple partners because they do not have a formal job that would allow them to earn money to sustain themselves and their families. When some men and women have a stable job, they become a source of income to other people, and they often end up having extramarital relationships (*andar fora*), as in the case of Shifa's husband. It was early in the morning when I met Shifa in her house. She was crushing peanuts to make *caril* (stew) for lunch. I noticed that she was a bit sad, so I asked her what was going on. Shifa said:

> I know that my husband has relationships with other women. I do not talk with him about it because I am afraid the conversation will end up in our separation. My husband is a driver. He gives me 250 Meticais per day [about 8 USD]. Sometimes he gives me 50 MT per day [about 2 USD], and I have to find ways to buy food for the day. The money my husband gives me is not enough. He uses a great part of his salary buying expensive clothes, shoes, and paying *biscateiras*.

Shifa is economically dependent on her husband; hence, because of her five children, she makes an effort to not get a separation even though she knows her husband has other relationships. She believes that she will not find another man who

will marry her because she has many children. Shifa's story shows that she has some recompenses for keeping calm about her husband's infidelity. First, Shifa's husband helps her and her extended family (brothers, sisters, aunties, uncles, cousin, and nephews) with money, food, and some tasks that they believe only men with money can do (repair houses and fences, among other things). Second, when there are traditional ceremonies, Shifa goes with her husband and she gains the respect from not only her own family but also her husband's family.

In Mozambique, as well as in many African countries, an important sign that shows that young people are adults is when they marry traditionally, religiously, or officially and have children (see also Honwana 2013; Paulo 2004). This is relevant in the case of Shifa and her husband who are married, have children and are considered by their families as adults. Separation would not be a good solution for Shifa, not only because she is economically dependent, but she also wants to maintain respect from her extended family. The respect Shifa receives from her extended family allows her to participate actively in many family activities. As such, she may have a word in the extended family's meetings and organize family ceremonies, among other family duties.

4.2.2. Infected condoms

In *Mafalala,* many people suspect that infected condoms have been produced in order to kill them, because the government sees poor people as useless and a burden to the country. The perception that free condoms are infected emerged when a factory producing ART medication was built in *Matola* city, *Maputo* Province. The factory was part of the government's response to provide free AIDS treatment for PLWHA, and it was built in collaboration with the Brazilian Government. Poor people in *Mafalala* then suspected that the government infected the condoms with the intention of increasing the demand for ART medicine. Thus, they believed that some government members from the Ministry of Heath together with the international pharmaceutical companies wanted to get poor people infected with HIV in order to improve their business.

In 2014, a team from the Ministry of Health of Mozambique, *AMODEFA,* and *Geração Biz* conducted HIV/AIDS prevention campaigns in *Mafalala*. I followed some people who did voluntary testing for HIV in order to understand their perceptions of HIV testing campaigns. People who tested HIV negative received free condoms, and people interpreted this as a way to encourage them to continue with a "good" behavior. People that tested HIV positive, however, did not receive condoms. Some people interpreted this as if they were blamed for having behaved "badly." Several people that I met claimed that both HIV negative and positive people should use condoms to live a better life. Moreover, in *Mafalala* as well as in many *bairros* of *Maputo* city, there is a commonly held idea that the HIV/AIDS activists paid by the Ministry of Health give free infected condoms to people who

tested HIV negative because they want to infect them in order to "open new terrain" for the government to sell ART medicine. One day during my fieldwork, I encountered some young people sitting in front of a house and I approached them, presented myself and I suggested that we talk about the rumor regarding infected condoms. They first laughed and then they agreed to talk about it. A young single man in his 20s said:

> I received condoms from an activist in one of these organizations. It looked very strange. I took it and put in the sun. After some minutes, I saw a maggot inside the condom. I did not believe what I saw. I called my friend. My friend advised me to put another condom in the sun and the result was the same, a maggot inside the condom. Can you imagine what the maggot would do if I used the condom? After that experience, my friend and I told all our friends what happened and all of them decided not to use free condoms.

What this young man said about infected condoms can be linked to the conspiracy theory that people suspect the government together with international pharmaceutical companies of planning to infect poor people with HIV and then make them buy ART medicine. A young woman in her 20s said: "I know that there are expensive condoms in many shops of this city. Why don't these organizations advertise them?" These ideas mirror the fact that people reflect on what they are told and given. People suspect that free gifts are not good because they learnt from the family that when somebody offers a gift they have to reciprocate, which in extension implies that free gifts are suspicious. Many health technicians and HIV/AIDS activists working for the Ministry of Health have heard the rumors about free, infected condoms. Some health technicians argue that people say that condoms are infected because they are less educated and do not want to protect themselves against HIV, as one health technician said:

> I have worked in this *bairro* for many years. Here [in *Mafalala*], there is a mixture of uneducated people coming from various provinces of the country. I know that people believe there are infected condoms. People always have excuses for not following orders. How can a person put a condom in the sun? Of course that flies can get in and produce maggots.

The health technician's argument is that people's lack of education makes them distort messages about condom use. The argument that "people always have excuses for not following orders" shows that the health technician thinks that people do not reflect upon what happens to them in their everyday lives. This shows a paternalistic approach toward condom use on behalf of the employees of the

Health Ministry. Yet, it is true that people may not assume that the free condoms are for them because they have little confidence in the government's activities targeting the poor.

4.2.3. Sharing of cutting instruments

To avoid sharing cutting instruments is one of the messages circulated in the HIV/AIDS prevention campaigns. This message claims that health personnel, healers, and drug consumer are groups of people who can easily spread HIV. Health personnel can spread HIV if they do not sterilize needles and have contacts with patients with open wounds without wearing gloves. Gloves are required for nurses when they treat patients, and the gloves should be discarded after each use.

Healers use razors to spiritually "vaccinate" their clients. They make small cuttings in the client's body to insert a mixture of herbs. Healers are advised by the Ministry of Health to not share razor blades among their clients. The Ministry of Health organizes training for traditional healers to teach them how they can insert *malhanganizo* (mixture of herbs) in the clients' body. A healer, member of the healer's association, said:

> I learned in the training provided by the Ministry of Health that I should use one razor for each person and then discard it. I should use gloves when I put herbs in the clients' body to avoid any contact with the blood.

However, it is not easy to ensure that all traditional healers follow this advice, among other things because some traditional healers are not registered with the healers association *AMETRAMO* and are thereby not included in the training provided by the Ministry of Health. Many people in *Mafalala* are "vaccinated" by traditional healers for various reasons, and the healers are often said to use the same blade for a number of people. Shifa said:

> Many times people receive *onze* [two small cuttings that healers do with a razor in the body of their clients to insert a mixture of herbs and animal blood] and the *curandeiro* [traditional healer] does not throw away the razor afterwards. This is because some *curandeiros* are too lazy to buy a new razor for each person. When I go to the *curandeiro,* I take my own razor so that I will not infect other people [with HIV].

Some traditional healers make their own cutting blades or they ask their clients to bring their own razor. Traditional healers who use their own blades say that these blades produce a more effective result than razor blades bought in a shop. In this way, it is up to clients to decide on whether they want to have their "vaccination" with razor blades or home-made blades. Moreover, there are differences between

traditional healers who are members of *AMETRAMO* and traditional healers who are not members. Traditional healers who are members pay an annual fee of 2000 MT (about 53 USD) to the association, and they have a certificate from the Ministry of Health that guarantees them the right to perform their activities. Traditional healers who are not members of the association claimed that they are not members because they do not have many clients. In the field, I noted that traditional healers who are not members of the healers association have lower prices for consultation e.g., between 50-100 MT (about 1-3 USD). The price presented by the healers' association, which was fixed for all healers in 2014, was 250 MT per consultation (about 7 USD).

Many poor people consult traditional healers who are not members of the healers' association because they offer lower prices. Sometimes the traditional healers that do not belong to the healers' association pay a fine to the healers' association because they are working without permission. As mentioned, the traditional healers who are members of the association receive training from the Ministry of Health to know how to deal with their clients in the HIV/AIDS era, but there is no guarantee that all trained healers adhere to the instructions from the Ministry of Health. After having participated in a training session, traditional healers receive a certificate that they can show to their clients. Some traditional healers hang up the certificates in their offices so that clients know that they have undergone training; therefore, people can feel safe with them.

4.2.4. Contracting HIV through bad spirits

Tenkorang (2011), Thomas (2007), and Mshana et al. (2006) argue that people in some African countries such as Namibia, Zimbabwe, and Tanzania relate HIV contraction to sorcery, "evil spirits," and witchcraft. Mshana et al. (2006: 48) affirm that people in rural Tanzania perceive that HIV can be contracted through "evil spirits" (*majini*). According to Mshana et al. (2006), people say that they can contract HIV when they break a taboo or go against the wishes of departed parents or other ancestors. The authors also say that people perceive that "infection and witchcraft are not perceived as two causes of the same illnesses; instead, 'real' AIDS is believed to be sexually transmitted, while a separate, AIDS-mimicking illness is believed to be caused by witchcraft for reasons such as jealousy, resentment, or punishment of the targeted person" (ibid. 2006: 54). However, the authors show that according to popular belief if a person does not believe in witchcraft s/he will not become a victim of evil forces.

In his study in Do Kay, Haiti, Farmer (1990) notes that people believe that AIDS was sent by sorcery from a malicious person. This kind of AIDS could only be prevented using charms that protect people against those kinds of illnesses that malevolent people send to others. In a similar vein, Dickinson (2014) has shown that in South African townships, people believe that they can contract AIDS when

they disrespect their ancestors' spirits. For these people, HIV/AIDS is the punishment from the ancestor's spirits for family members who disregard or break family norms, for instance, by having extra-marital sex or being a sex worker. In *Mafalala*, people also mentioned that it is possible to contract HIV through bad spirits, such as *mulhiua*, *nacuro,* and *supiana*. These are not the ancestors' spirits but spirits that some people buy from witches to cause afflictions to people in their family and/or neighborhood.

In Mozambique popular beliefs, there are a number of spirits such as: *mulhiua*, *nacuru, and supiana* that may cause afflictions. *Mulhiua* is a spirit that comes from the land. *Supiana* and *nacuro* are spirits that come from the water and they are considered to be strong and dangerous in terms of causing afflictions. All these spirits have come from a dead human body. According to local popular beliefs, when somebody dies who is not involved in any conflicts with family members or other persons, the body stays in the ground and the spirit is let free. However, when a person dies with unresolved conflicts, the spirit does not leave. Such conflicts, for example, can be quarrels with senior family members because of cohabitation without the family's consent. In these cases, the spirit of that person stays on where the life ended; it may be in the water or in the bush. These spirits are then used by *feiticeiros* (witches) to cause afflictions. Many poor people in *Mafalala* claim that everybody can become a *feiticeiro,* and learn from other *feiticeiros* how to carry out evil magical acts.

When there is somebody in the family with medically confirmed HIV who develops AIDS, senior members of the family may observe who from the family visits the ill person. If some family members do not visit the ill person and offer support, the senior members of the family can be suspicious that the ill person did not contract HIV in a "natural" way. The senior members of the family will then consult at least two healers to find out through divination why the ill person has HIV/AIDS. If the family finds out that their relative contracted HIV through bad spirits, they will use traditional healers' prescriptions to remove the bad spirit as part of the healing process. My informants affirmed that healers assured them that there is no cure for naturally nor spiritually caused HIV/AIDS.

As mentioned, people believe that witches can take spirits that are not free and manipulate them to cause afflictions. People argue that witches "sell" bad spirits to some people who want to bring suffering to others. According to this worldview, people who "buy" spirits should carry out some sacrifice. There is a popular belief that the sacrifice could be to give food to a hidden snake in the witch's house, or to "give" a close family member to the *feiticeiro* by causing this person's death. The sacrifice is made through rituals where the *feiticeiro* asks the interested person to bring the blood of an animal, needles, as well as pieces of white, black, and red clothing, among other things. The healer uses these materials to prepare a kind of symbolic "bomb" that will kill a selected person in the clients' family (cf.

Geschiere 2013, 1997). The witches that "sell" bad spirits act secretly, together with the persons that "buy" spirits. If people suspect that some family members caused the afflictions to other people, they call them *feitiçeiros*.

In *Mafalala,* it is a commonly held belief that some people "buy" bad spirits from witches and give them the name of HIV/AIDS and throw the bad spirit on someone in the family or neighborhood. As a result, within a short period of time that person will have symptoms similar to "natural" HIV/AIDS. In addition to "buying" evil spirits, people can also find evil spirits in the close family. In these cases, family members learn that the spirit of their relative did not go away when s/he died, which gives the opportunity for somebody to use it. When members of the family dream about the dead person, this is often interpreted as a sign that the spirit did not leave. After having this dream, some senior members of the family may consult more than one traditional healer to understand why the spirit appeared in the dream and what it wanted.

People in *Mafalala* sometimes believe that if you contract HIV through an evil spirit, you will behave in a way that makes the symptoms of HIV/AIDS worse. People have suspicions that somebody does not have "naturally" caused HIV when the ill person refuses to go to the health center, to take antiretroviral medication, and to accept support, such as food, conversation, or some kind of advice. When this happens, the ill person's family may go to several traditional healers to get divine answers as to why the person is ill. The traditional healers throw bones, and read the Bible or Koran for divine answers. Shifa, an informant presented earlier in this dissertation, believes that Lola contracted HIV through bad spirits because she had sex with her step-father. I decided to talk to some people in Lola's family to hear what they had to say about Lola's illness. Lola's sister (Ceci), a woman in her 20s, discussed her sister's illness and behavior. She said:

> My sister and my step-father are crazy. They should not do what they did. I suspect that somebody in our family is using Lola with a *mulhiua* [bad spirit]. I think my sister caught *essa doença* because of *mulhiua*. She sleeps around with different men because she needs money to drink *boss* [an alcoholic drink]. She has a daughter, but she does not care about her. Our family does not want Lola near us due to her behavior. [I believe that] somebody in our family who does not have a job went to a witch and bought a *mulhiua* [bad spirit] that is prejudicing her.

According to Ceci, her sister Lola had HIV/AIDS because she had multiple sexual partners and did not use a condom. Ceci affirmed that Lola's behavior is not "normal." She had multiple partners as a result of bad spirits. Lola was in a vulnerable condition, which implied that she could not always negotiate the use of a condom. Two things made Ceci believe that Lola was afflicted by bad spirits. First, Lola had

sex with her step-father, which is unacceptable from the family's point of view. In Mozambique, as well as elsewhere, consanguine families, people with the same surname and people that interact frequently with each other, cannot marry nor should they have sexual relations. Second, Lola did not "care about her daughter." As a result of her behavior, Lola's family abandoned and discriminated against her because she brought shame onto the family.

Lola was not able to keep her sexual desires at bay, which is expected from a family woman. Yet, the family was not ashamed to receive gifts from Lola, which she had acquired as a result of her sexual relations in exchange for money or goods. Moreover, Ceci claimed that unemployment and jealously are other reasons that lead people in the family to send bad spirits to Lola. The person that threw a *mulhiua* on Lola was unemployed and jealous of Lola because she was able to make money. Ceci blamed the person that sent a bad spirit to Lola as being responsible for Lola's behavior and illness. *Mulhiua* makes people act in an irrational way against the family and cultural norms.

It is also interesting to compare Shifa and Ceci's versions about what happened to Lola. Shifa blamed Lola for contracting HIV because Lola was irresponsible and, for instance, had sex with her step-father, which attracted evil spirits that gave her HIV. In short, Shifa argued that it was Lola's behavior that made her contract HIV. Ceci did not blame Lola for contracting HIV, but instead said that Lola contracted HIV because of bad spirits that influenced Lola to have multiple partners. Ceci's explanations include both biomedical (multiple sexual partners) and spiritual (evil spirits) reasons as to why Lola contracted HIV, whereas Shifa only gives spiritual explanations.

The idea that Lola became ill through bad spirits contrasts with what HIV/AIDS prevention campaigns say about the individual's responsibility to avoid HIV. The philosophy behind the HIV/AIDS prevention campaigns in Mozambique is that individuals will make the right decision when they have information about HIV/AIDS (Conselho Nacional de Combate ao HIV/SIDA 2004, 2010). Information about HIV/AIDS does not include local practices and beliefs about contracting HIV/AIDS and prevention. From the family perspective, individual behavior (as shown in Lola's case) could not make her contract HIV, but other people's behavior (sending bad spirits) made Lola ill with AIDS. Many people in Lola's family share the idea that people can contract HIV through bad spirits. Lola's sister (Lila), a saleswoman in her early 30s, believes that people can contract HIV through bad spirits. According to Lila, bad spirits can only create afflictions for people who are well known to the owner of the bad spirit. Lila expressed, "the victim [of the bad spirit] will refuse to go to the hospital and resist eating *comprimidos* [antiretroviral medication]*"* because she is under the control of bad spirits. Yet, Lila explained that it is possible to undo the effects of bad spirits:

> Some bad people go to a witch to buy *mulhiua*. The witch gives the *mulhiua* the name of *essa doença*. The owner of the *mulhiua* sends it to any person whom s/he wants to hurt. After the victim is given *mulhiua,* s/he will have *essa doença*. The victim [of the bad spirit] will refuse to go to the hospital and to take *comprimidos* [antiretroviral medication]. Only people that *mulhiua*'s owner knows very well can be a victim of *mulhiua*. One of the aims of *mulhiua* is to bring sorrow and at the end kill the victim. If the victim discovers that s/he has *mulhiua* and goes to *curandeiro* [traditional healer] to treat it, the *mulhiua* owner's life will become worse.

Also, Lola's brother Vito was convinced that bad spirits could cause HIV:

> People who say that *essa doença* [HIV/AIDS] cannot be contracted through *mulhiua* do not accept [that] *essa doença* [exists]. I know some people who went to *curandeiros* after testing [HIV] positive. They asked the *curandeiros* to throw bones [divine] to know if the illness was normal or if it was caused by *mulhiua*. Other people drink *medicamentos* [mixture of herbs provided by healers] to prevent *essa doença*.

The perception that people can contract HIV through bad spirits was also shared by a group of young people in *Mafalala* who affirmed that "many people do not talk about HIV/AIDS contraction through bad spirits as they feel ashamed" because they can be considered as being superstitious. Many people argue that bad spirits are sent by persons who cannot accept that other people live a better life. Thus, jealousy is seen as a main motive for sending a bad spirit.

4.3. Summary

In *Mafalala*, people pointed out some categories of people as being more vulnerable for contracting and spreading HIV. These people are *gigolôs*, *biscateiras,* and married men and women who have sexual relations outside of their relationship. In particular, poor people are at greater risk of contracting HIV/AIDS as they may be dependent on sex work for their survival and cannot negotiate the use of a condom. It is also common that married women have to accept their husband's infidelity in order to be seen as a "good" and tolerant wife.

People talk about contracting HIV in four different ways. First, "meat to meat" is when people do not use a condom when they have sexual relations because they believe that using a condom inhibits pleasure and reproduction. Second, people believe that the government, together with the international NGOs offer infected condoms to poor people to make them ill, and then exploit them by selling antiretroviral medication. Third, people know that they can contract HIV through

the use of cutting instruments, such as blades and needles without sterilization. Fourth, people perceive they can contract HIV though bad spirits. This is said to happen when people who do not like them "buy" a spirit from presumed sorcerers or witches and give it the name of HIV/AIDS and "throw it" on them to create affliction. It is also said that only people who know a person well, such as a family member, can throw a bad spirit on someone. Commonly, the reason is presumed jealousy.

Clearly, these ideas reflect a creative and deeply felt struggle to make sense of the causes of a disease, which has had devastating effects on many families. It is also clear that people are aware of biomedical explanations and that these are used in combination with other explanations that are very different from biomedical explanations (cf. Baer 2011).

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5
Trying to treat HIV/AIDS

This chapter will present government policies on HIV counseling and testing in Mozambique and how HIV testing is performed in *Mafalala*. The chapter discusses how people face HIV testing and treat AIDS and how they understand different treatments, both biomedical and ethnomedical, or so-called "traditional."

5.1. HIV testing and public policy

HIV testing is voluntary in Mozambique although young women are highly recommended by the Ministry of Health to do HIV testing. As many children have been born HIV positive, the Ministry of Health have decided to make HIV testing mandatory for pregnant women, to avoid the unborn child becoming infected if the mother is HIV positive. Many poor people in *Mafalala* do an HIV test in the public health center outside *Mafalala,* but those who can afford it test their HIV status in the private health posts, both inside and outside of *Mafalala.* Both nurses and HIV/AIDS activists are allowed to inform and advise people about HIV/AIDS epidemic. Before people perform the HIV testing, they shall be informed about what will happen if the HIV test turns out to be positive.

When there is a campaign, the HIV/AIDS activists may test all people, regardless of whether they are poor or rich. In this case, the HIV testing takes place in people's home or somewhere else in the neighborhood. Nurses and HIV/AIDS activists carry out the HIV testing in the same way, which is done in two phases. In the first phase, the nurse or activist uses a needle to collect blood from the person's finger for testing. After the first HIV testing, they give a card to the person that shows she/he did the first HIV testing. If the first result of HIV test is positive, they advise people to do a second HIV test after a week. If the second test also turns out to be positive, they confirm the result and inform the person about their HIV positive status. After the second HIV positive test, the person meets a doctor to

measure her/his CD4 cells in the blood. If the CD4 level is low, the person begins with ART.

If the result of the HIV testing is negative, both HIV/AIDS activists and nurses ask people to repeat the HIV testing three months later[3] (see Kiefer 2007). There are differences between the testing HIV in the public and private health center. In the public health center, the HIV testing is free, while in the private health center people pay about 50 USD for a consultation that includes HIV testing. Many people that I met who did a voluntary HIV testing in their houses in *Mafalala* complained that the HIV/AIDS activists from the NGOs, such as *AMODEFA* were poorly prepared to answer their questions, for example, about what would happen to them when they began the treatment, how PLWHA will live with AIDS, what kind of care PLWHA should have when they want to have children, and what would happen if someone forgot to take the ART medication, among other questions.

The *Conselho Nacional de Combate ao HIV/SIDA* (2015) emphasizes the need for nurses to care about the health of HIV positive people, including the treatment for opportunistic illnesses (e.g., tuberculosis), HIV co-infections control, psychosocial support, and home care provision. Tuberculosis is strongly related to AIDS, and people with tuberculosis are commonly submitted to HIV testing. Nurses also advise PLWHA to use a condom and to have only one sexual partner to prevent new infections. Some PLWHA receive psychosocial support and home care provision from nurses and/or HIV/AIDS activists working in collaboration with organizations and associations linked to the Ministry of Health.

The Ministry of Health does not allow private health services to distribute ART drugs. Therefore, people that show HIV positive in the private health service testing are advised to go to a public health service to start with treatment. After the availability of ART in 2004 in the public sector, a survey was carried out by a team from the Ministry of Health of Mozambique together with international organizations, such as Department of Health & Human Service USA, Johns Hopkins University, and ICF International Company, among other international organizations to understand what people say about using ART. The survey showed that 86% of people in *Maputo* knew that they could live longer if they used the antiretroviral medication (INSIDA 2009).

The effort to make ART available for all people included the collaboration with PEPFAR (The Unites States President's Emergency Plan for AIDS Relief) that began in 2004. This program aimed to prolong and save the lives of people living with HIV/AIDS by providing ART medication for 6 million people

3 This describes the procedure during my fieldwork. With recent changes in the HIV/AIDS prevention programs in the world, people today in Mozambique do not have to wait to check their CD4 counts to start with the treatment. After HIV testing turns positive the first time, they start immediately with ART medication (UNAIDS 2016b; Conselho Nacional de Combate ao HIV/SIDA 2015).

(*Embaixada dos Estados Unidos em Moçambique* 2016). PEPFAR cooperate with the Mozambique Government in three levels, namely: urban-rural health posts and centers, regional and general hospitals, and provincial and central hospitals. During fieldwork, I sometimes met HIV positive people who complained that there was no ART medication in the public health centers because of bureaucracy, as my informants Shifa said: "I did not collect my *comprimidos* (ART medication) because the nurse said there is none." It is common to hear many PLWHA, not only in *Mafalala* but also in other *bairros* of *Maputo* city, complaining about the lack of ART medication in the public health services.

5.1.1. Popular perceptions of HIV testing and confidentiality

Many poor people do not undergo HIV testing for a number of reasons such as fear of losing economical and moral support from their social network if the HIV testing turns out to be positive. Poor people in *Mafalala* are economically vulnerable. They live through *biscatos* (temporary work) and the help they receive from their social networks. Another important reason is the lack of trust and misunderstandings. Some healthcare staff are said to disclose people's HIV positive status to others.

Nurses in Mozambique generally diagnose, counsel, and treat people to maintain good health and to prevent people from becoming ill. Nurses have an official document provided by the Ministry of Health of Mozambique that guides them on how they should proceed with PLWHA, including ethical issues. The guide says that before nurses start treating people, they should explain about the illness to the patients and listen to the patient's experience concerning the illness. The guide forbids nurses from revealing people's HIV/AIDS status (MISAU 2008; cf. MISAU 2007).

In relation to this, the Ministry of Health also recommends nurses to maintain confidentiality concerning people's HIV/AIDS status and other activities that include human health (ibid.). However, not all nurses follow the guidelines and these recommendations. One of the nurse I talked to said, "not all nurses keep it secret about people's HIV positive status." According to this nurse, those who reveal people's HIV/AIDS status are not committed to their profession; rather, they are more concerned about money. She also said that some nurses do not listen to their patients and that patients feel they have to stand in line for long times.

Several of my informants claimed that some nurses' attitudes created distrust and that they felt that the nurses thought that those who decide to do the HIV testing did so because they have not "behaved well." This issue of confidentiality and trust in relation to HIV testing has been discussed in several countries. Mattes (2011) shows that people in urban Zambia have negative assumptions concerning AIDS treatment because some nurses do not keep medical results secret, which causes people to avoid or abandon treatment. In Mozambique, some poor people

whom I met during the fieldwork said that they did not denounce nurses who reveal people's HIV positive status to others because they fear that the nurses will not treat them and their families well next time when they need them. In addition, in the public health service facilities, there are claim boxes, but many poor people do not know how to write to be able to express their dislikes and concerns (see also Kleinman 2010).

5.1.2. Lack of trust, misunderstandings, and morality

Among my informants, trust is a very important concept when talking about HIV testing and AIDS treatment. As discussed above, many poor people do not trust some nurses because they suspect them of disclosing their HIV status to other people. Additionally, people said that nurses talk with them in a language that they do not understand and they feel uncomfortable to ask questions about things that they do not understand. Lack of trust prevents people from getting the HIV testing and AIDS treatment in the health services. Misunderstandings often occurred between poor people and nurses. In a long, disorganized queue in one of the health centers close to *Mafalala*, I heard a nurse rudely shout to people. Another nurse said:

> There are nurses that do not know how to work with people. Some nurses use technical language; nurses do not explain to people what they have and how they will be treated. Because of lack of training on how to deal with people, some of the nurses talk as if poor people do not know anything and nurses know everything.

People were of the opinion that poor people sometimes do not follow what nurses tell them because they do not want to be talked to in a patronizing voice.

Many people I met in *Mafalala* consider that they become ill with AIDS when they have some physical symptoms such as diarrhea, tuberculosis, loss of weight, or black pimples all over the body. When people become aware of some of these symptoms, they go to the healthcare services. They may also go to a healer for diagnosis and treatment. Of importance here is that illnesses are not only physical or mental but also socially constructed (Good 1994). In general, when people become ill, they want to understand not only *how* they became ill but also *why* they become ill and how the illness will affect them. Therefore, there is a need for a focus on experience and family as well as the community response to the illness (ibid.).

The individual and the community have their own perceptions of why an illness occurred and how to treat it. These perceptions often differ from the medical perspective (Kleinman 2006). Illness narratives may be helpful here to understand how people think and act concerning a specific illness. Of importance here is to interpret the illness within the context in which it occurs and to capture the moral

notions of people associated with the illness. The moral notions about the illness will make it accepted or not in a specific context (ibid.).

Morality is associated with family norms, gender relations, and religion (Smith 2003); thus, ideas concerning morality are highly relevant for an understanding of how HIV/AIDS is experienced, as people commonly associate it with promiscuity and contradicting values. In a study on morality among young people in Nigeria, it was shown that the "moral assessment and actual decisions about sexual behavior take place within the context of poverty and inequality, creating tensions between ideals and pragmatic needs, and producing situations in which contradictions are common" (Smith 2003: 346; cf. Dilger 2008).

5.2. People's experiences of AIDS opportunistic illnesses and ART

Many people I met in *Mafalala* believed that they had AIDS when they had a combination of tuberculosis, permanent diarrhea, and rapid weight loss. According to some nurses that I met, these symptoms occur when the CD4 level is low although there are, of course, people who become ill with tuberculosis and lose weight who are not ill with AIDS. Several people whom I met in *Mafalala* said that after about three to six months of testing HIV positive, they began to have health complications. Some of them went to the public health services to get treatment, others went to the healer's office to get divination and "spiritually" clean their bodies before they went to the health service center. People also had complications when taking the ART medication. One example is Lola, an HIV positive woman in her 30s. She shared her experience with me and complained about having permanent diarrhea:

> I started having pain in all my body. I thought that it would pass because the pain started after I worked hard in a *biscato* [temporary work carrying water for people who do not have water supply at home]. I arrived home and I ate paracetamol to kill the pain. The pain passed, but the next day I had diarrhea. Then, I decided to go to the health center where the nurse advised me to drink a lot of water to avoid being dehydrated, [and he said] maybe it is *comprimidos* (ART medication) reaction. I drank a lot of water as the nurse advised me, but the diarrhea did not go away. I had diarrhea for three months. I lost weight and strength. I could not walk. The women in my family helped me with everything. During this period, I thought I was about to die.

As Lola became ill with permanent diarrhea, she also suspected that it was the side effects of the ART medication she was taking, but her family was not of the same

opinion. The family took Lola to a healer's office to get divination and to get a "purification bath" and to "vaccinate" against the bad spirits, which, according to her family, may be causing her illness. However, Lola's family also encouraged her to continue taking the ART medication. During her illness, the females in her family supported her with prayers, bathing, food, and having conversations with her.

Many of the PLWHA that I met mentioned that they received information in the health center that the ART medication has side effects (dizziness, vomiting, and diarrhea) and that if people feel one of these side effects they should see a doctor to change the ART medication. A nurse said:

> The *comprimidos* [ART medications] used in Mozambique is not of good quality; people take more than one *comprimido* per day because the good *comprimido* is expensive and not available in Mozambique. Only those who can afford it take one pill per day. They buy these kinds of *comprimidos* abroad [e.g., South Africa].

The nurse also said that many poor people do not return to the health center when they have some of these side effects. They think that the ART medication is making their health worse. Vito, a man living with HIV/AIDS in *Mafalala*, said: "I have friends who get *comprimidos* [ART medications], and they told me that they feel dizziness after taking *comprimidos* and they say they will abandon the treatment." Some poor people that I met suspected that the ART medication side effects were evidence that some nurses deliberately gave them incorrect ART medication to kill them. Accordingly, there was very little trust between some PLWHA and some of the nurses. Tuberculosis is an opportunistic illness often associated with AIDS. Mico, a married man in his 30s, explained how he became ill with tuberculosis:

> I had a cough and I was losing weight. I decided to go to the health center and the nurse diagnosed me with tuberculosis. As the tuberculosis was not serious, the nurse allowed me to take the pills home during six months. The nurse advised me to be at home so that I would not infect other people.

Because Mico was losing weight, relatives, neighbors, and friends became afraid of visiting him. Mico underwent an HIV test that turned out to be negative, and the nurse asked him to repeat the HIV test after one week. However, Mico did not return to the health center because he did not feel comfortable doing so. Then, relatives, neighbors, and friends started to say that Mico had *essa doença* because he was losing weight. Although one may lose weight because of other illnesses, many people in *Mafalala* suspect that someone who loses weight is ill with AIDS. In the case of Mico, it was not clear whether he actually suffered from AIDS or not, but according to the people around him, he was ill with *essa doença*.

5.2.1. Treating AIDS and the problem with non-compliance

This section discusses antiretroviral medication and the Mozambican Government's view on AIDS treatment, as well as people's perceptions of ART and the methods used by healers to treat opportunistic illnesses (e.g., tuberculosis). ART is free in Mozambique, but many poor people do not start with treatment or abandon it for many reasons, as discussed above. In the public health service, doctors advise PLWHA to select a certain time of the day to take the ART medication. Those PLWHA that I met took the ART medication between one to three times per day. Irrespective of whether you take the ART medication one, two, or three times per day, you are advised to take them at a specific time, because the drugs work better in the body when consistently taken. Taking ART regularly will also reduce the transmission of HIV to other people, especially if the infected person also uses a condom. However, many PLWHA depend on other people to tell them when to take the ART medication, which may cause feelings of shame, low self-esteem, and stigma.

PLWHA are advised to rest for at least thirty minutes after taking the ART medication because ART has side effects, such as sleepiness, dizziness, and diarrhea. All PLWHA receive a card with selected dates to collect the ART medication every month and to check if they regularly take the ART medication. A nurse I talked to stated that another way that the health service controls to see if PLWHA take the ART medication is to check their CD4 levels. If the CD4 is low, it means that the PLWHA is taking the ART medication, but if the CD4 is high, it means that the PLWHA is not taking ART regularly. ART comes in a white or cream container with thirty pills. The container is clearly distinguishable from other chemical drugs and makes it possible for everyone to see that the person is on ART. I met several PLWHA who said that they did not like this, as it made them vulnerable for being stigmatized.

Some anthropologists who studied ART focused on themes such as the availability of ART and its side effects (Kalofonos 2010; Jones 2011) and ART and perceptions of time and time-keeping (Biehl 2007). In relation to availability, Jones (2011) argues that the fact that ART is available for people does not mean that people do not see barriers to using ART. The author notes that people in Grahamstown, South Africa, refused ART because they did not have access to basic necessities such as food. In trying to answer the question of why people refuse ART, the author explains that, "economic inequalities and structural barriers have created dire situations that force many PLWHA to choose between their economic security and health security" (Jones 2011: 68). The author concludes that there are conflicts and tensions related to economic factors, which have an influence in the implementation of the antiretroviral medication.

Another example that illustrates why people refuse to take ART is given by Kalofonos (2010), in his study in central Mozambique. The author argues that people in central Mozambique (*Manica* and *Chimoio* provinces) did not take the antiretroviral medication because of hunger. According to the author, many people on ART complain that it makes them hungry and that people do not have permanent jobs to earn money to buy food in order to continue using ART. The author explains that despite people having support from the Word Food Program, the food people received was not enough because the ill people shared the food with other members of the household.

With regard to the time to take ART, Biehl (2007) shows in his study in Brazil among homeless people that many of his informants were satisfied with ART since they achieved a higher quality of life because they rarely had opportunistic illnesses related to AIDS. However, the author also said that people complained about the fixed time they had to eat ART since his informants lived on the streets and found it difficult to keep to a specific time.

When comparing the studies by Kalofonos (2010) and Jones (2011) discussed above, there are similarities with *Mafalala* concerning the availability of ART (cf. Nguyen 2010) and the unwillingness to take ART. Many PLWHA had free access to ART medication, but they complained that ART creates hunger. Because of the perception that ART creates hunger, some PLWHA changed from taking ART to eating herbs provided by healers. These people mentioned that they were comfortable in using herbs and they continue going to the health center to measure their CD4, which they said was fine.

Summing up, the people I met in the *bairro* mentioned five reasons for not following prescriptions and taking their ART medication: 1. Lack of healthy food such as meat, milk, egg, vegetables, and protein-rich food (fish, beans, and rice); 2. Imposed restrictions by healthcare personnel such as avoidance of sexual relations without a condom and sex with multiple partners, and nightlife in general; 3. Negative perceptions about the side effects of ART medication such as bitterness, hunger, diarrhea, and dizziness; 4. Problems following the scheduling of the treatment; and 5. Stigma and hostile attitudes from some family members and friends.

As soon as people start with the ART medication, they receive advice from nurses to eat *comida saudável* (healthy food) and are told that the drugs are strong. However, many poor PLWHA whom I met in *Mafalala* claimed that they could not afford to eat healthy food because they were unemployed, did not have a plot of land to produce food, and they lived on temporary work. Poor people usually eat bread without butter and tea or maize and beans. In informal conversations with a nurse, he said that some nurses advise people to eat healthy food because it is a way to encourage poor people to eat well when they receive ART. It becomes a way for them to save the energy that the body needs to fight opportunistic illnesses (e.g., diarrhea and tuberculosis, among others). The nurse also said that the ideal is

to advise people to eat what they have in their houses, but added that nurses have little time to explain to each PLWHA what they can eat according to what they have at home.

Some PLWHA I met said they are not prepared to put restrictions in their lives (e.g., avoid alcohol and multiple sexual relations without a condom). Some PLWHA also said that nurses advised them to avoid sexual relations without a condom to prevent new infections. The nurses explained that when PLWHA take their ART medication, there is a low probability of infecting others, although some of the nurses I spoke to stated that they could not give this information to the general public. According to a nurse, the ideal is that PLWHA take ART, have one sexual partner, and use a condom. If PLWHA do not take the ART medication, do not use a condom, and have multiple sexual partners, they may infect themselves and others.

Apart from causing hunger, diarrhea, and dizziness, it was a generally held belief among PLWHA that ART has a bitter taste. Moreover, PLWHA in *Mafalala* complain about not being able to follow the time-schedule for ART for many reasons. They had difficulties reading and were not used to following a time-schedule, and some relied on other people to tell them the time to take their ART drugs. Many PLWHA I met said they took ART three times a day, while a few said that they took the antiretroviral drugs only once a day, commonly during the night to avoid calling attention to themselves from curious people. In a similar vein, poor homeless people in Brazil complained about the fixed time they had to take the ART medication, the rest required, and the food they were prescribed to eat. The rules did not match with the lifestyle that homeless PLWHA had in the streets (Biehl 2007).

People often abandoned taking the ART medication because of hostile and unsympathetic attitudes from some family members and friends. Lola, presented earlier in this thesis, had on one occasion abandoned her ART because, as she said, she was feeling well. She restarted the treatment when a HIV/AIDS activist from the Ministry of Health warned her about the disadvantage of not taking ART medications every day. One of Lola's neighbors said that Lola looked nice when she took ART regularly; she gained weight and did not have black pimples on her skin. However, Lola's decision to take the ART medication every day was threatened by her boyfriend's hostile behavior. The following event illustrates Lola's situation: One morning when I was walking in the *bairro*, Lola was fighting inside the house with her boyfriend. Neighbors arrived to appease the conflict because Lola was screaming. The boyfriend left after throwing away all the food they had in the house, food that was especially important for Lola to take before she took her medicine. After the event, Lola approached me and said:

> This is the reason I cannot eat *comprimidos* [ART] regularly. After a night of sex, he wanted more this morning. I refused and he beat me. He threw away the food. I do not know what I am going to eat today.

Lola also said that she could not take ART medication and have sex because the nurses advised all PLWHA to avoid sexual relations without a condom, which was not what her boyfriend wanted, and he did not want to help her follow the nurse's instructions. This event illustrates how difficult it can be for a poor woman that is economically vulnerable and who has little agency to persist with the antiretroviral medication.

5.3. Different ethnomedical ways of treating essa doença

The different non-western healers that use herbs and various objects to treat AIDS in *Mafalala* come from various provinces of Mozambique (*Nampula*, *Tete*, *Gaza*, *Inhambane,* and *Maputo*) and also from abroad (Nigeria and Democratic Republic of Congo). Many of these healers live in and have an office in the *bairro* (cf. Langwick 2011). All the Mozambique healers that I met communicate with their ancestors' spirits in their own languages (*Makwa*, *Changana,* and *Ndau,* among others). They always have someone with them to translate what they are saying so that clients who only speak Portuguese will understand. Herbs are used in three kinds of spiritual treatments that are carried out by the healers whom I met in *Mafalala*: A purification bath, a "vaccination," and a mixture of herbs to put in the food or water, especially for children and people who are very ill. In addition, healers perform spiritual cleansing, which I will discuss further in relation to the treatment of tuberculosis. These spiritual treatments always begin by performing a divination to know how the sufferer should be treated. After the divination, which the family of the ill person may carry out with different healers on various occasions, the ill person's family decides to receive spiritual treatment from one of the healers that they trust will help them. The first procedure, the purification bath, involves spiritually cleaning the client's body and house with a mixture of different herbs. The "vaccination" consists of making two small cuts in the body where the healer puts a powder, made of a mixture of burned herbs. The mixture of herbs is given to the client to take three times a day, together with food or water, to help bring out the "impurities" that the physical body produced because of spiritual problems that the ill person has. The healers I met claim that the spiritual treatments protect the ill people from sorcery, bad spirits, and prepare the ill person to go to the health centers/hospitals.

Many people in *Mafalala* combine ART with non-western therapies provided by healers. Apart from the herb mixtures, they may also be given, for example, dried and crushed bone of a frog. All healers I met said that they do not try to cure AIDS, but that they have herbs to help PLWHA have a qualitatively better life. The healers claimed that the Ministry of Health of Mozambique disallows healers to say that they cure AIDS, to avoid luring people into bad decisions.

Healers treat *essa doença* with a strong mixture of herbs called *malhanganisso*[4]; *xikepo,* the root of a plant that grows close to the *murô* or *nambo* (both words mean river in the *Makwa* and *Changana* languages) and a decoction of a root called *dema la kutxuca* (cf. Mariano et al., 2010). The healers I met in the *bairro* did not reveal all the names of the herbs they use to deal with opportunist illnesses related to AIDS. However, people who have money (about 1000 USD) and time (one year) can learn the names of the herbs, bulbs, roots, and other materials used to deal with *essa doença* and other illnesses from a healer, and in this way become a healer him/herself. Because I did not have the time and money to receive training from healers to know the names of herbs, I asked about the names in conversation with PLWHA that used the mixture of herbs and with some healers that sold the mixture of herbs in the *bairro* and in the *Xipamanine* market in *Maputo* city.

Figure 2 Mixture of herbs that some healers sell to treat opportunistic illnesses related to AIDS (photo by the author).

4 *Malhanganisso*, *xipeko, dema la kutxuca,* and *nambo* are words in *Changana*, one of the languages spoken in southern Mozambique. *Murô* is a word in the *Emakwa* language spoken mainly in Northern and central Mozambique (*Nampula*, parts of *Cabo Delgado*, *Niassa*, and *Zambézia*).

Healers whom I met in *Mafalala* tell their clients that the mixture of herbs they sell to deal with *essa doença* have a similar effect as ART because they help PLWHA to live longer than without any treatment. An example of someone who has used herbs for treating AIDS is Toni, a man in his thirties who lives in *Mafalala*. Toni said: *"*I started taking *malhanganisso* and I felt well*."* Toni as well as other PLWHA whom I met felt that the mixture of herbs helps them to have a better life. Some people began using the mixture of herbs because they felt safer than taking ART; the healers keep their AIDS status a secret. Furthermore, the healers talk to each of their clients in private, and they do not give the mixture of herbs or other kinds of material to their clients in a specific container that would catch the attention of family members or other people in the *bairro*. Clients bring their own container to store what the healers give to them.

There are many kinds of herbs to deal with opportunistic illnesses related to AIDS. Healers do not disclose their names because they fear that others will sell the herbs and they will lose their business. Moreover, the use of each herb depends on the clients' illness stage. The mixture of herbs is used in forms of powder or liquid. Some healers add 100 grams of the mixture of herb powder to five liters of water for one month's use. The mixture of herb powder may also be mixed with cooked food such as rice, vegetables, and beans, among other things. Some healers told me that if a client starts early on after having being diagnosed as HIV positive, by taking the mixture of herbs they would feel better and they could continue with their everyday activities. If, on the other hand, the client starts taking the mixture of herbs when they become ill with AIDS, it would take a longer time to recover.

Healers provide the mixture of herbs for the clients once a month because they want to see the progress of their clients. It is also a way of making money as each 100 g of mixture of herbs sold by healers from northern Mozambique costs 500 MT (about 11 USD). The healers from northern and central Mozambique whom I met said they acquired herbs, roots, and bulbs to treat AIDS from northern and central Mozambique because there is no plant used to treat AIDS in southern Mozambique. However, I learned from some healers from southern Mozambique that sell herbs and roots, among other things, in *Xipamanine* market in *Maputo city* that there are similar herbs in southern Mozambique to treat AIDS sold for 300 MT (about 7 USD). Healers from southern Mozambique whom I met said that they get herbs to treat AIDS from South Africa, *Gaza,* and *Inhambane* provinces of Mozambique. A healer from northern Mozambique that lives in and has an office in *Mafalala* explained:

> My mother showed me the plant, which roots one can use to treat *essa doença*. She had a dream, with her ancestors telling her to take the roots to help people living with *essa doença.* We walked together in the bush and when we found the plant, we dug down and we took the root home. We

> dried the root for a month and we crushed it in a specific pot. After that we could give [sell] the powder *para aqueles que pisaram mina* [lit. those who stepped on the mine, that is PLWHA] that we knew.

Healers that sell mixtures of herbs do not want other healers to know that they sell herbs to treat *essa doença*. This is due to three reasons, according to the healers I spoke to. Firstly, jealousy and competition; other healers can become jealous and send evil sorcery to them. Secondly, because the Ministry of Health tell healers that they should not say that they treat AIDS. Thirdly, healers are often uncertain about the individual effects of the herbs they sell. Therefore, they do not want to widely disseminate knowledge about the herbs. Many people that used these herbs said they felt self-confident and strong because they had consultation with healers without other people's interference. Among the PLWHA I met, none of them used both herbs and ART drugs at the same time, and a few that used the mixture of herbs affirmed that they had diarrhea and vomiting, which is why they stopped taking the herbs.

5.3.1. Treating tuberculosis with herbs

Many PLWHA said they had tuberculosis. A healer from central Mozambique, living in *Mafalala* for more than twenty years, explains how she started treating tuberculosis. She said:

> I started treating tuberculosis in 1972 when my grandmother taught me to treat children with tuberculosis. I always cook herbs and bulbs to treat my clients. I search for herbs alone in the bush and I prefer to travel twice a year to search for bulbs, roots, and herbs in my birthplace [Central Mozambique]. When a client has tuberculosis and the client is not very ill, I prepare a mixture of maize grain, salt, chicken feather, piece of clay pot, and powder of *nhamperapera*[5] [guava tree growing in the bush].

The healer emphasized that she cooks all the bulbs and roots she gives to her clients to make the herbs, roots, and other material less harmful for the clients' body. The healer also said she searches for herbs, bulbs, and roots to treat tuberculosis alone in her birthplace to avoid getting the wrong herbs and bulbs in the informal market in *Maputo*. The same herb may have a different name in the three regions of Mozambique (north, center, and south). She collects herbs from her birthplace also because she believes that they will work better for the ill people she treats. She continued by describing how she carries out the spiritual cleansing:

5 Nhamperapera is the name of plants in Ndau, one of the local languages spoken in central Mozambique.

> I mix all ingredients in the clay pot and I boil them. After boiling the mixture, I search for a crossroad where people throw away garbage. I bury the cooked mixture and I start asking for forgiveness from my ancestor and from the clients' ancestors for the bad things the client did and that s/he forgot. I apologize to the client's and my ancestors. I apologize on behalf of the client for not being able to avoid having sex with *onanara* ["dirty body" in the *Emakwa* language] or *ntximile* ["dirty body" in the *Changana* language).

Both *onanara* and *ntximile* are expressions that people in *Mafalala* use to name a widow/widower, a menstruating women, and others who make people impure and are considered to make people contract tuberculosis. Many people I met in *Mafalala* fear these kinds of spiritual contamination because it is difficult to treat. They often see tuberculosis as a consequence of spiritual contamination. Many believe that those who have tuberculosis have had sexual relations with a widow/widower that did not complete one year of mourning. This is so because during the mourning period, the spirit of the dead person is not separated from the body of the living person. After one year of mourning, the widow/widower should submit him/herself to a spiritual cleansing to remove the spirit of the dead in order to avoid the spirit of the dead creating an affliction to their family and other people. The healer said that she tries to change the client from the dirty to the clean or pure state through purification baths and by cleaning the house. The healer explained:

> I ask for my ancestors' forgiveness every day until the client has recovered. I also ask for forgiveness from my clients' ancestors and I ask my clients how they feel. If the client says they are feeling well and do not have pain, it means that the treatment is having effect. If the client is not feeling well, I stop with the treatment and I divine [using animal bones and a mirror] to see what else I can do to help them.

The divination system is used to tell why the clients are not recovering. Depending on the answer, the healer may interrupt, change, or continue with the treatment. Sometimes clients cannot recover because of sorcery or because the mixture did not work well with the client's body. According to one healer, tuberculosis can be caused by sorcery, but there is also "natural" tuberculosis that is said to be caused by the lack of fresh air or through physical contact with people who have tuberculosis. The tuberculosis caused naturally is detected and cured within a limited period of time, while tuberculosis caused by sorcery takes more time to cure. Ideally, according to the healer, people should first consult a healer to check if they have "natural" tuberculosis or the kind provoked by sorcery. One healer demonstrated how she would proceed with the treatment if the tuberculosis were caused by sorcery:

> When the client is feeling well, I take out the buried mixture and I bury it in another street where many people walk. The mixture will be there until the client is totally recovered. After the client has recovered, I take out the mixture, I boil it again and I give it to the client in a bath in my office. I also give the client another mixture to spiritually clean his/her house so that the client will be protected from other illnesses.

There is continuous interaction with clients that have tuberculosis because the healer has to know if the treatment is working or not. When the clients are fully recovered, the healer starts the process of finalizing the treatment: she/he digs up the buried mixture from the crossroad and boils it again and gives it to clients to drink and bathe with. According to the healer, the mixture was buried where people throw garbage, as the "dirty" state of tuberculosis can be compared to garbage.

As mentioned, people in *Mafalala* as well as people from other parts of Mozambique tend to believe that tuberculosis is contracted in many ways, which all are related to physical or spiritual dirtiness: lack of fresh air in the house, physical contact with somebody who is coughing because of tuberculosis, sex with a woman who had an abortion because people believe that women in that condition can create affliction, and sex with an "impure" menstruating woman or widow/widower.

According to Douglas (1966), there are notions of dirtiness and cleanness in all societies, and dirty is never a unique or isolated idea or event: "Where there is dirt there is system. Dirty is the by-product of a systematic ordering and classification of matter, in so far as ordering involves rejecting inappropriate elements. This idea of dirt takes us straight into the field of symbolism and promises a link-up with more obviously symbolic systems of purity" (Douglas 1966: 36). Dirty is socially constructed. It has to be understood in relation to how people are socialized (ibid.). Accordingly, people who suffer from AIDS and tuberculosis may be considered dirty and must therefore be avoided.

In sum, people experience both advantages and disadvantages of using a mixture of herbs. There is generally less stigma, but herbs are not available everywhere and they can be expensive for poor people who sometimes do not have the money to buy the mixture. Herbs may also have side effects such as diarrhea and vomiting. Nevertheless, some people switch from ART to the mixture of herbs as ART also may have side effects such as hunger, dizziness, vomiting, fever, and diarrhea.

5.3.2. Prayers

Prayers offered by some religious congregations such as the Zione Church, the Methodist Wesleyan Church, and some mosques, are used to provide moral support to their ill members with AIDS and their family. People I met believe that

prayers calm the ill persons and their families, stating that prayers give positive energy and hope for PLWHA and their families to copy with the illness. Shifa, the woman in her 20s discussed above, was a member of the Zione Church. She said:

> My brothers and sisters [in Christ] visit and pray for my family and me every weekend. Sometimes my brothers and sisters go with me to the health center. They stay with me in the queue, praying for me and for the nurses to attend to me properly. The prayers help me because we never have to queue for a long time [in the health center].

Moreover, some churches and mosques support their ill members living with AIDS and their families, not only with prayers but also with material things such as food and clothes. Shifa as well as her "brothers and sisters" believe that ART was the best way to treat AIDS, but the support from "brothers and sisters" is also important in order to feel good and to create hope. Shifa's "brothers and sisters" make her feel included in a context where many PLWHA are stigmatized and excluded from social gatherings. Interestingly, Shifa said that her "brothers and sisters" also prayed for the nurses to attend to her properly and for the treatment to turn out well.

The opportunity that Shifa had of receiving support from her "brothers and sisters" was not the same experienced by her neighbor Toni, who belongs to the Old Apostles Church (an evangelical church). Shifa said: "[Toni] is living with *essa doença* [HIV/AIDS] and he used to receive visits and prayers from his church members. After sometime, the church members stopped visiting him." I decided to visit Toni, and we spoke about the business he had when he was not ill with AIDS and we also spoke about his illness. Toni said: "I do not care if I have *essa doença*. Life is short. I prefer to die happy than to die unhappy." Because of economic vulnerability, Toni does not have money to buy what he wants. Some of his friends offer him beer instead of giving him food. This might be one of the main reasons why Toni stopped having visitors from his church. Toni as well as other PLWHA with less support from family and friends become desperate about their lives because they think they will die soon. They become fatalistic without plans for the future.

The Zione Church also has a practice to help PLWHA. The Zione Church works with HIV/AIDS and focuses on abstinence (when people are young and can wait to start the first sexual debut) and fidelity in cases where people are married. In short, the Zione Church focuses on A and B (Abstain and Be faithful) in the ABC model. The Zione Church's pastor in the *bairro* "does not encourage the use of condoms" because he thinks that "condoms encourage promiscuity." A woman member of the Zione Church explained:

> I have been part of the Zione church since I was born. The church came from South Africa with Mozambican miners. The pastor of my church is also a healer. When members of our church have *essa doença* [HIV/AIDS], the pastor gives *congotela* [blessing in *Changana* language spoken in southern Mozambique] and he says prayers. Other members of the church also pray for the ill person and for their families. The pastor also gives *xikepo* [a mixture of herbs in powder form] to the ill people and to those who need to prevent HIV. People have *xikepo* in the food or drink. This mixture prevents the ill person from having diarrhea, fever, and tuberculosis [opportunistic diseases associated with AIDS].

In general, the Zione Church does not allow its members to go to the healer nor do they accept pastors to work as healers. The argument for the avoidance is that healers can say and do things that will magically harm people. However, in practice, some members visit healers, and some priests are even healers. The pastor I met is a healer, and he uses a mixture of herbs to help people living with HIV/AIDS in his church. In practice, medical pluralism is very common in *Mafalala,* and people search for different solutions to their health problems.

Members of the Zione Church living with HIV/AIDS that need to use the mixture of herbs in powder form pay a smaller amount of money between 20 MT-100 MT (about 0.44 - 2 USD) to the pastor. People that are not members of the Zione Church pay a sum of 500 MT (about 11 USD) for a bottle of 100 mg of herb powder. Many children that contracted HIV/AIDS through their mothers also take the mixture of herbs in powder form. Some people provide social support (e.g., visits to the ill members and their families) and prayer for people living with HIV/AIDS and their families to be spiritually strong to deal with the illness.

5.4. Summary

HIV testing and antiretroviral medication are available for free in the public hospitals and health centers in Mozambique as well as in the health centers close to *Mafalala.* Since many children have been born HIV positive in Mozambique, the Ministry of Health decided to make HIV testing mandatory for pregnant women, and all young women are highly recommended to undergo an HIV test. People commonly perceive that they are ill with AIDS when they start having physical symptoms such as prolonged diarrhea, black pimples on the skin, and a cough (which may be the result of HIV/AIDS related tuberculosis). When people experience these symptoms, they usually go to the health center for treatment. Many also go to non-western healers and use herbs to treat opportunistic illnesses related to AIDS. Various religious congregations also offer prayers and moral support to the afflicted and their families.

Social exclusion, lack of confidentiality from the health institutions, and ART side effects are among the factors that make people avoid HIV testing and taking the medication. Many poor and economically vulnerable people fear that a positive HIV test result will make them socially excluded. They may be considered "impure," "dirty," or said to have "stepped on a mine." They may suffer economically as well as psychologically as people in their social network might stop giving them economical, material, social, and moral support. Some people also believe that health institutions release false and wrong results of the HIV testing. Moreover, some nurses' patronizing attitudes increase the antipathy that poor people feel in relation to health institutions. This lack of confidence is worsened as some nurses are said to reveal people's HIV/AIDS status to others. Taken together, this may create distrust and exclusion, leading to both avoidance of being tested and non-compliance with treatment.

Several PLWHA that I met in *Mafalala* avoid ART because of the possible side effects of the medication, and they may even perceive that ART increases the illness because of the side effects. Many have difficulties understanding that the medication can result in different side effects for different people. Moreover, the fact that many PLWHA depend on others to tell them the time to take their medication makes them insecure and ashamed because of societal moral attributes concerning people with PLWHA. For these reasons, some people prefer to use herbs and non-western treatments offered by healers. In the next chapter, I will take a closer look at how stigma in relation to HIV/AIDS is understood and perceived among the inhabitants of *Mafalala*.

6
Perceptions of stigma

This chapter discusses healthcare practices, and ways in which the family and the community create and cause stigma toward PLWHA. One of the main obstacles for HIV/AIDS interventions is the stigma that prevents people from getting tested for HIV and being treated for AIDS. Research on stigma has been carried out since the second half of the twentieth century. The concept of stigma was discussed in-depth by Goffman (1963) who claimed that stigma refers to situations when individuals are hindered from enjoying social acceptance. The author explains that the word stigma originates from Greek, where it refers to physical signs that highlight something bad about the moral status of a person. Goffman notes that scholars have found it difficult to define and delimit the concept of stigma because it is related to various attributes, including concepts such as reduced, handicapped, and weak. The stigmatized individuals may find that they feel insecure about how normal individuals will identify and receive them. Goffman notes that stigma is understood as something that may cause shame. In relation to studies on HIV-related stigma, a number of authors (Thomas 2007; Holzemer et al., 2007; Castro et al., 2005; Skinner and Mfecane 2004; Parker and Aggleton 2003; Wingood 2007) have discussed how PLWHA suffer from stigma in their social networks and how and what people do to suppress and counter stigma. Moreover, stigma may also increase social inequality when economically vulnerable PLWHA are excluded from social contacts and consequently receive less support from their social networks (Parker and Aggleton 2003).

I noted that PLWHA in *Mafalala* are stigmatized in different contexts, such as within their family, among friends and neighbors, and at the workplace (cf. Parker and Aggleton 2003). The PLWHA whom I met said that they felt stigmatized because, among other things, people think that they became ill because they had been engaged in sex work or were promiscuous. Some people in *Mafalala* believe

that physical contact and kisses, and contact through the sharing of spoons, forks, plates, and chairs can transmit HIV. This is especially true when PLWHA have black pimples on the body, then others think they are infected with AIDS. Avoiding physical contact with PLWHA is common in many families. Abiba, a married woman in her 20s, experienced this, as her family members were afraid to have physical contact with her. She explained: "I do not share cups and plates with other people because they [the family] think they will be infected if they touch me." In general, many people show their fear against PLWHA with acts that let the ill person feel uncomfortable within their social network. However, there are families that respect the ill family members because they have accurate information about how HIV is transmitted.

Another example of physical avoidance was given by Toni. He said: "my friends do not invite me to chat every Friday as we always did before, as soon as they knew I was living with *essa doença.*" Yet another example that shows avoidance of PLWHA is given by Bela, a woman in her 30s. She said: "I lost my job [as a domestic worker] when my boss knew I was living with AIDS. She said she could not let me continue working for her because she has children. My boss paid me three months in advance and dismissed me." I was told that it is common that PLWHA are dismissed from their work after their boss learns about their HIV/AIDS status. PLWHA really fear this, despite there being a law (*Boletim da República* 2002) and policies (Conselho Nacional de Combate ao HIV/SIDA 2015, 2010, 2004) that at least in theory is supposed to protect them from being fired by their bosses because of their HIV/AIDS status.

Economic vulnerability is also related to the spread of HIV. Many people in *Mafalala* lost their jobs when the structural adjustment program *Programa de Reabilitação Económica*, PRE (Rehabilitation of Economic Program), was implemented in the country in 1987. Others lived through informal activities and lost their income and were forced into illicit activities such as the selling of sex, which contributed to the spread of HIV (see also Nhantumbo 2006). They were often very poor and economically vulnerable, and they became stigmatized as they contracted HIV. The social inequality in society, therefore, also contributes to increase the stigma (cf. Parker and Aggleton 2003).

6.1. Government policy and healthcare practices

This section will discuss the Mozambican Government's policy related to stigma and how the government has acted to reduce the stigma in the healthcare practices. Some years after the beginning of the HIV/AIDS epidemic in Mozambique, the government opened *hospitais dias* (day hospitals) to make it easier for PLWHA to get their ART medication and to do HIV testing. The idea of opening the day hos-

pitals was to avoid people having to wait in long queues when they wanted to do an HIV testing and to get treatment. In the day hospitals, some vulnerable people living with AIDS had the opportunity to receive a basic food basket to improve their nutrition intake. However, many people began to view the day hospitals negatively as they became known as the place for PLWHA; as a result, the government closed the day hospitals in 2009. The government realized that the day hospitals contributed to increasing the stigma toward PLWHA and to those who were testing for HIV. Some public health services in *Maputo* that worked with the day hospitals such as the *Alto Maé* health center, and the *Machava* and *Zimpeto* hospitals still have specific places for PLWHA and tuberculosis, but people in *Mafalala* as well as people from other *bairros* of *Maputo* city still feel that these hospitals carry with them a sense of stigma, despite the fact that the government closed the day hospitals.

From the government's point of view, stigma should be avoided. It was well known that many families stigmatize and exclude members of their family living with HIV/AIDS from social contacts and therefore make life increasingly difficult for these persons (see MISAU 2000; Conselho Nacional de Combate ao HIV/SIDA 2004). Accordingly, when PEN IV (2015-2019) was created, the strategy included a plan to decrease the stigma toward PLWHA. PEN indicates that all health professional should be aware about ethical issues, such as confidentiality and human rights, and that they shall treat PLWHA in the same ways as they treat other patients. This view was taken as a strategy to increase the number of people using the health services and feeling comfortable doing so (see Conselho Nacional de Combate ao HIV/SIDA 2015).

As discussed above, the health centers that I visited actually increased stigma because they used a specific container (plastic flask) for ART. This container was viewed as increasing the stigma toward PLWHA and their social networks. The PLWHA I met argued that they felt ashamed when they collected their ART medication in the container because many people know that it is for treating *essa doença*. They suggested that the health center should give the ART medication to PLWHA in a plastic bag similar to what people with other illnesses receive.

An example that illustrates how PLWHA feel about the container used to store the ART medication comes from a woman in her 20s. She asked me to go aside and said in confidence:

> This morning when I was cleaning the yard, I found three empty containers of *essa doença* in front of my neighbor's house. I felt comforted because I knew that I was not alone taking the ART medication, but there are people [in this *bairro*] who do not react well when they know that other people are on ART medication. They call me pejorative names such as rotten, damaged, and said I have stepped on the mine, among other things.

Talking to a nurse about the feelings that PLWHA have in relation to the ART container, a nurse said: "it is difficult to please people. I think that those who complain about the container are not interested in taking *comprimidos* [ART]." The nurse's response showed little concern about the social perspective and the stigmatizing impact of using the container for PLWHA. He was only concerned about the physical body and seemed unaware of the social perspective on health (see Marston et al., 2016, cf. Fassin 2007).

Some PLWHA claimed that they did not feel comfortable going to the health center or the hospital to collect the ART medication because they feared meeting people they knew. If they met somebody, he or she could tell other people that they were living with HIV/AIDS and begin to stigmatize them. Shifa shared what happened when she was going to the health center to collect ART:

> I was going to the health center and my neighbor was following me. When I turned around, he would hide. I changed path and he continued to follow me. I decide to continue walking despite him following me. I arrived at the health center and when I was collecting my *comprimidos,* he was hiding behind a tree. When I returned home, he was not following me. A few days after this event, I heard my neighbor's sister telling her friend that I had *essa doença*.

To reduce the stigma when picking up the ART medication and to avoid losing their jobs because of many absences from the work place, some PLWHA organize themselves in groups. They select one person per month that will collect the ART medication for all. Toni is part of a group. He explained:

> I am in a group of people living with *essa doença,* and each month one of us collects *comprimidos* in the health center for everybody. This helps everybody because we do not miss everyday activities, and it prevents other people from seeing us go to the health center every month and therefore start stigmatizing us.

In other parts of Mozambique, people also organize themselves in groups to collect the ART medication to reduce stigma (Groh et al. 2011) and to allow people to continue their workday without interruption (cf. Moyer 2015; Hardon and Moyer 2014).

6.2. Rotten and damaged – stigma in the community and the family

How people in *Mafalala* talk about PLWHA also increases the stigma. *Podre* (rotten) and *estragado* (damaged) are two words used among many people in *Mafalala* to refer to PLWHA. These words are associated with the way people describe sexual relations as "eating," especially when people talk in public or when there are children or strangers to avoid embarrassment. PLWHA are described as "rotten or damaged" because they are not sexually "edible." Because they are "rotten or damaged," they can cause health problems for people who have sexual relations with them.

The idea that people are "rotten or damaged" is associated in different ways for rich and poor PLWHA. Many people in *Mafalala* consider that both rich and poor people living with AIDS are "rotten and damaged." This means that rich and poor PLWHA are not expected to have sexual relations. However, rich PLWHA who have sexual relations are less stigmatized because they have money and are not economically vulnerable. As Abiba, a woman in her 20s explained:

> I know a rich woman who has *essa doença*. She does not look like a person who is living with *essa doença*. She is beautiful. She does not have black pimples on her body. She goes to *barraca* (tent) to meet sexual partners. Everybody in the *bairro* knows that she has *essa doença,* but people do not stigmatize her because she has money. She pays for drinks and food for her friends. She helps other people in the *bairro* when they need.

Stigma toward PLWHA is related to how people view them physically, socially, and economically. PLWHA can be stigmatized if their body goes through changes, such as having black pimples on their skin or losing weight. If PLWHA do not have material things to share with people in their social network, they are more likely to be stigmatized. However, it is when PLWHA body changes that less informed people start to fear that they can contract HIV from the ill person.

Many people I met in *Mafalala* said they were worried about sharing their HIV positive status with other people because of fear of what they would say and do against them. Many poor people became worried because they feared losing their jobs, income or moral support, including encouragement from their families and friends and being able to talk about other things in life. Other people shared their HIV positive status only with some members of their family to avoid having too many people know about their HIV/AIDS status. Some women expressed that they were reluctant to share their HIV positive status with other people because they would think of them as being sex workers, and they would be given pejorative names. Moreover, people who were HIV positive were sometimes accused of

spreading *essa doença,* as a woman in her 20s stated, "I tested HIV positive and I was worried about telling my family, relatives, and friends. I was worried that they would think I am sex worker."

6.2.1. Stigma toward women

Women living with HIV/AIDS often suffer more stigma than men in similar situations. Geary et al. (2014) argued that people in different contexts have various perceptions of stigma toward men and women living with AIDS. Accordingly, men and women are treated differently within the family, among friends, and at work when they disclose their HIV positive status. Women perceive that the stigma toward men living with HIV/AIDS is less than the stigma toward women living with HIV/AIDS. Stigma toward women living with HIV/AIDS often occurs when family members feel ashamed of having a woman living with HIV/AIDS in their family (cf. Wingwood et al., 2008; Skinner and Mfecane 2004). A woman with HIV/AIDS tends to be seen as someone who cannot control her sexual desires and in extension that means that her family had failed to control her sexual desires. Bela said:

> I left my *comprimidos* [ART] on a chair, and my nephew took them. I searched for the pills, but I did not ask anyone at home because I was afraid that everybody would know that I am taking *comprimidos*. After a day, I found the *comprimidos* on the table. My nephew told my father that he found some comprimidos and he asked a friend that is HIV/AIDS activist about them. His friend said that the *comprimidos* were antiretroviral medication.

When Bela's nephew found out about the ART medication, he told Bela's father who asked for a family meeting to talk about the *comprimidos*. During the meeting, Bela's father said that he did not want to know who was ill, but he wanted to say that he was upset and angry with the ill person because that person was damaging the family's name. It meant that the family had a "rotten and damaged" person that probably would not be able to build a new family and raise children. Bela's father as well as her nephew did not offer any moral support to Bela. The suspicion against her and the bad treatment she experienced made Bela not tell her family about her medication. Bela's experience and the stigma toward HIV positive women in general put light on how socio-cultural norms put women in a subordinate position.

Socio-cultural norms are also important when beginning a relationship, and these norms can be stigmatizing for poor women who cannot live up to them. In many families in *Mafalala* as well as in Mozambique, women are expected to

wait for men to approach them to begin a relationship. This kind of relationship is called *namorados* (stable dating), and it occurs in well off families or in families where young people have a permanent job, which means that they can organize the required ceremonies to formalize their relationship. In both poor and wealthy families, a woman is expected to bring her partner home and present him to his family, which will then evaluate him and see how he treats the woman's extended family. When both family evaluations turn positive, the families advise the couple to think about organizing a *noivado* ceremony that would make their relationship formal. *Noivado* is a ceremony restricted to the man and woman's family and close friends. In this small ceremony, the couple exchange rings and have a party. In addition, there are different kinds of traditional ceremonies: *nikai* is specifically for Muslims, *lobolo* is used in central and southern Mozambique, and *haruci* takes place when the woman is a virgin and her family formalizes her relationship. There is also an official recognition of a relationship by the government called *casamento civil* (official wedding and/or religious wedding that could be Muslim or Christian).

Most of the time, couples who can afford it carry out all three types of ceremonies: the traditional, the religious, and the official; the new family law of Mozambique acknowledges all kinds of marriages as long as people register them. Couples who cannot afford to organize these ceremonies may decide to live together until they have money to formalize their relationship (see Honwana 2013; Bagnol 2008; Granjo 2005; Junod 1996). In these relationships, it is the woman who is affected most. If she has a partner without engaging in any ritual, she runs the risk of being viewed as a sex worker, a *biscateira* that breaks socio-cultural norms (cf. Leclerc-Madlala 2009).

6.2.2. Stigma toward men

Men get different reactions from their families when they share their HIV/AIDS status. Toni said: "I told my family that I tested HIV positive. They said 'do not worry, it is the illness of the century.'" Toni was not worried about what people would think, say, or do to him; moreover, his family encouraged him to share his experience with other people, to help others to prevent HIV. In *Mafalala,* there is a generally held belief that men are more tolerated than women when they test HIV positive; furthermore, there are different moral standards, as it is acceptable for men to have multiple sexual partners. Similarly, Geary et al. (2014) showed that men with a HIV positive status were treated differently compared to women.

The different moral standards in Mozambique are related to the fact that men are commonly viewed as *caçadores* (hunters). They are expected to hunt and "eat" (have sexual relations) with all women they hunt. Men are expected to be "hunters," even if they are married or in a relationship. The more women they "hunt," the better they are (see also Leclerc-Madlala 2009). Sometimes, men in *Mafalala*

are said to be *gigolos*, men that have sex with rich women in exchange for money or goods. They may be accused of spreading HIV, but if they receive a lot of money and use the money to help their families, they are often less stigmatized. An example of this is Ivo, a man in his 20s that was building a house with four rooms for his family (see Chapter 2). Interestingly, in *Mafalala,* there are a few assumed homosexuals, and they are not commonly blamed for spreading HIV because ordinary people usually do not relate homosexuality with HIV/AIDS.

6.3. Summary

People with HIV/AIDS in *Mafalala* may become stigmatized in the health center, in the community, or within the family. They feel stigmatized because their families do not include them in social gatherings and consider HIV/AIDS to be different from other illnesses. Within the community, people give pejorative names to PLWHA such as "rotten" and "damaged" and, as was discussed in the former chapter, say that they have "stepped on a mine." Poor, uneducated people often believe that they can contract HIV through physical contact and thus, avoid having physical contact with PLWHA. They are often excluded from the social networks, which makes it difficult for them to make a living. Women living with HIV/AIDS are more stigmatized compared to men as their condition is interpreted as a sign of promiscuity, and poor people are more stigmatized than rich people.

In the health center, the container designed to keep the antiretroviral medication has a certain shape and color that signals that the patient has HIV/AIDS, which, in turn, may cause stigma. The government recognized that PLWHA were being stigmatized in the so-called day hospitals, so they changed their names, but the health centers still have a specific space for PLWHA to collect their medication. PLWHA organize themselves in groups to collect medication in the health center to avoid being seen by other people every month when they collect their medication in order to not be stigmatized. This also allows people living with HIV/AIDS to continue doing *biscatos*, temporary work, which gives them immediate cash since many people living with HIV/AIDS in *Mafalala* do not have a formal, regular job. In the next chapter, I will look at people's understanding of prevention and the underlying reasons why they may not prevent HIV/AIDS and protect themselves.

7
Understandings of prevention

This chapter will look at people's perceptions of HIV/AIDS prevention and their reasons for caring or not caring about prevention. The chapter will also discuss spiritual practices concerning prevention and the government's view on spiritual prevention. Furthermore, it will also discuss how poor people prioritize basic things in their everyday lives, such as acquiring food and paying for housing instead of HIV/AIDS prevention, and how this is related to how time is being perceived.

Starfield et al. (2008: 580) argue that the concept of prevention in health services "has expanded so that its meaning in the context of health services is now unclear." The authors made this argument on the basis of a review of the definition of prevention in the World Health Organization (WHO) and the Dictionary of Public Health, which says that prevention "covers measures not only to prevent the occurrence of disease, such as *risk factor* reduction, but also to arrest its progress and reduce its consequences once established" (ibid: 580). This definition, however, looks at prevention in the long-term and does not take into consideration how poor people may experience prevention in their everyday lives.

People in *Mafalala* use the word *kutivikela* (prevention) in *Changana*, one of the local languages spoken in southern Mozambique, to name everything that can be avoided that brings misfortune, not only illness. Many poor people think of prevention as some actions they take to prevent immediate misfortune, not actions that prevent long-term or future misfortune and they act accordingly. For example, people in the *bairro* cleaned the drainage only when they had signs that it would rain, to prevent their houses from being flooded (see Paulo 2004; Ingstad 1990). People use the word *kutivikela* when they discuss HIV prevention, which means it becomes more difficult to understand prevention in the long-term, which is how biomedicine defines it. In the beginning of the HIV/AIDS prevention campaigns,

some poor people thought they should use condoms all the time, even if they were not having sexual relations and it was said that people who contracted HIV would die within a short time.

Condoms are an effective way of preventing HIV/AIDS, although in many places there is resistance toward its use. In rural Malawi, Tavory and Swidler (2009) discussed why people resist using condoms. They used 600 diaries to show that people give meaning to condoms, which varies from context to context. Many rural Malawians said that condoms mean less intimacy and less commitment. The authors conclude that it is important to understand the emic perceptions of condoms, which needs to be included in the HIV/AIDS prevention campaigns.

Ethnographic studies carried out in south and central Mozambique (Matsinhe 2005; Manuel 2009, 2005) showed that people did not use condoms because they thought that condoms reduce pleasure, prevent reproduction, and contribute to a lack of trust between partners. Moreover, heterosexual couples did not use condoms because they believed that condoms inhibit pleasure as it felt "like plastic." In a study in a secondary school of *Maputo* city, Manuel (2005) noted that young people stated that they stopped using condoms when they trusted their *namorado-/a* (boy/girlfriend). This made it difficult to prevent HIV, STIs, and pregnancies. A similar study in rural Malawi by Tavory and Swidler (2009) showed that people did not use condoms because they thought that condoms inhibit pleasure and reproduction. These studies show what also occurs in *Mafalala*, namely that many people believe that condoms inhibit pleasure and reproduction.

Figure 3 House painted with condom advertisement in Mafalala (photo by the author).

In *Mafalala*, one may find advertisements for the condom brand *jeito* promoted by PSI through pamphlets and paintings on walls (cf. Pfeiffer 2004b). I took a photo of a pamphlet showing three kinds of condoms distinguished by numbers, colors, and flavors. Condom 1 is blue, condom 2 is red with a picture of a strawberry, and condom 3 is yellow with pink spots. I showed the photo to some people in *Mafalala* and asked them what their understanding was of what they saw. Abiba, a woman in her twenties, said:

> The photo shows *preservativos* (condoms) with various colors and flavors. People were accustomed to having condoms without a flavor. The older condoms distributed in the health centers smelled like medicine and people did not like it. The condoms without flavors were free, and people rejected them. Now condoms cost 10 MT [about 0.27 USD]. I think PSI is concerned with publicity and not about how people understand or feel about the condoms they advertise.

Abiba started comparing the old condoms without any flavors with the new ones. She understood that PSI released condoms with flavors to satisfy people that did not like the neutral condoms. Abiba also thought that PSI was preoccupied with marketing condoms and not concerned with how people will use or negotiate the use of condoms. For Abiba, the new publicized condoms were made to sell and not to make people be aware of HIV prevention. Another man in his seventies, who lived in *Mafalala*, claimed:

> They are many poor people who cannot read because they did not attend school to understand what PSI is saying about condoms with colors, numbers, and the writing. I heard people saying that each number of condoms is to be used with a different sexual partner so that people will not become fed up with using only one condom. Some people accept that PSI paints their houses with pictures of condoms because they receive money. It is not because they care about HIV prevention. … Many owners of the houses that paint their houses with pictures of condoms do not sell condoms. They only advertise condoms because they receive some money for that *publicidade* [advertisement].

The idea that condoms with flavors are to be used with different sexual partners is linked to ideas about condoms promoting promiscuity. This is the position held by some religious faiths in *Mafalala*; they believe that sexual relations are for reproduction and not for pleasure. The fact that condoms can prevent unwanted pregnancies is not discussed by these religious faiths.

CHAPTER 7

7.1. Access to Antiretroviral Medication

In Mozambique, Høg (2008) noted that ART has not been accessible to all people and considered this to negatively affect the human rights in Mozambique. Likewise, Biehl (2007) showed what PLWHA thought about the use of ART. He showed that marginalized people such as drug consumers and sex workers did not have the means to struggle with the bureaucracies of the health sector to get access to ART medication and showed that taking ART medication requires discipline. This includes getting enough sleep, eating healthy food, and having safe sex with condoms. People living in the street found it difficult to keep up with this discipline.

I found similar problems among people in *Mafalala*. Many PLWHA I met thought that ART medication is important for treating AIDS, but they complained that the drugs caused feelings of hunger and required them to eat a lot of food. However, as discussed above, many poor people do not have food to eat before taking ART because of lack of money and other resources (cf. Kalofonos 2010; cf. O' Laughlin 2015). A man in his 30s living in *Mafalala* explained:

> I had girlfriends that passed away with *essa doença*. After that I went to the health center to do HIV testing and I found out that I was HIV positive. After a few months, I started eating *comprimidos* [ART]. I take them once a day during the night and it makes me hungry. I have to prepare food to eat before and after I take the *comprimidos*. Taking the *comprimidos* makes me spend a lot of money and I do not have *machamba* [plot of land] to produce food like I had in my birthplace. I spend a great part of my income on food.

7.2. Caring and not caring about prevention

7.2.1. Reasons why people do not care about prevention

In *Mafalala,* I found six overall reasons why people do not care about prevention: i) socio-economic vulnerability (i.e., being pressured by the social network to have children and having sexual relations in exchange for money or goods); ii) the idea that they will learn what to do when the illness strikes; iii) inadequate information about HIV/AIDS; iv) the rumor that HIV testing is unreliable in the public health services; v) the existence of various sources that circulate different information about HIV/AIDS, creating confusion for people; and vi) people still think that HIV/AIDS is taboo.

Socio-economic vulnerability leads many people to interrupt the HIV/AIDS prevention programs, and many struggle to have food for themselves and their children. A woman in her 40s who lives in *Mafalala* said:

> I wake up about 3 a.m. everyday to go to the *fajardo* market to *guevar* [to buy cheap products such as tomatoes, onions, garlic, and lettuce]. I return home and I try to resell the products. If I manage to resell something early in the day, I know that I will have breakfast, which sometimes is the only meal my children and I have in the day.

The woman was concerned about making enough money to solve the basic problems in her family's everyday life. The woman did not prioritize going to the health service or waiting for the HIV/AIDS activists to come to her home to do the HIV testing. She just wanted the basic things to survive. Additionally, the lack of supportive social networks made many poor people prioritize other things than prevention efforts. A woman in her 20s said:

> My step-mother does not give me powdered soap to clean my clothes. She sometimes hides sugar so that I cannot have my tea. I do not have relatives with a stable life to help me. I finished my secondary school studies, but I do not have the means to continue studying. I cannot find a job. My step-mother keeps sending some boys to have sex in exchange for money or goods.

The fact that the young woman's step-mother did not offer her basic things can be seen as a way of pressuring the young woman to start relationships that will give her and her family material benefits. The pressure this young woman received from her family is similar to what many young people in poor families' experience. It may lead them to become involved in activities such as having sex in exchange for money and/or goods.

In *Mafalala*, many poor people cannot choose to abstain from sex work, as they need money to pay for their expenses. Some young people also have sexual relations in exchange for money to buy flashy fashion items, things that their families cannot give them. To choose abstinence can be for religious, health, safety, moral or legal reasons, but for many poor people in the *bairro*, abstinence is not an adequate way to prevent HIV transmission.

Many poor people in *Mafalala* express that they do not need to prevent HIV because they will learn how and what to do if and when the illness strikes. The way poor people make decisions on what to do is related to the difficulties they faces to live their present daily lives. A woman in her 30s said:

> Many people here [in the *bairro*] do not have the basics to live. People struggle to solve their problems on a daily basis. Prevention, as informed by the HIV/AIDS campaigns, is for the future.

Moreover, some people do not have a clear idea of what prevention means. Ivo said: "I do not prevent HIV/AIDS because there is no cure for AIDS. Even if I prevent HIV, I will die." For Ivo, prevention meant to solve the problem, and not to avoid being infected with HIV. Like Ivo, some people understand that prevention is something people do to solve a particular problem and if there is no solution, there is no need to focus on it. Other people claimed that HIV/AIDS has always existed in Mozambique, as Canaco, a man in his 70s said:

> In Mozambique, there were always people dying after they lose weight. The deaths were not advertised, that is why people did not know about HIV… Now that HIV is advertised, people are not surprised about HIV/AIDS. What is new is that there are many people talking about HIV/AIDS.

Moreover, Canaco pointed out that the information about HIV/AIDS does not target poor and illiterate people in an appropriate way. Rumors have also circulated about the HIV test results being wrong. In a group meeting with twelve young people in *Mafalala,* we discussed HIV/AIDS prevention, sitting under a huge mango tree because the temperature that day was close to 40 °C. Most of the young people were hesitant about doing HIV testing. A young man said:

> I am not going to do HIV testing. I know some people that went to the health center to do HIV testing; they gave blood and were asked to come back after a week. After a week, the result was HIV positive. These people were frustrated about the result, and they shared the result with some friends they trusted. Their friends advised them to repeat the HIV testing in another health center. This time the HIV testing result came out negative.

Similar stories have been heard by many people in Mozambique. These narratives make some people avoid undergoing the HIV testing because they do not trust the health services. A nurse I met commented about what the young man had said. The nurse explained that in the beginning of HIV testing in the 1990s, some health technicians mixed up the HIV testing results by mistake because they had little instructions, space, and appropriate instruments to store and identify the blood that they collected from various people. Therefore, some people received wrong HIV testing results. The nurse added that today it is rare that people get wrong HIV testing results because there are new ways of testing HIV.

The fact that there are various sources (Ministry of Health of Mozambique, NGO's, churches, and mosques) that circulate information about HIV/AIDS prevention creates confusion for some people. These sources are not coordinated, and the health technicians and HIV/AIDS activists are not trained in the same way, as a man in his 30s explained:

> Here [in *Mafalala*], we have many organizations working with HIV/AIDS. Sometimes we have three organizations visiting families, and they bring similar information to the families. I see activists behaving in different ways. Some are keen to use simple words to explain to people about HIV/AIDS, while others do not give messages in a simple way.

As a consequence, some people say that they do not understand the content and the language used to circulate the HIV/AIDS information. In all health centers, the Ministry of Health has created cabinets to provide information about HIV/AIDS using simple language, cartoons, and pictures. However, not all people know that there is this service, and the health technicians and HIV/AIDS activists do not always use a simple and understandable language to inform people about HIV/AIDS. An example that illustrates the lack of communication was given by Toni:

> Before the nurse attended to us, she gave a small speech about HIV/AIDS prevention. She used pamphlets to illustrate what she was saying and she spoke in Portuguese. She said that HIV/AIDS is an epidemic that affects our country. We all have to prevent HIV by knowing our *seroprevalência* [serological] status. We need to do free counseling and HIV testing and she advised us to voluntarily do the HIV testing.

Toni said that he did not understand what epidemic and *seroprevalência* means, and he felt that the nurse did not give space for questions and answers. Toni as well as some people in the meeting felt that the nurse was poorly prepared for communicating with people. The information was not offered in privacy to ensure confidentiality between people, and the health technicians and people did not understand the technical terms. Many people also avoid talking about HIV/AIDS and how to prevent it. Bela, a woman in her thirties, said:

> There are many deaths related to *essa doença* [HIV/AIDS] in this *bairro*. The main problem is that people still see HIV/AIDS as taboo. People should talk about HIV, and people that know more about HIV/AIDS should explain to other people what HIV is and how people can prevent it.

This taboo about HIV/AIDS is related to the fact that sexual relations are the main way of contracting HIV. Some people, such as members of religious congregations and elderly people, consider that issues on sexuality cannot be talked about in the public sphere. This reluctance to talk about sex influences the HIV/AIDS prevention efforts. Many people feel embarrassed and, consequently, do not pay attention to the HIV/AIDS prevention issues. Prevention is also related to how people think about and relate to trust and sex. As a woman in her 20s said:

> I prevent myself from getting HIV, but I do not have warranty that I will not get infected with HIV because I am not sure if my partner also prevents himself. I trust my partner and we do not use a condom.

Some studies in southern Africa showed that once couples trust each other, they stop using a condom. The idea of trusting the partner, thus, not using a condom is commonly held among couples in southern Africa (cf. Leclerc-Madlala 2009; Manuel 2005). Leclerc-Madlala (2009) showed that in the beginning of many relationships in southern Africa, couples said they used a condom but after they trusted each other they stopped using it. According to Leclerc-Madlala (ibid.), the decision to stop using a condom puts couples in a high risk situation because many men in southern Africa affirmed that they had multiple sexual partners. Similarly, in *Mafalala*, I found that young people held similar ideas and behaviors.

7.2.2. Reasons why people care about prevention

There are two main reasons why people in *Mafalala* care about prevention: i) people think that HIV/AIDS prevention will help them to plan a better life and ii) people believe that prevention will stop the spread of HIV/AIDS. In relation to the first point, Abiba said: "prevention starts by receiving counseling and testing, using condoms, and accepting treatment." Abiba continued: "I did HIV testing after I got syphilis. After I recovered from syphilis, I continued doing HIV testing because it is the best way that I have to continue having a better life." Abiba did know the relevance of doing HIV testing, but syphilis gave her the incentive to actually do it.

Some people in *Mafalala*, in particular educated people, believe that prevention is important to stop the spreading of HIV/AIDS. Generally speaking, HIV/AIDS campaigns are not set up in relation to poor and less educated people's living situation and perspectives. Educated people are privileged because they understand the prevention information, and they voluntarily decide to undergo HIV testing. A young man in his 20s said: "I have a girlfriend, and before we began to have sexual relations we decided to do HIV testing to check that neither of us was infected with HIV." The young man and his girlfriend are studying in one of the private universities in *Maputo*. They belong to middle class families living in the *bairro,* and they are in a position to make more choices in their lives. In general, issues concerning prevention are strongly related to people's socio-economic situation.

7.3. Spiritual prevention

Besides public and private health services in urban and rural areas in Mozambique, many people also search for healers to spiritually prevent HIV and other illnesses. People engage in the so called spiritual prevention because they believe that they can become ill with AIDS or other illnesses if somebody spiritually provokes the illnesses (see also Tenkorang et al., 2011; cf. Thomas 2007).

There are many kinds of divination systems in *Mafalala,* depending on the origin of the traditional healer and how she/he has been trained. I was informed about three kinds of divination systems. The first is *tindjolo* (divination with animal bones and stones). A healer from southern Mozambique explained how he performs the *tindjolo* divination: "Before I give the root to prevent HIV, I first divine with *tindjolo* to know how many times I should give the roots and what kind of procedure I should follow. Each client has their own procedure of preventing HIV." The second way of divination is with a mirror. This practice is mainly carried out by traditional healers from northern Mozambique. The healers ask the mirror what problems the clients have, and the mirror gives a response that the healers can see. It is said that clients can also see the response if the healer prepares them to see. The third way of divination is using the Koran. In this kind of divination, the healers ask what problems the clients have, and they will find a response in the Koran. Many healers that use the Koran are not well regarded by some Muslims in *Mafalala* because they believe that healers are *ni mazunga* (distorting things).

Two healers that I met from northern and southern Mozambique living and working in *Mafalala* said that "there are two ways to spiritually prevent *essa doença* [that are commonly combined]: through "vaccination" with dry and burned frog bones and, secondly, consuming the decoction of a root [with the vernacular] name *dema la kutxuca."* The healers said that the spiritual "vaccine" with the dry bone from frogs should be renewed every year. For spiritual "vaccination," the healers explained that they make two small cuttings with a razor blade close to the clients' genitals and insert dry and burned bones from frogs. The healers and many people believe that they will be protected from HIV when the blood comes in contact with the mixture of burned roots and the frog bones. Healers and their clients believe that dry and burned frog bones spiritually clean the body and prevents HIV. As mentioned, some people also believe that they can contract HIV through bad spirits. Witches are entities that people believe can act through bad spirits to cause misfortune. The idea of getting the "vaccine" using bones from frogs is that this will prevent the witches from acting through bad spirits and creating HIV/AIDS by affecting the spiritual body of a person. Her/his spiritual body will then be like a frog that jumps away if witches try to put a bad spirit on it.

The second method people use to prevent HIV is through the decoction of a root called *dema la kutxuca.* This root is used to spiritually clean the body before people go to the health center to test for HIV. People also use the root after they know about their HIV positive status. Bela, a woman in her 30s, took *dema la kutxuca* before she did HIV testing in the health center to spiritually clean her body. Bela said:

> I took *dema la kutxuca* two weeks before I decided to do the HIV testing. I received instructions from my uncle [that is a healer] to eat roots to prevent HIV. My uncle told me to first spiritually clean my body and then to go to the health center to do HIV testing. After I spiritually cleaned my body, I did the HIV testing and the result was HIV negative.

Bela as well as other people I met in the *bairro* said that *dema la kutxuca* does not cure HIV/AIDS, but taking it frequently helps people to live a better life.

7.4. Summary

HIV/AIDS prevention is a complex issue in *Mafalala*. Many poor people perceive prevention as a cure, and not as something to do in order to avoid future health problems. Prevention is also seen as something people do when they have to solve some immediate problem. In contrast to this, the HIV/AIDS campaigns disseminate prevention as something people do to avoid becoming ill in the future. From the perspective of the HIV/AIDS prevention campaigns, prevention means to give the right information and to guide people to go to the hospital or health center for advice and for HIV testing and treatment. Additionally, people get various and sometimes contradictory information about HIV/AIDS prevention from different sources, such as religious congregations, health centers, and national and international organizations. Hence, it becomes difficult for people to transform the information they receive into a kind of knowledge they can use and understand in everyday life.

In *Mafalala*, the HIV/AIDS campaigns promote the use of condoms for those who do not abstain from sex. Some religious congregations, on the other hand, do not encourage people to use condoms. Instead, abstinence is the main message that religious leaders give to their members, especially to young people. This is particularly difficult for people who make a living through sex work and for those who cannot negotiate the use of condoms, and for people that have sexual relations without condoms to receive more cash or other assets from their partners. Prevention through condom use often clashes with religious and family ideals concerning relationships and reproduction. The HIV/AIDS prevention campaigns

have been carried out in the public spheres, with little sensitivity to the kind of public involved and without an understanding of people's own understanding of condom use and how people may look upon prevention from non-western and spiritual perspectives. Accordingly, people may not understand, or misunderstand, the information they get from the HIV/AIDS prevention campaigns.

8
Conclusion

The aim of this thesis is to inquire into how some of the most vulnerable people in Mozambique, the urban poor, experience and understand the HIV/AIDS epidemic and the government's efforts to control it. Based on eleven months of fieldwork in the poor urban area, or *bairro, Mafalala*, the study explores people's socio-cultural practices, ideas, and living conditions in relation to HIV/AIDS, or *essa doença*, as it is locally called. Hence, I am particularly interested in how people perceived they contract HIV, how they think they become ill, how they treat AIDS, and how of all this interplays with the government's view on the epidemic. I am also personally engaged in the topic of this research. Specifically, I have seen some friends and relatives die because of AIDS and opportunistic diseases. Some of them did not feel comfortable to share their HIV/AIDS status with other people because of the fear of being stigmatized. They also lacked knowledge about the epidemic and how to deal with it, knowledge that would have made their everyday struggles easier.

The HIV/AIDS epidemic is a huge problem in Mozambique. The country, which is one of the poorest in the world, has an average HIV prevalence of about 11%. Girls and women aged between 15-24 years are the most vulnerable to contract HIV (Conselho Nacional de Combate ao HIV/SIDA 2015). The HIV prevalence in *Maputo* is about 17%. The high prevalence of HIV/AIDS in the capital city is commonly explained by government sources as the impact of circular migration between *Maputo*, South Africa, and Swaziland, multiple partners, and men who have sex with men and their partners (Conselho Nacional de Combate ao HIV/SIDA 2015; INSIDA 2009). During my fieldwork in *Mafalala* in 2014, some of the people I met as well as many other residents died because of HIV/AIDS and others tested HIV positive. There are no statistics on the prevalence of HIV in *Mafalala,* but the fact that the government promotes HIV/AIDS campaigns in the

bairro indicates that there are many people who are vulnerable to being infected with HIV/AIDS in *Mafalala*.

As a national response to the HIV/AIDS crisis, Mozambique has since 1988 acted in different ways to reduce the number of people being infected with HIV. One important measure has been to promote campaigns in which international and national NGOs circulate information on HIV/AIDS counseling, testing, contraction, prevention, and treatment. These campaigns have mainly been based on surveys assessing individuals' sexual behavior and their risk of contracting HIV. The campaigns on behavioral change have promoted abstinence from sex before marriage, being "faithful to one sexual partner," and/or "reducing the numbers of sexual partners to a single partner," "delay in the sexual debut for young people," and "male and female condom use" (INSIDA 2009: 6). It is not until recently that these campaigns have also begun to include more socio-cultural informed ways to prevent new infections (Conselho Nacional de Combate ao HIV/SIDA 2015). Over the years, the campaigns have mainly emphasized an individual perspective, focusing on individual responsibility and individual behavior in relation to the HIV/AIDS epidemic.

The Mozambican Government has tried to respond to the HIV/AIDS epidemic by producing the National Strategic Plans to Fight HIV/AIDS (PEN), and the first PEN was launched in 2000. The PEN currently in force is PEN IV. The first three PENs highlighted the role of individuals' behavior, which implied insufficient attention to socio-economic and cultural factors in policy and planning. This individual approach mainly focuses on disease (Kiefer 2007) and not on the social perspective to prevent and treat HIV/AIDS. Actually, there is a shift in the government approach, and PEN IV focuses more on the social perspective, which includes the family and other social actors in the fight against HIV/AIDS. The four PENs provide various information and guidance about HIV/AIDS infection, prevention, and treatment. However, much of this information is difficult or impossible for poor people to transform into knowledge that is usable in their daily lives (cf. Drobac et al., 2013). In *Mafalala*, people were of the opinion that the Government and the NGOs working with HIV/AIDS prevention in the *bairro* rarely ensured that poor people understood the biomedical information that was disseminated.

The implementation of the PENs in *Mafalala* is made in collaboration with associations, national and international NGOs, and the Ministry of Health (cf. Joralemon 2017), which together disseminate information about HIV/AIDS. The government has also worked with the Institute for Traditional Medicine and trained some healers, although there have been doubts about whether this cooperation has been sufficiently adapted to the healers and their illness explanations and methods. In addition, there is no public health center in *Mafalala* to deliver service to residents. There is only one private health center, which does not meet

the needs of the poor, as the fees are high. The NGOs working with HIV/AIDS in *Mafalala* do not have an office in the *bairro*, and the activists are young and tend to work without adequate supervision. Generally, the inhabitants of *Mafalala* have little confidence in most of the activists and their work.

The focus on individual responsibility and individual behavior, which is informed by the biomedical perspective, does not fully take into account that health problems are also social problems and that people's struggle for health and well-being is also a social act. Health problems are often related to deep poverty, a limited agency, stigma, and cultural perceptions. In *Mafalala*, people's health problems cannot be distinguished from their social problems. On the contrary, their suffering is social and affected by political, economic, and institutional powers. This social suffering involves their family, neighbors, and their wider social network. People's powerlessness, and their limited agency and choices, can here be understood in terms of structural violence (cf. Farmer 2004), as this is related to the overarching structuring of society. The outcome is an embodiment of marginalization, inequality, stigmatization, and hunger. Limited agency reduces the possibilities to respond properly to both health problems and social problems in the daily struggle against deep poverty and its consequences. However, this does not mean that people are totally without choices. Both HIV/AIDS afflicted persons and their families do take action and make choices relating to HIV/AIDS on a daily basis.

Accordingly, based on a people-centered approach that focuses on the needs of local people in the local context, this thesis argues that the HIV/AIDS epidemic in *Mafalala* is closely related to a situation of deep poverty, an everyday struggle for the most basic necessities, a patronizing and insensitive health sector, stigmatization of PLWHA, cultural perceptions, and gender values. Moreover, the study shows that understandings, treatments, and local prevention efforts concerning HIV/AIDS are related to religious, spiritual, and ethnomedical practices. These insights are necessary in order to combat HIV/AIDS and to understand why the disease continues to spread in *Mafalala* despite the fact that HIV/AIDS campaigns are promoted.

Mafalala was chosen as the ethnographic case for this study for various reasons. Many of its inhabitants are extremely poor and live by making money from temporary work. Many houses lack electricity and basic sanitation; moreover, the streets become flooded during the rainy season, which makes it difficult to trade and do temporary work. To survive, many are forced to make a living through transactional sex or sex work for longer or shorter periods. In *Maputo*, *Mafalala* is known as the place where one should go to find a sexual partner and engage in a temporary relationship. All of this makes people vulnerable for HIV transmission. This also means that many people in *Maputo* believe that *Mafalala* is a neighborhood where many people are HIV-positive. In *Mafalala*, many are vulnerable to

HIV infection as they may be dependent on sex work for their survival and cannot negotiate the use of a condom. Married women often have to accept their husband's infidelity in order to be seen as a "good" and tolerant wife. If they are poor and economically dependent, they may also have to accept being abused by their husbands.

People in *Mafalala* use a combination of biomedical explanations and other cultural beliefs when they explain how they contract HIV. Overall, they discussed four different ways of contracting HIV, namely: "*carne a carne"* (lit. "meat to meat"), infected condoms, the sharing of cutting instrument (e.g., needles and blades) without sterilization, and "bad spirits." First, "meat to meat" refers to sex without a condom. Many people believe that intercourse without a condom increases the pleasure and it also gives a possibility to reproduce. Sex workers, such as *biscateiras* and *gigolos*, claim that they accept to have sexual relations without a condom when their clients pay a large amount of money. Second, some people believe that national and international NGOs, together with the government, conspire to infect poor people with HIV through the distribution of free condoms perceived to be of low quality. Many in *Mafalala* feel excluded from the Mozambican society when they are given these condoms, as there are condoms of higher quality sold in the shops in *Maputo* city. Third, people learned from the HIV/AIDS campaigns that they could contract HIV if they share cutting instruments without sterilization. This relates to the practices of health professional, healers, and people in general when they use blades and needles. Fourth, many poor people believe that they can contract HIV when somebody "buys" a "bad spirit" from an unscrupulous healer, witch, or sorcerer, give it the name of HIV/AIDS, and "throw" it on them. Often, a person they know well, such as a family member, is said to have done this. The victim will then have HIV/AIDS caused by a "bad spirit."

Commonly, people in *Mafalala* perceive they become ill with AIDS when they start observing physical symptoms, such as black pimples on their bodies, weight loss, or persistent diarrhea. These symptoms usually occur when the ill person is in the last stages of the illness. Often, it is when people observe these symptoms that they go to the health center and/or to a healer. People in Mozambique as well as in *Mafalala* seek out healers for various reasons. First, people believe that the illness can occur "naturally" or be caused by a "bad spirit." When the illness is "naturally" caused, the ill person commonly goes to the hospital, and the medical doctors diagnose and treat it. When the illness is considered to be caused by a "bad spirit," on the other hand, the ill person cannot be diagnosed and cured by the biomedical system. It is only healers who can remove the "bad spirit." Second, many poor people do not have the possibilities and knowledge to transform the cultural and social, often insensitive, information they receive in the health institutions into knowledge they may use in their daily lives and therefore may lack confidence in biomedical treatments. Third, health professionals' technical language and lack of

time often make people choose healers. Fourth, the experience people have from their families and community of seeking treatment from healers make them trust healers before other kinds of health institutions. Fifth, healers make an individual appointment with their clients in private, when other people cannot see them. This makes people feel confident that others will not know that they are ill.

The stigma surrounding HIV/AIDS in the health institutions, in the community, and within the family; rumors that the results of the HIV testing are wrong because of poor equipment in the health institutions as well as some nurses' patronizing attitudes have meant that some people avoid HIV testing altogether. People on ART commonly interrupt their treatment for social and economic reasons. Many are afraid that they will be socially excluded. Economically, people fear that they will lose material support from their family and friends if they disclose that they are HIV positive. PLWHA may also avoid taking antiretroviral medication because of side effects, which causes them to believe that the medication makes the illness worse. In *Mafalala*, stigma takes many different expressions. Poor women who suffer from HIV/AIDS are more stigmatized than others as their illness is seen as a sign of promiscuity. Antiretroviral medication is handed out in a specific place at the health center, and distributed in a specific container that signals that the patients have HIV/AIDS. To avoid being stigmatized, people have therefore organized themselves in groups and take turns to collect the medication for several people.

In *Mafalala*, people's economic conditions and socio-cultural perceptions also affect HIV/AIDS prevention. Among those who live in deep poverty, their understanding of prevention and prevention campaigns are closely related to socio-economic realities and priorities, i.e., what people think is most important to do to get through the day and what can be left for later. The embodied suffering that people experience makes it difficult to make choices about even the most basic issues and even more difficult to make plans for the future. Many in *Mafalala* see prevention in relation to actions carried out when there is an immediate problem. Moreover, prevention campaigns in *Mafalala* have often been carried out without being sensitive to people's own religious, non-western and spiritual perceptions and understandings.

From an anthropological point of view, biomedical perspectives and the implementation of policies must be related to a people-centered health delivery approach, where the need and care of people in the local context is in focus, rather than specific illnesses. In this approach, people and health institutions work together to empower the people in need as well as the wider community. Accordingly, the social perspective on health (Farmer et al., 2013; Kleinman 2010; Kleinman et al., 1997) is important to understand how poverty and socio-economic conditions influence health problems and vice versa. Healthcare goes hand in hand with poverty reduction, and healthcare delivery can only be improved and made

more effective by being sensitive to both individual and social needs. This will contribute to people's access and acceptability, in relation to biomedical health institutions. The stigma and social exclusion experienced by many residents of *Mafalala* suffering from HIV/AIDS clearly shows that a people-centered health delivery approach is needed.

In *Mafalala*, as well as in similar urban settings in Mozambique and elsewhere, such as in Southern Africa, where urban poor people are severely affected by HIV/AIDS, there is a need to find ways to create more stable incomes to improve life in general. At the same time, it is important to support those that are sick. This could be done by paying neighbors a small fee to help those that are sick, with preparing and buying food, and by helping them to take their medicine on time. In addition, a closer cooperation with healers could help to bridge the gap between the biomedical and the non-western, "traditional" health sector. Healers could be educated concerning biomedical interventions for HIV/AIDS and take part in information campaigns. Biomedical staff could be educated about the healers' treatments and learn about why people seek out healers.

In *Mafalala* as well as in similar settings in Mozambique, the Ministry of Health should provide more supervision of activities related to HIV/AIDS. NGOs working with HIV/AIDS should be better at reporting about their activities and results. The Ministry of Health could also carry out dialogues with people to know about their satisfaction or dissatisfaction related to the information and services they receive. The Ministry of Health and the NGOs should guarantee that activists working for different organizations receive adequate and similar training and that HIV/AIDS activists representing different organizations transmit similar information. Local authorities, associations, NGOs, and religious leaders working with HIV/AIDS programs in their congregations should work together to discourage people in *Mafalala* from discriminating against PLWHA and emphasize that giving pejorative names to PLWHA is counterproductive and does not help in the fight against the epidemic. In the health centers, containers with ART medication should be of the same shape and color as for other medication. The day hospitals that still work with PLWHA should be utilized by other kinds of patients as well to reduce the stigma people experience in visiting these hospitals.

CHAPTER 8

Svensk sammanfattning (Swedish Summary)

Avhandlingen undersöker hur några av de mest sårbara människorna i Mocambique, de urbant fattiga, upplever och förstår HIV/AIDS epidemin och regeringens försök att kontrollera den. Studien, som är baserad på elva månaders fältarbete i det fattiga urbana området *Mafalala*, Maputo, undersöker människors sociokulturella praktiker, idéer, och levnadsförhållanden i förhållande till HIV/AIDS. Av särskilt intresse är att undersöka hur människor upplever att de får HIV, hur de anser sig bli sjuka, hur de behandlar AIDS, och hur allt detta samspelar med regeringens syn på epidemin. Sedan år 2000 har regeringen försökt bemöta HIV/AIDS krisen genom strategiska, nationella planer. Dessa har framför allt varit fokuserade på individuellt beteende och inte tagit tillräcklig hänsyn till socioekonomiska och kulturella faktorer. Det är inte förrän nyligen som dessa strategiska planer också börjat fokusera mer på sociala perspektiv, inklusive familjen och andra sociala aktörer, i kampen mot HIV/AIDS.

Ett biomedicinskt perspektiv med fokus på individuellt ansvar och individuellt beteende tar inte tillräcklig hänsyn till att hälsoproblem också är sociala problem och att människors kamp för hälsa och välbefinnande också är en social handling. Hälsoproblem är ofta relaterade till djup fattigdom, begränsad agens, stigma och kulturella föreställningar. I *Mafalala* kan inte människors hälsoproblem skiljas från deras sociala problem. Lidandet är socialt och påverkas av politiska, ekonomiska och institutionella krafter. Detta sociala lidande inbegriper familj, grannar och det större sociala nätverket. Människors maktlöshet och deras begränsade agens och valmöjligheter kan här förstås i termer av strukturellt våld eftersom det hänger samman med samhällets övergripande strukturering. Resultatet är ett förkroppsligande av marginalisering, ojämlikhet, stigmatisering och hunger. En begränsad agens reducerar möjligheterna att på tillfredsställande sätt bemöta både hälsoproblem och sociala problem i den dagliga kampen mot djup fattigdom och dess konsekvenser. Detta betyder dock inte att människor är helt utan valmöjligheter. Både personer med HIV/AIDS och deras familjer agerar och gör dagligen val avseende HIV/AIDS och relaterade problem.

Utifrån ett perspektiv som fokuserar på människor på lokalnivå och deras behov argumenteras det i avhandlingen för att HIV/AIDS epidemin i *Mafalala* står i nära relation till djup fattigdom, en daglig kamp för grundläggande nödvändigheter, en nedlåtande och okänslig hälsosektor, stigmatisering av människor med HIV/AIDS, kulturella föreställningar och värderingar avseende genus. Studien visar också att förståelser, behandlingar och lokala preventionsinsatser avseende HIV/AIDS är relaterade till religiösa, andliga och etnomedicinska praktiker. Dessa insikter är nödvändiga för att bekämpa HIV/AIDS och för att förstå varför sjukdomen fortsätter att spridas i *Mafalala* trots att HIV/AIDS kampanjer genomförs. I

Mafalala är många sårbara för HIV infektion eftersom de är beroende av sexarbete för att överleva och för att de inte kan kräva kondomanvändning. En gift kvinna måste ofta acceptera att hennes man är otrogen för att betraktas som en ”god” och tolerant hustru.

Människor i *Mafalala* kombinerar biomedicinska förklaringar och andra kulturella idéer och föreställningar när de förklarar hur någon smittas av HIV. Den första förklaringen, ”kött mot kött”, refererar till sex utan kondom. Många anser att samlag utan kondom ökar njutningen samtidighet som det ger möjlighet till reproduktion. Sexarbetare hävdar också att de accepterar samlag utan kondom när sexköparen betalar en stor summa pengar. Den andra förklaringen bygger på föreställningen att organisationer och regeringen konspirerar för att infektera människor genom att dela ut kondomer som anses vara av låg kvalité. Människor upplever sig exkluderade när de får dessa samtidigt som kondomer av högre kvalité säljs i butiker. Den tredje förklaringen är att HIV/AIDS kan överföras genom osteriliserade nålar och knivar. Den fjärde förklaringen bygger på föreställningen att någon skickat en ”dålig ande”, som ges namnet HIV/AIDS, på en person som då infekteras. Ofta anses en person som står offret nära att var den skyldige, såsom en släkting.

I *Mafalala* söker sig människor till botare av olika anledningar. Om en sjukdom anses vara orsakad av en dålig ande kan den sjuke varken diagnosticeras eller botas av det biomedicinska hälsosystemet. Den dåliga anden måste då istället avlägsnas av en botare. Många har också ett bristande förtroende för det biomedicinska hälsosystemet och har svårt att översätta den ofta socialt och kulturellt okänsliga hälsoinformationen till något användbart i det dagliga livet. Hälsovårdsarbetares tekniska språk och tidsbrist får också människor att istället välja botare. Människor väljer också, och litar på, botare utifrån andras erfarenheter. Dessutom träffar botare sina klienter privat. Det får människor att känna sig trygga eftersom andra inte kan se att de är sjuka.

Stigma avseende HIV/AIDS på hälsoinstitutioner, i samhället, inom familjen, rykten att HIV test blir felaktiga på grund av dålig utrustning, och en del sjuksköterskors nedlåtande attityd, har inneburit att en del människor undviker HIV tester. Människor som genomgår antiretroviral behandling avbryter denna på grund av sociala och ekonomiska orsaker. Många är rädda att de ska bli socialt exkluderade och förlora ekonomiskt och materiellt stöd från familj och vänner om det kommer fram att de är HIV positiva. De kan också undvika medicineringen på grund av sidoeffekter. Fattiga kvinnor med HIV/AIDS stigmatiseras i högre grad eftersom deras sjukdom ses som ett tecken på promiskuitet. Dessutom delas antiretrovirala läkemedel ut på särskilda platser i hälsoinrättningar och medicinen ges i särskilda behållare. Detta signalerar till andra att patienten har HIV/AIDS. För att undvika stigmatisering brukar därför flera personer organisera sig och en person i gruppen hämtar ut medicinen också för de andra.

I *Mafalala* är prevention och de preventionskampanjer som genomförs nära sammanlänkade med människors ekonomiska förutsättningar, dagliga prioriteringar och sociokulturella föreställningar. Det förkroppsligade lidande som människor upplever ger få valmöjligheter även när det gäller det mest basala i livet och det gör det svårt att planera inför framtiden. Många i *Mafalala* ser prevention som sammanlänkat med handlingar som genomförs när det föreligger ett omedelbart problem. Preventionskampanjer i *Mafalala* har dessutom ofta genomförts utan känslighet inför människors religiösa, icke-västerländska och andliga upplevelser och föreställningar.

Istället för ett fokus på specifika sjukdomar måste biomedicinska perspektiv och implementering av policy relateras till människors behov på lokalplanet. Ett sådant scenario kräver ett samarbete med hälsoinstitutioner för att öka agensen och handlingsutrymmet hos dessa människor. Utifrån detta sociala hälsoperspektiv är det viktigt att förstå hur fattigdom och socioekonomiska förhållanden påverkar hälsoproblem och vice versa. Hälsovård går hand-i-hand med fattigdomsminskning och kan endast förbättras och effektiviseras genom en känslighet inför både individuella och sociala behov. Detta bidrar i sin tur till människors tillgång till vård och acceptans inför de biomedicinska hälsoinstitutionerna.

I *Mafalala*, på samma sätt som på andra urbana platser i Mocambique och på andra ställen, såsom i södra Afrika, där fattiga människor har drabbats allvarligt av HIV/AIDS, finns ett behov att skapa mer stabila inkomster för att förbättra livet i allmänhet. Samtidigt är det viktigt att stödja de som är sjuka. Detta skulle kunna göras genom att betala grannar en mindre summa för att hjälpa de sjuka med att köpa och laga mat och hjälpa dem att ta sina mediciner vid rätt tidpunkt. Dessutom skulle ett nära samarbete med botare kunna minska klyftan mellan den biomedicinska sektorn och den icke-västerländsk, ”traditionella” hälsosektorn. Botare skulle kunna utbildas avseende biomedicinska interventioner mot HIV/AIDS och delta i informationskampanjer. Biomedicinsk personal skulle kunna utbildas avseende botarnas behandling och om varför människor söker sig till botare.

Både i *Mafalala* och på liknande platser i Mocambique bör hälsoministeriet öka sin tillsyn avseende HIV/AIDS relaterade aktiviteter. Icke-statliga organisationer bör förbättra sin rapportering avseende aktiviteter och resultat. Hälsoministeriet skulle också kunna genomföra dialoger med människor avseende hur nöjda de är med den information och service de erbjuds. Alla aktivister som arbetar med HIV/AIDS bör också få tillräcklig träning. Lokala organisationer och myndigheter, icke-statliga organisationer och religiösa ledare bör samarbeta mot diskriminering av människor med HIV/AIDS. I hälsoinrättningar bör behållare för HIV/AIDS läkemedel ha samma färg och form som andra läkemedel. De dagsjukhus som används särskilt för HIV/AIDS patienter bör också användas av andra patienter för att minska den stigma människor upplever när de besöker dessa sjukhus.

Appendix: Households selected for long-term participant observation

N.	Members in the household	Members with HIV/AIDS	Children	Economic activities/ support	Other
1	5	Woman in her 20s	3	Informal trading in front of the house Transport of water and merchandise	Belong to Methodist Episcopal Zion Church Section A
2	2	Man in his 20s	-	Carrier in harbor Support from family	Belong to Universal Church of the Kingdom of God Section C
3	6	-	2	Trading home-made biscuits	Belong to Pentecostal Church Consult healers Section C
4	8	-	4	Selling snacks in front of the house	Belong to Universal Church of the Kingdom of God Consult healers Section A
5	4	-	2	Selling second-hand clothes in the informal market	Belong to Muslim congregation Section C
6	4	-	2	Selling second-hand clothes in the informal market	Belong to Muslim congregation Section B
7	5	Man in his 30s	3	Formal employment	Consult healers Section A
8	5	-	2	Carpenter Selling snacks in public institutions	Consult healers Section C
9	7	Woman in her 40s	3	Selling food and other items from own tent	Consult healers Section C
10	10	-	6	Owner of a small hotel	Consult healers Belong to Muslim congregation Section B
11	4	-	1	Healing activities Selling tobacco and coal in the yard	From Northern Mozambique Section A
12	4	Man in his 30s	2	Healing activities	Belong to Muslim congregation Section B

References

AAA (American Anthropological Association). 1996. *Ethical Code*. Washington DC.

Agha, Sohail, Karlyn, Andrew and Meekers, Dominique. 2001. The Promotion of Condom use In Non-regular Sexual Partnerships in Urban Mozambique. *Health Policy and Planning* 16 (2): 144-151.

Airhihenbuwa, Collins O. and Webster, Jonas D. 2004. Culture and African Contexts of HIV/AIDS Prevention, Care and Support. *Journal of Social Aspects of HIV/AIDS* 1 (1): 4-13.

Åkesson, Lisa. 2004. Making a Life. Meanings of Migration in Cape Verde. [Doctoral Thesis in Social Anthropology]. Gothenburg: University of Gothenburg, Department of Social Anthropology.

Arnaldo, Carlos. 2004. Factores Sócio-Económicos Associados a Percepção Individual do Risco de Contrair o HIV/SIDA em Moçambique. Maputo: UEM.

Arnfred, Signe. 2000. Family Forms and Gender Policies in Revolutionary Mozambique (1975-1985) available on: http://www.cean.u-bourdeux.fr/pubcean/td68-69.pdf (Accessed on December 14, 2016).

Arnfred, Signe. 2011. Sexuality and Gender Politics in Mozambique: Rethinking Gender in Africa. Uppsala: Boydell and Brewer Ltd.

Audet, Carolyn M.; Sidat, Mohsin; Blevins, Meridith; Moon, Troy D.; Vergara, Alfredo and Vermund, Sten H. 2012. HIV Knowledge and Health-Seeking Behavior in Zambézia Province, Mozambique. Journal of Social Aspects of HIV/AIDS 9 (1): 41-46.

Ayikukwei, Rose; Ngare, Duncan; Sidle, Jonh; Ayuku, David; Baliddawa, Joyce and Greene, James. 2008. HIV/AIDS and Cultural Practices in Western Kenya: The impact of sexual cleansing rituals on sexual behaviours. *Culture, Health & Sexuality* 10 (6): 587-599.

Baer, Hans A. 2004. Medical Pluralism. In: Ember, Carol R. and Ember, Melvin (eds.) *Encyclopedia of Medical Anthropology: Health and Illness in the World's Cultures*, pp. 109-115. New York: Kluwer Academic/Plenum Publishers.

Baer, Hans A. 2011. Medical Pluralism: An Evolving and Contested Concept in Medical Anthropology, pp. 405-423. In: Singer, Merrill and Erickson, Pamela I. (eds.). *A Companion to Medical Anthropology*. Oxford: Wiley-Blackwell.

Bagnol, Brigitte and Mariano, Esmeralda. 2011. *Género, Sexualidade e Práticas Vaginais*. Maputo: Departamento de Arqueologia e Antropologia/Universidade Eduardo Mondlane.

Bagnol, Brigitte. 2008. Lovolo e Espíritos no Sul de Moçambique. *Análise Social* 43 (187): 251-272.

Bandali, Sarah. 2011. Norms and Practices within Marriage which Shape Gender Roles, HIV/AIDS Risk and Risk Reduction strategies in Cabo Delgado, Mozambique. *AIDS Care* 23 (9): 1171-1176.

Berreman, Gerald D. 2012. Behind Many Masks: Ethnography and Impression Management, pp. 153-174. In: Robben, Antonious C. G. M. and Sluka, Jeffrey A. (eds.). *Ethnographic Fieldwork an Anthropological Reader*. Malden and Oxford: John Wiley and Sons Ltd.

Biehl, João. 2007. *Will to Live: AIDS Therapies and the Politics of Survival*. Princeton and Oxford: Princeton University Press.

Biehl, João. 2008. Drugs for all: The Future of Global AIDS Treatment. *Medical Anthropology* 27 (2): 99-105.

Boletim da República Lei n° 5/2002, de 5 de Fevereiro. Maputo: Governo de Moçambique.

Bolton, Ralph and Singer, Merrill. 1992. Introduction. Rethinking HIV Prevention: Critical Assessments of the Content and Delivery of AIDS Risk-Reduction Messages. *Medical Anthropology* 14 (2-4): 139-143.

Bolton, Ralph. 1989. Introduction: The AIDS Pandemic, a Global Emergency. *Medical Anthropology* 10 (2-3): 93-104.

Braga, Carla M. T. 2012. “Death is destiny”: Sovereign Decisions and the Lived Experience of HIV/AIDS and Biomedical Treatment in Central Mozambique. [Doctoral Thesis in Cultural and Social Anthropology]. New York: The University of Buffalo, State University of New York.

Brodwin, Paul. 1996. *Medicine and Morality in Haiti: The Contest for Healing Power*. Cambridge and New York: Cambridge University Press.

Caifaz, António. 2005. *O Xitique a Mulher e a Economia Familiar nas Zonas Urbanas: O Caso da Cidade de* Maputo *1992-2002*. Maputo: Departamento de História/Universidade Eduardo Mondlane.

Casimiro, Isabel M. and Andrade, Ximena 2002. *Levantamento e Estudo Sobre o Grau de Cobertura na Disponibilidade do Preservativo Masculino pelos Inervenientes Existentes*. Maputo: Universidade Eduardo Mondlane/Centro de Estudos Africanos e Conselho Nacional de Combate ao HIV/SIDA.

Castro, Arachu and Farmer, Paul 2005. Understanding and Addressing AIDS-Related Stigma: From Anthropological Theory of Clinical Practice in Haiti. *The American Journal of Public Health* 95 (1): 53-59.

Chrisman, Noel J. and Kleinman, Arthur. 1983. Popular Health Care, Social Networks, and Cultural Meanings: The Orientation of Medical Anthropology, pp. 569-590. In: Mechanic, David (ed.). *Handbook of Health, Health Care, and the Health Professions*. New York: Free Press.

Colson, Elizabeth. 2010. The Social History of an Epidemic: HIV/AIDS in Gwembe Valley, Zambia, 1982-2004, pp. 127-147. In: Dilger, Hansjörg and Luig, Ute (eds.). *Morality, Hope and Grief: Anthropologies of AIDS in Africa*. New York and Oxford: Berghahn Books.

Comaroff, John L. and Comaroff, Jean. 2001. On Personhood: An Anthropological Perspective from Africa. *Social Identities* 7 (2): 267-283.

Conselho Nacional de Combate ao HIV/SIDA. 2004. *Plano Estratégico Nacional de Combate ao HIV/SIDA* (2005/2009), PEN II. Maputo: Conselho Nacional de Combate ao HIV/SIDA.

Conselho Nacional de Combate ao HIV/SIDA. 2010. *Plano Estratégico Nacional de Resposta a HIV e SIDA, PEN III, 2010-2014*. Maputo: Conselho Nacional de Combate ao HIV/SIDA.

Conselho Nacional de Combate ao HIV/SIDA. 2015. *Plano Estratégico Nacional de Combate ao HIV/SIDA* (2015/2019), PEN IV. Maputo: Conselho Nacional de Combate ao HIV/SIDA.

Crandon-Malamud, Libbet. 1991. *From the Fat of Our Souls: Social Change, Political Process, and Medical Pluralism in Bolivia*. Berkeley, Los Angeles and London: University of California Press.

DeWalt, Kathleen M. and DeWalt, Billie R. 2011. *Participant Observation: A Guide for Fieldworkers*. Lanham and New York: AltaMira Press.

Dickinson, David. 2014. *A Different Kind of AIDS: Folk and Lay Theories in South Africa Townships*. Auckland Park: Fanele.

Dilger, Hansjörg. 2008. "We Are All Going to Die": Kinship, Belonging, and the Morality of HIV/AIDS-Related Illnesses and Deaths in Rural Tanzania. *Anthropological Quarterly* 81 (1): 207-232.

Dilger, Hansjörg. 2010. Introduction. Morality, Hope and Grief: Towards an Ethnographic Perspective in HIV/AIDS Research, pp. 1-18. In: Dilger, Hansjörg and Luig, Ute (eds.). *Morality, Hope and Grief: Anthropologies of AIDS in Africa*. New York and Oxford: Berghahn Books.

Douglas, Mary. 1966. *Purity and Danger: An Analysis of the Concept of Pollution and Taboo*. London and New York: Routledge.

Drobac, Peter; Basilico, Matthew; Messac, Luke; Walton, David and Farmer, Paul. 2013. Building an Effective Rural Health Delivery Model in Haiti and Rwanda, pp. 133-183. In: Farmer, Paul; Kim, Jim Y.; Kleinman, Arthur and Basilico, Matthew (eds.). *Reimagining Global Health: An Introduction*. Berkeley and Los Angeles: University of California Press.

Ember, Carol R. and Ember, Melvin (eds.). 2004. *Encyclopedia of Medical Anthropology: Health and Illness in the World's Cultures,* Vol. I & II. New York: Kluwer Academic/Plenum Publishers.

Espling, Margareta. 1999. Women's Livelihood Strategies in Processes of Change: Cases from Urban Mozambique. [Doctoral Thesis]. Gothenburg: University of Gothenburg/Department of Human and Economic Geography.

Farmer, Paul. 1990. Sending Sickness: Sorcery, Politics and Changing Concepts of AIDS in Rural Haiti. *Medical Anthropology Quarterly* (*New Series*) 4 (1): 6-27.

Farmer, Paul. 1992. *Aids and Accusation: Haiti and the Geography of the Blame*. Berkeley, Los Angeles and London: University of California Press.

Farmer, Paul. 2004. An Anthropology of Structural Violence. *Current Anthropology* 45 (3): 305-325.

Farmer, Paul; Kim, Jim Y.; Kleinman, Arthur and Basilico, Matthew (eds.) 2013. *Reimagining Global Health: An Introduction*. Berkeley and Los Angeles: University of California Press.

Fassin, Didier. 2007. *When Bodies Remember: Experience and Politics of AIDS in South Africa*. Berkeley and Los Angeles: University of California Press.

Foucault, Michel. 1984. *The Use of Pleasure: The History of Sexuality 2*. London: Penguin Books Ltd.

French, Heleen; Greeff, Minrie; Watson, Martha J. and Doak, Colleen. M. 2015. HIV Stigma and Disclosure Experiences of People Living with HIV/AIDS in an Urban and a Rural Setting. *AIDS Care* 27(8): 1042-1046.

Galtung, Johan. 1969. Violence, Peace and Peace Research. *Journal of Peace Research* 6 (3): 167-191.

Gausset, Quentin. 2001. AIDS and Cultural Practices in Africa: The Case of the Tonga (Zambia). *Social Science & Medicine* 52 (4): 509-518.

Geary, Cindy; Parker, Warren; Rogers, Susan; Haney, Erica; Njihia, Carolyne; Haile, Amaha and Walakira, Eddy. 2014. Gender Differences in HIV Disclosure, Stigma and Perceptions of Health. *AIDS Care* 26 (11): 1419-1425.

Geffray, Christian. 2000. *Nem Pai, Nem Mãe: Uma Crítica ao Parentesco Macua*. Lisboa: Ndjira/Collecção Estudos Africanos.

Geschiere, Peter. 1997. *The Modernity of Witchcraft: Politics and the Occult in Postcolonial Africa.* Charlottesville and London: University of Virginia Press.

Geschiere, Peter. 2013. *Witchcraft, Intimacy, and Trust: Africa in Comparison*. Chicago and London: University of Chicago Press.

Goffman, Erving. 1963. *Stigma: Notes on the Management of Spoiled Identity.* New York, London and Toronto: Simon & Schuster Inc.

Good, Byron J. 1994. *Medicine, Rationality and Experience: An Anthropological Perspective*. Cambridge and New York: Cambridge University Press.

Gorman, Michael and Mallon, David. 1989. The Role of a Community-Based Health Education Program in the Prevention of AIDS. *Medical Anthropology* 10 (2-3): 159-166.

Granjo, Paulo. 2005. *Lobolo em* Maputo*: Um Velho Idioma para Novas Vivências Conjugais*. Porto: Campo das Letras.

Greeff, Minrie. 2013. Disclosure and Stigma: A Cultural Perspective. In: Liamputtong, Pranee (ed.). *Stigma, Discrimination and Living with HIV/AIDS*: *A Cross Cultural Perspective*, pp. 71-95. London and New York: Springer.

Green, Edward C. 1994. *AIDS and STDs in Africa: Bridging the Gap Between Traditional Healing and Modern Medicine*. Boulder, Colorado and Oxford: Westview Press.

Green, Edward C. 2003. *Rethinking AIDS Prevention: Learning from Successes in Development Countries*. Westport, Connecticut and London: Praeger.

Green, Edward C. 2011. *Broken Promises: How the AIDS Establishment has Betrayed the Developing World*. Sausalito, CA: PoliPoint Press.

Green, Edward C.; Dlamini, Cedza; D'Errico, Nicole C.; Ruark, Allison and Duby, Zoe. 2009. Mobilising Indigenous Resources for Anthropologically Designed HIV-Prevention and Behaviour-Change Interventions in Southern Africa. *African Journal of AIDS Research* 8(4): 389-400.

Green, Edward C.; Jurg, Annemarie and Dgedge, Armando. 1993. Sexually-Transmitted Diseases, AIDS and Traditional Healers in Mozambique. *Medical Anthropology* 15 (3):261-281.

Groes-Green, Christian. 2013. "To Put Men in a Bottle": Eroticism, Kinship, Female Power, and Transactional Sex in Maputo, Mozambique. *American Ethnologist* 40 (1): 102-117.

Groh, Kate; Audet, Carolyn M.; Baptista, Alberto; Sidat, Mohsin; Vergara, Alfredo; Vermund, Sten H. and Moon, Troy D. 2011. Barriers to Antiretroviral Therapy Adherence in Rural Mozambique. *BMC Public Health* 11 (650): 1-8.

Gune, Emídio S. 2001. *O Papel da Cultura na Prevenção do HIV em Moçambique 1987-1999*. Maputo: Universidade Eduardo Mondlane/Faculdade de Letras e Ciências Sociais.

Hardon, Anita and Dilger, Hansjörg. 2011. Global AIDS Medicines in East African Health Institutions. *Medical Anthropology* 30 (2): 136-157.

Hardon, Anita and Moyer, Eileen. 2014. Anthropology of AIDS: Modes of Engagement. *Medical Anthropology* 33 (4): 255-262.

Hawkins, Kirstan, Price, Neil and Mussá, Fatima. 2009. Milking the Cow: Young Women's Construction of Identity and Risk in Age-Disparate Transactional Sexual Relationship in Maputo, Mozambique. *Global Public Health* 4 (2): 169-182.

Hennink, Monique M. 2014. *Focus Group discussions: Understanding Qualitative Research*. Oxford and New York: Oxford University Press.

Høg, Erling. 2008. The Process: Experiences, Limitations, and Politics of ARV Treatment in Mozambique [Doctoral Thesis in Anthropology]. London: London School of Economics and Political Science.

Holzemer, William L.; Uys, Leana; Makoae, Lucy; Stewart, Anita; Phetlhu, René; Dlamini, Priscila S.; Greeff, Minrie; Kohi, Thecla W.; Chirwa, Maureen; Cuca, Yvette and Naidoo, Joane. 2007. A Conceptual Model of HIV/AIDS Stigma from Five African Countries. *Journal of Advanced Nursing* 58 (6): 541-551.

Honwana, Alcinda. 2013. *O Tempo da Juventude: Emprego, Política e Mudanças Sociais em África*. Maputo: Kapicua Livros e Multimedia Lda.

Ingstad, Benedicte. 1990. The Cultural Construction of AIDS and Its Consequences for Prevention in Botswana. *Medical Anthropology Quarterly* 4 (1): 28-40.

INSIDA. 2009. *National Survey on Prevalence, Behavioural Risks and Information about HIV and AIDS, in Mozambique: Final Report*. Maputo: Ministry of Health/National Health Institute.

Instituto Nacional de Estatísticas (INE). 2007. *Sinopse dos Resultados Definitivos do 3° Recenseamento Geral da População e Habitação. Cidade de Maputo*. Maputo: Governo de Moçambique.

Janzen, John M. and Arkinstall, William. 1978. *The Quest for Therapy in Lower Zaire*. Berkeley, Los Angeles and London: University of California Press.

Jones, Chaunetta. 2011. "If I Take My Pills I'll go Hungry": The Choice Between Economic Security and HIV/AIDS Treatment in Grahamstown, South Africa. *Annals of Anthropological Practice* 35 (1): 67-80.

Joralemon, Donald. 2017. *Exploring Medical Anthropology*. London and New York: Routledge.

Junod, Henri A. 1996. *Usos e Costumes dos Bantu*, Tomo I & II. Maputo: Arquivo Histórico de Moçambique.

Kagitçibasi, Cigdem. 1997. Individualism and Collectivism, Vol 3, pp. 1-50. In: Berry, John W.; Segall, Marshall, H. and Kagitçibasi, Cigdem (eds.). *Handbook of Cross Cultural Psychology: Social Behavior and Applications*. Boston: Allyn and Bacon.

Kalofonos, Ippolytos A. 2010. "All I Eat Is ARVs": The Paradox of AIDS Treatment Interventions in Central Mozambique. *Medical Anthropology Quarterly* 24 (3): 363-380.

Kiefer, Christie W. 2007. *Doing Health Anthropology: Research Methods for Community Assessment and Change*. New York: Springer Publishing Company, LLC.

Kim, Jim. Y.; Porter, Michael; Rhatigan, Joseph; Weintraub, Rabecca; Basilico, Matthew, Holstein, Cassia Van der H. and Farmer, Paul. 2013. Scaling Up Effective Delivery Models Worldwide, pp. 184-211. In: Farmer, Paul; Kim, Jim Y.; Kleinman, Arthur and Basilico, Matthew (eds.). *Reimagining Global Health: An Introduction*. Berkeley, Los Angeles and London: University of California Press.

Kleba, Maria E. and Wendausen, Agueda. 2009. Empowerment: Strengthening Process of Subjects in Spaces of Social Participation and Political Democratization. *Saúde Sociedade* 18 (4): 733-743.

Kleinman, Arthur and Benson, Peter. 2006. Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It. *PLoS Medicine* 3 (10): 1673-1676.

Kleinman, Arthur. 2006. *What Really Matters: Living a Moral Life Amidst Uncertainty and Danger*. Oxford and New York: Oxford University Press.

Kleinman, Arthur. 2010. Four Social Theories for Global Health. *The Lancet* 375 (9725): 1518-1519.

Kleinman, Arthur; Das, Veena and Lock, Margaret (eds.). 1997. *Social Suffering*. Berkeley, Los Angeles and London: University of California Press.

Kotanyi, Sophie and Krings-Ney, Brigitte. 2009. Introduction of Culturally Sensitive HIV Prevention in the Context of Female Initiation Rites: An Applied Anthropological Approach in Mozambique. *African Journal of AIDS Research* 8 (4): 491-502.

Langwick, Stacey A. 2011. *Bodies, Politics, and African Healing: The Matter of Maladies in Tanzania*. Bloomington and Indianapolis: Indiana University Press.

Laranjeira, Rui. 2016. Uma Perspectiva Histórica da Mafalala, pp. 53-104. In: M. Ribeiro e W. Rossa (eds.). *Memórias e Espaços de Um Lugar*. Coimbra: Imprensa da Universidade de Coimbra.

Leclerc-Madlala, Suzanne. 1997. Infect One, Infect All: Zulu Youth Response to the AIDS Epidemic in South Africa. *Medical Anthropology* 17 (4): 363-380.

Leclerc-Madlala, Suzanne. 2003. Transactional Sex and the Pursuit of Modernity. *Social Dynamics* 29 (2): 213- 233.

Leclerc-Madlala, Suzanne. 2009. Cultural Scripts for Multiple and Concurrent Partnership in Southern Africa: Why HIV Prevention Needs Anthropology. *Sexual Health* 6 (2): 103-110.

Lemos, Manuel J. C. de. 1988. Reviver a Ilha na Mafalala. Maputo: *Arquivo Histórico de Moçambique*.

Loforte, Ana M. 2003. *Práticas Culturais em Relação à Sexualidade e Representações sobre Saúde e Doença. HIV/AIDS Determinantes em Moçambique*. Maputo: CEP/UEM.

Lundin, Iraé. 1996. *Estratégias de Sobrevivência na Cidade de Maputo: Uma investigação antropológica*. Maputo: Departamento de Arqueologia e Antropologia/Universidade Eduardo Mondlane.

Manuel, Sandra. 2005. Obstacles to Condom Use among Secondary School Students in Maputo City. *Culture, Health & Sexuality* 7 (3): 293-302.

Manuel, Sandra. 2009. Presentes Perigosos: Dinâmicas de risco de Infecção ao HIV/Aids nos Relacionamentos de Namoro em Maputo. *Physis Revista de Saúde Coletiva* 19 (2): 371-386.

Mariano, Esmeralda; Samucidine, Mário; Boaventura, Inês B. and Sousa, César P. 2010. Healers, Nurses, Obstetrics-Gynaecologists Dealing with Women in the Quest to Become Pregnant in Southern Mozambique. *F, V & V IN OBGYN, Monograph*: 43-50.

Marston, Cicely; Hinton, Rachael; Kean, Stuart; Baral, Sushil; Ahuja, Arti; Costello, Anthony and Portela, Anayda. 2016. Community Participation for Transformative Action on Women's, Children's and Adolescents' Health. *Bulletin of the World Health Organization* 94: 376-386.

Matsinhe, Cristiano. 2005. *Tábula Rasa: Dinâmica da Resposta Moçambicana ao HIV/SIDA*. Maputo: Texto Editores.

Mattes, Dominik. 2011. "We are just supposed to be Quiet": The Production of Adherence to Antiretroviral Treatment in Urban Tanzania. *Medical Anthropology* 30 (2): 158-182.

Mattes, Dominik. 2012. "I am also a Human Being!" Antiretroviral Treatment in Local Moral Worlds. *Anthropology & Medicine* 19 (1): 75-84.

Mazula, Brazão. 1995. *Educação, Cultura e Ideologia em Moçambique: 1975-1985*. Porto: Edições Afrontamento.

MISAU (Ministério de Saúde). 2000. *Plano Estratégico Nacional de Combate ao HIV/AIDS* (2000-2002). Maputo: Governo de Moçambique.

MISAU (Ministério de Saúde). 2007. *National Policy on Health and Sexual and Reproductive Rights*. Maputo: Mozambique Government.

MISAU (Ministério de Saúde). 2008. *Manual de Educação para a Saúde*. Maputo: Governo de Moçambique.

Monteiro, Ana P. 2011. HIV/AIDS Prevention Interventions in Mozambique as Conflict of Cultures: The case of Dondo and Maringue Districts in Sofala Province. [Doctoral Thesis in Social Anthropology]. Johannesburg: University of the Witwatersrand.

Moyer, Eileen and Hardon, Anita. 2014. A Disease Unlike Any Other? Why HIV Remains Exceptional in the Age of Treatment. *Medical Anthropology* 33 (4): 263-269.

Moyer, Eileen. 2015. The Anthropology of Life After AIDS: Epistemological Continuities in the Age of Antiretroviral Treatment. *Annual Review of Anthropology* 44: 259-275.

Mshana, Gerry; Plummer Mary L.; Wamoyi, Joyce; Shigongo, Zachayo S.; Ross, David A. and Wight, Daniel. 2006. "She was Bewitched and Caught an Illness Similar to AIDS": AIDS and Sexually Transmitted Infection Causation Beliefs in Rural Northern Tanzania. *Culture, Health & Sexuality* 8 (1): 45-58.

Mutinta, Given; Govender, Kaymarlin; George, Gavin and Gow, Jeff. 2014. The Influence of Biological Factors on Students' Sexual Behaviour at the University of KwaZulu-Natal, South Africa. *African Journal of AIDS Research* 13 (4): 321-329.

Nguyen, Vinh-Kim. 2010. *The Republic of Therapy: Triage and Sovereignty in West Africa's Time of AIDS*. Durham and London: Duke University Press.

Nhantumbo, Fátima. 2006. Processos de Transformação Social com Referência ao Estigma e Discriminação no Contexto do HIV e SIDA: Uma Análise a partir da Cidade de Maputo. Maputo: Universidade Eduardo Mondlane/ Faculdade de Letras e Ciências Sociais.

Nkwi, Paul N. 2005. The Impact of Cultural Practices on the Spread of HIV/AIDS: An Anthropological Study of Selected Countries in Sub-Saharan Africa. *Discovery and Innovation* 17: 21-35.

O'Laughlin, Bridget. 2015. Trapped in the Prison of the Proximate: Structural HIV/AIDS Prevention in Southern Africa. *Review of African Political Economy* 42 (145): 342-361.

Panter-Brick, Catherine. 2014. Health, Risk, and Resilience: Interdisciplinary Concepts and Applications. *Annual Review of Anthropology* 43: 431-448.

Parker, Richard and Aggleton, Peter. 2003. HIV and AIDS-Related Stigma and Discrimination: A Conceptual Framework and Implications for Action. *Social Science & Medicine* 57 (1): 13-24.

Parker, Richard. 2001. Sexuality, Culture, and Power in HIV/Aids Research. *Annual Review of Anthropology* 30: 163-179.

Paulo, Margarida. 2004. Fertility, Sexuality and HIV/Aids prevention campaigns in Mafalala barrio, Maputo, Mozambique. [Master's Thesis in Social Anthropology]. Cape Town: University of Cape Town.

Paulo, Margarida. 2009. Sexuality and HIV/AIDS among Young Residents of Mafalala bairro, Maputo, Mozambique, pp. 51-76. In: CODESRIA (ed.). *Youth, HIV/AIDS and Social Transformation in Africa*. *Monographs Series*: CODESRIA.

Paulo, Margarida; Tvedten, Inge and Rosário, Carmeliza. 2007. "*Xiculungo": Social Relations of Urban Poverty in* Maputo*, Mozambique*. Bergen: Chr. Michelsen Institute (CMI Report R 2007: 13).

Paulo, Margarida; Tvedten, Inge and Rosário, Carmeliza. 2011. "*Xiculungo" Revisited: Assessing the implications of PARPA II in* Maputo *2007-2010*. Bergen: Chr. Michelsen Institute (CMI Report R 2011:1).

Pfeiffer, James. 2004a. International NGOs in the Mozambique Health Sector: The "Velvet Glove" of Privatization, pp. 43-62. In: Castro, Arachu and Singer, Merrill (eds.). *Unhealthy Health Policy. A Critical Anthropological Examination*. Lanham and Boulder: AltaMira Press.

Pfeiffer, James. 2004b. Condom Social Marketing, Pentecostalism, and Structural Adjustment in Mozambique: A Clash of AIDS Prevention Messages. *Medical Anthropology Quarterly* 18 (1): 77-103.

Pfeiffer, James. 2013. The Struggle for a Public Sector, pp. 166-181. In: Biehl, João G. and Petryna, Adriana (eds.). *When People Come First: Critical Studies in Global Health,*. Princeton: Princeton University Press.

Population Service International (PSI). 2001. *Comunicação e Marketing para a Prevenção da SIDA: Aconselhamento e Teste Voluntário. Inquérito sobre Conhecimento, Atitudes e Práticas*. Maputo: PSI.

Population Service International (PSI). 2002a. *Inquérito Nacional Sobre Prevenção do SIDA*, Maputo: Moçambique.

Population Service International (PSI). 2002b. *Comunicação e Marketing para a Prevenção da SIDA III*: *Inquérito Nacional sobre a Prevenção da SIDA, Comportamento Sexual e Uso do Preservativo*. Maputo: PSI.

Quaranta, Ivo. 2010. Politics of Blame: Clashing Moralities and the AIDS Epidemic in Nso' (North-West Province, Cameroon), pp. 173-191. In: Dilger, Hansjörg and Luig, Ute (eds.). *Morality, Hope and Grief: Anthropologies of AIDS in Africa*. New York and Oxford: Berghahn Books.

Raimundo, Inês M. 2011. Migração e HIV/SIDA em Moçambique: Desafios da região centro de Moçambique. *GEOUSP-Espaço e Tempo* 29: 43-55.

Russell, Margo. 2003. Are Urban Black Families Nuclear? A Comparative Study of Black and White South African Family Norms. *Social Dynamics* 29 (2): 153-176.

Schoepf, Brooke G. 2001. International Aids Research in Anthropology: Taking a Critical Perspective on the Crisis. *Annual Review of Anthropology* 30: 335-361.

Schoepf, Brooke G. 1992. AIDS, Sex and Condoms: African Healers and the Reinvention of Tradition in Zaire. *Medical Anthropology* 14 (2-4): 225-242.

Singer, Merrill. 2009. Interdisciplinarity and Collaboration in Responding to HIV and AIDS in Africa: Anthropological perspectives. *African Journal of AIDS Research* 8 (4): 379-387.

Skinner, Donald and Mfecane, Sakhumzi. 2004. Stigma, Discrimination and the Implications for People Living with HIV/AIDS in South Africa. *Journal of Social Aspects of HIV/AIDS* 1 (3): 157-164.

Smith, Daniel J. 2003. Imagining HIV/AIDS: Morality and Perceptions of Personal Risk in Nigeria. *Medical Anthropology* 22 (4): 343-372.

Smith, Daniel J. 2014. *AIDS Doesn't Show Its Face: Inequality, Morality, and Social Change in Nigeria*. Chicago: University of Chicago Press.

Sovran, Steven. 2013. Understanding Culture and HIV/AIDS in sub-Saharan Africa. *Journal of Social Aspects of HIV/AIDS Research Alliance* 10 (1): 32-41.

Starfield, B.; Hyde, J.; Gérvas J. and Heath, I. 2008. The Concept of Prevention: A good Idea Gone Astray? *Journal of Epidemiology and Community Health* 62 (7): 580-583.

Susser, Ida. 2009. *AIDS, Sex and Culture: Global Politics and Survival in Southern Africa*. Malden and Oxford: Wiley-Blackwell.

Talle, Aud. 2010. Living beyond AIDS in Maasailand: Discourses of Contagion and Cultural Identity, pp. 148-172. In: Dilger, Hansjörg and Luig, Ute (eds.). *Morality, Hope and Grief: Anthropologies of AIDS in Africa*. New York and Oxford: Berghahn Books.

Tavory, Iddo and Swidler, Ann. 2009. Condom Semiotics: Meaning and Condom Use in Rural Malawi. *American Sociological Review* 74 (2): 171-189.

Tenkorang, Eric Y.; Gyimah, Stephen O.; Maticka-Tyndale, Eleonor and Adjei, Jones. 2011. Superstition, Witchcraft and HIV Prevention in Sub-Saharan Africa: The case of Ghana. *Culture, Health & Sexuality* 13 (9): 1001-1014.

Thomas, Felicity. 2007. "Our Families are Killing Us": HIV/AIDS, Witchcraft and Social Tensions in the Caprivi Region, Namibia. *Anthropology & Medicine* 14 (3): 279-291.

Thornton, Robert J. 2008. *Unimagined Community*: *Sex, Networks, and AIDS in Uganda and South Africa*. Berkeley, Los Angeles and London: University of California Press.

Thornton, Robert J. 2009. Sexual Networks and Social Capital: Multiple and Concurrent Sexual Partnerships as Rational Response to Unstable Social Networks. *African Journal of AIDS Research* 8 (4): 413-421.

Tivane, D. 2002. Mafalala o Poço das Mil e uma Histórias. *Revista Proler Número Especial* 15-16.

Treichler, Paula A. 1999. *How to Have Theory in an Epidemic: Cultural Chronicles of AIDS*. Durham and London: Duke University Press.

Trindade, Catarina. 2011. *Convívio e Solidariedade: Práticas de Xitique em Moçambique*. Bahia: XI CONLAB - UFBA.

Trotter, Robert T., II. 2011. Applied Medical Anthropology: Praxis, Pragmatics, Politics, and Promises, pp. 49-68. In: Singer, Merrill and Erickson, Pamela I. (eds.). *A Companion to Medical Anthropology*. Malden and Oxford: Wiley-Blackwell.

UNAIDS. 2016a. *Ending AIDS, Realizing Right*. Geneva: Joint United Nations Programme on HIV/AIDS. Available on: http://aidsdatahub.org/sites/default/files/publication/UNAIDS_HumanRights_SnapshotHLM2016.pdf (Accessed on October 20, 2016).

UNAIDS. 2016b. Fact Sheet. Global HIV Statistics. Geneva: Joint United Nations Programme on HIV/AIDS. Available on: http://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf (Accessed on November 27, 2016).

Visser, Muriel. 2002. Where Teachers Fear Tread- Communicating about HIV/AIDS in Mozambique. [Paper presented at the International Conference of the Association for Educational Communications and Technology (AECT), Dallas, TX, Published in the Proceedings of the Conference]. Florida: Florida State University/Learning Development Institute.

Wedel, J. 2004. *Santería Healing: A Journey into the Afro-Cuban World of Divinities, Spirits, and Sorcery.* Gainesville: University Press of Florida.

Wengraf, Tom. 2001. *Qualitative Research Interviewing: Biographic Narrative and Semi-Structured Methods*. Thousand Oaks, CA: Sage.

Whelehan, Patricia. 2009. *The Anthropology of AIDS: A Global Perspective*. Gainesville: University Press of Florida.

WHO. 2010. *Antiretroviral Therapy for HIV infection in Adults and Adolescents*. Recommendations for a Public Health Approach. Genèva: WHO Press.

Whyte, Susan R. (ed.). 2014. *Second Chances: Surviving AIDS in Uganda.* Durham: Duke University Press.

Whyte, Susan R. 1997. *Questioning Misfortune: The Pragmatics of Uncertainty in Eastern Uganda*. Cambridge: Cambridge University Press.

Wingood, Gina M.; Reddy, Priscilla; Peterson, Shani H.; DiClemente, Ralph J.; Nogoduka, Coceka; Braxton, Nikia and MBewu, Anthony D. 2008. HIV Stigma and Mental Health Status among Women Living with HIV in the Western Cape, South Africa. *South African Journal of Science* 104: 237-240.

Winkelman, Michael. 2009. *Culture and Health: Applying Medical Anthropology*. Hoboken: John Wiley and Sons, Inc.

Worldometers. 2017. Mozambique Population (Live). Available on: http://www.worldometers.info/world-population/mozambique-population/ (Accessed in October 6, 2017).

Wreford, Joanne. 2007. Rapprochement and Resistance? Utilising Traditional Healing Principles and Practice to Enhance HIV/AIDS Treatment in South Africa, pp. 95-104. In: *Women, AIDS and Access to Health Care in Sub-Saharan Africa: Approaches from the Social Sciences*. Catalunha: Medicus Mundi Catalunha

“The illness of the century”

Everyday struggles with HIV/AIDS in Mafalala, Maputo (Mozambique).

The study is based on extensive anthropological fieldwork, including participant observation and a number of interviews in the urban area Mafalala, Maputo, and it seeks to understand and discuss how the HIV/AIDS epidemic in urban Mozambique relates to people’s own voices, experiences, and understandings. By using a people-centered approach, where the needs and care of the people in the local context is in focus rather than specific illnesses, the study explores people’s socio-cultural practices, ideas, and living conditions related to HIV/AIDS. The thesis shows that the HIV/AIDS epidemic in Mafalala is closely related to a situation of deep poverty, an everyday struggle for the most basic necessities, a patronizing and insensitive health sector, stigma, cultural perceptions, and gender values. Moreover, the study demonstrates that understandings, treatments, and local prevention efforts concerning HIV/AIDS are related to religious, spiritual, and ethnomedical practices, and it argues for an integrative approach where socio-cultural and medical approaches should be applied together in combatting what one informant has called “the illness of the century.”

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