SUMMARY

This research investigates how the speech community living in Maputo city uses language in relation to HIV / AIDS and studies related stigmas which impede women's access to HIV / AIDS counselling services. My hypothesis is that frequent use of gender stereotypes in AIDS discourse aims at stigmatising women as AIDS propagators, while minimizing male sexual transgressions in the AIDS crisis. Interpretation of primary data collected via focus group discussions and interviews is done with five different approaches that study respectively: social meanings and representations of AIDS embedded in context, the stigmatising process correlating gender stereotypes and discrimination against women, stereotypical speech attitudes and speech mechanism as well as the functions and effects of stereotyping. My conclusion is that deeply rooted gender barriers are to be removed in order to combat the social plague of AIDS and that ethnography of communication offers interesting models for development projects that can initiate behavioural changes through speech.

KEY TERMS

Sociolinguistics; Stereotypes; HIV / AIDS ; Gender; Stigmas; Access to counselling services; Speech community; Focus Group Discussion; Context-embedded meaning; Discourse analysis; Stereotyping; Speech attitudes; Functional analysis; Ethnography of communication.

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ABBREVIATIONS

ADASBU:	Associação para o Desenvolvimento de Água e Saneamento do Bairro da Urbanização
AIDS:	Acquired Immune Deficiency Syndrome
AMETRAMO:	Associação de Medicos Tradicionais de Moçambique, Association of traditional healers of Mozambique
ARV:	Antiretroviral
FGD :	Focus Group Discussion
f. i. :	for instance
FNUAP:	Fundo das Nações Unidas para o Apoio à População
G&D:	Gender and Development
GDP:	Gross Domestic Product
HIV:	Human Immunodeficiency Virus
IV :	Intravenous
KIT :	Koninklijk Instituut voor de Tropen (Royal Tropical Institute)
MSF:	Médecins Sans Frontières
PLWHA :	People living with HIV / AIDS
PMTCT :	Prevention Mother to Child Transmission
RSA :	Republic of South Africa
SAFAIDS:	Southern Africa AIDS Information Dissemination Service
SIDA:	Sìndroma de Imuno-Deficiência Adquirida
STD :	Sexually Transmitted Disease
TB:	Tuberculosis
UNAIDS:	Joint United Nations Programme on HIV / AIDS
UNDP:	United Nations Development Programme
UNFPA:	United Nations Population Fund
VCT:	Voluntary Confidential Testing
W&S:	Water and Sanitation

KEY DEFINITIONS

Definitions of key concepts are presented here as well as the methodological context in which they are used.

1. **Sociolinguistics** studies the multidisciplinary nature of language in interaction with social life, giving interesting clues to the understanding of social behaviour. A distinction is made between sociolinguistics and the sociology of language, the former focusing on language in relation to society and the latter on society in relation to language.

2. The **sociology of language** also explores the intersection between the HIV / AIDS disease and the multiple dimensions of social life that will highlight the cultural constructions of gender, and representations and associations of AIDS.

3. The **Sapir-Whorfian hypothesis** assumes that there is a mutual relationship between language, thought and behaviour that is explored in the use of the speech variety of gender stereotypes.

The methodology used in this study is based essentially on theories developed by Hymes (1974), Saville-Troike (1989) and Fishman (1971) who emphasize the importance of studying the members of the speech community in their natural setting.

4. **Ethnography** is a field of study which is concerned primarily with the description and analysis of culture, accounting for the interrelationship of language and culture, for instance (f. i) culture specific linguistic patterns intersecting with patterns in social organization and in other cultural domains.

5. The trend in sociolinguistics called the **ethnography of communication,** initiated by Dell Hymes, takes language first and foremost as a socially situated cultural form, while recognizing the necessity to analyse the code itself and the cognitive process of its speakers and hearers (Saville-Troike 1989:3).

5. **Discourse analysis** is the close, systematic analysis of written texts or records of language in use. Collecting the data for this approach often involves audio recording together with transcription (Johnstone 2000:126).

7. **The analysis of speech attitudes** presupposes a correlation between the form and content of a language and the beliefs, values and needs present in a culture of its speakers (Saville-

Troike 1989:32). In line with Saville-Troike, the research examines how language can be used to discriminate and to control through the categorization of people (Saville-Troike 1989:182)

8. **Semantics** is the study dealing with meanings and signs. Semantics calls our attention to the fact that there is no direct relation between words and things. Meaning is the reciprocal relationship between the name and the sense, which enables the one to call up the other (Ullmann 1951:33).

9. In the **functional approach**, social function is considered to give form to the ways in which linguistic features are encountered in actual life. To understand the meaning of language in the context of social interaction, one should understand why a language is being used as it is as well as the consequences of such use (Hymes 1974:65). According to Hymes, functions served in speech must be derived directly from the purposes and needs of human beings engaged in social action. Speakers have a variety of intentions at any given moment in speech, varying in scope from relatively long-term intentions to short-term intentions (Hudson 1980:110-112).

10. An approach to the functional classification of speech is based on the **speech-acts theory** conceived by J. L. Austin (Austin 1962). He makes a distinction between the illocutionary force of a speech act and its perlocutionary force. The former is the “inherent” function of the speech-act, which might be established by simply looking at the act itself in relation to existing beliefs. Perlocutionary force concerns the effects of the act, whether intended or actual. Bits of social interaction can be categorised into their inherent properties and their effects.

1. PRESENTATION OF THE RESEARCH

1.1 INTRODUCTION

This first chapter introduces the research topic of the dissertation. Firstly, the main authors consulted are referred to along with their definitions of the concepts cited in the research topic. Secondly, the research problem is presented as well as the hypothesis of the investigation, including sociological and linguistic evidence. The chapter ends with the general research aims and the central research questions which form the basis of the investigation.

1.2 RESEARCH TOPIC

A Sociolinguistic Investigation of Gender Stereotypes in HIV / AIDS Discourse.

1.2.1 STEREOTYPES, GENDER AND HIV/AIDS DISCOURSE

A **stereotype** can be defined as an erroneous perception based on an accessible cluster of associated ideas (Allport 1958:166). However, a more operational definition for sociolinguistic research is used by Saville-Troike: "Stereotypes are linguistic features which are correlated with extra-linguistic categories in a society such as race, sex, social class, religion and ethnicity" (Saville-Troike 1989:194).

Labov has used the term "stereotypes" to only refer to connections between linguistic and non-linguistic characteristics which people are aware of at a conscious level, in contrast to the majority of such connections (Labov 1972, in Hudson 1980:202).

Gender is a symbolic construction composed of symbolic associations given to categories of men and women as the result of cultural ideologies (Moore 1988:16). Gender polarization is problematic as it creates dichotomous categories of women and men and establishes a cultural connection between sex and virtually every other aspect of human experience (Bem 1993, in Bing & Bergvall 1998:503). UNAIDS uses a broad definition of gender that determines an individual's position in society, namely "What it means to be male or female,

and how that defines a person's opportunities, roles, responsibilities and relationships" (UNAIDS September 1998:3).

HIV/AIDS are abbreviations of scientific terms describing respectively the virus and the syndrome of the disease. The term "AIDS" (Acquired Immune Deficiency Syndrome) came into widespread use at the end of 1982. In 1986, the type of retrovirus which was the probable cause of AIDS was designated the Human Immunodeficiency Virus (HIV).

The medical description of AIDS is littered with medical jargon. Therefore, a more appropriate definition of AIDS is the disease / illness distinction of Kleinman. AIDS the disease is approached by biomedical practitioners with the rational-technical language of disease control (Farmer & Kleinman 1989, in Hopson et al. 2000:32). AIDS the illness incorporates judgments about its meaning for sufferers and society and judgments that are culturally specific which are expressed through the medium of metaphor (Taylor 1990:55). The research focuses on the latter and examines more specifically the HIV / AIDS language and meanings of participants in a community-based disease prevention and intervention programme.

HIV / AIDS remains a largely taboo subject. This means that people either avoid the subject or talk about it in a biased way. Thus, perceptions of HIV / AIDS expressing gender bias are called **gender stereotypes**. They constitute the focus of this research.

The examples of gender stereotypes are selected from transcripts of taped conversations and interviews used as primary data, as well as from other survey material relating to people's perceptions of HIV / AIDS. All these sources are referred to as the **HIV/AIDS discourse** and are real samples of speech uttered by people in a given context.

Selected illustrations have a series of common attributes concerning their nature, function and effects which will be analysed from a sociolinguistic perspective. Their frequent use in discourse results in the particular linguistic mechanism of **stereotyping**, a speech process that can lead to stigmatisation.

1.2.2 From stereotyping to stigmatisation

Stereotyping is a speech category used worldwide for social typing or categorization that allows the establishment of preliminary relationships (Abrahams 1972, in Saville-Troike 1989:195).

To Allport, stereotyping is the selective thinking of a prejudiced person (Allport 1958:170). Reasoning becomes a process of rationalising combined with generalisations and labelling which have the same effect as categorization: magnifying one attribute out of all proportion to its true significance and masking other important attributes of the individual. Stereotypes are thus the result of the accentuation, generalization and simplification of speech.

The process of stereotyping further involves an exaggerated belief associated with a category. The social categories in turn carry with them traditional attitudes and expectations which strongly influence all communication and which govern, what Goffman calls, "the interaction ritual" (Goffman 1967, in Saville-Troike 1989:194).

The stereotype acts both as a justificatory device for categorical acceptance or rejection of a group, and also as a screening or selective device to maintain simplicity in perception and in thinking. However, Allport states that the rationalizing and justifying function of a stereotype exceeds its function as a reflector of group attributes (Allport 1958:192).

Although stereotypes are not always negative, they are often stigmatised. Stigmatised stereotypes express negative thoughts about a person or group based on a prejudiced attitude. Some kinds of behaviour require stereotypical modes of thinking of which "scapegoating" (Allport 1958:166) is predominant. For instance, in HIV / AIDS discourse women may be stigmatised as "AIDS transmitters" and be blamed as "scapegoats".

Stereotypes related to taboo issues such as HIV and AIDS are particularly prejudicial because they engender inappropriate attitudes and behaviour in the face of HIV / AIDS and reinforce the stigmatisation of infected people.

The stigma related to HIV / AIDS builds upon and reinforces earlier prejudices and existing social inequalities – especially those of gender, sexuality and race. Saville-Troike suggests that stereotypes be systematically recognized at the discourse level so as to bring them under conscious control (Saville-Troike 1989:197).

Many social scientists argue that: "Social constructions of AIDS and the inherent biases and imbalances of power with regard to gender have intersected to increase women's risk of contracting the AIDS virus, limiting as such their access to appropriate and adequate health care" (Cohan & Atwood 1994:5). The following paragraphs develop this argument that constitutes the research problem.

1.3 RESEARCH PROBLEM

How gender stereotypes impact on women's access to HIV / AIDS counselling is the research problem under investigation. In other words, this sociolinguistic research project explores the nature, function and use of gender stereotypes in the discourse about HIV / AIDS and their effects on a given social reality.

1.3.1 HYPOTHESIS

Stereotypes related to HIV / AIDS are numerous and are often gender biased. Gender stereotypes not only reflect existing gender roles and images but in a society confronted with an alarming HIV / AIDS progression and unequal gender relations, they also become the instrument to justify men's sexist conduct while blaming women for being responsible for the HIV spread. Thus, female stigmatisation in HIV / AIDS discourse is believed to be the social function of gender stereotyping.

Further, women encounter particular difficulties when seeking HIV / AIDS counselling services. The HIV / AIDS stigma which targets the female population is expressed through specific speech attitudes such as gender stereotypes and gender metaphors. Discrimination against women is believed to be one of the effects of using gender stereotypes.

Moreover, the social consequence of this particular language use is that of accentuating gender differences and in the particular context of an increased prevalence of HIV / AIDS, that of engendering inappropriate behaviour and stigmas which fuel rather than reduce the impact of HIV / AIDS.

Thus, if findings show the correlation between female stigmatisation and gender stereotyping, it then follows that combating gender bias in the discourse on HIV / AIDS will considerably contribute to the reduction of the spread of HIV / AIDS in society. The validity of this three-fold hypothesis concerning the function, use and consequences of gender stereotyping in HIV / AIDS discourse is demonstrated through findings which are collected at sociological and linguistic level.

1.3.2 SOCIOLOGICAL EVIDENCE

The function of gender stereotyping in the Mozambican society serves particular social arrangements that unconsciously reproduces social categories and consciously confines women and men into different worlds, respectively into domestic and public spheres. In other words, gender stereotypes emphasise the false division between the reproductive role of women and the productive role of men (KIT & SAFAIDS 1998:8).

The HIV / AIDS stigma affects women more than men, especially in societies where women have a subordinate position and are therefore more likely to be stigmatised. Gender inequalities, as a consequence, create additional barriers in the combat against HIV / AIDS.

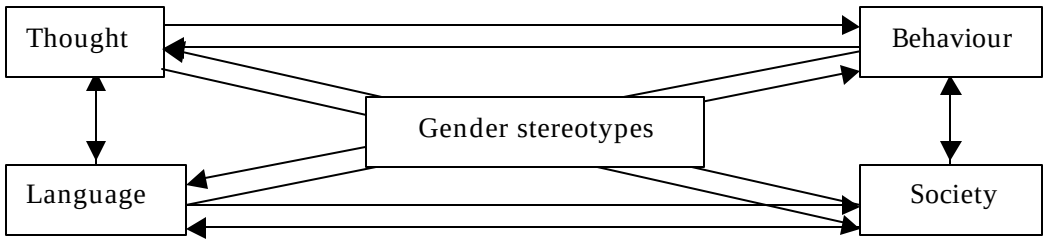
1.3.3 LINGUISTIC EVIDENCE

A typical gender stereotype often heard is that women are the propagators of AIDS in society. Language is the reflection of reality and can also serve as an instrument to manipulate reality. Gender stereotyping is a linguistic mechanism which can caricature and stigmatise women making their social discrimination acceptable. The use of gender stereotypes thus paves the way to the discrimination of women in society.

1.3.4 SOCIOLINGUISTIC RESEARCH

In conclusion, the influence of gender stereotyping in HIV / AIDS discourse on women's access to HIV / AIDS counselling is the main objective of this sociolinguistic research project. In the following scheme, the Sapir-Whorfian hypothesis is schematised, representing the intervention field of sociolinguistics and its multiple interaction spheres, that is explored in the use of the speech variety of gender stereotypes.

Table 1: Sociolinguistic intervention field



The following Research Aims guide the investigation at social, linguistic and sociolinguistic levels.

1.4 RESEARCH AIMS

1.4.1 A SOCIOLINGUISTIC INVESTIGATION ON HIV/AIDS

The interaction between HIV / AIDS, gender and stereotypes is studied from different perspectives. The following five sections describe the various approaches which form the concrete objectives of this investigationcalled Research Aims (see also Research Design in Section 2. 7). Conclusions will be drawn from the results of each of these aims in Chapter 5.

1.4.1.1 General social aim

As HIV / AIDS has turned into a tangible and crucial problem in contemporary society, the combat against HIV / AIDS has to be tackled as a social phenomenon requiring a holistic approach of all social disciplines. Language is central to human social behaviour. Therefore, solutions should also be explored from a sociolinguistic perspective. This highlights the social meaning of AIDS from the standpoint and interests of a community itself. An understanding of how HIV / AIDS is discussed (f.i. in the form of “gender stereotypes”) and the function that stereotypes serves within the community, can inform HIV / AIDS prevention efforts.

1.4.1.2 Sociolinguistic aim

The discourse analysis identifies and analyses the ways the community talks about AIDS and this investigation explores in particular the conditions of their use of stereotypes. Speech attitudes are explored in patterns of beliefs, values, users and use of gender stereotypes. The purposes and effects of gender stereotypes are analysed from a functional perspective. The different sociolinguistic approaches offer an overall picture of this particular language use from a multidimensional perspective.

1.4.1.3 Linguistic aim

This research demonstrates that biased perceptions of HIV / AIDS create additional problems with regard to effective HIV / AIDS prevention. For this reason, it is also important to

understand the linguistic mechanism of stereotyping which operates at the discourse level in general, and which underlines the discourse on HIV / AIDS in particular.

1.4.1.4 Gender aim

The question of primary interest here is: if gender stereotypes were denounced and combated, would that help to combat HIV / AIDS more effectively? In other words, the AIDS combat becomes a fight of gender inequalities. In the given socio-cultural context, the question makes sense as the underlying gender inequities have a direct impact on the progression of HIV / AIDS. The research demonstrates how gender stereotypes cultivate gender inequalities which increase women's vulnerability in relation to AIDS and denounces them as pernicious obstacles for the AIDS combat.

1.4.1.5 Methodological aim

Finally, the relationship between gender stereotypes and discrimination against women attending HIV / AIDS counselling in the social context of Maputo city is an ideal topic for an ethnographic research supported by a development aim. Ethnography of communication is the recommended approach for doing meaningful inquiries.

1.4.2 RESEARCH QUESTIONS

The key research questions are listed below and are classified under their specific research aim.

1.4.2.1 General social questions

- What can samples of conversation tell us about a given society confronted with an increasing HIV / AIDS problem?
- How does the given speech community refer to AIDS?
- What are the social conditions that make people vulnerable to HIV infection?

1.4.2.2 Sociolinguistic questions

- What are the levels of understanding about AIDS?
- How do people behave when confronted with AIDS and AIDS victims?
- Is there a link between informants' perceptions, attitudes and behaviour?

- What is the relation between gender stereotypes and HIV / AIDS stigmas?
- Who uses gender stereotypes?
- For which purpose are gender stereotypes used in relation to HIV / AIDS?
- What are the effects of gender stereotypes on women and on the AIDS epidemic?

1.4.2.3 Linguistic questions

- What is the nature and structure of stereotypes used in HIV / AIDS discourse?
- How frequent are gender stereotypes used in HIV / AIDS discourse compared to other stereotypes?
- What mental processes underlie stereotypical language use ?

1.4.2.4 Gender questions

- How are sex roles depicted, preserved and conveyed in gender stereotypes?
- Which power relations do they reflect between women and men?
- How do gender stereotypes impact on HIV / AIDS and what are the specific gender barriers?

1.4.2.5 Methodological questions

- What is the motivation of the researcher for the choice of topic?
- How can the ethnography of communication help to identify development projects?
- What are the principal constraints and advantages of the applied method?

1.5 CONCLUSION

This sociolinguistic investigation of gender stereotypes in HIV / AIDS discourse studies the interaction between HIV / AIDS, gender and stereotypes. The research problem focuses on the impact of gender stereotypes on women's access to HIV / AIDS counselling. The hypothesis of the research is three-fold: 1) gender stereotyping leads to female stigmatisation, 2) discrimination against women is the effect of using gender stereotypes in AIDS discourse and 3) female stigmatisation fuels the AIDS progression and creates gender barriers. Various approaches are proposed which examine the research problem at social, sociolinguistic and linguistic levels as well as from a gender and methodological perspective. These five orientations or Research Aims form the objectives of the investigation and are presented with their core questions.

2 RESEARCH CONTEXTS

2.1 INTRODUCTION

Chapter two sets the research problem in context. Starting with the setting of the investigation, an account of the evolution of the HIV / AIDS pandemic and the associated stigma is then given, followed by a description of the HIV / AIDS situation in Mozambique. After that, the theoretical context is described, which focuses on the sociolinguistic concepts and models used in this research. This chapter also includes a literature review that situates the research problem against the background of existing findings on HIV / AIDS stigmas, gender literature and sociolinguistic theories. A research design concludes this chapter and introduces the following chapter on methodology.

2.2 SETTING OF INVESTIGATION

2.2.1 THE WATER & SANITATION PROJECT

A survey on HIV / AIDS perceptions is conducted by the healthcare organisation Médecins Sans Frontières (MSF) in Maputo city. The MSF investigation aims at promoting access to HIV / AIDS counselling to the people living in *Bairro Urbanização*, a district near the airport where MSF is currently supporting a Water and Sanitation (W&S) Project. The general objective is to gather information about HIV / AIDS issues in order to implement an extended prevention and home-based care programme in the capital and in other places in Mozambique.

Present since 1984, MSF intervention in Mozambique dealt with emergency situations during the civil war and after (access to healthcare and epidemics, natural catastrophes). The organisation was very much involved during the floods in February 2000 which ravaged the Gaza, Maputo and Inhambane Provinces. Since then, MSF shifted its operational focus towards HIV / AIDS (access to treatment, prevention and stigmatisation), although continuing to respond to recurrent epidemics. MSF has started AIDS prevention and treatment programmes in the capital city of Maputo as well as in the Lichinga and Tete

provinces. MSF treats opportunistic infections, cares for AIDS patients and supports them psychologically. Voluntary counselling and testing is encouraged. Radio programmes, travelling exhibitions and advocacy campaigns promote prevention (www. accessmed-msf. org).

As HIV / AIDS is largely a taboo subject, MSF officials expect some resistance from the population before they start using these services. One of MSF's main concerns is how to minimize the stigmatisation of the population who require assistance on a regular basis, in particular HIV infected mothers and their babies participating in the Prevention Mother to Child Transmission (PMTCT) part of the project.

MSF started a three-year W&S project in the district *Bairro Urbanização* to minimize the risk of cholera transmission by improving the sanitary conditions of this area. The absence of a drainage system to drain rain water, together with the low infiltration capacity of the soil aggravated by the high population density, meant this project was badly needed. Stagnating rain and waste waters create unhygienic living conditions but a breeding ground for malaria and cholera epidemics. Other aspects of the project are related to access to clean water and individual sanitation, together with behavioural change through hygiene promotion.

About 1,800 families (a total of 13,747 people) reside in mostly stucco houses. Around 7 people per family occupy a plot of approximately 15 x 30 m. The district is divided into three parts and in 27 blocks (*quarteirões*). A survey on sanitation conditions was done in 2000 (MSF Moçambique Septembro 2000).

Residents are organised in a social organisation called ADASBU (Associação para o Desenvolvimento de Água e Saneamento do Bairro da Urbanização). The organisation's main objective is to improve the sanitary conditions of the district, and to organise activities such as waste collection. ADASBU is supported by MSF-Luxemburg and promotes networking between the population and the administration and technical directions of Maputo City.

2.2.2 THE SPEECH COMMUNITY

The speech community, as defined by Hymes, is a community sharing knowledge of rules for the conduct and interpretation of speech (Hymes 1974:51). In line with Gumperz, the notion of community is reserved for a local unit, characterised for its members by common locality and primary interaction (Gumperz 1962, in Hymes 1974:51).

The speech community in the survey is composed of residents of *Bairro Urbanização*, a district of Maputo city. Their vernacular, or primary mode of interaction, is Shangane. The speech situation is the survey conducted by MSF to collect perceptions on HIV / AIDS from the target population of its W&S Project located in the same district of *Urbanização.*

The people who participated in the survey are representatives of the young (14-25), adult (26-60) and old (61-75) population living in Maputo city. The young people are females (14-20) and males (19-25) playing football in the local club and either enrolled in a night course or out of school. There are young female and male trainers (18-25) recruited by the W&S project to follow up the activities of the project in the community and single young males (18-34) involved in the W&S project to collect waste material.

Adult groups are the representatives of the local authority. The group of community leaders are all married men aged between 45-63. Female members of an association of traditional healers AMETRAMO (Associação de Medicos Tradicionais de Moçambique) form another group. Other adult groups are more mixed in age and in marital status, for example the female market traders and members of the male community.

A group representing the older generation are the water pump managers who are married men and in the majority over 60 years old.

A last group, mixed regarding age and gender, is composed of members of ADASBU, the project members centralising the W&S activities in *Bairro Urbanização*.

For a presentation of the speech community, see also Section 4. 4. 3 and Annexure 1.

2.3 THE EVOLUTION OF HIV/AIDS

2.3.1 HIV ASSOCIATED WITH DEVIANT GROUPS

Although HIV was first detected in gay men in the USA (1981), the rate of infection has decreased amongst gay men but increased amongst intravenous (IV) drug users and heterosexuals. This shift appears to be related to high risk behaviour which is associated with the transmission of HIV, specifically the sharing of IV needles used for hard drugs and the exchange of blood and semen during unprotected heterosexual intercourse (Borchert & Rickabaugh 1995:657). As these “high risk groups” were blamed for the spread of the disease, other vulnerable groups were either refused or denied assistance.(Hopson et al.

2000:33). The barrier to action seems to be the inevitable association with stigmatised behaviour which health education and risk reduction activities entail (Quam 1990:29-44).

2.3.2 HIV ASSOCIATED WITH RISK GROUPS

Formalized policies have failed to dissuade the most prevalent belief that risk of exposure is determined not by engaging in behaviour that increases one's vulnerability in contracting the virus, but by engaging in these behaviours with specific at-risk groups. As a result, women have come to believe that they need not be concerned with AIDS if they are involved in a stable, monogamous relationship with one sexual partner (Cohan & Atwood 1994:7).

However, contrary evidence shows that women are rapidly becoming the "at-risk group" for HIV infection and AIDS. Heterosexual intercourse between partners accounts for most infections in sub-Saharan Africa (Painter 2001:1397).

2.3.3 HIV/AIDS ASSOCIATED WITH OTHER DISEASES

HIV / AIDS are slashed together as an inevitable progression from the latent, asymptomatic stadium of the virus, to the manifestation of symptoms and the development of opportunistic diseases causing malignancies. These include asymptomatic carriage for several years and non-specific symptoms such as fever, diarrhoea, weight loss, and generalized lymphadenopathy susceptibility to certain opportunistic pathogens (Mc Combie 1990:12).

AIDS is misleading as it is neither a disease nor a syndrome as traditionally defined. To have AIDS one must have some other disease. But an HIV + person who becomes ill and dies does not have AIDS unless evidence for one of these or a number of other conditions is found. For this reason, AIDS is defined in relationship to other known diseases (Mc Combie 1990:13).

2.3.4 HIV ASSOCIATED WITH TABOO

An important aspect of HIV / AIDS is the stigma attached to it (Cohan & Atwood 1994:18). Cultural barriers and beliefs have made the topic taboo and people living with HIV / AIDS (PLWHA) are frequently discriminated against. Some people may not even know they are HIV+ or do not want to admit to or talk about the virus. Often governments refuse to even acknowledge the existence of HIV / AIDS and are not willing to take a political engagement to confront the epidemic.

2.3.5 HIV ASSOCIATED WITH WOMEN

The perception of women in relation to HIV / AIDS resembles the way women were depicted during the syphilis epidemic in Victorian times: the female as the seductive infector of males (Hartel 1994:35). One example of this prevailing perspective on women as transmitters of the virus is the disproportionate amount of studies on AIDS in relation to prostitution (Cohan & Atwood 1994:11).

Misogynist bias is obvious in HIV research but also in access to treatment and HIV prevention-related services (Hartel 1994:41). It is however anticipated that the need for HIV-related medical care for women will greatly increase over the next several years. This is due to the increasing number of new cases and the deterioration in health of those already infected (Hartel 1994:49).

2.3.6 HIV PREVENTION ASSOCIATED WITH TREATMENT

As the HIV / AIDS pandemic reaches massive proportions with little sign of abating, the need for a global response is vital. The figures speak for themselves. Since the AIDS epidemic began, 25 million people have died and more than 40 million are now living with HIV and AIDS. Three million people died of AIDS in 2000 alone (Red Cross Website May 2002).

Antiretroviral (ARV) drugs are needed in order to directly combat HIV. Without the appropriate medicine, prevention efforts are severely limited and treatment is impossible. During the XIVth International HIV / AIDS Conference 2002[1], one of MSF recommendations was to move towards equitable access of the ARV drugs and to simplify its treatment, as most of the 30 million HIV + people living in Africa can't afford ARV treatment (MSF website July 2002).

[1] The XIVth International HIV / AIDS Conference was held in Barcelona between from 7th - 12th July 2002.

2.4 HIV/AIDS IN MOZAMBIQUE

Mozambique is one of the poorest countries in the world. Almost 70% of the population live in absolute poverty and the number of street children is growing. In 2001, the average GDP was US$196 per person. This developing country is largely dependent on external aid and the unemployment rate is very high (Red Cross Website 2002).

Mozambique is extremely vulnerable to disasters and both the capacity of communities to survive and government aid is very limited. The principal causes of death are: malaria, epidemics, malnutrition and diarrhoeal diseases. Estimated infantile mortality is 139/1000 living newborns. The maternal mortality rate is estimated by the United Nations Population Fund (UNFPA) to be between 600-1100 maternal deaths per 100 000 live births (UNFPA 2000:1).

The AIDS epidemic strikes Mozambique in a drastic way. This country is amongst the 10 most affected countries in the world. Approximately 1. 4 million people, or 8% of Mozambique's population, are currently infected with HIV. In the age group between 15 and 49, the rate of infection is 13%. This is one person out of seven. Every day, over 500 new infections occur and an estimated 220 people die of HIV/AIDS. Numbers are increasing, especially in the Nacala, Tete, Beira and Maputo corridors to Malawi, Zimbabwe and South Africa, where the incidence rate is 20% (Red Cross Website 2002). Each year more than 24,000 children are born with AIDS. It is estimated that 45% of new infections are among young people (more or less 300 cases of newly infected people a day). Due to AIDS, the average life expectancy is expected to drop from 57 to 36 over the next ten years (UNFPA 2000:2).

In Mozambique about 16% of young women aged 15-24 are HIV + compared to 6% of men in the same age group. Seventeen per cent of women who attend antenatal clinics tested in 6 sites, were HIV +, 3% higher than the national statistics in this age group. Statistics show that young women especially are the most vulnerable to HIV infections due to both their biological and their socio-economic vulnerability (UNAIDS October 1997:3). This trend is later confirmed in a census which highlights the number of young women infected with AIDS (UNAIDS 2000:6).

Adolescent girls and young women are often forced to resort to transactional sex[2]. But also married women can be infected "not through improper behaviour but in consequence of complying with norms of fidelity, if their husbands have unprotected sex outside of marriage" (Baylies & Bujra 2000:11).

In the HIV / AIDS census in Mozambique conducted by Kindlimuka, statistics show that most women are widows whereas the majority of interviewed men are married or bachelors, and that women's educational level is significantly lower than that of the male population. This means that women are more exposed to HIV / AIDS out of ignorance and that married women are more at risk of being infected by their husbands than the other way round (Associação Kindlimuka 2000:8-9). Statistical data confirm that women's lower status and ignorance are important factors in their vulnerability.

The portraits of interviewed HIV+ people in a qualitative survey[3] relate their trajectory in similar terms: first they become sick, then they are tested (often without their knowledge) and then informed about their HIV status (generally without pre- and post-counselling). After repeated absences they are fired from work (with little or no financial compensation), then themselves and their relatives are stigmatised, rejected and isolated.

Despite the alarming HIV / AIDS situation in Mozambique, the epidemic has not been a top priority for the government. As of July 2001, the use of antiretrovirals was still not allowed, even in the prevention of mother-to-child transmission (MSF website February 2003).

[2] Transactional sex is defined as the exchange of sex for comfort, goods or money, not necessarily on a professional basis (UNAIDS 1999:15).

[3] Abovementioned book (Associação Kindlimuka Novembro 2000) relates the life stories of infected and affected people, what makes it complementary to the accompanying survey document (Associação Kindlimuka 2001) in many aspects. In this way, portraits of people become real and the subjects are not just treated as numbers, percentages of a sample and statistical data.

2.5 THEORETICAL BACKGROUND

2.5.1 SOCIOLINGUISTICS

Sociolinguistics, a hybrid term derived from sociology and linguistics, reflects the special relationship between both disciplines. Until the first half of the 20th century, linguists approached language as an autonomous study object in itself, focusing upon the description of structure. From the second half of the 20th century onwards, a growing interest in the integration of language in a socio-cultural context can be observed, as well as the focus upon the analysis of function (Hymes 1974:208). From then onwards, a new discipline was born, namely sociolinguistics.

Sociolinguistics throws linguistics from its scholastic pedestal into human society and re-establishes language as an empirical science. The sociolinguist studies language variations rather than standard language, function rather than structure, meaning rather than grammar. Starting from the actual performance of language users, by relating purely linguistic areas to broader socio-cultural factors, this discipline tends to gain insight into both the social and linguistic behaviour of mankind.

From this new generation of linguists some perpetuate purely linguistic aims (f.i. William Labov). Others (in particular adepts of the sociology of language such as Joshua Fishman, Richard Hudson and John Gumperz) take a more sociological orientation. Muriel Saville-Troike and Dell Hymes integrate ethnography in their language approach. For Dell Hymes, the ethnography of speaking, as he conceives sociolinguistics, is ultimately part of the study of communication as a whole.

2.5.2 THE MULTIDISCIPLINARY NATURE OF LANGUAGE

Language is a multidisciplinary field that can be approached from various angles. First of all, language can be considered as a prime symbolic system in the myriad of symbols which constitute culture. Language is a network of conceptual categories which result from shared experiences acquired during the enculturation process (Saville-Troike 1989:22). There is a correlation between the form and content of a language and the beliefs, values, and needs present in the culture of its speakers. In this sense, language influences thought and this functional role of language in relation to worldview is a worldwide phenomenon called the

functional relativity of languages. On the other hand, languages and cultures differ arbitrarily and unrestrictedly from one another, giving evidence that different people live in different intellectual and physical worlds (Hudson 1980:103).

Words do not live in isolation in the language system. They enter into all kinds of groupings held together by a complex, unstable and highly subjective network of associations: associations between the names and the senses, associations based on similarity or some other relation. It is by their effects that these associative connections make themselves felt (Ullmann 1951:34).

Language is part of communicative conduct and social action. In meaning there is social as well as referential import. In between there are relationships not given in ordinary grammar but there for the finding in social life (Hymes 1972:197-198).

Language reflects and also influences social behaviour, what Bernstein calls "the cyclic influence between social patterns and linguistic patterns". For him, a particular kind of social structure leads to a particular kind of linguistic behaviour and this behaviour in turn reproduces the original social structure (Bernstein 1961**,** in Wardhaugh 1998: 327).

To be born into a speech community is to inherit the mode of vision and the scale of values peculiar to it and crystallised in its language (Ullmann 1951:91). Some behaviour is produced in analogy with the linguistic formula in which the situation is spoken of and allotted its place in a given context, which is to a large extent unconsciously built upon the language habits of the group (Carroll 1956, in Wardaugh 1998:218).

Taboo is a Polynesian term denoting anything sacred and mystically untouchable whether a person, an object, or a word. According to Ullmann, taboo words must be replaced by a harmless alternative, a so-called "*noa"* term. This results in the use of euphemisms (Ullman 1951:75).

Social categories are primarily part of the social system, but they also become embedded in the language system as it is used to mark them. The use and valuation of the linguistic markers in turn may affect the nature and persistence of the categories themselves. For instance, language markers help perpetuate gender inequalities in the social system by marking male-female distinction in the language system. They become labels that are loaded with beliefs and values concerning these social categories (Saville-Troike 1989:35).

Finally, language also provides a screen or filter to reality; it determines how speakers perceive and organize the world around them, both the natural and the social world

(Wardaugh 1988: 229). The role of language varies from culture to culture but it often includes the establishment of boundaries, the marking of social categories, the maintenance and manipulation of individual social relationships and networks, and various means of effecting social control (Saville-Troike 1989:35).

In this vast field of sociolinguistic issues, there is a place for all kinds of research projects as long as they investigate language as it is actually used and they correlate linguistic areas to social phenomena.

2.5.3 THEORETICAL MODELS OF THE DISSERTATION

This research project enters into the field of the sociology of language, which studies language as a reflection of the way people perceive their environment and experience their world (Wardhaugh 1998:12-13). This supposes a relationship between language, thought and behaviour in line with the Sapir-Whorfian tradition (Wardhaugh 1998:216-222).

The use and function of gender stereotypes is analysed with the discourse analysis as the principal research approach. Discourse analysis examines written speech which reproduces language "as it naturally flows in a situation" and which at the same time takes social context and meaning for granted (Agar 1993:160).

The investigation focuses on what Saville-Troike calls "attitudes to language" (Saville-Troike 1989:181) and on the role of language as a means of social power (Blakar 1979 :112).

Gender stereotyping is a conversational style, the process of which is analysed with the aid of semantics (Ullmann 1951:32). A quantitative investigation of stereotypes reveals some important aspects of the frequency and nature of gender stereotypes in the AIDS discourse.

The functional approach throws light on the meaning of using gender stereotypes in a specific speech community confronted with a threatening AIDS problem and on its influence in perpetuating social categories.

This research is eclectic in nature as it makes use of a mixture of approaches. They aim at analysing gender stereotypes from different perspectives and contribute to an overall picture of the nature, function and purpose of the studied speech variety in a given social context.

2.6 LITERATURE REVIEW

2.6.1 INTRODUCTION

The preliminary literature review forms the referential backbone of the dissertation around which the research is modulated. Four elements in the formulation of the research problem are determinant for the selection of sources: Stereotypes, Gender, Impact negatively (or Stigmatisation) and HIV / AIDS. These are the keywords in the procurement of documentation per topic, either online or for enquiries in library catalogues. Furthermore, each element corresponds to a specific category of source as is explained hereafter.

2.6.2 CATEGORIES OF SOURCES

2.6.2.1 Four main categories of sources

First of all, sources can be divided into four main categories which form the cornerstones of the dissertation. They are in order: (i) Literature in sociolinguistics, (ii) Gender and development (G&D) literature, (iii) Survey documents and papers, and (iv) Anecdotal documentation. The abovementioned topics are related to the main categories as follows: stereotypes are the study objects of literature in sociolinguistics; gender barriers are analysed via G&D literature; HIV / AIDS and related stigmas are the principal objects of survey documents and discrimination experienced by PLWHA is illustrated in sources falling under anecdotal documentation.

2.6.2.2 Referential framework

The first two categories are explanatory and interpretative whereas the two following categories are more focus-oriented. Sources from (i) to (iv) carry different kinds of information moving from a theoretical to an ethnographic description of facts, starting from a purely linguistic area and ending in an essentially social area. This is the essence of sociolinguistics: it studies language in use by relating linguistic areas to broader socio-cultural factors. This research focuses on the function and social significance of gender stereotyping and on its social effects on the HIV / AIDS endemic. It also explores the cultural context in which gender stereotypes are produced, namely Mozambique and the urban population living in one of the suburbs of Maputo city. The social arrangements that this

particular speech variety serves are explored from a community based experience with AIDS.

How this referential framework relates to the research problem is now explained for each category of sources.

2.6.2.2.1 Literature and research methods in sociolinguistics

Stereotypes are linguistic markers and carriers of a specific social meaning which have been studied at length in sociolinguistics. During my first exploration in the research field, I needed theoretical background information and methods to investigate this speech variety. The selected research approaches are: discourse analysis, the study of speech attitudes and the functional analysis. Models derived from the speech-acts theory and semantics are also applied. The ethnography of communication is commented on as the ideal model for doing meaningful research. These essentially qualitative methods are discussed in detail by Fishman (1971), Agar (1993), Hudson (1980), Hymes (1974), Saville-Troike (1989) and Wardaugh (1998). In the papers assembled in Feldman's Reader Language and Culture (1990), cultural issues in relation to AIDS are discussed. Ullmann (1951) and Allport (1958) are more concerned with linguistics proper, the former focusing on semantics and the latter on prejudices. How to conduct research is explained in research methods written by McNeill (1990) and Johnstone (2000). Last but not least, the Sociol-K Only study guide for sociolinguistics (1987) gives an overall picture of theories and scientists working in this field. Most of these selected sources are taken from the recommended books and are standard reference texts in sociolinguistics.

2.6.2.2.2 Gender and development literature

Theories and practical tools on how to conduct a gender analysis abound in the world of development; the gender concept is however not always correctly appreciated and understood. In this research, I consider gender an effective approach for analysing power relations in AIDS in line with Blakar (1979). The most widely used sources are UNAIDS documents presenting factual data with gender-based responses to the challenges of HIV / STD / AIDS (UNAIDS 1997, UNAIDS 1998, UNAIDS 1999, UNAIDS 2000, KIT & SAFAIDS 1998). Moore's Feminism and Anthropology (1988) is also referred to as well as a Reader on Language and Gender issues (Bing & Bergvall 1998). Papers and surveys focusing on the relationship between gender and AIDS are mentioned in the following unit.

2.6.2.2.3 Survey documents and analytical papers

Most of the secondary data used in this research derives from a compilation of survey documents and papers where AIDS is the principal topic (Baylies & Bujra 2000; Painter 2001; Mc Combie 1990). Survey documents are produced in the context of development projects (IDRC 1997; MSF September 2000, Associação Kindlimuka November 2000). These describe the AIDS situation in Mozambique, including information about VCT (Voluntary Confidential Testing) in Mozambique (UNFPA 2000). The United Nations Development Programme (UNDP) Monitoring and Evaluation guide explains how to conduct a focus group discussion (UNDP 2000). Statistical data is generally procured online (Red Cross website 2002, Red Cross website May 2002, MSF website 2002, MSF website February 2003). One document, Saùde Sexual e Reprodutiva, is a literature review compiling sources which describe the cultural and social context in which gender identities are shaped (Osorio & Arthur 2002). These sources are referred to many times in footnotes to support the results of the analyses. In this category of sources, I also include analytical papers exploring possible intersections between HIV / AIDS, gender and stigma on the one hand (Borchert & Rickabaugh 1995; Cohan & Atwood 1994; Hartel 1994; Quam 1990; Range & Starling 1991; Lewis & Range 1992) and between AIDS and language on the other (Smith et al. 1999; Taylor 1990, Hopson et al. 2000). All these sources provide background information on the research topic.

2.6.2.2.4 Anecdotal documentation

This last category deals with records of personal accounts about the situation of PLWHA and how stigmatisation affects them (Associação Kindlimiku 2001). These sources are called anecdotal because people either talk about themselves in the first person or their story is transcribed textually by an external author using word-for-word citations. In this category of sources, I also include the MSF reports from the field (MSF website January 2003) which describe how women attending the counselling services deal with AIDS. They complete the collection of primary data that could not be collected first-hand due to the difficulty in reaching PLWHA. One source is a journalistic account of the development of HIVin Southern Mozambique set against the socio-economic situation of the country (Sida, Conselho Cristão de Moçambique).

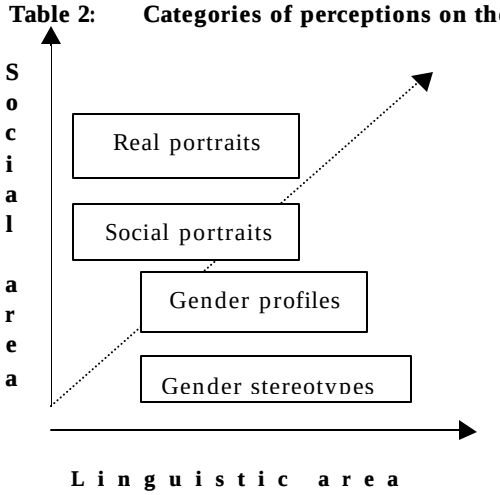
2.6.3 KINDS OF INFORMATION AND MEDIUM

Categories of sources convey different kinds of information and have a specific medium corresponding to their function and use. For instance, the first category of sources are intricate theories and methodologies to be referred to many times and are generally hard-cover books. The second category of sources concerned with G&D is partly theoretical, partly instrumental. In this research, the gender tool is more important than the gender philosophy, and manuals and papers are the principal sources. Surveys that make the core of the third category are generally in the form of documents, articles or papers and are topic-oriented: the sources illustrate in words or in numbers the HIV / AIDS problem and related stigmas. The last source, namely the anecdotal category, is subject-orientated and are generally presented as articles. The focus lies on personal accounts of living with HIV / AIDS and discrimination at societal, family and individual level.

2.6.4 THEMES

Sources can be related thematically as there is a continuum of themes between the categories along an abstract-concrete axis. Moving from abstract to concrete, the categories of perception are: gender stereotypes, gender profiles, social portraits and real portraits.

Table 2: Categories of perceptions on the abstract-concrete continuum



Furthermore, these categories of perceptions are related to the principal themes of the research problem in the following way:

a) gender stereotypes are perceptions about the roles, images and expectations of men and women based on a gender division; they cultivate dichotomous gender profiles,

b) HIV / AIDS stigmas observable in attitudes and values are gender differentiated and correspond to segregated social portraits,

c) discriminatory behaviour and rejection of the infected female population raise real portraits of women in the face of HIV / AIDS.

"Stigmatisation" is the underlying process between these perceptions which correlates language categories and social categories on the abstract-concrete continuum.

The research will demonstrate that the snowball effect induced by gender stereotypes and ending in discriminatory behaviour towards women is the result of using a stigmatising speech variety in the particular context of HIV / AIDS and in a society essentially structured around dichotomous gender images and roles.

The following Research Design schematises the methodological phases, procedures and approaches that receive full focus in the following chapter.

2.7 RESEARCH DESIGN

1. Primary data collection (May-June 2002)	Primary investigation	Primary data collected during: 1) FGDs 2) Unstructured interviews	Materials: - 14 transcripts of FGDs - 4 transcripts of interviews
2. Secondary data collection (from October 2002 onwards)	Secondary investigation	Documentation about: 1) Literature in Sociolinguistics 2) G&D literature 3) Survey documents and analytical papers 4) Anecdotal documentation	Sources: 1) Classics and methodologies 2) Theory and manuals 3) Project documents, articles in journals and online info 4)Interviews and on-line articles
3. Organisation of collected data (July-October 2002)	1) Indexation 2) Classification 3) Codification 4) Indexed list	1) Categories of informants 2) Categories of HIV / AIDS perceptions 3) Categories of perceptions divided into language themes, social themes and discourse items 4) Stereotypes	1) Differentiated by gender, age groups, occupation and level of education 2) Level of knowledge and beliefs, values and attitudes, and behaviour 3) Levels of understanding (knowledge / myths), levels of attitudes / values and levels of conduct at personal and social level 4) Indexed per group, speaker and theme

		Objectives	***Results***
4. **Analysis and interpretation of the findings** (November 2002-March 2003)	Sociology of language	• Assess representations and associations of HIV / AIDS at the discourse level • Select labels, metaphors and allusions to AIDS • Detect social themes	• Interpret the meaning of HIV / AIDS for the interviewees • Examine worldview and gender constraints • Examine the social constraints
	Discourse analysis or the horizontal analysis	• Analyse the FGDs separately • Estimate levels of practical and stereotypical knowledge • Estimate levels of stigma • Estimate levels of discrimination • Compare these estimates to each other	• Detect cause and effect relations between categories of perceptions • Assess the levels of understanding about HIV / AIDS • Ascertain the level of stigma in attitudes • Ascertain the level of discrimination in behaviour • Discern a continuum in perceptions - attitudes – behaviour
	Analysis of speech attitudes or vertical analysis	• Compare the FGDs to each other • Correlate categories of perceptions to categories of informants and themes	• Identify patterns of subjects, perceptions, attitudes and themes • Examine constraints at various language and socio-cultural levels
	Analysis of the process of stereotyping	• Select stereotypical expressions in AIDS discourse • Explain the underlying structure with the semantic model	• Examine the nature, distribution and frequency of stereotypes • Demonstrate the false associations in stereotypical reasoning
	Functional analysis	• Determine the functions and effects of gender stereotyping • Explain by means of speech-acts theory	• Illustrate functions and effects with anecdotal documentation • Demonstrate the illocutionary and perlocutionary force of gender stereotypes

		Objectives	***Results***
5. **Conclusions and recommendations** (April-June 2003)	Social level	Describe the social context of the given speech community, their representations of AIDS and the socio-economical conditions of vulnerability	Determine the social constraints of AIDS in the given context
	Sociolinguistic level	Demonstrate the causal relation between gender stereotypes and discrimination against women	Reject or confirm the validity of the hypothesised function and effects of the use of gender stereotypes
	Linguistic level	Define the nature of gender stereotypes and the process of stereotyping in general	Conclude on the nature of stereotypes and the process of stereotypical reasoning
	Gender level	Describe the gender barriers of AIDS	Propose the gender tool to analyse gender constraints in sexual behaviour
	Methodological level	Discuss advantages and constraints of the applied FGD method	Propose a methodology for a meaningful research on AIDS in the speech community

2.8 CONCLUSION

The sociolinguistic investigation of gender stereotypes in AIDS discourse implies at least two different kinds of contexts: a social context in which HIV / AIDS is situated and a theoretical context providing sociolinguistic models for the investigation. *Bairro Urbanização* sets the boundaries of the investigation context. The speech community under investigation represents the young, adult and aged population living in this neighbourhood, who are either involved in the W&S project or just members of the speech community.

The changing demographics of HIV / AIDS is not followed with the appropriate epidemiological focus. HIV prevalence in Mozambique demonstrates a higher vulnerability of the female population, specifically adolescent girls who are rapidly becoming the "at-risk group".

The literature review presents the four categories of sources with their corresponding theme and supplied by their specific media. They are based on the main concepts of the investigation that constitute the research problem: stereotype, gender, stigmatisation and HIV / AIDS. The abstract-concrete continuum of perceptions traces the underlying trajectory of stigmatisation moving from most abstract to most concrete categories of perceptions.

The Research Design outlines the methodology, procedures and approaches of the research. Expected results at the various levels of the investigation are summarised in the framework of conclusions.

3 METHODOLOGY

3.1 INTRODUCTION

This chapter outlines the methodology used in this sociolinguistic research, and describes more explicitly the research type, techniques and context followed by an explanation about the researcher's position and a research design. The following sections provide respectively: a description of the data, subjects, materials and procedures used for data collection including the organisation of focus group discussions and interviews. The next section is concerned with the analysis proper starting with the classification of data followed by an account of the various analyses and their approaches. A series of relevant constraints are enumerated and commented on in the Conclusions (Chapter 5).

3.2 RESEARCH

3.2.1 RESEARCH TYPE

The communicative situation is largely determined by the field techniques of the focus group discussion (FGD) and the unstructured interview. The collected data is used as a database for the MSF investigation as well as for this sociolinguistic research.

The research is basically qualitative based on essentially interpretive and theoretical information and on anecdotal evidence derived from the sociological and linguistic findings. Qualitative data is in the form of words rather than numbers. Transcription of the spoken word is believed to be valid data for the discourse analysis which is the principal approach chosen in this sociolinguistic research. Therefore, much of the research report is composed of word-for-word utterances from those being studied.

However, to a very limited extent a quantitative method is applied in order to measure the frequency of gender stereotypes and to evaluate the significance of "gender" stereotypes compared to other stereotypes expressed during primary research.

The research aims are descriptive and explanatory, increasing our understanding of the nature and use of gender stereotypes and interpreting their purpose and impact. The

research method is naturalistic and ethnographic in its ideal conception. Direct interaction with the speech community and participant observation are the recommended methods for examining the language and the meanings that the participants assign to HIV / AIDS (see also Sections 5. 6. 2 and 5. 6. 3).

3.2.2 RESEARCH TECHNIQUES

In this study a variety of research techniques are used to produce primary and secondary data. The fieldwork techniques are FGDs and unstructured interviews. The technique of focus group discussion is particularly adapted to conduct qualitative research and is generally used to gain an in-depth but not representative understanding of the attitudes, beliefs and perceptions of groups of people (UNDP 2000:278).

The group approach is used to get a feel for the language, the values expressed by this language, the range of meanings and also to identify areas in which there is agreement or disagreement between members of the speech community. Participatory styles and inclusive approaches, give voice to those who are never heard (UNDP 2000).

Secondary material comes from a diversity of sources which are procured on-line or in libraries and documentation centres. The choice of the research techniques is largely determined by the research context, the choice of the topic, practical issues such as the researcher's position and the amount of time available, as described in the research design.

3.2.3 RESEARCH CONTEXT

This sociolinguistic research is conducted in parallel with and in the same context as the MSF investigation on HIV / AIDS perceptions. MSF pursues its own investigation aims namely to gain insight into the population's perceptions and to create a database of their knowledge, beliefs, attitudes and behaviour in relation to HIV / AIDS. Their general objective is the implementation of an extended HIV / AIDS counselling programme which is outlined in the previous chapter. Their specific objective is to promote access to HIV / AIDS counselling of the population living in the district *Bairro Urbanização* targeted by the W&S Project.

3.2.4 RESEARCHER'S POSITION

FGDs and interviews do not only take place for sociolinguistic data collection. The researcher in sociolinguistics[4] does not take part in the FGDs (except as an observer in the two which were conducted in Portuguese). However, the researcher participates actively in the preparation, follow-up of data collection and data analysis. The role of the researcher is generally covert in the FGD sessions (except in the two FGDs mentioned above) but overt in the interviews. Not collecting data first-hand has advantages and disadvantages. On the one hand, the participants feel more comfortable in the presence of Mozambican interviewers and the group's behaviour is more natural. On the other hand, the researcher has no effective control over the procedure and relies completely on feedback from the data collectors (see also Section 5. 6. 3).

3.2.5 RESEARCH DESIGN

The following sections give a brief description of the five main phases of the research and their time schedule. The research design is summarised in Section 2. 7.

3.2.5.1 Primary data collection

FGDs are set up with target groups of the Project. The participants, who are grouped according to their age, sex and occupation, are invited to take part in a discussion on HIV / AIDS. Interviews are held with nurses and other people who work in close relation with PLWHA. The duration for conducting primary investigation takes 2 months and is scheduled during the months of May and June 2002.

3.2.5.2 Secondary data collection

The procurement of secondary data is a continuing process and the bibliographic research starts seriously from October 2002 onwards. Books are borrowed online and airmailed to Morocco (where I live) passing through Brussels (where my official address is). Articles and statistics on HIV / AIDS are procured online.

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[4] The researcher in Sociolinguistics, alias myself, is designated as the researcher in the dissertation in opposition to the data collectors who form the MSF investigation team.

3.2.5.3 Organisation of data collection

This phase is undertaken from July until October 2002. Collected data is indexed, classified and codified so that it can be used as meaningful units for the analysis (see Section 3. 6. 2). From this database, variables are identified and correlated. In this last phase, the researcher is able to test ideas and identify patterns of speech and behaviour.

3.2.5.4 Analysis and interpretation of the findings

From November 2002 until March 2003, data is analysed and interpreted with five different approaches outlined in Section 3. 8. The analyses are presented in Chapter 4.

3.2.5.5 Conclusions and recommendations

The results at the various levels of the research are concluded during April until June 2003. Conclusions and recommendations are the focus of Chapter 5.

3.3 DATA

3.3.1 PRIMARY AND SECONDARY DATA

3.3.1.1 Primary investigation

The conversations held during primary investigation phase are recorded, transcribed and computed. The FGDs are principally held in Shangane, then translated into Portuguese and finally dassified in categories and themes (see Section 3. 10. 1). The FGD-transcripts represent a list of word-for-word utterances in their translated version. Four more transcripts of the interviews complete the collection of primary data.

3.3.1.2 Secondary investigation

For secondary data collection, an array of sources are used such as: on-line and updated Population Census Statistics on HIV / AIDS, previous surveys, project documents, literature on stereotypes, G&D manuals and papers, and research methods (see Bibliography).

3.3.2 DATA COLLECTORS

The MSF investigation team collecting the data is composed of a facilitator, a note-keeper and an observer. The researcher and the project coordinator of the W&S Project play a role in the analysis and the supervision of the research. The note-keeper and the observer are both MSF officials whereas the facilitator is a Red Cross trainer who has been recruited to guide the FGDs.

The facilitator and note-keeper are respectively a man and a woman. These people have not been in contact with the target community so far. Their neutral position in the W&S Project is considered important so as not to influence the responses. They have received training in the techniques of focus groups and about HIV / AIDS. The facilitator is also involved in the preparation of the research, in data transcription and translation, and in data analysis.

Apart from collecting data, the MSF investigation team also ensures all the logistics required for conducting FGDs such as organising the event, contacting and inviting the participants, and tape-recording. In this, the observer who works in the community on an everyday basis, plays an essential role.

Two pilot groups, a male group of logisticians and drivers (pilot group 1) and a female group composed of MSF housecleaners (pilot group 2), are organised at the MSF office in order to test the questionnaire and the recording material. The sound quality of the recording in these two occasions is disrupted by construction works next to the office. As a consequence, these sessions have underlined the necessity to arrange a quiet and comfortable venue for the discussions.

3.4 SUBJECTS

3.4.1 ACCESS TO SUBJECTS

The researcher has no direct access to the subjects due to the language barrier except in the two FGDs held in Portuguese. Fortunately, communication with subjects normally takes place in Shangane which is the vernacular of the speech community and also of the MSF investigation team. The researcher receives regular feedback from the note-keeper and the facilitator.

Moreover, the regular field visits and follow-up meetings with the organising nucleus ADASBU and the whole network of contacts created around the W&S Project certainly facilitates the access to the subjects.

3.4.2 THE INFORMANTS

In total MSF conducted 14 FGDs: two with pilot groups and the twelve other focus groups with members of the speech community (see Annexure 1).

In this research, only 10 focus groups are retained for data analysis. The pilot groups are not considered for analytical purposes as the participants are not residents of *Bairro Urbanização* and FGD 4 and FGD 12 are excluded from the analysis because of the loss of the transcripts.

The subjects of the FGDs are either involved in the W&S Project or occasional recruits who are asked to participate in the discussion. All subjects live in the district and project area *Bairro Urbanização*. In total there are 99 participants, 58 males and 41 females. There are approximately 10 participants per focus group.

Of the 14 groups participating in the open-ended discussion, 4 are involved in the W&S Project. The fact that sanitation trainers are selected in the project area makes them first-hand informants.

For the interviews, the initial intention to select women who attend HIV/AIDS services is rejected as inappropriate. It is then decided that, instead, two MSF doctors treating HIV/AIDS patients would be interviewed on their behalf. Two more interviews are conducted with members of an association for PLWHA called Kindlimuka.

3.5 MATERIALS AND RESOURCES

- For primary data collection, the following materials are used:
  - recording material with a good microphone
  - the FGD-guide for the facilitator
  - a notebook and pen for the note-keeper and the observer

- incentives for the participants: red bows symbolising the anti-AIDS campaign, calendars, 2 free tickets per person for a VCT, and condoms distributed on their demand (see also ethical problem in Section 3. 9).

➢ For the procurement of secondary data collection, essential resources include people involved in development projects, library advisers and professors (see Acknowledgements) and a computer with internet connection.

➢ No additional financial resources other than the ones required to conduct the MSF survey are necessary, as the collaboration is established on a voluntary basis and logistics are put at the researcher's disposal when required.

3.6 PROCEDURES FOR DATA COLLECTION

3.6.1 FOCUS GROUP DISCUSSIONS

All the FGD sessions take place in the district *Bairro Urbanização* where the participants live. The discussions are held in different but accessible places and at the most convenient hours for the participants.

Each FGD session is tape-recorded with the permission of the participants. The discussions last one and a half hours. At the end of the discussion, the participants have the opportunity to ask questions. They receive incentives after the discussion (see Materials 3. 5).

The facilitator of the FGDs stimulates interaction among the participants by asking their opinion about HIV / AIDS. His role is to be as open-minded and receptive as possible and to ensure that all issues are discussed. With this intention, a FGD-guide containing open-ended questions is provided (see Annexure 2). This questionnaire, drafted by the project officers and the researcher, is used as a support for the facilitator during the group discussions.

3.6.2 ORGANISATION OF DATA

FGDs are translated, transcribed and numbered in chronological order. Subjects are listed per focus group with mention of their age, sex, occupation and in some cases (mostly younger people) the level of formal education is also given. The organisation of data as such is called **indexation**.

In the **classification** phase, utterances are organized in main and sub-categories.

In the next phase, another classification takes place called **codification**. Opinions receive a code corresponding to an identified theme such as: knowledge of the difference between HIV and AIDS, degree of acceptance of the disease, gender relations, traditional treatment, degree of proximity with HIV / AIDS, degree of willingness to live close to infected people, willingness to be tested, etc. These perceptions and behaviours are classified in rubrics called **language themes** (see Section 3. 10. 1). Marked this way, a horizontal and vertical analysis of collected data can take place (see Chapter 4).

3.6.3 INTERVIEWS

Interviews with nurses caring for HIV / AIDS infected women are planned in order to compare the life stories of their patients with collected gender perceptions and to draw conclusions on social stigmatisation of the women seeking HIV / AIDS counselling. Two interviews with MSF employers take place; one interview is held with the director of Kindlimuka and the other with a volunteer of the same association. In this primary investigation phase, reports from the field of MSF are also used (MSF Website January 2003) as well as a journalistic account containing anecdotal information about the HIV / AIDS situation in Southern Mozambique (Conselho Cristão de Moçambique). These findings are checked against ethnographic data and other theoretical material on the research topic, which is procured during the secondary investigation phase.

3.7 DATA ANALYSIS

3.7.1 DESCRIPTION PHASE

An important procedure preceding the analysis as presented under 3. in the Research Design (2. 7), is the organisation of collected data and the creation of meaningful units for a sociolinguistic investigation. For the analysis of stereotypes, I only retain the category of perceptions that express popular beliefs and myths about HIV / AIDS and gender roles and norms. In line with Fishman's model (Fishman 1971, in Sociol-K 1987:12) "Who says What, To Whom, How and For which purpose?", stereotypes are defined as a set of variables:

- What? (popular beliefs and myths expressing gender bias)

- Who? (categories of informants classified by sex, age-group, occupation and level of formal education)
- How? (stigmatising from a prejudicial position)
- To whom? (during FGDs and in an interview situation)
- About whom? (women + HIV / AIDS)
- For which purpose? (rationalise female stigmatisation to justify male sexual transgressions)
- With what effects? (reinforcing existing discrimination forms against women and creating additional gender barriers to HIV / AIDS)

The last two variables are hypothesised and remain to be tested with the functional analysis (in Section 4. 6. 2 and 4. 6. 3).

3.7.2 An operational definition of gender stereotypes

Gender stereotypes thus correspond to a category of perceptions based on popular beliefs and myths about gender roles and norms (What?), expressing bias towards women (About whom?) and revealing the prejudicial position of the speaker (How?). They rationalise female stigmatisation with a view to justifying male sexual transgressions (For which purpose?). They reproduce gender inequalities and create additional gender barriers to an effective combat against AIDS (With what effects?).

3.8 Research approaches

3.8.1 Sociology of language

The first approach, the sociology of language, studies the social context in which the interaction takes place through a selection of linguistic items and samples of conversations uttered by the community talking about AIDS. The aim is to gain insight into the social meaning of AIDS as it is embedded in its socio-economical and cultural context. In this part of the analysis, the researcher also examines the existing constraints at the various language and socio-cultural levels: language system, labels for HIV / AIDS, gender representations, world-view, power-relations, social barriers, etc.

3.8.2 DISCOURSE ANALYSIS

Discourse analysis is the second approach and focuses on the message content of the FGDs. It highlights the "What?"variable of Fishman's model. It is called the horizontal analysis of stereotypes as it sets correlations between perceptions of AIDS, attitudes and behaviour to AIDS in one and the same focus group. It aims at depicting patterns of cause and effect through the connection of extra-linguistic aspects and pure linguistic aspects, such as between perceptions of risk and levels of understanding about HIV / AIDS.

3.8.3 SPEECH ATTITUDES

The third approach, the analysis of speech attitudes, correlates speech attitudes of users and social patterns of perceptions. This part of the research, also called the vertical analysis, compares data from various focus groups and relates categories such as age groups and belief systems or levels of perception and stigma. It focuses on the description of the users ("Who?"variable) and their use of stereotypes as a particular speech attitude which receives further attention in the following approaches.

3.8.4 STEREOTYPING

In the fourth approach, the process of stereotyping is studied from a semantic perspective calling our attention to the underlying structure of this speech variety. Stereotypical reasoning is examined in discourse and focuses on the "How?"variable. A quantitative investigation of stereotypes examines the content and frequency of the uttered stereotypes and highlights the important place of gender stereotypes in HIV / AIDS discourse (see Section 3.8.6).

3.8.5 FUNCTIONAL ANALYSIS

The functional analysis describes the functions and effects of gender stereotypes or the hypothesised "For which purpose?" and "With what effects?" variables. This part of the analysis puts the analysis back in context, namely the Mozambican society threatened by an increasing HIV / AIDS progression. The research problem is demonstrated with examples of women's difficulties in gaining access to HIV / AIDS counselling centres.

3.8.6 STATISTICAL ANALYSIS

Statistical data is collected in order to test part of the hypothesis stating that in the discourse about HIV / AIDS: a) stereotypes are frequently used and b) a great number of stereotypes are gender biased. This part of the analysis rests upon a definition of the "What?" variable which makes stereotypes and gender stereotypes highly visible and easily discernible linguistic markers. Gender stereotypes and other stereotypes are indexed in Annexure 4. However, a high risk of bias can be predicted from the start as some of the FGD-guide questions are formulated in a stereotypical way. Another possible interpretation is to count the number of positive and negative reactions to stereotypical expressions for example question 2,1 "Some people say that HIV / AIDS is transmitted by the female sex, what do you think?" The reactions are expected to give an indication about the level of gender sensitivity of the informants.

3.9 METHODOLOGICAL CONSTRAINTS

Although the choice of topic is feministic oriented, the methods of focus group discussion and interviews are supposed to be value-free and objective. However, bias in qualitative methods is commonplace especially in topic-oriented sampling. For instance, how can one be sure that the subjects' perceptions are true pictures of the way they behave in the real world and not just answers to questions in an interview situation with the intention of pleasing the experimenters. This influence of the experimenter on the subjects is called the experimenter effect (McNeill 1990:56). Moreover, how objective can observation be and to what extent is the experimenter's eye not sampling the information on the basis of what the researcher considers to be important. Bias created this way is called the experimental effect (McNeill 1990:55).

The ethnographic method is often considered unreliable because the research cannot be repeated as a means of checking its descriptions and conclusions (Mc Neil 1989: 83). Therefore, the emphasis of the method is on the validity of the data collected at the price of its reliability and its representativeness, as data doesn't rest upon an exhaustive ethnographic description. An important test for the validity of the findings is that the people involved recognize themselves in the portrayed characters. Subjects should thus receive

feed-back from the results of the investigation and be able to discuss them before they are reported (see Recommendations 5. 7).

A problem of anonymity can arise if people recognize themselves in the report. Researchers should always be reminded of the taboo nature of HIV / AIDS. Results therefore are to be treated as anonymous responses to HIV / AIDS so that they do not leave room for any possible association with the authors.

Opinions diverge regarding the implication of children (under 15 years old) in the survey evoking an ethical problem. Should they be involved in discussions on HIV / AIDS or excluded on the grounds that they are not sexually mature? This last position is finally resolved in the survey, as the participation of children required prior authorisation of their parents who appeared to be reluctant. [5]

Another ethical problem arises with adolescents who are not yet sexually active and who received condoms as an incentive for their participation. These participants, however, are considered to be old enough to receive information about HIV / AIDS prevention and are free to accept or refuse the proposed condoms.

Studying social life as it is experienced by those involved is reducing the distance between the observer and the observed. Participant observation, therefore, is ideally achieved by ethnographers of communication who have direct access to the speech community. This researcher does not find herself in this fortunate position but works closely with the MSF investigators who know the speech community well, are good communicators and experienced data collectors (see Section 5. 6. 2).

[5] Children are an important population stratum representing almost 50% of the total urban population. They also represent the future generation of Maputo and a window of hope in the combat against HIV / AIDS, considering the absence of HIV infection in this age group. However, the number of children infected through mother-to-child transmission of HIV is estimated to be 52,000 cases at the end of 1999 (UNAIDS 2000:3).

3.10 TABLES AND MODELS FOR DATA INTERPRETATION

3.10.1 CATEGORIES OF PERCEPTIONS AND LANGUAGE THEMES

The table below (Table 3) is inspired by William Leap's conceptual contribution for the study of language and AIDS, that emphasises the necessity to generate a set of language themes and categories evolving out of the conversations and narratives of the interviewees (Leap 1990, in Hopson et al. 2000:34).

In this framework, themes emerging from the conversations and narratives of the participants are ranked in categories of language themes, one set of themes representing an individual perspective (A, B, C, D) and a second set of themes characterizing the social discourse of HIV / AIDS (E, F).

Language themes are mentioned in a frame per FGD (see Table 4) when they are evoked and are given an estimation of their degree of accuracy or of appropriateness (+, + / -, -). The levels of perceptions regarding attitudes and behaviour are considered irrelevant (nr) when they are not mentioned in the discussion.

Table 3: Language themes and their estimation scales

Perceptions	***Language themes***	***Estimation scales***
A) Knowledge	a) Transmission	High (+)
	b) Prevention	Medium (+ / -)
	c) Spread	Low (-)
	d) Treatment	
	e) Approximation f) Symptoms	
	g) Statistics	
	h) Information	
	i) AIDS jargon	
B) Stereotypes	a) Transmission	Nature
	b) Prevention	Frequency
	c) Propagation	Distribution
	d) Cure	
	e) Origin	
	f) Analogy	
	g) Taboo	
	h) Gender dichotomy	
	i) Race dichotomy	
	j) Social dichotomy	
C) Attitudes / Values	a) Conscious of being at risk	High (+)
	b) Acceptance of disease in others	Medium (+ / -)
	c) Shared responsibility in the HIV spread	Low (-)
D) Behaviour	a) Practise safe sex	High (+)

	b) Do Voluntary Confidential Testing c) Offering support to PLWHA	Medium (+/-) Low (-)
E) Social Themes	a) Prostitution / Poverty	Frequency
	b) *Sexta Feira / Barracas / Crianças* [6]	
	c) Generation conflict	
	d) Hospitals, traditional healers, private nurses	
	e) The government's responsibility	
F) Discourse	a) Associations of HIV / AIDS	Illustrations
	b) Metaphors of AIDS	
	c) Other names / labels for AIDS	

3.10.2 SOCIOLOGY OF LANGUAGE

The sociology of language focuses on social themes and discourse corresponding to categories E) and F) in the abovementioned framework. Their content and frequency are considered important indicators in this analysis.

The multiple interaction spheres of sociolinguistics inspired by the Sapir-Whorfian hypothesis are represented in Table 1 (Section 1. 3. 4).

3.10.3 DISCOURSE ANALYSIS

The stigmatising process of gender stereotypes leading to discrimination against women is illustrated in the abstract-concrete continuum in Table 2 (Section 2. 6. 4).

FGDs and interviews are the chosen methods for primary investigation (see Sections 3. 6. 1 and 3. 6. 3). The collected perceptions are classified into four main categories and a series of sub-categories, called language themes (see Table 3), that are generated from the FGD transcripts. They are respectively:

- at the level of HIV / AIDS understanding (A): transmission, prevention, spread, treatment, approximation, symptoms, statistics and information;
- at the level of stereotypes (B): transmission, prevention, propagation, cure, origin, symptoms, taboo and gender;
- at the level of attitudes (C): conscious of being at risk, acceptance of HIV / AIDS in others and shared responsibility in the HIV / AIDS spread;
- at the level of behaviours (D): practise safe sex, go for a VCT and willingness to cope.

[6] Friday night, Street bars, Girls

The discourse analysis (see Section 4. 3) highlights perceptions of stigma, attitudes of risk and control, and discriminatory behaviour towards infected people. The perceptions are schematised in frames per FGD as follows:

Table 4: Frame of perceptions per focus group (example)

	Level of understanding		*Social responses*	
Perceptions	**Knowledge +/-**	**Myths (5)**	**Attitudes (+/-)**	**Behaviours (-/+)**
Language themes	Approximation + Symptoms + Transmission + Prevention +/-	Propagation (3) Gender (2)	Conscious + Acceptance - Shared responses +/-	Safe sex – Do VCT – Support +

The levels of perception are examined per group in the following questions:

1. What is the practical knowledge of the participants concerning the various AIDS issues?
2. What is the frequency and nature of evoked stereotypes in relation to HIV / AIDS?
3. What is the degree of stigma in attitude in relation to HIV / AIDS?
4. What is the degree of discrimination in relation to HIV / AIDS victims?

Perceptions of knowledge and stereotypes are scaled on the same continuum of understanding, from the most accurate to the most stereotypical. Perceptions of attitudes and behaviour are placed on a social continuum, and ranked from most appropriate to most inappropriate with regard to an effective HIV / AIDS strategy.

The level of accuracy in perceptions and of appropriateness in social responses are estimated and schematised in a general framework (Table 9) including all the focus groups (see Section 4. 3. 3. 1).

The aim of this investigation is to demonstrate that gathered perceptions not only reflect the participants' level of understanding about HIV / AIDS but also unravel their level of stigma and discrimination towards PLWHA. In the conceptual framework, three main categories of perceptions, attitudes and behaviour are preliminary established, which are believed to be important stages in the trajectory of stigmatisation. The discourse analysis should demonstrate a cause-and-effect relationship between gender stereotypes and discrimination against women moving from abstract to concrete categories of perceptions presented in

Table 2. The mutual relationship between stereotypes, stigmas and discrimination is schematised in the following framework:

Table 5: The process of stigmatisation

Categories of perceptions		
Understanding	*Attitudes*	*Behaviour*
Stereotypes (+)	Stigma (+)	Discrimination (+)

Estimations for stereotypes, stigma and discrimination can be high (+), medium (+/-) and low (-) as long as there is a continuum of the scores in these categories of perceptions. See Section 4. 3. 3.

3.10.4 ANALYSIS OF SPEECH ATTITUDES

Categories of informants are compared to categories of messages (f.i., categories of people compared to language themes) in order to detect social patterns of beliefs, norms and attitudes, prototypical behaviour and profiles of people. Correlations between perceptions grounded in myths and belief systems, stigmatising attitudes and discriminatory behaviour are examined in the speech attitudes of the participants, as illustrated in Table 6.

Table 6: The mutual relationship between gender stereotypes and discrimination against women

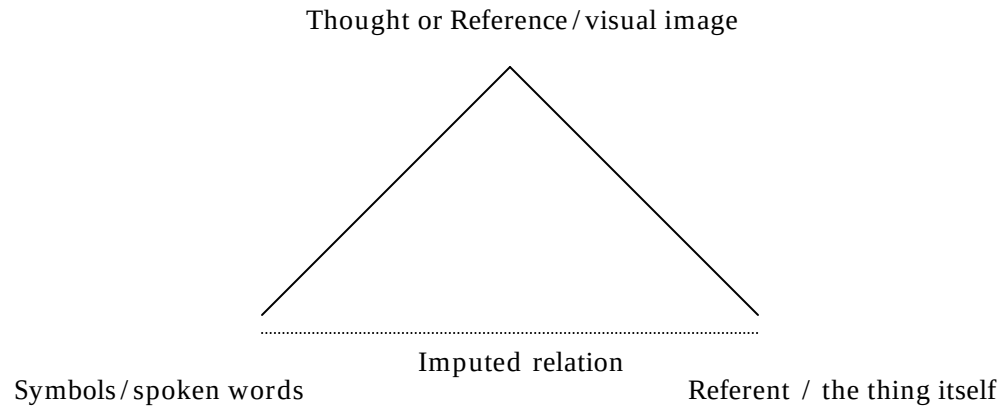
Categories	Perceptions		Attitudes		Behaviour
	Beliefs / Myths	⇄	Stigma	⇄	Discrimination

3.10.5 ANALYSIS OF STEREOTYPES AND STEREOTYPING

Stereotypes are ordered in function of their nature, and their distribution and frequency in the HIV / AIDS discourse are also important indicators. Encountered themes of stereotypes are schematised under category B in the framework of language themes (Table 3).

The following semantic model is used in the analysis of the stereotyping process to demonstrate how the referent is linked to the name via the reference (referential meaning).

Table 7: Semantic diagram



3.10.6 FUNCTIONAL ANALYSIS

The functional analysis demonstrates the various functions and effects related to the use of gender stereotypes. The application of Austin's speech-act theory on gender stereotypes will highlight the speaker's intention (illocutionary force) of this specific speech act and its effects on the receiver (perlocutionary force).

Table 8: Speech-acts model

Speech-acts		
Locutionary force Produced speech in context as a kind of social behaviour	**Illocutionary force** Inherent function	**Perlocutionary force** Effects: - Intended - Unintended

3.11 CONCLUSION

A qualitative research is organised with MSF Mozambique in order to collect the HIV / AIDS related perceptions of the speech community targeted by the W&S project.

Participation for the researcher, even as an observer, is not possible without provoking additional bias considering the fact that many subjects only express themselves in Shangane, their usual communicative idiom. The role of the researcher, who hasn't mastered the vernacular of the speech community under scrutiny, is thus marginalized in primary data collection and emphasised in the research.

However, the MSF investigation team has a high understanding of the speech community. Collaborators of the W&S Project also play a role as key informants, reporting regularly on the inhabitants and sanitation conditions of the project area which facilitates the access to the speech community living in *Bairro Urbanização*.

The operational definition of gender stereotypes founded on Fishman's model (see 3. 7. 2) focuses on one of the following variables so as to facilitate its classification and interpretation. Thus, the discourse analysis studies the message content or the "What?" variable; the approach of speech attitudes focus on the categories of users of stereotypes or the "Who?" variable; the "How?" variable receives attention in the investigative part concerned with the process of stereotyping, and the functions and effects of stereotypes corresponding to the "For which purpose?" and "With what effects?" variables, are the study objects of the functional analysis. Moreover, HIV / AIDS related speech will be analysed within a real context through the sociology of language corresponding to the "In which context?"variable.

Some methodological constraints are then discussed such as: objectivity, validity and reliability as well as anonymity and ethical issues.

In the last section of this chapter, tables and models are presented in order to facilitate the interpretation of the results of the various approaches which are described in the following chapter.

4 RESEARCH

4.1 INTRODUCTION

In this chapter, the AIDS discourse is analysed from five different approaches which are respectively: sociology of language, discourse analysis, analysis of speech attitudes, stereotyping, and functional analysis. The research design with methodological procedures and frameworks for data analysis are summarised in Sections 2. 7 and 3. 10.

4.2 SOCIOLOGY OF LANGUAGE

In this first part of the research, the relationship between the epidemiological constructions of AIDS in a speech community and their social experience with the disease is observed. Starting from images, connotations, symbols, and stereotypes of HIV / AIDS, facets of the cultural values and beliefs, social institutions and forms, and the historical and political context of a community are examined in their bearing on communicative events and patterns. This approach highlights a new variable of gender stereotypes, namely In which context?, which will be added in the final description of stereotypes in HIV / AIDS discourse (Conclusions, Section 5.3.2).

4.2.1 ELEMENTS OF DISCOURSE

"*SIDA*" is the lusophone counterpart of AIDS and is adopted unanimously by all Mozambicans as the only existing name referring to the disease in question. Portuguese is the official language of Mozambique, an inheritance of the former Portuguese colonisation that lasted between 1629 and 1975. During the civil war which followed indepe ndence (1976-1992), the country's boundaries were largely closed to foreign traffic and human passage. This fact protected the country from the spread of AIDS which in 1994, with the election of Chissano as President of the Republic of Mozambique, had already reached high

proportions among the adult population of two neighbouring countries Zambia and Malawi[7] (IDRC 1997:3).

4.2.2 ALLUSIONS, CONNOTATIONS AND METAPHORS

AIDS has many allusions as people have started to talk about it. A participant making indirect reference to AIDS calls it "the sickness of the adults" (*la wa khulu*, in FGD 2, 1); when referring to the high vulnerability of young people, an old man said: "In particular young people can get the disease, not an old chap (*madala*) like me" FGD 10, 8); and alluding to its foreign origin they also call it "the sickness of the white people" (*mavabyi ya xilungo*, in pilot group 2, 6).

AIDS is perceived primarily as a sexually transmitted disease (STD) and is referred to in connection with most current STDs in Maputo such as gonorrhoea (*Xikandzameto*, in pilot group 2, in FGD 8 and FGD 9). This can be divided respectively into *Xikandzameto xa duna*) or gonorrhoea for a man and *Xikandzameto xa wassate* or gonorrhoea for a woman, as symptoms are different for a man and a woman (FGD 9, 3). Other names for STDs associated with AIDS are *ximbatata*, *mukutuza* and *ntungo* (in FGD 11).

Some metaphors for AIDS as an STD refer to the imagery of the animal world, such as *Xikavalwana* (FGD 6, 1), which is a small horse, in allusion to the galloping nature of STDs. "*Ha lumiwili hi xindwanyane*" in FGD 8, 10 literally means: "He was bitten by a small dog." Dogs in Mozambique have not gained the status of pets in western societies and are considered unhygienic, dirty animals which generally live as strays (see also dogs in AIDS metaphors 4. 5. 4).

Other metaphors are rooted in the historical context of Mozambique which was the battleground of several wars, namely the struggle for Independence in 1975 quickly followed by the Civil war in 1976. In both wars, mines were placed around villages and along the roads which still cause casualties among the population[8]. This explains the allusion

[7] At that time, a sero-prevalence of 10 to 40 % in cities, and of 5 to 15 % in rural communities was registered in Eastern Africa.

[8] It is estimated that there are still 2 million anti-personnel mines in Mozambique, and that it will take 160 years to clear them at the present rate, during which time human beings will continue to be killed and maimed (Red Cross Red Crescent 2002).

"*Ni pwsanyile*" in FGD 8 meaning: "he stepped on a mine. " A metaphor cited by the same person refers to the spread of AIDS via blood, namely *"xitsemile"*, meaning: "He was cut" FGD 8, 2).

A young male participant from FGD 5 speaks in a figurative way as if AIDS was a living person: "AIDS has chosen the sexual way to enter into the human body" (FGD 5, 1).

According to a member of the male community, "every body is responsible for oneself and must take care. Some people, however, do and then fate (*o azar* in Portuguese) reaches them and they get the disease" (FGD 10, 2).

A last metaphor is cited by a young male in the same group mixed in age in allusion to the sexual transgression of their fathers: *"Comportam-se como patos que metem as bocas em qualquer sítio sem escolher"*[9] (FGD 10, 6).

Condoms are called little shirts or *"camisinha*" in Portuguese and a figurative way of saying that men refuse to use them is: "You don't take a shower with a rain coat, do you?" (FGD 7, 10).

4.2.3 ASSOCIATIONS WITH OTHER DISEASES

AIDS is associated with other diseases (see Section 2. 3. 3). Participants in different focus groups report that a number of people in Mozambique still don't believe in the existence of AIDS. A lot of people deny it, arguing that they had never seen anyone with AIDS: "AIDS manifests itself through other diseases like tuberculosis (TB), diarrhoea, etc. When a person gets TB and later on diarrhoea, people believe that the person died from TB and not from AIDS" (FGD 1, 12).

The diseases mostly mentioned in relation to AIDS are in order of importance: TB, STDs, cholera, cancer, leprosy and rabies. Except cancer, they are epidemics that have struck large parts of the population in the last fifty years and some continue to have devastating effects like STDs and cholera, and to a lesser degree leprosy in Northern Mozambique.

In the discussions, AIDS is mostly associated with TB as it is one of the principal manifestations of AIDS. Thus, the association is easily made: people don't die of AIDS but of TB. That is one of the reasons why people still refuse to believe in AIDS. Indeed, according to

[9] They are acting like ducks who put their beaks wherever they please.

some respondents, saying so could be a strategy of some people to ignore the disease as they are too scared to face the reality (see also Speech attitudes in Section 4. 4. 4. 5).

Drastic weight loss is associated with AIDS as it is one of the first symptoms of AIDS. Many times, thin people are suspected of having the disease (FGD 1, 7 - FGD 5, 2 - FGD 6, 1) . In the neighbourhood, there are suspicious cases (FGD 10, 6). However, people get better but their neighbours remain suspicious and wonder if these people are infected or not (FGD 2, FGD 8).

4.2.4 AIDS REMAINS A TABOO ISSUE

Not surprisingly people haven't invented a new name or adopted a local name for AIDS which is believed to have come from elsewhere. The label *"SIDA"*, as it is called in Maputo, is already an acronym of a medical paraphrase describing a deficient immune system, which is further abbreviated to *"CD"* (FGD 8, 8).

For some reason, people prefer to stick to the scientific concept. In discussions, a lot of people even avoid mentioning AIDS and prefer to refer to it as "the disease". The label "SIDA" has a magic force shrouded in taboo. Out of superstition, AIDS deserves to be kept at a distance, and by naming it people are afraid of catching AIDS themselves (see Ullman in Section 2. 5. 2).

It wasn't clear if *CD* is a euphemism for AIDS or if it refers to the CD4 count [10]. However, calling an infected person *"humano positivo"* (FGD 8, 2) or a positive human is certainly a euphemism. It means that a person with a positive HIV status receives a positive label [11] for a negative outcome of a serological test. This is ambiguous and contradictory. Similarly, the positive characterisation of the test in a phrase like your test came out positive, turns out to be confusing to people receiving their HIV test results, as well as to the person supplying the information. This is a general observation which is not restricted to this context.

AIDS is not discussed openly without provoking suspicion. This is expressed as follows in a Mozambican context where malaria remains the principal cause of mortality: "You don't say you have a relative with AIDS as you would say that your sister has got malaria" (FGD 2, 2).

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[10] CD4 cells are a type of white blood cell which is part of a body's immune system.

[11] In this case "positive" refers to the presence of HIV-antibodies, evidence of previous exposure to the virus whereas negative status indicates an absence of that evidence.

Another says that you can hide the problem until symptoms start to appear: "At that moment, infected people suffer discrimination from their neighbours and will finally put an end to their lives so as not to suffer from isolation" (FGD 2, 4).

Why is malaria not a taboo subject like AIDS? The taboo surrounding AIDS is related to the stigma commonly associated to sexually transmitted diseases indicating "socially deviant behaviour". PLWHA are discriminated against because they chose to have AIDS through participating in deviant behaviour. These people become a category of social "otherness" whose behaviour marks them as not "us" but "the other" (Worth 1990:112).

The association of AIDS with prostitution results in making women a category of social otherness and a risk group as a whole. In Mozambique, these pernicious perceptions of the female population result in higher stigmatisationof infected women seeking HIV / AIDS counselling as will be discussed later.

Contrary to most other countries, AIDS associations with other stigmatised groups such as IV drug users and homosexuals, are completely absent in the discussions with focus groups. It is only mentioned once in the male group of football players (FGD 8) that men are likely to take drugs as a pastime and that needle sharing is one of the ways AIDS is transmitted. Does that mean that homosexuality and drug use don't exist in Mozambique or that they are not the principal infected groups? Data contradict this fact and point out that drugs and homosexuality are presumably also taboo issues which are not overtly discussed[12].

As a matter of fact, prostitution is not taboo in the Mozambican context considering the way people talk about it (FGD 2, FGD 6 and FGD 10). For most people, prostitution is a social phenomenon caused by poverty. "Women at street corners" (FGD 1, 7) are numerous; they are part of the social setting. Therefore, poverty is intrinsically linked to AIDS (see Social Theme 4. 2. 8. 1).

However, the taboo nature of AIDS which aggravates the HIV spread is discussed in FGD 1 (see Section 2. 5. 2). According to the sanitation trainers, postponing the problem makes it even worse in terms of the number of infections. Young adults condemn this attitude of voluntary blindness of some people for "within 3 or 4 years, as the disease progresses, reality

[12] Homosexuality is accepted when a man is compelled to have sex with men, f. i. in prison. In all circumstances, men have to maintain sexual relations and in certain circumstances, homosexuality is unavoidable (Bagnol 1996, in Osorio & Arthur 2002:6).

will face them" (FGD 1). A woman of FGD 3 criticizes the fact that hospitals send sick people back home in a critical state. Hospitals don't tell people the truth. Another woman comments on this claiming: "For the environment it is better to know but for the individual it is better to ignore" (FGD 3, 7).

AIDS is also described as a "camouflaged disease" that doesn't choose its victims (FGD 9, 3). The hidden connotation of AIDS refers to the fact that many people are still ignorant of their positive status when they are still in an asymptomatic state of the illness (FGD 6, 6). "AIDS is not selective. Babies, old people, adults, young people, everybody can die of AIDS. Even the rich are not spared" (FGD 9, 3), meaning that it strikes indifferently all age groups and all social strata. AIDS is an STD but nonetheless it kills babies and old people all the same (FGD 3, 6). This fact astonishes people a lot. As AIDS progresses throughout the population, it becomes more and more difficult to associate a sense of otherness to those groups that were previously not perceived as being at risk. The unexpected apparition of AIDS in wider population groups feeds mythical explanations regarding its spread.

4.2.5 MYTHS AND STEREOTYPES

People's understanding of AIDS is loaded with stereotypes about its origin, spread and transmission (see also Section 4. 5. 4). For instance, the association of AIDS as "the sickness of the white people" could be an allusion to white people's responsibility in the spread of AIDS in Mozambique, a myth evoked in various discussions (FGD 4, 8) or it can also reflect black people's stereotypical vision that whites are more knowledgeable. Male respondents consider women the principal HIV propagators. The origin of the pandemic could be caused by the transgression of the nature/culture dichotomy and the HIV spread aggravated by social disorder.

In all cases, white people are not like black people. Women are not like men. Rich people are not like the poor. Not surprisingly, Mozambicans account for the pandemic by citing the foreign origin of the virus. This explains why there is no local name for the disease so that it is imbued with a sense of strangeness. Reference to AIDS through Portuguese language terms, rather than local ones, is entirely consistent with the "we" versus "they" dichotomy implicit in such discussions. Instead of highlighting the socially accepted meanings of AIDS, this strategy lets speakers obscure these meanings (Worth 1990:113).

4.2.6 DISCRIMINATION AGAINST CONTAGIOUS PEOPLE

AIDS-related prejudice is reinforced by the contagious and malevolent nature of AIDS. One of the societal responses to the AIDS epidemic is demands for isolation of the individuals thought capable of transmitting the disease (Lewis & Range 1992:211). Discrimination acts towards AIDS victims are mentioned in FGD 3, FGD 5 and FGD 10. In Mozambique, isolating the lepers was a way of distancing leprosy and stopping the infection of healthy people, as they were quarantined on Xefina, an island situated 6 km from Maputo in the Maputo Bay (FGD 10, 8).

4.2.7 SEXUAL BEHAVIOUR

Young men accuse older men of transgressing sexual rules while they have sex with adolescent girls of their generation. They say that their fathers are acting like ducks, putting their mouth everywhere (FGD 10, 6). The habit of men going out alone in search of sexual adventure on Friday night is a male privilege and a recently attained right which is institutionalised as *"Dia dos homens"* or Men's day (FGD 3, 3).

AIDS is not a game "*nao é brincadeira*" but people still don't take AIDS seriously (FGD 8, 5). Men like to play or "*gostam de brincar*" (5, 7) and "*nao brincam com as mulheres. Fazem e desfazem das miudas*"[13] (FGD 8, 1), in allusion to their sexual games with younger girls. "*Brincadeira*" and "*brincar*" have the same root, and is used first in a negative statement and then in an active, positive sense. This supposes that there is a direct cause and effect relation between AIDS and people's unsafe sexual practices[14]. All the female participants express their concern about this social habit in relation to the AIDS pandemic. "Women rightly associate men's sexual practices to the rapid AIDS progression in Mozambique", as a man of

[13] They don't have sexual games with adult women. They just love and leave young girls.

[14] The influence of men's sexual behaviour on the high level of HIV in Mozambique is alluded to in the literature review Saùde Sexual e Reprodutiva written by Osorio & Arthur: "In the last 30 years, Mozambique has undergone enormous social, economic and political change which caused an upheaval in the social stratification and a break from traditional values. These affected and continues to affect women in particular, especially the position they had in the family and in the social structure. Sexual practices of men are the result of the reinforced male identity, linked to their dominating position in society" (Negrão 1991, in Osorio & Arthur 2002:6).

FGD 6 admits. Besides, men don't contest or try to hide this fact but rather justify their behaviour through gender stereotypes (see Section 4. 6. 2. 2).

Another fact is men's aversion to using condoms. Condoms are eschewed in a figurative way (see above). On the other hand, "*Jeito*" a metonymy for condoms called after its commercial brand name is widely known in Mozambique. Its high degree of popularity presupposes that condoms are widely distributed and that the message for practising safe sex is widely heard and, hopefully, also followed.

Unfortunately, the myth that "condoms transmit AIDS" has also reached the Mozambican public at large. The condom myth, as it is called hereafter, is used by the facilitator to open the discussion on prevention. It appears to be a hot issue considering people's reactions and the way they argue and counter-argue its efficiency. A female trainer observes that "even if a man walks with a condom in his pocket, he forgets to use it as soon as he sees the body of some girl" (FGD 1, 1). Besides, the numerous myths surrounding condoms do not favour the acceptance of this HIV preventative method[15].

4.2.8 SOCIAL THEMES

4.2.8.1 Prostitution and poverty in the hands of the Government

Prostitution is increasing in Mozambique. Moreover, several groups report that child prostitution exists in the neighbourhood (FGD 3, FGD 8 and FGD 10). Girls of *Bairro Urbanização* go to the *barracas* or local bars, especially on Friday nights, to seek money or a favour such as a drink for sex. The government has failed in its attempt to restrict the access of minors to these local bars where beer is manufactured and rooms are rented. As well as this, prostitutes in Mozambique don't have the same standards as in other countries where they are registered and have good sanitation conditions. According to a man of FGD 2, "This is why our girls are identified as the propagators of the disease" (FGD 2, 9).

Prostitutes constitute the most important risk group in the face of HIV / AIDS. Prostitutes try to earn a living and a lot of Mozambican women practise commercial sex to make ends meet. To the government, prostitution is the result of the bad behaviour of some girls that parents

[15] Popular myths about condoms transmitting AIDS or causing infertility are also reported in the literature review Saùde Sexual e Reprodutiva (Osorio & Arthur 2002:20)

are incapable of controlling. The adult population, however, accuses the government of not taking measures to stop prostitution and improve the living standards of Mozambicans.

4.2.8.2 Generational gaps impeding communication

Parents express their impotence in talking to their sons and daughters about the preoccupying AIDS problem. Young people consider them out of touch and refuse to listen to parental advice. A member of the male football club explains that some girls disobey and find themselves in the street punished by their fathers. "There should be a happy medium in education, not too severe nor too loose, because in both cases the result is the same: girls get pregnant and sometimes also infected" (FGD 8, 2). Parents criticize the behaviour of the young generation characterised by a lack of respect for elderly advice. Also young men accuse their fathers of transgressing sexual rules.

4.2.8.3 The RSA where AIDS comes from

The Republic of South Africa (RSA) is identified as one of the most prevalent places of HIV infection. Most people coming back from the RSA are reported sick and after a while they die from AIDS, leaving an infected widow behind. Mozambique has a great number of migrant workers in South-African coal mines who are recruited in Southern Mozambique (Maputo, Gaza, Inhambane Provinces). Poverty forces Mozambican people to seek a living elsewhere.

4.2.8.4 *Curandeiros* in search of a treatment for AIDS

Traditional healers practise ritual cleansing called "*tratamento verde*" or "green treatment" to treat HIV / AIDS (in pilot group 1). Typically people go to "*curandeiros*" (traditional healers) for STDs, that are believed to be linked to fetishism [16]. Most people, even the *curandeiros*, don't believe in traditional treatment for AIDS as it is a disease which comes from elsewhere that nobody has been able to cure until now. Others believe that traditional treatment can alleviate the sick and prolong their lives. Some believe that traditional healers should be given the opportunity, meaning by this financial means, to find a cure. One female *curandeiro* is convinced that she cured two infected people by using a similar treatment as for an STD but in higher doses (FGD 9, 4).

[16] Spiritual influence is cured with cleansing rituals (GEMT 1993, in Osorio C. & Arthur 2002:17)

4.2.8.5 Hospitals and alternative health services are not trustworthy

A lot of participants distrust public health services. Hospitals are not safe places any more and one can contract infectious diseases there. Medical equipment is not sterilised. AIDS is also transmitted by using the same syringes. The same happens with private nurses practising at night in the neighbourhood and traditional healers who sometimes use the same needles from one person to another. According to the community leaders of FGD 11, people should be better informed about the various ways of HIV transmission in order to reduce the risks of infection. However, most participants have a relatively high level of understanding of HIV transmission and prevention.

4.2.8.6 The shortcomings of tradition in confronting AIDS

A male football player of FGD 8 is convinced that information is delayed by African tradition. This explains why Africa has the highest number of HIV / AIDS cases. "African people like to go to traditional healers when something goes wrong. Information came too late and many people were already infected before the information could reach them" (FGD 8, 7). Many people in Africa still cannot afford a radio or a television which are considered important communication means and educational instruments (FGD 6, 5).

Moreover, the believe that a health problem cannot be caused naturally but is provoked by fetishism is widespread. Tradition is used to exonerate oneself. People generally don't believe that AIDS can be cured by traditional healers. But in crisis situations people turn to traditional belief systems, especially in desperation, such as animism and fetishism.

4.2.9 CONCLUSION

It is interesting to explore the various possible meanings and uses of the concepts of AIDS. Selected samples constitute the threads of conversation about AIDS and, interwoven with events of the Mozambican context, they reconstitute the life experience of conversing people and the meanings they attribute to AIDS. It becomes a narrative of AIDS told by concerned people. Here and there allusions are made to the history of Mozambique within living memory and the description of some important socio-cultural and economic aspects places the account into a broader perspective.

How discourse reflects who is speaking and what is said in relation to HIV / AIDS is analysed with the discourse analysis in this second part of the research.

4.3 DISCOURSE ANALYSIS

4.3.1 INTRODUCTION

This investigative part, also called the horizontal analysis of stereotypes (see Section 3. 8. 2), analyses the HIV / AIDS perceptions of the participants in one and the same transcript and also classifies and codifies per FGD (see Section 3. 10. 3). An example of a classified and codified transcript is presented in Annexure 3. These perceptions are commented on and schematised in a framework per focus group. Categories of perceptions are grouped in a general overview ascertaining the degree of understanding, including knowledge and myths, and the levels of stigma and discriminatory behaviour per FGD (see Table 9). This continuum of perceptions allows to compare levels of understanding, stigma and behaviour, that are further discussed per category.

4.3.2 RESULTS OF DISCOURSE ANALYSIS

4.3.2.1 Trainers of ADASBU (FGD 1)

4.3.2.1.1 General

This mixed group of young people have a basic level of understanding of HIV / AIDS. However, young women are more conscious of the dangers of the HIV threat than young men. A female trainer observes that young men cannot resist temptation but accuse women of being responsible for the HIV spread. Female respondents put the highest blame on prostitutes. According to the female trainers, men are also the principal propagators of the disease as they engage in higher risk behaviour. They believe that responsibility is shared as women also have lovers. All are fully aware that it is not easy to accept the disease and that this is an important reason why many people refuse to do the VCT. Trainers, therefore, suggest that testing should be accompanied by pre- and post- counselling so as to prepare people for the outcome of their test.

4.3.2.1.2 Comments

In the following scheme, one observes a gender differentiation in sexual behaviour. Although they are all conscious of the dangers of AIDS, men in particular don't always practise safe sex. They have numerous sexual partners and also have sexual relations with prostitutes and with girls of the neighbourhood, who occasionally practise commercial sex.

There is a contradiction between the males' high level of knowledge and self-awareness of being at risk on the one hand and their high risk behaviour on the other. The use of gender stereotypes are there to compensate for this distortion. In this case, behaviour influences discourse or young men manipulate discourse in their own interest (see Section 4. 6. 2. 2).

Frame 1: Perceptions of FGD 1

	Level of understanding		*Social responses*	
Perceptions	**Knowledge +**	**Myths – (7)**	**Attitudes +**	**Behaviours +/-**
Language themes	AIDS jargon + Transmission + Symptoms + Approximation –	Analogies (2) Gender (4) Taboo (1)	Self-awareness + Acceptance + Shared responsibility +	Safe sex – (**M**) Do VCT + Cope +

(**M**) Characteristic of young males' behaviour in particular

Compared to other groups, the participants have a high level of understanding and a low level of stereotypical perceptions. Young trainers comment on the process of stigmatisation of AIDS victims, starting with taboo and ending in discriminatory behaviour. They themselves don't talk stereotypically about HIV / AIDS and don't show any signs of stigma and discrimination towards PLWHA.

Scale 1: Stigmatisation process in FGD 1

Stereotypes (-)	Stigma (-)	Discrimination (-)

4.3.2.2 Members of ADASBU (FGD 2)

4.3.2.2.1 General

In this mixed group, the level of understanding about AIDS is high and gender differentiated. Women seem to have a more stereotypical view of HIV / AIDS than men, who have a more scientific explanation. People express their deep concern with the AIDS propagation. They have however some mythical stories about the AIDS transmission and stereotypical thoughts about women's role of responsibility in the AIDS progression.

Women are aware of gender inequity in sexual relations and gender inequality in society. Men have multiple partners; this is normal. Prostitution is accepted but should be controlled. Male adolescents have many girlfriends and are not always responsible. Amongst young people, AIDS spreads out of negligence.

4.3.2.2.2 Comments

Contrary to the first focus group, the use of stereotypes are numerous in this second group although the participants have a high level of understanding of AIDS. However, looking closer at the nature of stereotypes and the people creating them, they do not cover shortcomings in understanding but they rather reflect people's personal fears and prejudices towards the disease.

Stereotypes are gender differentiated: Women's fears are provoked by their husband's promiscuous sexual behaviour. However, it's not men but women who express the most stigma towards condoms and its suspected role in the AIDS propagation. In these cases, the condom myth could have an influence on women's behaviour which is the result of stereotyping causing confusion.

Stereotypes used by men are functional: male respondents blame women for being the principal propagators although they are the ones who participate in unsafe sexual activities. They also sum up other possible but not principal sources of infection such as the hospital, traditional healers and the fact that Mozambican women have sex with strangers. What's more, male distrust of health structures in response to the personal risk of AIDS is a way of not admitting one's own responsibility in HIV / AIDS.

Frame 2: Perceptions of FGD 2

	Level of understanding		*Social responses*	
Perceptions	**Knowledge +**	**Myths + (10)**	**Attitudes +/-**	**Behaviours +/-**
Language themes	Symptoms + HIV / AIDS dif. + Propagation + / - Approximation +	Condom 3 Propagation 2 Gender 2 Transmission 2 Analogy 1	Conscious + Responsibility + / -	Safe sex – (**M)** Do VCT + with pre- and post- counselling Cope +

(**M**): Characteristic of young males' behaviour in particular

Men's gender vision is stereotyped and, in line with the hypothesis, gender stereotypes are evoked to justify their risky behaviour from an exclusively male position.

Scale 2: Stigmatisation process in FGD 2

Stereotypes (+)	Stigma (-)	Discrimination (-)

The discontinuity between high level of knowledge and high level of mythical explanation is commented on in Section 4. 4. 4. 5.

4.3.2.3 Female market traders (FGD 3)

4.3.2.3.1 General

These women show great concern about the AIDS progression. Their understanding of AIDS is not far reaching and is mixed with misleading information. They know people in their neighbourhood who died from AIDS and feel that nobody will be spared, even themselves. The AIDS problem, they say, has become a real threat for society and a daily preoccupation for them. They fear for their children and for themselves as the ways of transmission are multiple and unclear and condoms are not safe. The women criticize their husbands for being unfaithful, girls of wearing miniskirts and the government of letting night life go on without restrictions.

4.3.2.3.2 Comments

The fear of being infected by HIV and ignorance about how AIDS is transmitted, reinforces women's belief in their inability to control what happens to them. In an attempt to control the disease, one woman suggests isolating those afflicted with the disease in order to neutralize their polluting effect on society. The social stigma that accompanies AIDS is responded to fatalistically. On the other hand, their attitude is contradictory: although they are very conscious of the dangers of the HIV spread, they believe it is preferable for an individual to ignore their sero-status. With this group, VCT is not even cited. Their highly conservative attitude contrasts with the attitude of the socially more engaged women of the ADASBU association of FGD 2 (see Section 4. 4. 4. 5).

Frame 3: Perceptions of FGD 3

	Level of understanding		*Social responses*	
Perceptions	**Knowledge +/-**	**Myths +/- (6)**	**Attitudes +/-**	**Behaviours -**
Language themes	Approximation + Symptoms + Transmission +/-	Gender 3 Condom 1 Propagation 1 Transmission 1	Conscious + Responsibility -	Safe sex – Do VCT – Cope +/-

Scale 3: Stigmatisation process in FGD 3

Stereotypes (+/-)	Stigma (+/-)	Discrimination (+)

4.3.2.4 Waste collectors (FGD 5)

4.3.2.4.1 General

This group has a low level of understanding of HIV / AIDS, corresponding to their low level of formal education. Out of ignorance they have many questions about the origin, transmission and prevention of the disease and become suspicious about white people, hospitals and condoms. For instance: “Do white people get AIDS? Why do hospitals distribute condoms for free?” They associate AIDS with TB in many aspects. They believe that in the end, nobody will escape AIDS as it is sexually transmitted and also because men cannot live without women. This group is very much in need of information. Messages are confusing as images on television show only black people with the disease as if white people couldn’t contract it.

4.3.2.4.2 Comments

These young men are conscious that AIDS exists although their information about AIDS is quite limited. In their discourse, AIDS seems unavoidable but in their acts they don’t take any preventative measures. They perpetuate many myths and stereotypical gender and race differences as if they were saying: AIDS is beyond our control and others are responsible for its spread. In other words, they blame others in order to justify their own negligent behaviour. They stigmatise the disease by creating social others. On the other hand, this group as a whole responded to the invitation of MSF to do the VCT, demonstrating by this that they are willing to cope at an individual level (see also Section 4. 4. 4. 5).

Frame 4: Perceptions of FGD 5

	Level of understanding		*Social responses*	
Perceptions	**Knowledge -**	**Myths + (14)**	**Attitudes +/-**	**Behaviours +/-**
Language themes	Approximation + Symptoms + Transmission +/-	Race 4 Condom 3 Analogy 3 Propagation 2 Gender 1 Social 1	Conscious + Responsibility -	Safe sex – Do VCT + Cope +

Scale 4: Stigmatisation process in FGD 5

Stereotypes (+)	Stigma (+/-)	Discrimination (+/-)

4.3.2.5 Water pump managers (FGD 6)

4.3.2.5.1 General

This group of adult men have an imprecise understanding of AIDS based on what they have heard and seen about it. They know many PLWHA from the neighbourhood, often coming back from the RSA. They compare the symptoms of AIDS with TB and also to other STDs. Their vision of AIDS is very stereotypical. They accuse the government of laxity and look back to the old times. They don't believe in traditional treatment nor in the church as a means of salvation. Some tell mythical stories about white people and dogs which are the origin of the spread; others have curious explanations for the transmission of HIV via condom use.

4.3.2.5.2 Comments

Although they have a basic understanding of AIDS, myths are numerous. Attitudes correspond to their fatalistic view of the AIDS problem and their failure to take their own share of the responsibility. Indeed, the spread of AIDS is blamed on the government and women, and AIDS is the result of social disorder and of people's rejection of tradition. Implicitly, they perceive AIDS as a threat to their cultural ideals based on concepts of chauvinism that, in turn, creates obstacles in the use of condoms. They are in favour of isolating PLWHA and of finding a method to eradicate AIDS in a radical way, using the eradication of rabies as a model. The stigma they hold towards the diseased is heightened by

misinformation and unrealistic fears of contracting the disease, such as via condoms. Instead of reconsidering their own position in the face of the AIDS crisis, they remain nostalgic about traditional values. However, they are in favour of doing VCT and of supporting anti-AIDS campaigns (see also Section 4. 4. 4. 5).

Frame 5: Perceptions of FGD 6

	Level of understanding		*Social responses*	
Perceptions	**Knowledge +/-**	**Myths + (15)**	**Attitudes -**	**Behaviours +/-**
Language themes	Approximation + Symptoms + Prevention - Information +/-	Condom 5 Propagation 3 Origin 2 Race 2 Analogy 1	Conscious - Acceptance - Responsibility -	Safe sex - Do VCT + Cope +

Scale 5: Stigmatisation process in FGD 6

Stereotypes (+)	Stigma (+)	Discrimination (+/-)

4.3.2.6 Young female football players (FGD 7)

4.3.2.6.1 General

This group has a low level of understanding of HIV / AIDS and is very much in need of information. They exchange ideas essentially about transmission, prevention and treatment. Some have received information about HIV / AIDS at school focusing on prevention. What they know is that AIDS is an STD without a cure and that symptoms manifest later on. They haven't been in contact with the disease or sick people but they recognize the symptoms. The real problem for them is how to find a trustworthy partner with whom they can have children, without running the risk of being infected. They express the view that you can't trust anyone except oneself.

4.3.2.6.2 Comments

Young women don't use condoms due to their partners' aversion to using them although they know that men can have various partners at the same time. This behaviour is contradictory to their expressed fears of contracting the disease from their sexual partners. The belief that God can bring salvation to faithful people is not excluded as impossible for many of them, even if this is seen as a myth. Here there is a case of Fatalism in the literal

sense: they believe in fate or destiny as the expression of their inability to control what happens to them. It becomes a question of fate to escape AIDS.

Frame 6: Perceptions of FGD 7

	Level of understanding		*Social responses*	
Perceptions	**Knowledge -**	**Myths +/- (9)**	**Attitudes +/-**	**Behaviours -**
Language themes	Approximation - Symptoms - Treatment - Prevention +/- Information -	Cure (7) Propagation (1) Analogy (1)	Conscious + Acceptance nr Responsibility -	Safe sex - Do VCT nr Cope nr

Scale 6: Stigmatisation process in FGD 7

Stereotypes (+/-)	Stigma (nr)	Discrimination (nr)

4.3.2.7 Young male football players (FGD 8)

4.3.2.7.1 General

Young people have heard about HIV/AIDS and are well-informed about the disease but their understanding is sometimes imprecise or even false. They are eager to know more, and to provide AIDS information to other young people. They generally have not been in direct contact with the disease, but know the symptoms of AIDS and also that symptoms don't appear immediately. Some say that they are not afraid of being tested, that they would accept being HIV + and that life would continue almost normally except in their sexual relations.

4.3.2.7.2 Comments

These young people have quite a high understanding of the AIDS symptoms, are conscious of being at risk and don't have a stereotypical vision of AIDS. In fact, they question all the evoked myths about AIDS. They are against tradition which they perceive as delaying the diffusion of useful information.

Young people are at high risk of contracting AIDS because they are sexually active and don't always practise safe sex. Although they are well informed of the ways of transmission and conscious of their acts, they may still believe the adolescent myth that they are invulnerable. The fact that they don't care about being HIV + is another way of showing their bravery and of behaving in a manly way.

Frame 7: Perceptions of FGD 8

	Level of understanding		*Social responses*	
Perceptions	**Knowledge +**	**Myths – (3)**	**Attitudes +**	**Behaviours +/-**
Language themes	Approximation - Symptoms + Treatment + Prevention + Information +	Treatment (1) Analogy (1) Condom (1)	Conscious + Acceptance + Responsibility +/-	Safe sex - Do VCT + Cope +

Scale 7: Stigmatisation process in FGD 8

Stereotypes (-)	Stigma (-)	Discrimination (-)

4.3.2.8 Female members of AMETRAMO (FGD 9)

4.3.2.8.1 General

Traditional healers are conscious that HIV / AIDS is not like the other STDs as it manifests much later and when symptoms appear it is already too late to cure it. That is why some healers think that it is a question of getting treatment early before the virus has destroyed everything inside the body. One member is even convinced that she has got the treatment to cure people with HIV / AIDS symptoms as it proved successful with two people. Notwithstanding, they insist on prevention and would like MSF to sensitise their children about HIV / AIDS as they encounter great difficulties in talking with them. They are open to receiving more information.

4.3.2.8.2 Comments

They prefer to talk about their children rather than about themselves and believe that the dissemination of information about AIDS prevention is most useful, especially for their children. They are realistic, showing professionalism and openness. Traditional healers are not conservative in their perceptions of treatment. They don't pretend to have the only treatment. For a modern disease, one should find modern solutions.

Frame 8: Perceptions of FGD 9

	Level of understanding		*Social responses*	
Perceptions	**Knowledge +/-**	**Myths – (0)**	**Attitudes +**	**Behaviours +**
Language themes	Approximation + Symptoms + Treatment +/- Prevention + Information +		Conscious + Acceptance + Responsibility nr	Safe sex + Do VCT nr Cope +

Scale 8: Stigmatisation process in FGD 9

Stereotypes (-)	Stigma (-)	Discrimination (-)

4.3.2.9 Members of the male community (FGD 10)

4.3.2.9.1 General

Most of the men believe HIV / AIDS exists but those who haven't been in contact with the disease still remain sceptical and express their doubts about the ways of transmission and prevention. To them, some people in the community have only been informed about the existence of HIV / AIDS via the radio and television. Some men in this group still have their doubts about the existence of AIDS as people present symptoms of other diseases. They express their desire to see a person with HIV / AIDS so that they can recognize the disease and avoid it. They are against the practice of hospitals and doctors who send infected people home without telling them the truth. Some prefer to isolate the sick, others who have nursed their relatives until they died of AIDS tell others that transmission is not automatic, such as it is with cholera or leprosy.

4.3.2.9.2 Comments

This group has diverging understanding, attitudes and beliefs in relation to HIV / AIDS and is quite representative of the male population of Maputo. Some men remain sceptical about the use of condoms; some are in favour of using them and others don't believe that using condoms is a sufficient way of prevention, arguing that there are other ways of transmission. Still others believe that it is an impossible method that would impede the continuity of the human species. Moreover, AIDS is mysterious in its manifestation leaving room to

scepticism, suspicion and stigma. This results in the desire to isolate infected people and is heightened by misinformation and unrealistic fears of contracting the disease.

Frame 9: Perceptions of FGD 10

	Level of understanding		*Social responses*	
Perceptions	**Knowledge +/-**	**Myths +/- (6)**	**Attitudes +/-**	**Behaviours -**
Language themes	Statistics + Approximation + Symptoms - Information + Education + Trad. Treatm. + Prevention +	Analogy (2) Taboo (2) Transmission (2)	Conscious + Acceptance +/- Responsibility +/-	Safe sex - Do VCT nr Cope nr

Scale 9: Stigmatisation process in FGD 10

Stereotypes (+/-)	Stigma (+/-)	Discrimination (+)

4.3.2.10 Community leaders (FGD 11)

4.3.2.10.1 General

The level of understanding in this group is not very high, considering the questions formulated and the demands to receive more information. However, they know AIDS is threatening and that Africa is the most affected continent. Migrants coming back from the RSA are a high risk group because a high proportion die from AIDS and infect their wives, as they refuse to use condoms. Information is believed to be an important way of limiting the AIDS propagation and to raise people's consciousness. They compare HIV / AIDS with cancer, STD, TB and cholera, the difference being that there still isn't a cure for HIV / AIDS. The level of concern varies but all pin their hopes in MSF to find a cure. They also ask MSF to play the role of information providers and educators and volunteer to help MSF in this.

4.3.2.10.2 Comments

In their discourse, they talk about "the others" who act improperly aggravating by this the AIDS situation while they consciously avoid talking about themselves and their own behaviour (see Section 4. 2. 4). Indeed, they perceive that white people refuse to help find a cure, that the government refuses to increase salaries, that women act against tradition, and

that infected people spread the disease around them. Moreover, there is a lot of confusion about the mode of transmission of this infectious disease. However, community leaders are willing to cope with MSF in an anti-AIDS campaign.

Frame 10: Perceptions of FGD 11

	Level of understanding		*Social responses*	
Perceptions	**Knowledge +/-**	**Myths - (5)**	**Attitudes +/-**	**Behaviour +**
Language themes	Symptoms + Approximation + Transmission +/- Information -	Transmission (1) Treatment (1) Propagation (1) Gender (1) Condom (1)	Consciousness + Responsibility – (talking about others)	Safe sex nr Do VCT nr Cope +

Scale 10: Stigmatisation process in FGD 11

Stereotypes (-)	Stigma (nr)	Discrimination (nr)

4.3.3 THE CONTINUUM OF PERCEPTIONS

4.3.3.1 Categories of perceptions

Stereotypes in language create attitudes of rejection that encourage discriminatory behaviour (conform Table 5). The process of stigmatisation is explored in utterances reflecting stigma and discrimination in adopted speech and social conduct. In line with other analyses (Lewis & Range 1992), estimations for the degree of stigma and discriminatory behaviour are generally inversely proportional to the levels of knowledge per focus group (see Frames and Scales). In some cases, expressions of stigma and discrimination are not evoked and are then considered irrelevant (nr).

However, highlighted FGDs below present a distorted scheme in the hypothesised continuum axis (see Section 3. 10. 3). First three groups (FGD 6, FGD 5 and FGD 2) have the highest level of mythical explanation. The other groups (FGD 3 and FGD 10) have a medium level of myths but are mixed age-groups. These incoherencies in categories of perceptions correspond to specific speech attitudes that are highlighted in Section 4. 4. 4. 5.

Table 9: The continuum of perceptions

	Knowledge	Myths	Stigma	Discrimination
Water pump managers (FGD 6)	+/-	+ (15)	+	+/-
Waste collectors (FGD 5)	-	+ (14)	+/-	+/-
Members of ADASBU (FGD 2)	+	+ (10)	-	-
Female football players (FGD 7)	-	+/- (9)	nr	nr
Trainers of ADASBU (FGD 1)	+	- (7)[17]	-	-
Female market traders (FGD 3)	+/-	+/- (6)	+/-	+
Male community (FGD 10)	+/-	+/- (6)	+/-	+
Community leaders FGD 11)	+/-	- (5)	nr	nr
Male football players FGD 8)	+	- (3)	-	-
Female traditional healers (FGD 9)	+/-	- (0)	-	-

Categories of perceptions are now commented on individually in the following paragraph.

4.3.3.2 The levels of understanding of the participants

The level of knowledge is inversely proportional to the use of stereotypes for the focus groups 1, 5 and 6. Sanitation trainers of ADASBU (FGD 1) and male football players (FGD 8) have the most rational explanation about HIV / AIDS which corresponds to their low level of stereotypes. For the waste collectors (FGD 5), their stereotypical perceptions about gender and race differences reflect important shortcomings in their understanding of HIV / AIDS transmission. In the groups FGD 6 and 5, stereotypes take the place of misleading and false information about HIV / AIDS. However, the lack of knowledge about HIV / AIDS is not always correlated to a stereotypical vision about HIV / AIDS (see Section 3. 10. 3). For instance, in FGD 2 the multiple stereotypes are indicators of a societal uneasiness created by and around AIDS.

[17] FGD 1 has a low estimation for myths notwithstanding its medium score since this one reflects the stereotypical level of other people they mention.

4.3.3.3 The degree of stigma in the participants' attitudes

The use of stigmas is a way of creating social rejection. The average respondent reports low stigma toward and moderately high willingness for social interaction with PLWHA. However, some adult women and men of FGD 3, FGD 5 and FGD 10 are in favour of isolating infected and sick people in order to stop the HIV spread. In these groups, a higher understanding about HIV / AIDS would probably be beneficial in reducing prejudice, but should be accompanied by a debate on inherited values and belief systems which influence people's attitude: projection of female / male images and expected behaviour for FGD 3, information and communication for FGD 5, and father-son relationships for FGD 10.

4.3.3.4 Levels of acceptance of HIV/AIDS

The acceptance of HIV / AIDS in others is presupposed to be higher if people are capable of projecting HIV / AIDS in themselves, if they are willing to do a VCT, and to cope at a personal and social level.

In some focus groups, some of the questions about people's social responses towards AIDS (see FGD-Guide in Annexure 2. 3) are not asked due to a lack of time, and are considered irrelevant (nr).

The willingness to be tested varies: the sanitation trainers of ADASBU (FGD 1) have already done a VCT, some participants of FGD 5 and FGD 7 report to be ready for a VCT and some respondents of FGD 2 and 10 share the opinion that everybody should be tested. Married women prefer to ignore their sero-status. They admit that they don't have the courage to do a VCT and that they wouldn't be able to live positively with AIDS (FGD 3). Female market traders, for instance, would prefer not to be informed by doctors. They also feel that it is better for infected patients to be left uniformed about their sero-status, so that they are not discriminated against and even abandoned. They consider it immoral that some women leave their husbands because they are infected.

The young people of FGD 8 say that they are not afraid to be tested, that they would accept being HIV + and that life would continue almost normally except in their sexual relations. However, this behaviour doesn't correspond to the average reaction of people acknowledging their positive status. They either take revenge by spreading the disease around them or fall into a deep depression (FGD 1, FGD 3, FGD 11). The project trainers

therefore believe that prevention is always a good thing, but they themselves don't always practise safe sex.

In FGD 2, a person claims to be ready to assume his positive sero-prevalence. The problem is that people are stigmatised as soon as symptoms start to appear. At that moment, infected people will suffer discrimination from their neighbours and will finally put an end to their lives in order not to continue the additional suffering of being isolated. According to the members of ADASBU (FGD 2), the taboo surrounding AIDS can be defeated if people are offered a treatment.

Water pump managers (FGD 6) are ready to participate in anti-AIDS campaigns but they predict that a lot of people will not heed the advice as they would during malaria and cholera campaigns. Contrary to female market traders, the members of the male community (FGD 10) are against the practice of doctors hiding the real status of their patients.

4.3.4 CONCLUSIONS

Perceptions of understanding compared to attitudes and the behaviour of the group reveal the participants' degree of acceptance of the disease at a personal and social level, and in PLWHA.

In general, the population of *Bairro Urbanização* is conscious that HIV / AIDS exists and that it is a reality they have to confront. The general level of understanding is basic and intermingled with mythical stories. People know the means of transmission, are conscious of being at risk but men in particular don't change their behaviour as a consequence. Indeed, their attitudes in relation to condom use and sexual behaviour in particular, foretells high levels of risk in the HIV / AIDS transmission.

Residents of *Bairro Urbanização* talk about the influence of poverty on HIV / AIDS, generation conflicts around sexual behaviour and the stigmatisation of people who present similar characteristics to those with AIDS symptoms. There are many beliefs which demonstrate the lack of access to clear and confirmed information.

The level of consciousness of the AIDS threat has risen as the disease propagates. Adults have been in direct contact with the disease and they are willing to talk overtly about their relatives and neighbours who have contracted the disease. As a consequence, AIDS is not framed any more as a disease affecting only risk groups such as returning miners and prostitutes, but also young people are considered vulnerable, women trading at borders,

disobedient girls wandering the streets at night and people going to the *barracas*. According to the interviewees, these groups should be targeted for information sessions.

The stigma associated with AIDS is part of the fear and taboo that is commonly attached to this disease. Stereotypes demonstrate that the ways of propagation and transmission are excessive. This explains why some people are still in favour of isolating individuals with AIDS and their families.

According to the MSF investigation team, the situation of *Bairro Urbanização* is believed to be quite similar to other places in Maputo and Mozambique (MSF- Luxemburgo 2002:17).

The scores of perceptions in five FGDs don't follow the predicted pattern of continuum between perception, attitude and behaviour illustrated by the stigmatising process. They are the groups with the highest levels of prejudice or are mixed gender- and age-groups. The speech attitudes of these FGDs will be commented on in Section 4. 4. 4.

4.4 SPEECH ATTITUDES

4.4.1 INTRODUCTION

An analysis of speech attitudes aims at detecting patterns of users, themes, levels of understanding and (in)coherence in attitudes. This part of the research, called the vertical analysis (see Sections 3. 8. 4 and 3. 10. 5), is done in collaboration with MSF investigators who are also the key informants in this research. Categories of perceptions, informants and messages in the various FGDs are compared with one another. After a general presentation of the participants and their degree of participation, the analysis focuses on content messages and the profile of their users. The description of social and linguistic findings demonstrates relations of language to world view and social organisation.

4.4.2 COMMUNICATION EVENTS

4.4.2.1 General degree of participation

The invited people of *Bairro Urbanização*, who participate in the communicative event, are receptive and participative. Tape recording is not a problem, on the contrary, the participants are very flattered. A few discussions are held in Portuguese (FGD 1 and FGD 2)

some groups code-switch from Portuguese to Shangane (FGD 8 and FGD 9) but all the other groups talk in Shangane (FGD 3, FGD 5, FGD 6, FGD 10 and FGD 11).

A presentation is now given of each focus group separately and of the participants general communicative behaviour.

4.4.3 THE PARTICIPANTS

4.4.3.1 Project trainers of ADASBU (FGD 1)

The sanitation trainers of the ADASBU association, are a mixed group of young people who are members of the speech community. They are selected by the Project to intervene in their neighbourhood in water, sanitation and hygiene matters. During the conversation, they are willing to discuss questions openly and frankly and comment on the various HIV / AIDS issues from their own perspective: how they would react and act, how they think men and women should behave, etc. The discussion is held in Portuguese and the research team report it to be very informative. An interesting exchange takes place about gender relations and people's responsibility in the HIV / AIDS spread. All are fully aware that it is not easy to accept the disease and that this is an important reason why many people refuse to do the VCT. Trainers, therefore, suggest that testing be accompanied by pre-counselling so as to prepare people if the outcome is positive.

4.4.3.2 Members of ADASBU (FGD 2)

The senior members of the ADASBU association are also residents of *Bairro Urbanização* and received training about water, sanitation and hygiene. They have regular meetings about problems occurring in the neighbourhood relating to these issues. Their level of understanding is good, especially those who are engaged in other networks such as political parties and associations where they already received information about HIV / AIDS. This group discuss some interesting points about important promulgators of the AIDS disease in the community: the impact of taboo on the spread of AIDS, unequal gender relations and men's uncontrollable sexual urge. The participants have many stories to tell about neighbours, friends and relatives with HIV / AIDS but also confirm this is still a taboo subject which people normally avoid or gossip about. They argue the fact that you cannot talk about it, which complicates the problem of AIDS. They believe that the taboo can be eradicated if people are offered treatment. They suggest that MSF provide ARV drugs to HIV + people

and also information about VCT and counselling centres. Participants also comment on the condom myth and, at the end of the discussion, they say they are happy that they have a deeper understanding of the issue.

4.4.3.3 Female market traders (FGD 3)

A group of female market traders, who are responsible for various sectors of the market Mazambane, are very receptive to discussing HIV in spite of the initial confusion about the motive of their invitation. They speak openly about their personal concerns, their uncertainties and opinions. For them, the loss of moral values in Mozambican society is one of the principal reasons for the spread of the disease. They are very resentful towards the government for not taking measures to prevent bad conduct and to resolve the problem of AIDS. According to the research team, their strategic position in the community can make them key information providers.

4.4.3.4 Male members of AMETRAMO (FGD 4)

A group of men representing the association of traditional healers (AMETRAMO) are fairly responsive in spite of the Project's initial fears to approach them. Traditional healers coming from different provinces (called *curandeiros* in Portuguese) are well represented in the city district *Bairro Urbanização*. They settled in this neighbourhood after the civil war and formed an association. As they treat many AIDS patients, they are convinced that nobody in the community has seen so many PLWHA as themselves. They talk about their beliefs and traditions and link HIV / AIDS to other well known STDs as well as lack of personal hygiene. They are convinced that they could find a natural treatment against AIDS if the government provided them with the necessary means. (This group's perceptions are not treated in the analysis).

4.4.3.5 Waste collectors (FGD 5)

FGD 5 are a group of young men recruited by the project to collect waste material. Their level of education is low and they generally don't speak Portuguese. They came to Maputo from neighbouring provinces in search of a job. They admit that they don't understand the disease and that the information they picked up about AIDS is still very confusing. Their perception of AIDS is stereotypical and confusing. They talk openly about their problems and are receptive to information[18].

[18] This group, after receiving free testing, went for a VCT and came back to show the results to MSF. This was seen as a very encouraging reaction.

4.4.3.6 Water pump managers (FGD 6)

The water pump managers are adults aged between 46 and 69 and one young man of 20. They are at ease during the meeting which is organised at the headquarters of ADASBU. The discussion is held in Shangane as only a few speak Portuguese. This group is highly superstitious, their explanations are based on traditional beliefs. Most of them are convinced that condoms contain the virus and therefore they prefer not to use them. Nevertheless, at the end of the conversation they take home condoms. For one of the participants, the solution against the spread of AIDS is to test everybody, and isolate the infected people on the island of Xefina or in the most remote province of Mozambique.

4.4.3.7 Female football players (FGD 7)

Young female footballers playing at the club of Magude (a place within *Bairro Urbanização*) are sympathetic and open. Their level of education varies between 2nd and 7th grade. A few don't want to speak in Portuguese. Some members of this group don't have any other activity besides playing football, others are students at night school. These adolescent girls are badly informed about the disease, especially those who do not have any other social activity than the football club. They say that they heard about HIV via their peers who receive information through this. Those who are at night course, say they received information through their school.

4.4.3.8 Male football players (FGD 8)

This group is composed of young men aged between 19 and 25, who are members of the same football club. They are jovial and happy people, although they are aware of the HIV / AIDS drama and discuss it openly. They talk about their own concerns and also about their lack of pastimes. They believe that if they were active they would not have time to think about sex, alcohol and drugs. They suggest informing others during their football matches with other clubs.

4.4.3.9 Female members of AMETRAMO (FGD 9)

This group, the female wing of the AMETRAMO association, show deep concern for the AIDS problem. The discussion is held in Shangane. Some are parents of the trainers of FGD 1. They find it especially difficult to talk to their children. Due to the generation gap, the children don't listen to their mother's advice they see as old-fashioned. They ask MSF to take

over the role of advisers because their children are more influenced by their peers. Curiously, these women don't talk about the condom myth. On the contrary, they believe that if they received condoms, they could distribute them to their patients. It is a positive outcome.

4.4.3.10 Members of the male community (FGD 10)

Some men of the community playing *tchuva*, a traditional game of draughts, are asked during lunch time to participate in a discussion about HIV / AIDS. They respond to the invitation and there is a good attendance. They are a mixed group in age and also in their understanding of HIV / AIDS. Some people are better informed, linked to the fact that they are in other organisations. They argue that travellers are more at risk and that information providers should target them in particular. Most HIV / AIDS cases living in the neighbourhood come from the RSA and Zimbabwe. Young men accuse elder men of sexual abuse which they consider to be an important element in the HIV propagation.

4.4.3.11 Community leaders (FGD 11)

This group is composed of leaders of *quarteiros* representing the local authority. The discussion is an opportunity to hear their opinion about how they would like information campaigns to be organised. They have already participated in a cholera campaign, distributing pamphlets and pasting posters on walls, and suggest doing the same for HIV / AIDS. This will help because people won't be able to say that they have not been informed. They are worried about the HIV / AIDS propagation in the neighbourhood where they have seen many deaths, providing that AIDS is a serious problem in the neighbourhood. Prostitution is one of the causes of the spread. The proliferation of private nurses in the neighbourhood is another concern, as well as the sterilisation of material. According to a participant (FGD 6, 11), information should target scholars and teachers.

4.4.4 GENERAL OBSERVATIONS

4.4.4.1 Levels of knowledge and categories of people

Socially engaged people who are members of associations and political parties are better informed about AIDS than others who do not participate in any organisation.

Those who are at school or who have attended school long enough[19] have a higher level of understanding than people with a low level of formal education.

Men are generally better informed than women.

4.4.4.2 Language themes and age-groups

Age-groups have different attitudes towards prevention, information and traditional treatment due to their diverging experiences.

Adults know migrants who returned from the RSA with the disease. Young people generally don't know people from their close environment who died from AIDS but they can often recognize the symptoms of AIDS.

Some adults regret the loss of traditional ways of obtaining information, whereas young people accuse tradition of impeding the dissemination of useful information about AIDS. According to adults, Brazilian soap operas have a negative influence on girls in particular. Advertisements and television send confusing images about HIV/AIDS which people sometimes misinterpret.

Adults and elders accuse the government of not taking responsibility for the AIDS progression. Their attitude towards the government is an inheritance of the former socialist regime in which the government was a central regime and was omnipresent also in private spheres. Young people don't even mention the government.

Young people in general don't believe in a possible traditional treatment. Older people sometimes leave this possibility open and at least believe that traditional treatment can prolong people's life. That traditional medicines can cure AIDS is generally contested except by the traditional healers themselves. They save their own skins.

Youths and adults have a different attitude towards prevention. Older people are extremely suspicious about condoms. For young people, not using condoms is a matter of negligence. Young people generally don't believe that condoms are infected even if they are influenced by the misleading effects of myths (see Condom myth 4. 5. 5. 3).

[19] Participants have an average educational level between primary and secondary school. Those who left school early generally don't speak Portuguese.

4.4.4.3 Beliefs, attitudes, behaviour and gender

The female respondents talk about their own experience and concerns, and show more compassion towards PLWHA. Male participants talk about AIDS in accepted terms and with precise data about statistics in Mozambique. They are generally more informed in their discussions and like to argue about socio-economic issues. They have however a stereotypical vision of the AIDS transmission and propagation and women are at the centre of their accusations.

Mothers express deep concern about the vulnerability of their children in the face of AIDS. Fathers talk about their problem of controlling their daughters.

Men and women don't agree about religion as a means of salvation. Young and adult women pin their hopes in God to be spared from AIDS although this is also contested by the group of adolescent girls. Going to church is a social habit especially for women and corresponds to the ideal image of exalted chastity of the female community. Not going to church for a girl is acting against social norms which women associate with the AIDS progression.

Women and men have distinctive roles to play, and consequently have different behaviour and expectations. A female trainer wonders: "I don't know if this is tradition why some men don't give to women the rights they deserve. Women stay at home to look after the children and cook for the family whereas men go out with other women and just come home to infect their wives" (FGD 1, 1).

However, even women (in FGD 3 and pilot group 2) have a restricted vision of their own role and would rather stick to their saintly housewife figure than change their behaviour. This conservative position contrasts with their fears of contracting AIDS in their conjugal relationship which often results in fatalism rather than in changes in attitude and behaviour. Even young women are desperate rather than revolted and instead of conquering a new position in society, they are still ready to put up with the situation while they desperately try to make the men change their behaviour.

Adolescent girls of the new generation are accused of being promiscuous; nobody says so about adolescent boys. Prostitutes are AIDS transmitters; nobody says so about their clients.

Married men in need of sex go out, especially on Friday nights, to seek sexual adventure. Married women don't go to night bars. This is clearly a male habit and privilege. Friday night is institutionalised as "Man's Day". Why isn't there a counterpart for women?[20]

Women are different. In an infected couple, they die later than men. As in the other STDs, symptoms appear much later in women than in men. Delay of symptoms in women is to their disadvantage because women are not conscious of spreading the disease, which is morally incorrect.

On the other hand, women have a natural advantage over men by having their monthly period because the menstruation discharge is believed to flush the virus from their bodies [21].

Men don't always practise safe sex. The motive they evoke for not using condoms is linked to the belief that condoms are contaminated. But the real reason is that they don't want to use them. Women also claim to be against condoms, either because they also believe that they are infected or because women are eager to have children (see also Section 4. 6. 3. 3).

Womanhood is traditionally equated with motherhood. Procreation is threatened in the AIDS crisis. How to find a trustful partner with whom one can procreate safely, is a real problem for adolescent girls who still want to correspond to their culturally defined image.

4.4.4.4 Share of responsibility in the spread of AIDS and gender

Single young people (FGD 1, FGD 7, FGD 8) generally say that their responsibility in the spread of AIDS is shared as adolescent boys and girls have multiple partners. However, according to female trainers, men are the propagators of the disease as they engage in higher risk behaviour. The difference of sexual behaviour between men and women is linked to a traditional vision of gender roles.

For the female football players (FGD 7), men are more responsible because they are the sexual initiators. The problem with adolescent boys is that they have a high number of partners (going out with 7 lovers at the same time) which makes them untrustworthy in the eyes of adolescent girls. "You think you have a stable partner but your partner considers you

[20] Mozambican women's day is the 7th of April called *Dia da mulher mozambicana* corresponding to the date Josina Machel, the wife of the first President of the Republic of Mozambique, died. However, this is no counterpart.

[21] Menstruation is often regarded as a natural form of therapeutic bleeding (Comaroff 1999:318).

his lover just for the time he is with you", (FGD 7, 10). Moreover, adolescent boys often refuse to take preventative precautions and force adolescent girls to have unprotected sex with them.

In the group of young male football players (FGD 8) opinions diverge: one says women are more responsible for the HIV spread, another says he would prefer that responsibility be shared and another is convinced that this is so as both have lovers.

Women (FGD 2 and FGD 3) react as sexual gatekeepers and talk about their personal difficulties with their husbands due to their dominating position and multiple partnerships. They are conscious that being married place them in real danger of contracting the disease. However, female market traders (FGD 3) put the blame on prostitutes and girls with low morals rather than on their husbands.

Accusations of men (FGD 2) are highly gender stereotypical. They blame women for being the principal propagators or mention other ways of transmission (at hospital, traditional healers) and the fact that Mozambican women have sex with strangers. They associate women with prostitutes but avoid talking about their wives and their own conduct.

The men of FGD 5, FGD 6, FGD 10 and FGD 11 believe that women have their share of responsibility in the HIV spread for various reasons. Although men are the sexual initiators, women accept being conquered (FGD 5) and are certainly no less ambitious in their efforts to seduce men (FGD 6, 4).

According to water pump managers (FGD 6) and community leaders (FGD 11), women nowadays take charge and are to blame for this inappropriate conduct which contributes to the spread of the disease. Men have stereotypical visions of women as poisonous, unavoidable creatures (FGD 5), eager to experiment with sex at an early age and seducers who want to look like cinema stars (FGD 6). See also semantic explanation in Section 4. 5. 5. 2.

4.4.4.5 Stereotypical attitudes and categories of people

Participants report that some people still don't believe in the existence of AIDS pretending that they haven't seen a concrete case or because people don't die of AIDS but of other malignancies. According to the participants, ignoring the disease at this stage of its progression could be a strategy to live positively without facing one's responsibility in the spread of AIDS.

Excessive fear associated with the taboo nature of HIV / AIDS influence the level of stigma and discrimination of some people. Typically these people are worried about their children too. For this reason, they are in favour of isolating PLWHA or mark them in order to avoid their polluting influence. Adult women of FGD 3 and the adult and elder men of FGD 10 correspond to this category of people (see Section 4. 3. 3. 1).

Others have seen some cases of AIDS but it remains at a distance and outside of their reality. For this group of people AIDS is still taboo and is associated with other diseases that present analogical symptoms as for AIDS. They make a point of highlighting differences in people like men are not like women, blacks are not like whites, etc. Their prejudicial attitude in relation to AIDS compensates for their shortcomings in understanding about the disease. The speech attitudes of the young male adults of FGD 5 correspond to this category of people (See Section 4. 3. 2. 4).

A third group of people relates AIDS to otherness considering their mythical stories about the influence of white people, dogs and women in the AIDS progression. They don't want to face their own responsibility in the spread of AIDS nor change their sexual habits. They defend a traditional and chauvinistic point of view and have misleading and even false information about the disease. This attitude is typical of the married men of FGD 6 (See Section 4. 3. 2. 5).

The last group of people don't consider AIDS seriously not because they are ignorant or prejudicial by nature but because they are consciously seeking excuses for their most risky conduct in the face of AIDS. Their use of stereotypes is functional. That condoms transmit AIDS is a typical story for this group as well as their frequent evocation of gender stereotypes. Adult males in FGD 2 are prototypical for this speech attitude (see Section 4. 3. 2. 2).

These speech attitudes are highlighted in Table 9 as inconsistent with respect to the hypothesised continuum of perceptions in Table 5 (see Section 3. 10. 3).

4.4.5 Conclusions

This chapter unit explores the intersection between speech attitudes and social portraits. Correlations are made between language themes and age-groups, and between categories of perceptions and gender. As a result, women are more affected by the AIDS stigma than men. This can be observed in the AIDS discourse which is coloured with gender bias, and also in

the gender perceptions and the gender relations of the participants interacting during the communication events. Besides, women and men have a different sense of responsibility corresponding to their expected gender role and behaviour.

How discourse about AIDS is structured by the biased reasoning of gender stereotyping, is examined in the next chapter unit.

4.5 STEREOTYPING

4.5.1 INTRODUCTION

Starting from a general description of how stereotypes are produced in the AIDS discourse, the underlying process of stereotypes is analysed via the semantic model (see Sections 3. 8. 4 and 3. 10. 5). Concrete examples of gender stereotypes in the AIDS discourse receive the focus. Their frequency and nature and their effects on AIDS are commented on as well as how they are produced. The process of stereotyping is explained and the chapter unit ends with illustrations of gender stereotypes embedded in their social context.

4.5.2 GENERAL DESCRIPTION

Stereotypes are uttered in the particular context of the speech event, in this case the survey situation, in which the participants are invited to express their perceptions on HIV / AIDS. Stereotypes express a belief or a myth that cannot be checked nor observed in society. It is a declarative statement composed of two parts (the object and the stereotypical explanation) which are associated in a haphazard but rather categorical way (x is y). The source of information often remains vague and is generally formulated as a rumour[22] "they say that…" Some examples, however, are presented with facts which are supposed to provide evidence of what is said. The issues generally concern the ways of transmission and propagation and some cases are about the origin of HIV / AIDS and a possible cure. They are often combined with other stereotypes such as race and social differences or dichotomies and are associated with other diseases (see list of indexed stereotypes in Annexure 4).

Myths and stereotypes are numerous in relation to AIDS. They are often spread through gossip[23] (they say that . . .) or by word of mouth (I was told that…). What is expressed is not real but true in people's mind (I believe so). The opinions concerning the issues generally diverge and are commented on at length during the conversation. Some say that they don't believe in it and give an explanation why these myths are created and maintained, but they stand apart from the group. Others confirm the myth expressing their own concerns or talking about their own experience with the debated issue.

Myths provoke a lot of discussion. They are often accompanied with evidence and details which is why they are misleading. They provoke confusion and perturb people's thoughts. In the end, people don't know any more what they should believe and how they should behave in order to escape AIDS. Attitudes of fatalism are a frequent response to AIDS.

There is a stereotypical reasoning, a stream of consciousness created through false analogies. This is possible because AIDS is still a taboo issue and because the level of understanding about AIDS is quite low.

[22] Rumors are tales, passed from a person to another, whose origin and validity are never certain (Smith et al. 1998:121).

[23] Gossip implies that the communicating people have an intimate social relationship (Smith et al. 1998:122)

4.5.3 THE FREQUENCY AND NATURE OF AIDS STEREOTYPES

4.5.3.1 The distribution of stereotypes

There are many stereotypes in relation to HIV / AIDS issues. I counted no less than 75 in 10 FGDs. In some groups, stereotypes are more numerous than in others. Except in one group of female healers FGD 9), stereotypes are found in all the other discussions in variable proportions. Its distribution in the various focus groups is as follows:

The number of HIV / AIDS stereotypes (ranked in order of importance)

1) In FGD 6 of water pump managers: 15
2) In FGD 5 of waste collectors: 14
3) In FGD 2 of members of ADASBU: 10
4) In FGD 7 of female footballers: 9
5) In FGD 1 of ADASBU trainers: 7
6) In FGD 10 of the male community: 6
7) In FGD 3 of female market traders: 6
8) In FGD 11 of the community leaders: 5
9) In FGD 8 of male footballers: 3
10) In FGD 9 of female healers: 0

4.5.3.2 The nature of stereotypes per focus group

Themes vary and are distributed as follows in the groups:

- Water pump managers (15): Condom (5), Propagation (3), Race (3), Origin (2), Analogy (1), Gender (1)
- Waste collectors (14): Race (4), Condom (3), Analogy (3), Propagation (2), Gender (1), social difference (1)
- Members of ADASBU (10): Condom (3), Propagation (2), Gender (2), Transmission (2), Analogy (1)
- Female football players (9): Cure (7), Propagation (1), Analogy (1)
- Trainers of ADASBU (7): Gender (4), Analogy (2), Taboo (1)

- Members of the male community (6): Taboo (2), Analogy (2), Age (1), Transmission (1)
- Female market traders (6): Gender (3), Propagation (1), Condom (1), Transmission (1)
- Community leaders (5): Transmission (1), Cure (1), Gender (1), Condom (1), Propagation (1)
- Male football players (3): Cure (1), Analogy (1), Condom (1)
- Female healers (0)

4.5.3.3 Frequency and content of themes

The frequency of themes (in order of importance) are:

Condom (14), Analogy (13), Gender (12), Cure (9), Propagation (9), Race (7), Transmission (5), Taboo (3), Origin (2), Social difference (1) and Age (1)

The most evoked stereotypes are about transmission via condoms, analogies with other diseases, and gender stereotypes. Stereotypes concerning the ways of transmission and propagation (14 in total), demonstrate important shortcomings in the understanding of HIV / AIDS: AIDS is transmitted via condoms, rotten food and by sharing food with an infected person. AIDS is propagated through water and air, and also through bee and mosquito bites and via dogs' excrement. Transmission is facilitated by a lack of personal hygiene or circumcision.

4.5.4 THE CONTENT OF STEREOTYPES

Groups with the highest rate of stereotypes (FGDs 6 and 5) often intermingle their mythical stories about AIDS with race dichotomies. As a matter of fact, race stereotypes are only found in these groups. Other themes that people typically gossip about is the origin of AIDS which is believed to come from dogs and the fact that Mozambican women had sex with dogs. This myth is evoked with precise detail: it happened in the 80's in a well-known building in Maputo called *33 Andares* under the pressure of white men who forced women to do so after the intake of drugs. Dogs are further mentioned to be the propagators of AIDS by a community leader (FGD 11, 1) and a man of FGD 6 says that there is a traditional treatment

for AIDS prepared with a dog's liver (which doesn't work) that was used in colonial times to cure haemorrhoids.

Adolescent girls participating in FGD 7 believe that going to church and faith in God can help people to recover from AIDS. A possible cure for people with money is also evoked in this group as well as by a community leader in FGD 11.

Analogies are encountered in most groups (in 7 out of 10) and this theme counts for the highest distribution. AIDS is principally associated with other STDs and TB. Most evoked symptoms in relation to AIDS are in order of importance: drastic weight loss, coughing, skin lesions, diarrhoea, and hair loss. These symptoms appear and disappear in people. People who have these symptoms are discriminated against.

The fact that people haven't seen concrete cases of AIDS and that symptoms are not apparent immediately contributes in making AIDS a taboo subject. How people get AIDS is blurred by the increasing infection rates and it becomes a matter of fate or bad luck. Doctors don't tell the truth to their patients. People suspect and gossip about their neighbours who are marked with previously evoked symptoms. AIDS is created this way and the way people talk about it reinforces its taboo nature.

The transmission of AIDS through condom use is frequently mentioned (14) together with the test (3 times) that provides evidence for this belief. However, as this stereotype was introduced by the facilitator to start a debate about prevention, its frequency cannot be considered as an indicator.

The high level of AIDS stereotypes in a group is an indicator of a low level of education for the first two groups (FGD 6 and FGD 5). The fact that many stereotypes appear in the third group of members of ADASBU (FGD 2) probably denote that the participants had divergent levels of understanding. Women are more stereotypical in their explanations than men and men evoke the gender stereotypes in this group. Curiously, a high number of women aged 30-45 believe that condoms infect their users (see Functional analysis 4. 6. 3. 2).

In the groups with the lowest rates of stereotypes (FGD 8 and FGD 11), themes are very diverging. These two groups have an exclusive male participation, which indicate that men are less stereotypical than women.

Gender stereotypes appear essentially in the mixed groups of ADASBU trainers and ADASBU members, respectively 4 (in FGD 1) and 2 (in FGD 2). In these groups, gender relations are debated and the participants express their opinion about the share of

responsibility of both sexes in the spread of AIDS. Gender stereotypes are also mentioned three times in the group of female market traders in reaction to the rumour often heard that women are the principal propagators of AIDS. Women generally contest this by defending their own point of view and accusing men of being unfaithful (see Speech attitudes 4. 4. 4. 3).

Stereotypical reasoning behind gender stereotypes are now described from people's reflections.

4.5.5 THE PROCESS OF STEREOTYPING

4.5.5.1 Gender myths

AIDS is associated with promiscuity, and stigmatised as a shameful disease. Yet men are victims of their sexual urge and need multiple sexual partners. Prostitutes are the accessible partners and, due to their profession, they are carriers of STDs. Many girls of the neighbourhood have occasional sex with men for favours and are also identified as AIDS carriers. From this observed reality, it is easy to deduce that women are AIDS transmitters.

> Husbands are not trustworthy and conquering female partners is part of the social game. "It is normal for men to have multiple partners" (FGD 1, 1)

Other examples of gender stereotypes in line with this reasoning are:

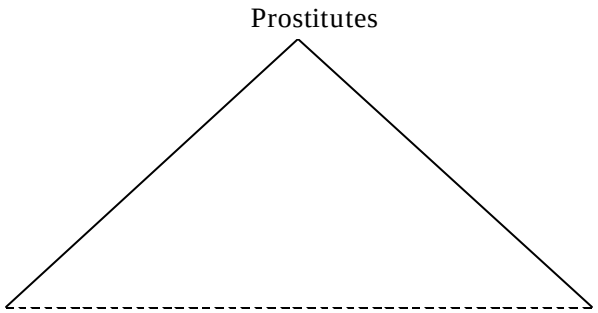
> Adult and elder men admit that "men like younger girls. Men seek sexual adventures with younger girls" (10, 6). But men also say that "younger girls want to experiment with older men" (FGD 6, 7).
>
> "The virus entered first in women. Then men got the virus through sex with women" (FGD 1, 1 and FGD 5, 1). From a male point of view women are the ones who transmit AIDS to men.
>
> Some men admit that they are responsible for the HIV spread as they seduce women. However, women are seductive and expect to be seduced. "Women wear make-up to look younger. Women are also seducers" (FGD 6, 4). Thus, women have their share of responsibility in the HIV spread.

4.5.5.2 Semantic explanation

How analogies function in stereotypical reasoning is now illustrated with the aid of the semantic model (see 3. 10. 5).

Table 10: Example 1 of gender stereotype

FGD 1, 12: Men say that women are responsible for the spread of AIDS because prostitutes are women.

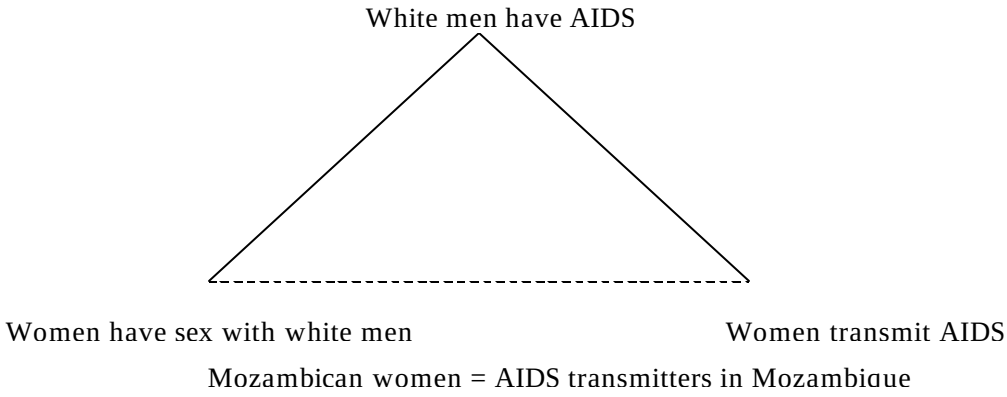


In the evoked image (reference), not all the attributes are false. Rather the association of ideas is false in stereotypical reasoning. It is a fact that prostitutes are a high risk group and that prostitutes are generally women in Mozambique. Thus, women become the AIDS propagators.

Another belief which explains why women are AIDS transmitters is the following:

Table 11: Example 2 of gender stereotype

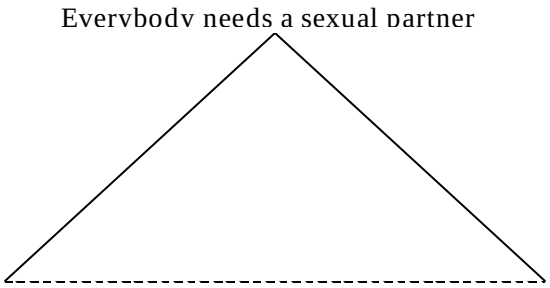
In FGD 6, 6: White strangers make AIDS worse since they corrupt our girls with money and also give them AIDS.



In this example, the analogy between AIDS and women is not a direct one but passes through another stereotypical association that white men are infected with AIDS.

Table 12: Example 3 of gender stereotype

FGD 1, 1: People say men are less numerous than women and that is why men have more partners.



To resume the analogies in the above mentioned examples:

Example 1: Women are associated with AIDS propagators.

Example 2: Mozambican women having sex with white men are the AIDS propagators in Mozambique

Example 3: Women are more numerous, so men have sex with various women.

These are imputed relations as they are not logical in themselves. They are made logical through a link with the reference that is the thought or the visual image.

The links are respectively:

Example 1: Prostitutes are women, thus women are AIDS propagators.

Example 2: White men, with whom Mozambican women have affairs, are infected with AIDS; that is the reason why women transmit AIDS in Mozambican society.

Example 3: Men have to compensate in number which explains why men have multiple sexual partners.

The evoked image is embedded with a false attribute so that the link between symbol and the referent (the thing itself) also becomes a false one. It is indeed not right to link the symbol and the referent directly to one another but the meaning embedded in the relation between them induces this implicitly.

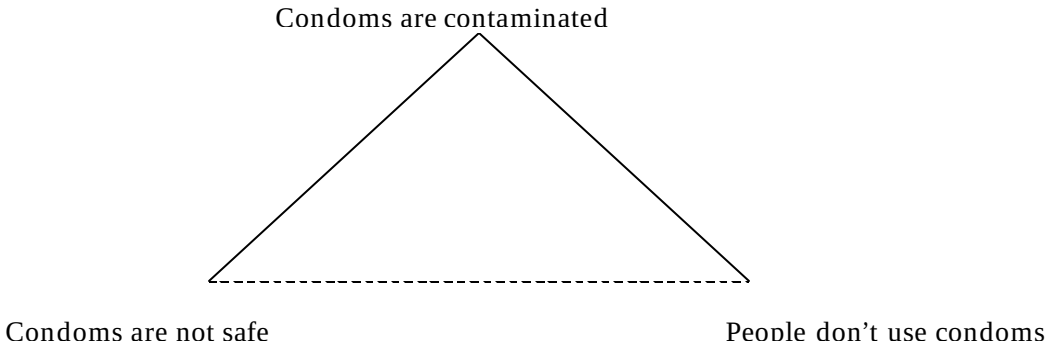
The evoked images of men and women in examples 1 and 3 are quite opposite in tone but complementary in a way: women are prostitutes and men are promiscuous. In the former case, women are stigmatised and, in the latter, men find justification for sexual transgressions. They demonstrate that the concepts for women and men are integrated in different semantic-associative networks (Blakar 1979:126).

The gender myth that women are the AIDS propagators is also explained in analogy with changes in society and the fact that women act against tradition. These changes include: women don't respect their traditional roles; women take charge; girls of the new generation don't believe in God any more; they want to experiment with sex at an early age and go to places where only adults were allowed to go in previous times; they drink beer and seduce men (see also Speech Attitudes 4. 4. 4. 3).

4.5.5.3 The condom myth

One widely known stereotype implies that condoms are contaminated and that by using them people get AIDS. There is even an experiment with condoms that provides evidence for the condom myth and which various people have cited in various focus groups (FGD 2, 3; FGD 3, 3; FGD 6, 5 and FGD 8, 2). "Put water in the condom, wait 2 or 3 days, you can see the female and male microbes swimming around. They are infected with HIV. " Thus, condom use is not a trustful preventative method. Instead of preventing AIDS, it has the opposite effect of contaminating its users. That is why people don't use them.

Table 13: The condom myth



Actually, people find all kinds of counterarguments that justify the fact that they don't use condoms. Apart from the fact that condoms are uncomfortable and reduce the pleasure, other good reasons are also cited for not using them:

Unreliable method: Prevention is not enough. “Even condom-users get AIDS all the same” (FGD 10, 2 and FGD 11, 4).

Impossible method: Besides, you cannot use condoms all the time. “Imagine if you have to use condoms with your wife” (FGD 5, 5). This is impossible and against the customs.

Contraception method: There is even a very good reason not to use them: “How will we have children, if we have to use them all the time?” (FGD 8, 10)

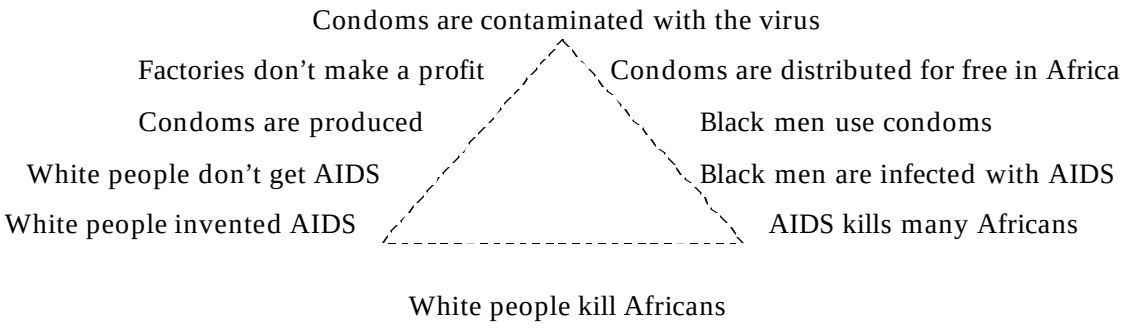
Eradication method: Worse, some even point out that condoms should be avoided because they spread AIDS: “Condoms are used as a strategy to reduce the population density in Africa” (FGD 5, 3 and FGD 6, 7).

Other associations related to the condom myth are:

> “Before there were no condoms and AIDS didn’t exist. Now condoms exist and people get infected” (FGD 6, 3).
>
> “Condoms are distributed for free at hospitals. Drugs have to be paid for. Why don’t they do the opposite?” (FGD 5, 2).
>
> “Condoms are distributed for free. Producers usually sell their goods. Producers of condoms don’t want to make a profit. What kind of aim do condom producers pursue if not commercial ones? Producers aim at infecting people” (FGD 5, 3).
>
> “In poor countries in Africa, there are not the same drugs as in other continents (Asia, Europe and America) because they say that we are numerous and thus they don’t send them here so that we die” (FGD 6, 6).
>
> “White people don’t get AIDS. African people get AIDS through condoms which white people distribute to them” (FGD 5, 3 and FGD 6, 6).
>
> “Condoms are contaminated. Women refuse to use them. Mothers advise sons not to use them” (FGD 3, 3).
>
> “Condoms are contaminated. Husbands use contaminated condoms with other women. Husbands get infected through condoms. Husbands infect wives. ” FGD 2, 9).
>
> “Condoms were our only hope of salvation. Now we know that condoms also transmit AIDS. What will save people from AIDS?” (FGD 2, 3).

Stereotypes can evoke various images and establish a series of links increasing the distance between speech and reality further more, as is demonstrated in the following table.

Table 14: The condom myth and its multiple associations



4.5.6 CONCLUSION

This chapter unit supports the hypothesis that stereotypes in HIV / AIDS discourse are quite numerous and that their contents concern essentially the transmission of AIDS. Semantic links demonstrate how women and condoms are stigmatised as AIDS transmitters and how these connections are embedded in the social context. Obviously, there is a stereotypical reasoning at work in the AIDS discourse which is called stereotyping. Stereotyping is a conversational style that is indicative of a particular social behaviour.

In the last part of the analysis, the implications of stereotyping in the AIDS propagation are examined in the light of the functions of this particularly vicious speech mechanism.

4.6 FUNCTIONAL ANALYSIS

4.6.1 INTRODUCTION

The functions of using gender stereotypes in HIV / AIDS discourse are multiple and the motivation for using them varies according to their users. This is the object of the following analysis: examine the social functions of gender stereotypes in the social reality of *Bairro Urbanização* and their effects on the speech community and on the evolution of the AIDS epidemic. These findings are checked against anecdotal data of primary investigation.

4.6.2 SOCIAL FUNCTIONS OF GENDER STEREOTYPES

4.6.2.1 Gender stereotypes stigmatise women as AIDS transmitters

This first function corresponds to the hypothesis of the research.

To resume from previous analyses, men make frequent use of gender stereotypes in which gender differences are highlighted. Women generally respond to male accusations with gender stereotypes reversing the responsibility to men.

Two main messages can be derived from the gender stereotypes used by men:

- women are to blame because they have their share of responsibility in the spread of AIDS
- women are different and should accept their social condition.

Therefore, self-justification for transgressions of sexual behaviour is suspected to be the cause of men's frequent use of gender stereotypes. For women, however, their stereotypical attitude corresponds to a mixture of attitudes engendered by fatalism, a conservative vision of gender roles and a tendency to believe in stories about AIDS which people gossip about.

On the other hand, the sexual practices in *Bairro Urbanização* as they can be reconstructed from the collected perceptions are in line with women's accusations. Men are promiscuous and admit it (FGD 7, 11); one man (but only one) even accepted women's accusation that men are the principal AIDS propagators since they are the sexual initiators (FGD 6, 8). Men are attracted to younger girls who loiter in the *barracas* (FGD 8, 10) and married women accept this from their husbands on the grounds of their culturally defined gender norms (FGD 3, 3). However, young men don't accept the sexual conduct of their fathers taking girls of their generation (FGD 10, 6).

To sum up, gender stereotypes correspond to a social behaviour. They are speech-acts that in line with the speech-acts theory (Austin 1962), can be described as follows:

Locutionary force: Women transmit AIDS

Illocutionary force: Accusative (Women are stigmatised as AIDS transmitters)

Perlocutionary force:

- Intended effect: Men continue to behave in an irresponsible way
- Actual effect: Women are victimised in the AIDS propagation

- Actual effect: AIDS continues to spread throughout the population

Moreover, other gender stereotypes are used that mark women in a particular way. These prejudices amplify women's share of the responsibility in the spread of AIDS:

Locutionary force:	Illocutionary force:
Women are seducers (FGD 6, 4)	Simplifying (stereotypes create a prototype of women)
Women are poisonous (FGD 5, 5)	Characterising (women are associated with poison)
Women take charge (FGD 11, 5 and 6, 8)	Reprimanding (women are role transgressors)

Some gender stereotypes highlight the difference between women and men in relation to AIDS.

Locutionary force:

Women are more vulnerable to contracting the disease than men (FGD 8)

Symptoms in women appear later than in men (FGD 8, 3)

Women die later than men (FGD 3, 8)

Women have menstruation (FGD 2, 4)

Illocutionary force:

Women are stigmatised as a different creature. Differences create boundaries based on natural, observable dichotomies which put women at a disadvantage.

Perlocutionary force:

- Intended effect: Natural differences justify the social differences between women and men

- Actual effect: Women are more vulnerable than men in relation to AIDS

In conclusion, gender stereotypes are used by men to compensate for their more biased attitude. To quote a female market trader: "I understand that men blame women for one or another tacit reason and also because prostitutes are women" (FGD 3, 8). Couldn't this reason be that men are not ready to change their behaviour?

4.6.2.2 Stereotypes compensate for inappropriate male sexual behaviour in relation to the HIV spread

This second function also makes part of the hypothesis.

Why do so many men refuse to use condoms although they are aware of being at risk? Frequently, chauvinism has been mentioned as creating obstacles to the use of barrier methods of protection (Worth 1990:116). Men feel it is unmanly or unnatural to use such protection. To justify the fact that they don't practise safe sex in the face of AIDS, men created the condom myth (see Section 4. 5. 5. 3).

Indeed, men of most male groups (FGD 5, FGD 6, FGD 8 and FGD 11) pretend to believe that condoms transmit AIDS to their users because they are poorly motivated in using them. Preventative methods such as having protected sex and abstinence, violate the normative expectations of a man who should be sexually potent and experience orgasm. For the waste collectors (FGD 5), the only way to avoid AIDS is to avoid sexual relations, which is impossible as men cannot live without sex. Various young men admitted that for them not using condoms was a question of negligence (FGD 1, 8). Messages of prevention methods have generally reached this age group of men but sometimes condoms are not used effectively. One said that a man was motivated to use condoms but he cut the end first in order to feel "meat to meat" (FGD 3, 4) and a mother explained that her son didn't succeed in putting condoms on and wondered if there was a different size of condoms which could fit him (FGD 2, 4).

For a woman offering a condom to a man is perceived as a violation of both women's role and men's role as respectively sexual gatekeepers and sexual initiators. Women who carry condoms are stigmatised as "loose" and may be suspected of having lovers (FGD 2, 4).

Promiscuity in women is seen in the same way as drunkenness is perceived, namely a violation of the female gender role. Women who drink and who seduce men at the "*barracas*" are seen as prostitutes (FGD 9). On the other hand, drunkenness and promiscuity are not considered out-of-role behaviour in men and are in line with the masculinity norms advocating adventurous, risk-taking behaviour (Borchert & Rickabaugh 1995:659).

Why then do so many women adhere to the condom myth? This attitude can be partly explained as a desperate reaction to the AIDS epidemic (nothing will help to protect us against AIDS) and partly as a normal reaction in light of the culturally defined gender roles

(condom use is a male's decision). In addition, popular reasoning about AIDS is influenced by the misleading effects of stereotyping (see 4. 6. 3. 2).

The condom myth can also be considered as a speech act and is described as follows:

The condom myth is not a gender stereotype but it is has a devastating effect for men and women, men being the one who decide not to use condom and women are victimised by this decision.

Locutionary act: Condoms transmit AIDS

Illocutionary force: Stigmatising (condoms are unsafe and shouldn't be used)

Gossiping (rumour spreads in the population)

Convincing (rumour becomes a belief)

Perlocutionary force:

- Intended effect: Belief is taken for granted and condoms are not used

- Actual effect: People have unprotected sex and expose themselves to the AIDS virus

4.6.2.3 Gender stereotypes perpetuate gender categories

This function is inherent to the frequent use of stereotypes.

The image that stereotypes reflect gender relations, is typically a traditional one. The Mozambican woman centres her life on her husband and children. At her marriage she is provided with a dowry (*lobolo*); once this ceremony is finished she is supposed to serve her husband and her family (*cumprir*). A woman should correspond to the image of exalted chastity that implies being religious, committed to her family, obedient to her husband, and respectful towards tradition.

The normative expectations of the Mozambican man is to earn a living and provide for all the expenses of the family, including housing, food, clothing and schooling. His image is defined by cultural constructions of chauvinism. Apart from having responsibility for his children and controlling his daughters, there are no other restrictions on how he should behave in his marital relationship.

Female market traders make a point of dissociating themselves from those girls who go out at night, who corrupt their husbands, who have lost their faith in God and who transmit AIDS. They are not that kind of woman but on the contrary, are respectful housewives committed to their family and committed to God.

This is dramatic in a way because by blaming prostitutes and not their husbands in the first place, being an AIDS victim is seen as a logical consequence of their marital status, and their husbands are just one unavoidable link in the contamination chain. This explains why personally they keep their eyes closed, they accept the disease in others while they condemn women who abandon their infected husbands.

According to female trainers, the difference of sexual behaviour between men and women is linked to a traditional vision of gender roles. These adolescent girls are gender sensitive in their arguments and show signs of protest regarding men's conduct, although they don't take measures to counterbalance the existing gender relations. They only implore men to face their responsibility in the spread of AIDS.

4.6.3 THE EFFECTS OF GENDER STEREOTYPING

We now look at interviews with AIDS victims and secondary data about the situation of PLWHA in Mozambique to seek social evidence confirming the relationship between gender stereotypes, female stigmas and discrimination. What are the effects or the consequences of the use of gender stereotypes on the social reality?

4.6.3.1 Women are blamed for the spread of AIDS

The participants' responses toward PLWHA can be explained in part as a result of their stereotypes, in particular their gender-role stereotypes. The thin line between fact and image shows the persistent bias in viewing women as immoral and a source of sexual contagion.

According to the director of Kindlimuka, an association for PLWHA people, the tendency of HIV + people who participated in a survey conducted by the Kindlimuka association (Associação Kindlimuka 2001), was to blame someone for their infection. Mozambican men generally put the blame on their wives (see "scapegoating" in Section 1. 2. 2).

In a journalistic account on the AIDS situation in Mozambique (Sida, Conselho Cristão de Moçambique), the director of the Mozambican miners' union claims that the AIDS problem in the rural communities is caused by the immoral behaviour of unfaithful women. He explains that the miners' wives don't wait for their husbands to become pregnant. For him, women shouldn't receive condoms because it encouraged disrespect and promiscuity. He associates women with prostitutes and blames them for the spread of HIV.

An interesting observation in this articleis the comparison between the spread of HIV in Mozambique to the spread of sexually transmitted diseases in Victorian times that occurs within a particular socio-economic situation: "driven partly by economic changes that created legions of impoverished women with few alternatives besides prostitution, and prevailing attitudes that let men get away with adultery but punished women for it". The

comparison makes sense as in both situations the gender aspect as well as the socio-economic instability are strikingly similar (see also 2. 3. 5).

4.6.3.2 Stereotypes of traditional gender-roles influence perceptions of control and risk

AIDS is not perceived as a disease which only affects high risk categories nor as a matter of individual responsibility. Men continue to have intensive and unprotected sexual activities which place them and their stable partner at a high degree of risk for exposure to the virus. To justify their irresponsible behaviour in the face of the AIDS epidemic, men make frequent use of gender stereotypes.

Women don't use condoms and put themselves at risk for three different reasons: partly by their level of ignorance, partly by their subordinate position in society and also under the influence of mythical stories about condoms transmitting AIDS and provoking sterility.

Women are fatalistic as AIDS can strike anybody; solutions should come from prayers, conservative conduct and hopes but never from a collective action against AIDS in which women would be the initiators. For them, being infected becomes a matter of fate, or is linked to the deviant behaviour of some women who act in disrespect of traditional values.

According to an interviewed MSF doctor, women generally don't use condoms out of ignorance and men because they don't want to use them.

Furthermore, it is impossible for a woman to impose condom use on her stable partner. For a married woman, it is even impossible to bring a condom home and to ask her husband to use it.[24] A woman who received a condom at the hospital was almost thrown out of the house for having acted this way (FGD 2, 4).

Curiously, adult women also claim to be against condoms (FGD 2, FGD 3) and believe they are infected.

4.6.3.3 Gender stereotypes impact negatively on women seeking AIDS counselling

This is the hypothesised effect of gender stereotypes.

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[24] These perceptions on condom and women are confirmed in the literature review Saùde Sexual e Reprodutiva and illustrate the fact that women are not in the position to negotiate the sexual act (Osorio C. & Arthur 2002:7, 20 and 23).

Women coming to prenatal consultation in the clinic of Alto Mae are encouraged to do a VCT. Of these female visitors, 17 % are HIV +, which is 4 % more than the national AIDS prevalence. The danger of HIV sentinel surveillance in pregnant women is the potential to use knowledge of the infection status of the mother to discriminate against her in a period of great vulnerability (Hartel 1994:42).

A woman who wants to enrol in the PMTCT has to confront various difficulties:

- First she has to disclose her sero-status to her family. Generally, women inform a female relative, her sister or mother. Others inform their husbands. Some people don't tell their family they are HIV + for fear of being thrown out of the house. Cases of expulsion from houses are not rare but in general the family displays support and sympathy. According to a MSF doctor, rejection would be avoided if a couple came together for testing. A frequent reaction of husbands is to impede their wives in following the MTCT treatment. They want to hide the HIV status from their neighbours.
- Another problem is how to explain to her relatives that she will not feed her newborn baby in the usual way, which means in Mozambique a combination of breastfeeding with other foods or liquids. A midwife employed by MSF, explains how difficult it is to make exclusively artificial milk acceptable to a mother and her family. Not only is it hard to convince the mother, but also the grandmother and the mother-in-law who have a say in these matters. [25] The influence of the mother-in-law in breastfeeding is also mentioned in pilot group 2, 6. It also raises suspicion about illness and provides a good motive for stigmatising the family.
- An additional problem is how to endure stigmatisation and discrimination in society. Often this is initiated by the neighbours and it is then extended to the whole family, who are believed to be at risk of being infected. This increased rejection, called "courtesy stigma" (Quam 1990:36) is particularly feared by husbands because it implies being rejected and isolated from the district and from society.

[25] Generally, the father and not the mother decides when to stop breastfeeding (Korfker 1987, in Osorio & Arthur 2002:11). Women's low status is particularly visible in her absence of decision taking over reproduction, that is the natural role of women and culturally most valorised role of women in Mozambique.

- Among the regular visitors of the clinics Alto Mae and Chamanculo, the level of poverty is high. The access to the health service can be complicated by a lack of means as patients are supposed to come to the hospital once a month. Some will not reach the hospital because they cannot pay transport fees.

4.6.3.4 Gender stereotypes perpetuate gender roles and inequalities in AIDS

It is important to pay attention to how AIDS affects women in their role as carers for their families and their status in their communities.

Men and women react differently after being tested positive. Women generally don't speak Portuguese and they are among the ones who don't perceive the seriousness of the disease. Those who do realise, are either depressed or want to struggle against the disease. Men's first reaction is to deny it. Women express deep concern for what will become of their children.

Poverty makes young women and adolescent girls particularly vulnerable. The HIV prevalence rates in Mozambique (see Section 2. 4) show a strong gender inequity and also that adolescent girls are more at risk due to anatomical as well as social, traditional and cultural imbalances and norms (UNFPA 1998:2).

According to MSF, young Mozambican women are more at risk because they are frequently forced to have sex with older men. : "There is a pattern of intergenerational sexual relationships - young women having sex with older men - in which the women have little or no say" (MSF Website February 2003).

In sexual initiation, women learn to be subordinate to men in their sexual behaviour. Even in motherhood women don't have power although procreation is considered the highest value in the female identity. A woman is forced to have sex with her husband; this makes part of the attributions of "being the spouse of somebody". As a matter of fact, a woman cannot refuse to have sex with her husband (Bagnol 1998, in Osorio & Arthur 2002:11).

The general level of education is low in Mozambique: over 60% of the population is illiterate, most of whom are female. The opportunities for girls to attend school are limited by poverty and also by the expectations linked to their roles in society.

Moreover, in Mozambican society education has its own pitfalls. School fees and uniforms might be paid for by an uncle or friend of the family who then expect sexual favours in

return (MSF website February 2003). Premature pregnancy caused by sexual abuse of teachers is a commonplace in Mozambique (Wamahu 1997, in Osorio & Arthur 2002:9).

4.6.4 CONCLUSION

Using gender stereotypes in HIV / AIDS discourse is a marked choice of speech serving specific social aims: stigmatising women as AIDS transmitters, compensating for inappropriate sexual behaviour, and perpetuating gender categories. As a consequence, women are blamed for the spread of AIDS, people have erroneous perceptions of risk and control, women encounter particular difficulties in acceding counselling services, and gender roles and inequalities in AIDS are perpetuated.

The functional analysis of gender stereotypes confirms the hypothesised "For which purpose?" and "With what effects?" variables of the research.

As a result, women are particularly vulnerable to contracting AIDS, not only physically but also socially, economically and culturally. In particular gender inequity in sexual relationships creates multiple barriers to women's access to HIV / AIDS counselling. This fact widens the inequality gap between women and men in their respective confrontation with the AIDS epidemic.

5 CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The Research Aims presented in Section 1. 4 are commented on individually and general recommendations close the dissertation.

5.2 GENERAL SOCIAL AIM

5.2.1 THE SOCIO-CULTURAL CONTEXT

The socio-cultural context is that of an urban population living in *Bairro Urbanização* in Maputo city, which is representative of Mozambican urban society. Stereotypes are formed in a particular context and reveal important socio-cultural aspects of the speech community. Gender stereotypes reflect and also reproduce social behaviour. For instance, the freque nt use of gender stereotypes reinforce dichotomous gender profiles which are based on perceptions of machismo and marianismo. Inequality in power relations results in women carrying the stigma for the spread of AIDS and not men. Another example is the association of AIDS with prostitution, which serves to stigmatise women. The Sapir-Whorfian hypothesis is thereby confirmed.

5.2.2 REPRESENTATIONS OF AIDS

AIDS is perceived as an imminent problem that can affect anybody and not just risk groups. It is stigmatised as a polluting social phenomenon and is also a stigmatising disease that makes PLWHA the continuing object of discrimination.

"*SIDA*" is the label-of-choice for the disease and is mostly referred to as "the disease". AIDS initially entered the community through white people; women are the principal agents of transmission, and strangers, condoms and dogs are also believed to spread AIDS.

As a matter of fact, AIDS is misleading as it manifests through opportunistic diseases such as TB and skin lesions. People die from other diseases but not from AIDS. For this reason, some people still don't believe in the existence of AIDS.

As AIDS spreads, those infected are believed to be cursed. These popular beliefs and myths are an excuse for people to carry on their high risk behaviour.

5.2.3 SOCIO-ECONOMICAL CONDITIONS OF VULNERABILITY

Research into HIV / AIDS demonstrates that AIDS in Mozambique interacts with social life in many ways and that the disease is above all a social plague rooted in poverty.

AIDS is not perceived as high up on the list of problems that poor people have to cope with on a daily basis. As carers for their families, women are often forced to resort to prostitution or transactional sex to make ends meet.

Along with the economic situation, social conditions must be improved by: reducing poverty, creating employment, raising the levels of educational achievement and reducing discrimination against women. These social conditions intermingled with cultural and economic constraints are considered to be the structural determinants which make people vulnerable to HIV infection.

Other social aspects that are believed to increase the spread of AIDS are: the traditional belief system, lack of information, inadequate health care, the use of unsterilised material in hospitals and by private nurses, the government's inability to control prostitution and also to improve the living standards of Mozambicans.

5.3 SOCIOLINGUISTIC AIM

5.3.1 QUALITATIVE INVESTIGATION

Various methods have been used to interpret the qualitative data collected during the primary investigation. Ordering perceptions on an abstract-concrete continuum is a way of demonstrating that language is not neutral in its use but intentionally marked. The horizontal classification of categories of perceptions underlines the cause-and-effect relationship between gender stereotypes and discrimination against women, providing evidence for the hypothesis of the research. In other words, the numerous HIV / AIDS

misconceptions encountered in gender stereotypes influence in a considerable way people's stigmatising attitudes and discriminatory behaviour towards infected and affected women. They generate a stigmatising process that underlies people's stereotypical reasoning about women in general.

Important language themes derived from the conversations of the participants, are used to classify people's perceptions on an estimation scale, allowing a vertical comparison of the various focus groups. In this way, one can better visualise the preventative needs for each group that are preliminarily differentiated by age, gender and occupation.

The speech variation « gender stereotypes" is defined as a set of variables in order to facilitate their classification and interpretation. In this research, the following variables are examined: "Who?", "What?", "How?", "For which purpose?", "With what effects?" and "In which context?". Five sociolinguistic approaches are selected which focus specifically on one of these variables, respectively the analysis of speech attitudes examines the "Who?" variable, discourse analysis highlights the "What?" variable, the process of stereotyping analyses the "How?" variable, and the "For which purpose?" and "With what effects?" variables are the object of the functional analysis. Last but not least, the HIV/AIDS discourse in a given context is highlighted with the sociology of language and is defined as the "In which context?" variable. This last variable is added to Fishman's model on which the operational definition of gender stereotypes is rooted.

As is demonstrated in this research, the "In which context?" variable is indispensable , not only for the comprehension of HIV/AIDS speech embedded in a socio-cultural context but also for the application of the recommended approach, the ethnography of communication (see Section 5.6.2).

5.3.2 A NEW DESCRIPTION OF STEREOTYPES

Having completed the investigation on the use of stereotypes in HIV/AIDS discourse, it is now possible to broaden the operational definition with concrete elements of the research:

Stereotypes in HIV/AIDS discourse are erroneous perceptions expressing a belief or myth about a category of people or objects, such as the gender and condom myth. This speech variation is uttered in a specific communicative situation, namely during FGDs and interviews, which is embedded in a larger socio-cultural context represented by the Mozambican urban society. In the collected perceptions expressed by the speech community

living in *Bairro Urbanização*, these people or objects are associated with false attributes with a view to discriminating or rejecting them. As a matter of fact, a stereotype is not a neutral speech variety; it is rather a special speech attitude revealing the prejudicial position of the user. The speaker uses stereotypes in order to manipulate reality. For instance, Mozambican men use gender stereotypes as a conscious, self-justifying device for their sexual transgressions. Gender stereotypes create additional gender barriers to women attending HIV / AIDS counselling. Stereotypes are therefore unsuitable tools for the fight against HIV / AIDS and should be eradicated from the HIV / AIDS discourse.

5.3.3 RESULTS OF THE INVESTIGATION

Some of the most important results of the analyses are summarised in the following paragraphs:

Although all the participants are aware of the sexual transmission of AIDS, women and men's sexual behaviour is not perceived in the same way. For a man, sexual transgression is considered normal. For a woman, promiscuity is perceived as a violation of her gender role.

The members of the speech community participating in the FGDs are ready to accept HIV / AIDS as a social plague that affects everybody**.** However, they don't seem to be able to change their social practices and reconsider their social relations in order to fight actively and consciously the spread of AIDS. Men are negligent in their sexual conduct and women are passive and powerless.

Fatalism, a return to tradition and traditional medicine, belief in God are some of the responses given to AIDS. AIDS is not accepted because of the silence surrounding the disease. PLWHA are either isolated or rejected.

The referential meaning of AIDS is that of social otherness and social disorder associated with risk groups. However, the meanings assigned to AIDS are changing along with people's increasing confrontation with the illness and the apparition of new risk groups such as disobedient girls wandering the streets at night, trade women travelling through borders, wives of miners who are infected by their husbands during their annual leave, etc. The unexpected apparition of AIDS in babies and old people encourages mythical explanations regarding its transmission such as through condom use, mosquitoes, food, etc.

Gender stereotypes are frequently used in the discourse on AIDS along with other myths about the transmission and propagation of AIDS. Gender stereotypes highlight physical and

social differences between men and women. Gender stereotyping marks women as deviant and different. As a result, women especially will not attend formal health structures because of the stigma attached to women as STD propagators. Consequently, this linguistic mechanism has a pernicious influence on the progression of AIDS in Mozambique and on women's social position in society.

5.4 LINGUISTIC AIM

5.4.1 THE NATURE OF GENDER STEREOTYPES

Most evoked stereotypes are about transmission via condoms, analogies with other diseases and gender stereotypes. Stereotypes concerning the ways of transmission and propagation demonstrate important shortcomings in the understanding about HIV / AIDS.

This marked mechanism of language use is more apparent in a male dominated society with a clear dichotomous division of gender roles. In a society already marked by segregation, AIDS becomes just another motive to accentuate the differences between women and men.

Stereotypes enter into the speech repertoire and become slogans that live by themselves. They become accepted expressions, deeply rooted in worldview and which enter the collective memory. They influence people at an unconscious level. They are vehicular of common values and they are anchored in speech. In this way, stereotypes perpetuate social relations.

5.4.2 THE PROCESS OF STEREOTYPING

Stereotyping is the conversational style of a speech community living in the same locality who share a common network of conceptual categories and associations. The gender myth falsely links the label (women) directly to the reference (AIDS transmitters) through an image that becomes implicit through the use of gender stereotypes (women are prostitutes / prostitutes are women). This stereotypical reasoning is characteristic of prejudiced people who accentuate dichotomous visions of whites and blacks, rich and poor, women and men. However, in the social context of the speech community, there are clearly distinguishable patterns of users and use. These stereotypical speech attitudes serve particular social

arrangements: they pin women in a vicious circle of normative associations about their subordinate position in society and their role as gatekeeper.

5.4.3 THE FUNCTIONS OF STEREOTYPING

The functions of stereotypes are various: they screen reality, they project our frustrations on scapegoats, they prejudice people and they create groups of social otherness. The hypothesised function is confirmed in the analysis: gender stereotypes are a victimizing device that blame women for male transgressive sexual behaviour.

Gender stereotypes are social actions. Their use is motivated by a special purpose. They produce a number of effects that are sometimes voluntary, sometimes involuntary. One of the effects of using gender stereotypes is that they impact negatively on women's access to HIV / AIDS counselling, the research problem under investigation.

Gender stereotypes are a type of speech behaviour which induce social behaviour. This is demonstrated by the speech-acts theory: at a locutionary level, gender stereotypes can be jokes; at an illocutionary level, they stigmatise; and at a perlocutionary level, they discriminate against women. Thus, gender stereotypes create ideology, construct and perpetuate the cultural identity of women and discriminate against the female population.

5.5 GENDER AIM

Personal accounts of women affected and infected by AIDS provide evidence for the hypothesis: gender stereotypes widen the inequality gap between women and men in their respective confrontation with the AIDS epidemic. They are poor, ignorant, stigmatised and submissive women living in a male dominated society. Women are particularly vulnerable because they are often forced to resort to prostitution or transactional sex. Women are also wives who accept (for better or worse) being infected by their irresponsible husbands.

Moreover, as is demonstrated in the research, women are blamed for the spread of AIDS. The HIV / AIDS stigma is associated with female stigma. This means that women living with AIDS are highly stigmatised. Therefore, they think twice before attending counselling services and health clinics and are afraid of the courtesy stigma of their husbands or are not allowed to participate in PMTCT projects as they are not empowered to take decisions in motherhood.

Thus, gender inequity in sexual relationships in combination with female stigmatisation create multiple barriers to women's access to HIV / AIDS counselling.

5.6 METHODOLOGICAL CONTRIBUTION

5.6.1 THE CHOICE OF TOPIC

Firstly, it is evident that the choice of the topic was not neutral and value-free. As a feminist, gender stereotypes have always had an irritating effect on me and I was therefore interested in investigating the social motivation of people for using them, as well as the effects they produce in society.

However, to become an aspirant sociolinguist, I am committed to studying social and linguistic phenomena with the required methodological rigour of analytical heuristics (Johnstone 2000: 123) and hope that the sociolinguistic standards in this approach of gender stereotypes have been achieved.

Secondly, being an anthropologist, studying people living in non-European societies was most appealing to me. Living in Mozambique at the time of the primary investigation, I opted to study biased perceptions used by the inhabitants of one of the suburbs of Maputo city.

The analysis also has a practical purpose and aims at complementing the results of the MSF investigation on the HIV / AIDS perceptions of the population targeted by the W&S project. This research focuses on gender perceptions in the HIV / AIDS discourse and on gender stereotypes in particular. Hopefully, MSF practitioners will find some useful information in the sociolinguistic approach to AIDS, gender and stigma for the implementation of their HIV / AIDS intervention programme.

5.6.2 ETHNOGRAPHY IN DEVELOPMENT PROGRAMMES

The ethnography of communication is the ideal methodology to gain insight into the speech attitudes of the group which development projects intend to impact. The model for studying a speech community should be specifically context-orientated, especially when development workers deal with societies that are socially, culturally and economically different from their own.

In addition, in order to gain insight into the social context of HIV / AIDS, one should understand it in the way that the participants do. In my opinion, only people belonging to the same speech community are in a position to describe the meaning of the situation for those involved (validity) whereas outsiders of the speech community can only give a description of the situation which may be reliable but not meaningful.

The research team rests on an ideal collaboration between experienced data collectors familiarised with the speech community and the debated issue, and a would-be sociolinguist doing the supervision with the required distance of a neutral observer. The researcher stays in the background in the primary investigation but compensates for this with regular feedback and a close implication in the MSF investigation.

Gaining direct access to the speech community wouldn't have been possible for the researcher. First of all, there is a serious language barrier; then there are the experimenter and the experimental effects that would have been much more important if the researcher, who is white, female and a complete outsider of the speech community, had been the experimenter.

5.6.3 METHODOLOGICAL ADVANTAGES AND CONSTRAINTS

Participants in the W&S activities are not only direct beneficiaries of the project but also the representatives of the urban population targeted in the coming HIV / AIDS intervention programme. Their inclusiveness in the survey is important as the participants' language and meanings assigned to HIV / AIDS can contribute to design and implement a culturally appropriate HIV / AIDS intervention.

Not collecting data first-hand has advantages and disadvantages. Collaborating with MSF offers the practical advantage of having a research team organising the communication event and conducting the FGDs. Our arrangement is based on the principle of mutual support: a database of HIV / AIDS perceptions in exchange for my contribution in the supervision of the MSF survey.

One of the disadvantages is that the collected data doesn't focus explicitly on language use but on HIV / AIDS perceptions which are the pursued aim of the MSF investigation. Although some questions about the language use proper are integrated in the questionnaire (2. 5 and 2. 6), they haven't always systematically received full attention.

The fact that the researcher doesn't have an effective control over data collection, data transcription and data interpretation makes reliability of the method a critical issue. As there was no other alternative than relying on this data, I assumed that the transcripts put at my disposal were a valid reproduction of the produced discourse. It then becomes a matter of interpreting the messages in a meaningful way provided that the proper procedures are followed.

The advantage of tape-recording is that the researcher doesn't have to be the one who collects the data. The disadvantage of this data procedure is that taping can influence the ways of speaking and interaction of the subjects (Johnstone 2000: 104-105). In this survey, however, being on tape didn't seem to embarrass the participants who were, on the contrary, very natural and receptive (MSF Luxemburgo 2002).

The transcription of spoken speech into written speech and the translation process respectively from Shangane into Portuguese and from Portuguese into English, outdistance three times the transcripts from the original speech. This process including the interpretation of the researcher leaves room for many possible biases.

People's definition of AIDS is community based and acquired through experience. In this research, direct interaction with the speech community and participant observation are the recommended methods for examining the language and the meanings that the participants assign to HIV / AIDS. For this reason, fieldwork and not just FGDs would have been more appropriate to analyse speech in relation to behaviour.

As is mentioned before, the research method is naturalistic and ethnographic in its ideal conception. Although the research was considered feasible in these circumstances, I would recommend limiting the intermediary process in the primary investigation. In its concrete application, a series of practical constraints such as the loss of two focus groups, indexation problems, and the fact that the researcher left Mozambique immediately after the survey, complicated things somewhat.

5.7 RECOMMENDATIONS

The shortcomings of a narrow epidemiological focus on risk groups instead of risk factors have created a bias in HIV / AIDS prevention. The research underlines the necessity of exploring the changing demographics of AIDS by focusing on heterosexual intercourse in an

urban community confronted with an increasing HIV / AIDS problem. Prevention will depend on the capacity of individuals and societies to induce behavioural change associated with ARV treatment. Messages of hope that there is a life for infected people and not just a fatal outcome, will progressively change the perception of the threat of AIDS and help dissociate the illness from the taboo.

As I have tried to demonstrate with different approaches, infected women are the most victimised in this vicious circle of AIDS and gender stigmas. Stigmatising effects on women seeking HIV / AIDS counselling must, therefore, receive special attention in the HIV / AIDS intervention programmes. Tackling the AIDS problem from a gender perspective to remove gender barriers in AIDS is the recommended approach in a society where sexual practices are based on a dichotomous vision of gender roles, norms and expectations. At the level of individual relationships, positive role models are also necessary to overcome the many inherent biases and imbalances of power with regard to gender.

How AIDS is defined affects who will be diagnosed and who will receive care. An open-ended qualitative discussion exploring themes related to perceptions and meanings assigned to HIV / AIDS will help to understand how the disease is affecting the speech community and other discourse and attitudes surrounding the disease.

Changes in attitudes and behaviour can be initiated by changes in speech behaviour in which sociolinguistics could be a guiding instrument. The denouncing of oversimplification and stereotyping in HIV / AIDS discourse in order to combat biased behaviour in sexual relations is the concrete recommendation of this investigation.

Giving feedback of the survey to the participating speech community could be a good opportunity to introduce a debate on HIV prevention, gender inequalities and speech based on the shortcomings in HIV / AIDS understanding and stereotypical language use about HIV / AIDS. The denouncement of used gender stereotypes accompanied with complementary information about AIDS can give a concrete and useful follow up to the initiated debate about AIDS with the speech community concerned.

Validation of the results could be achieved if the participating subjects recognize themselves in the reported data. Portrayed subjects in feedback, however, should be kept at the level of social portraits and not be pictured as real portraits so that participating subjects remain anonymous and the sources of anecdotal information irretraceable.

Development workers should further promote interaction among the members of the speech community in which the former would participate as observers. Being attentive to the language use of their target population will increase their understanding of the perceptions, attitudes and behaviour of the people involved that should be targeted as different groups in terms of age, gender and educational level.

Of course, focusing on language, even as a contextual aspect, is not enough to combat an epidemic as serious as AIDS. However, on the one hand, the involvement of a sociolinguist in a multidisciplinary team will give a meaningful sense to “AIDS the illness” and, on the other hand, an orientation to biomedical research in the control of “AIDS the disease” (see Kleinman in Section 1.2.1).

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Annexures

Annexure 1: ***The focus groups and the participants***

Annexure 2: ***FGD-guide***

Annexure 3: ***Example of a transcript***

Annexure 4: ***List of indexed stereotypes***

ANNEXURE 1: FOCUS GROUPS AND THE PARTICIPANTS

1. 1. Focus groups

Pilot groups

- Pilot group 1: MSF Drivers and logisticians (&)
- Pilot group 2: MSF Domestic workers (&)

Focus groups

- FGD 1: Trainers of ADASBU (&)
- FGD 2: Members of ADASBU (&)
- FGD 3: Female market traders
- FGD 4: Male members of AMETRAMO (*)
- FGD 5: Waste collectors (&)
- FGD 6: Water pump managers (&)
- FGD 7: Female football players
- FGD 8: Male football players
- FGD 9: Female members of AMETRAMO
- FGD 10: Members of the male community
- FGD 11: Community leaders
- FGD 12: Members of the female community (*)

(*) Groups indicated with (*) are not included in the analysis.

(&) Groups with this indication are involved in the W&S project

1. 2. Number of participants

Pilot groups

FGDs	*Subjects*	*Total*	*M*	*F*
FGD 1	MSF Drivers and logisticians	10	10	
FGD 2	MSF Domestic workers	8		8

Focus groups participating in the survey

FGDs	*Subjects*	*Total*	*M*	*F*
FGD 1	Trainers of ADASBU	12	7	5
FGD 2	Members of ADASBU	9	6	3
FGD 3	Female market traders	10		10
FGD 4	Male members of AMETRAMO	3	3	
FGD 5	Waste collectors	6	6	
FGD 6	Water pump managers	9	9	
FGD 7	Female football players	10		10
FGD 8	Male football players	11	11	
FGD 9	Female members of AMETRAMO	5		5
FGD 10	Members of the male community	10	10	
FGD 11	Community Leaders	6	6	
FGD 12	Members of the female community	8		8
	Total	*99*	*58*	*41*

1. 3 Age-group, gender and marital status of the participants

FGDs	*Subjects*	*Total*	*Age group*	*Sex*	*Marital Status*
FGD 1	Trainers of ADASBU	12	All young	F^5 / M^7	All single
FGD 2	Members of ADASBU	9	Y^1 / A^4 / O^1	F^3 / M^6	All married
FGD 3	Female market traders	10	All adults	All females	S^2 / Ma^8
FGD 4	Male members of AMETRAMO	3			
FGD 5	Waste collectors	6	Y^1 / A^5	All males	All singles
FGD 6	Water pump managers	9	Y^1 / A^3 / O^5	All males	S^1 / Ma^8
FGD 7	Female football players	10	All young	All females	All singles
FGD 8	Male football players	11	All young	All males	All singles
FGD 9	Female members of AMETRAMO	5		All females	
FGD 10	Members of the male community	10	Y^1 / A^8 / O^1	All males	S^6 / Ma^4
FGD 11	Community leaders	6	A^5 / O^1	All males	All married
FGD 12	Members of the female community	8	Y^1 / A^5 / O^2	All females	S^2 / Ma^6

Legend

Age groups: - 25: Young (Y) / 26 – 60: Adults (A) / + 60: Old (O) / Mixed Y / A, A / O, Y / O

Sex: Female (F) / Male (M) / Mixed (F^n / M^n) / Number (^{n})

Marital Status: Single (S^n) / Married (Ma^n)

ANNEXURE 2: FOCUS GROUP DISCUSSION-GUIDE

2.1 Perceptions

2. 1. 1 Levels of understanding

1. Is there a difference between HIV and AIDS?
2. How do you get HIV / AIDS?
3. How can you avoid HIV / AIDS?
4. How is HIV / AIDS propagated?
5. What are the means of protection against HIV and AIDS?
6. Do you know how you can have access to counselling?
7. Would you go there? Why yes / no?
8. Where do you go when you have a reproductive health problem?
9. Where can you get information about HIV / AIDS?
10. Do you know the Health Centre “Primeiro de Mayo”?
11. Where can you find condoms?
12. Do you know how many people are infected by HIV / AIDS in Mozambique?
13. Do you know someone with HIV or AIDS?
14. What are the symptoms of HIV that you have seen?
15. What are the symptoms of AIDS that you have seen?

2. 1. 2 Beliefs / Myths

1. Some people say that HIV / AIDS is transmitted by women. Why do they say so?
2. What do they also say? Do you know other stories?
3. What are the traditional beliefs about HIV and AIDS?
4. Comment: The female sex is a source of diseases.
5. Which are the expressions and words used to refer to HIV?
6. Which are the expressions and words used to refer to AIDS?

7. Do you think that traditional healers can cure HIV?
8. Do you think that traditional healers can cure AIDS?
9. Are there people with HIV or AIDS in your community?
10. If yes, do you think that these people are viewed as normal patients or not?

2.2 Attitudes and values

1. AIDS has no colour. What does that mean?
2. Some relatives don't want to talk about the disease. Why?
3. Do people speak openly about their infected relatives?
4. How would you react if you discovered that a close relative is infected?
5. Being aware of all the dangers of HIV / AIDS spreading, would you change your sexual behaviour and how?
6. Do you think it important to do the HIV test? Why yes / no?

2.3 Behaviours in the face of HIV/AIDS

Responses to HIV/AIDS

1. Have you already seen someone with AIDS?
2. How can we help the people that are affected by AIDS?
3. Are there organisations in the community that support PLWHA?
4. Do you know some people in the community who are willing to help? How?
5. How do you think the community would react if HIV infected mothers were giving artificial milk to their babies?
6. How do you think the community would react if nurses came to visit AIDS patients at home?
7. What would you do if you were HIV + ? What kind of support would you like to have?
8. What should we do with the people left behind as a result of AIDS (orphans, widows)?

9. What kind of support should these people receive?
10. What should society do with orphans and widows and those who are believed to be HIV + ?
11. Is there a difference in support between AIDS patients and HIV infected people?
12. What would you do if your partner were HIV + ?
13. What would you do if your neighbour told you to be at the terminal stage of AIDS?
14. Where would you go for treatment? To the health post, the traditional healer or to the hospital?

ANNEXURE 3 : EXAMPLE OF A TRANSCRIPT

Grelha de Transcrição

Focus Group N°: 08 Data: 17 de Maio de 2002 Horas: 14:10

Nome do observador: Arlette Makobero

Nome do moderador : Sérgio Horàcio Nhaúle

Outros: Maria Hortência Mariquele

Lugar: Casa Comunitaria

Participantes

António Macamo	67 anos
César Macamo	20 anos
Herinques	67 anos
Abrantes	67 anos
Carlos Dinis	69 anos
Carlos Chichava	47 anos
Mário Sitóe	46 anos
José Dhlamine	67 anos
Matsinhe	53 anos

N° de partic.	Conteúdo oral	Temas
	.	
	NIVEL DE CONHECIMENTO E INFORMAÇÃO	
8	• Existe SIDA que são borbulhas, aparecendo numa pessoa forte que acaba emagrecendo são sinais mais visíveis numa pessoa que tem SIDA.	Symptoms
	• A doença existe aqui no mundo. As mulheres assim como os homens apanham o SIDA e gostaria que tivéssemos melhores explicações para podermos nos prevenir.	Demand for info
1	**O SIDA existe, ultimamente até um doente com tuberculose e considerado como um doente de SIDA porque ele emagrece e as vezes tem borbulhas.**	AIDS/TBC
4	• O SIDA é um assunto que preocupa muitas pessoas, ninguém sabe a origem desta doença, só achamos que tem muita semelhança com a tuberculose que é uma doença muito conhecida.	
	• Todos os órgãos de informação falam sobre esta doença e dos sinais que a pessoa pode apresentar.	
	• Não concordo com o que dizem sobre os sinais. Se houvessem locais apropriados para fazer os testes seria muito bom porque **oiço dizer** que os cientistas estão a trabalhar fortemente para encontrar a cura	Demand of VCCT
6	• O SIDA está escondido e para descobrir é difícil não é como as doenças que já são conhecidas.	
	• Nos tempos passados quando um indivíduo tinha uma DTS via-se logo pela maneira de andar porque o mesmo tinha de abrir bastante	Symptoms

	logo pela maneira de andar porque o mesmo tinha de abrir bastante as pernas para poder caminhar.	Symptoms
	• O SIDA é como qualquer DTS porque sempre demora a manifestar-se na mulher.	
	• A doença só se manifesta passado muito tempo começando por aparecer manchas escuras na pele e diarrea contínua.	
	• Eu próprio conheço uma pessoa que morreu da doença aqui no bairro no Q. Nº 1.	Approximation
	• O que me preocupa é que os brancos não morrem da doença.	Myth of race
	• O SIDA é só doença dos negros, é aqui onde tenho dúvida e desconfiança.	
5	**SIDA existe.**	
	• Nos tempos passados, quando houvesse uma pessoa com uma doença esquisita, os mais velhos se reuniam, chamavam os chefes tradicionais e debatiam o assunto, depois disso eles tinham que rezar a Deus para ele perdoar e fazer desaparecer a doença.	Tradition
	• Agora esta prática não existe mais, para já poucas pessoas sabem sobre a doença porque por exemplo elas não tem acesso a informação da rádio, dos jornais e até mesmo da televisão.	Lack of info
	• Também lá no campo já não há aqueles encontros que se realizam debaixo dos cajueiros com as populações para falarem dos seus problemas.	Traditional way of info
	• Como dizem algumas pessoas, eu também acho que o preservativo contamina a doença para as pessoas que usam, porque ao deitar um pouco de água quente no preservativo depois de 3 dias, consegue-se ver uns micróbios no interior do mesmo, que são os tais que provocam a doença.	Myth of condom
3	• Eu também acho que é o preservativo que provoca a doença porque não consigo perceber como é que uma fábrica produz o preservativo para oferecer as pessoas.	Myth of condom

	• Nos tempos passados não se morria de SIDA porque não havia preservativo. Agora que existe o preservativo para evitar a doença, morre-se muito mais, isso não é possível.	
8	• Estou ciente que o SIDA vêm da África do sul porque conheci muitos familiares do ex-patrão que morreram da doença lá, tentaram vários tratamentos hospitalares, mas não resultaram nada, e 4 pessoas morreram.	RSA
	• Conheci um companheiro da igreja universal que tinha muitas borbulhas e estava muito magro que também acabou morrendo.	Approximation
	• Um vizinho meu no Q. Nº 11, me chamou para me dizer que tinha SIDA.	Approximation
	• Fiquei triste por ele, mas contente de saber que ele não pretendia esconder o seu estado de saúde.	
	• Este também disse que tinha a certeza que tornou-se seropositivo por causa das mulheres na África do sul.	RSA
	• Existe mais uma moça do Q. Nº 11 que tem SIDA e o que o marido que era do norte do país, já morreu da mesma doença.	Approximation
	• Eu acredito que o SIDA vêm da RSA porque todos os Moçambicanos que lá freqüentam, voltam com esta doença e não escapam da morte.	RSA
	• Os Sul Africanos quando vêm que a pessoa esta a morrer, mandam de volta para Moçambique.	
5	· *SIDA existe e foi enviada através de uma pessoa contaminada para o nosso país.* · Foi esta pessoa que expandiu a doença em todo o país, fazendo sexo com qualquer pessoa só para poder contaminar.	Myth of origin

	com qualquer pessoa só para poder contaminar. · Recordou-me que em tempos a atrás os brancos trouxeram um cão envenenado, que tinha muita raiva e mordia as pessoas, deixando o veneno que era mortal. · Só que para este caso houve uma solução porque se eliminaram muitos cães, agora para o SIDA a coisa é outra e muito mais difícil.	Dogs Rabia
6	• Nos anos 80, no prédio 33 andares, haviam uns brancos que foram descobertos a prostituírem- se com as mulheres Moçambicanas, depois de lhes darem drogadas. • Essas mulheres praticavam sexo com os cães, que transmitiram o SIDA as mulheres e foram os tais que trouxeram a doença. • Por sua vez estas mulheres transmitiram a doença aos homens. • ***Na Ásia, Europa, e América*** existe um medicamento para esta doença só que como os Países Africanos são pobres, não tem o mesmo medicamento. • Aqui em África também querem nos diminuir porque dizem que somos muitos então não enviam o medicamento, e assim morremos mais.	Dogs / girls Spread For poor Africa, no treatment A way to reduce population
2	**Seria melhor que existisse um remédio para matar o vírus antes de se desenvolver no corpo, porque após a entrada do mesmo vírus a pessoa começa a ficar com o corpo destruído.**	HIV / AIDS
9	- SIDA é diferente da gonorréia porque um indivíduo com esta DTS, vai ao hospital e consegue ficar curado, enquanto que o SIDA já não. Esta doença existe é muito perigosa e mata.	Other SDTs

4	• Tenho um amigo que só tinha 4 filhos e eles todos trabalhavam na RSA e morreram todos de SIDA, estas mortes foram em anos seguidos. • Acredito que na RSA conhecem muito bem este problema, porque todo Moçambicano que vai a RSA tem voltar com a doença.	Approximation RSA
5	• Esta doença do SIDA transmite-se como o veneno do cão que passou o mesmo veneno as pessoas. • A pessoa contaminada foi trazida para o país e a mesma pessoa transmitiu o SIDA através do sexo. • Os preservativos também transmitem o SIDA porque na experiência que já se fez mostra os bichinhos que ficam lá no interior.	Myth of transmission via dogs Myth of condom
1	• Neste ano faço 68 anos, desde jovem usava preservativo e não concordo com essa teoria de que o preservativo tem bichinhos que provocam o SIDA. • Em tempos passados haviam DTS como ***XICAVALUANA (cavalinho), MULA, KENGUEDZO*** , se a pessoa não se preveni-se usando preservativo. • Para mim é novidade dizer que o preservativo provoca o SIDA e também se isso fosse verdade eu já teria morrido.	Condom myth contested
6	• Os estrangeiros “brancos” é que pioram com esta doença porque enganam as nossas filhas com o dinheiro e deixando também o SIDA. • Agora o nº de prostitutas nos seus locais de concentração aumentou, será que o governo não pode tomar medidas para essas pessoas,	White people spread Prostitution too numerous

	porque a polícia quando passa a frente delas não faz nada.	
	• Nós os pais já não conseguimos controlar as nossas filhas porque não é possível ficar a noite toda a espera de ver se elas saem ou não.	Generation conflict
	• O governo só sabe dizer que nós os pais não controlamos as nossas famílias.	Government does not move
	• Aqui no bairro existem pessoas que se prostituem dentro mesmo do bairro.	Prostitution in district
	• Gostaria de dizer que a transmissão do SIDA acontece através da partilha de seringas, lâminas sangue das feridas abertas.	Transmission
	• Neste debate aprendi alguma coisa, não sabia que metendo água no interior preservativo, podemos ver o tal micróbio, só fico em dúvida e gostaria de ter mais detalhes.	Myth of condom
	• Agora começo a acreditar no que dizem os testemunhas de Jeová que dizem que o mundo já chegou ao seu fim, porque esta doença vai por fim as nossas vidas.	Fatalism
7	**Não acredito que os médicos tradicionais curam o SIDA.** **Mesmo a igreja universal dizem que podem curar a doença.** **Conheci uma pessoa que tinha SIDA que morreu lá na igreja durante a missa.**	Traditional treatment Cure at Church Contested
8	• Não acredito que os médicos tradicionais curam o SIDA, só acredito que eles retardam o desenvolvimento da doença. • Já ouvi e algumas pessoas que quando foram postas fora de hospitalização e em seguida foram aos médicos tradicionais e conseguiram melhoraram porque até chegaram a engordar só que logo que apanham outra doença qualquer morrem.	Traditional treatment can prolong life Opportunistic diseases

7	**Os médicos tradicionais, no tempo colonial davam fígado do cão a pessoa que tivesse hemorróides.**	Cure with dog' liver
	Esses médicos tradicionais que tentam curar com o fígado de Cão deveriam fazer outro tipo de tentativas para poderem curar o SIDA.	Contested
8	• O homem e a mulher são responsáveis pela transmissão da doença, só que quem procura a doença é o homem porque não consegue sossegar. • Não conheço nenhuma prostituta que anda a agarrar os homens para dormir com os homens. • Um homem consegue conquistar a mulher do amigo, mesmo que ela se recuse, este continua a insistir e diz não quer o amigo, mas sim quer a ela, por isso quando as mulheres culpam os homens do alastrar da doença tem as suas razões.	Gender Men are more responsible for the spread of HIV / AIDS Men seduce women
7	• Ambos somos responsáveis, só que existem mulheres que se vestem mal, com saias muito curtas com os umbigos de fora, só para atrair os homens por isso mesmo que eles não queiram acabam existindo. • Todos nós infectamo-nos uns aos outros.	Women provoke Both are responsible
5	**Não concordo que nós os homens por conquistarmos as mulheres é que transmitimos a doença.**	Contested, men are not transmitters
4	• Eu já sou velho e tenho uma mulher muito nova, só que ela ainda pinta o cabelo e ainda se maquilha, veste sempre a roupa da moda, questiono-me se ela ainda faz isso para mim? • Eu tenho a certeza que ela faz isso para conquistar os outros homens.	Girls attract men

	• As mulheres quando vê um fazem de tudo para que eles cheguem ao ponto de dizer alguma coisa. • Não existem velhas neste mundo , só existem velhos, vejo velhas que se maquilham para serem vistas. **O homem velho nunca pinta cabelo mas, as velhas morrem a pintarem-se porque querem ser vistas pelo os homens.**	Women pretend to stay young, men don't
5 8	• O governo é que estragou o país porque nos tempos atrás onde entram os mais velhos não entravam os meninos. • As mulheres tinham respeito para com os seus marido, infelizmente, nestes tempos as mulheres é que mandam, gostam muito de imitar as novelas e os jovens no cinema assistem filmes pornográficos e isso contribui para a má conduta das pessoas e até mesmo para a transmissão da doença.	Government is responsible In older times it was different
7	**Agora, mesmo as crianças dos 10-14 anos praticam o sexo porque vêm as novelas e elas não se preocupam em encontrar pelo menos uma pessoa da idade delas para terem uma relação.**	Young girls want to experiment sex with older men
9	• Nos tempos passados não havia SIDA porque não tínhamos televisão e morríamos pouco. • Devido ao elevado nº de filmes pornográficos que vemos em, as mortes estão a piorar.	Influence of Tv on AIDS

7	• A diminuição desta doença não será fácil, se a fábrica de preservativos continuar a produzir e nós continuarmos a usar os tais preservativos não vamos salvar.	Myth of condom
	• O produtor do preservativo é propagador do SIDA, tenho pena de Moçambique que tem a sorte de receber preservativos o SIDA.	
	• Agradecemos bastante a MSF por nos passar uma mensagem e por nos ter explicado bem sobre os vários assuntos relacionados com a doença porque estamos a morrer muito aqui dentro do bairro do Urbanização.	MSF
	• Vamos saber como nos prevenir da cólera, da malária, só que do SIDA não somos todos que vamos ouvir o conselhos.	AIDS campaigns not like malaria / cholera campaigns
	• Gostaríamos de pedir a MSF a construção de um posto médico para esses casos do SIDA.	
8	**Uma vez que esta doença existe gostaríamos de ir a MSF para sermos testados para sabermos da nossa real situação.**	VCCT

ANNEXURE 4: LIST OF INDEXED STEREOTYPES

N	*Index*	*Individual*	*Illustration*	*Themes*
1	FGD1, 7	Armindo, 23 ys S° trainer	Drastic weight loss is associated with AIDS.	Analogy
2	FGD1, 12	Sergio, 22 ys trainer	People die from TB and not from AIDS.	Analogy
3	FGD1, 5	Orlando, 22 ys trainer	People still don't believe in AIDS and AIDS continues to spread until the number of sick people will have increased within three or four years.	Taboo
4	FGD1, 12	Sergio, 22 ys trainer	Men say women are responsible because they want to blame women.	Gender
5	FGD1, 1	Rosa, 25 ys trainer	People say men are less numerous than women and that is why men have more partners (3 to 7 partners).	Gender
6	FGD1, 1	Miguel, 22 ys trainer	Men get AIDS from women as they have sex with women and not with men.	Gender
7	FGD1, 12	Sergio, 22 ys trainer	Men say that women are responsible because prostitutes are women and men in need of sex get it there and bring it home.	Gender
8	FGD2, 8	Julieta, marr ADASBU	Condoms transmit AIDS; they contain female and male beasts; especially condoms from RSA and Mozambique are not trustful.	Condom
9	FGD2; 7	Rosa, 29 ys married	Condoms transmit AIDS – put water in the condom, after three days you see the beasts (+ test).	C ondom + test

10	FGD2, 7	Rosa	They say AIDS can be transmitted through the air.	Propagation / air
11	FGD2, 9	Teresa, Married	If my husband uses condoms with other women he can contract AIDS and then he would infect me.	Condom
12	FGD2, 1	Augusto, 62 ys married	Women are AIDS transmitters because they get it from strangers who cannot resist African beauties, and men who travel abroad get it from women abroad.	Transmission
13	FGD2, 1	Augusto, 62 ys married	At the start women propagated AIDS to men, now both sexes are responsible for the spread of AIDS.	Gender / Transmission
14	FGD2, 4	Mariamo, 55 ys married	Men who are not circumcised can get AIDS and transmit it to their wife if he is not hygienic – the same for women who is not hygienic.	Transmission / Circumcision Hygiene
15	FGD2, 4	Mariamo, 55 ys married	Women have an advantage over men, during her menstruation she loses some of HIV virus and men don't; that is why men die earlier then women.	Gender / Menstruation
16	FGD2,		A woman with injuries on her hands selling food propagates the disease by touching them.	Propagation / food
17	FGD2, 6	Euclidio	A person had skin lesions and then hair loss but lesions disappeared and hair grew again. Is that person infected?	Analogy
18	FGD3, 5	Victoria 40 ys market marrid	AIDS passes through blood. Can mosquitoes also transport and transmit AIDS?	Propagation / Mosquitos
19	FGD3, 3	Albertina 29 Single	She heard about condom myth, her sons use them, they will die if they don't take care.	Condom
20	FGD3,2	Amina 34 Single	How can we be AIDS transmitters, if women don't have sex with women. In that case, only she	Gender

			would be contaminated but as men have sex with women, both are contaminated.	
21	FGD3, 8	Helena 49 ys married	How can men say that HIV is in women sex. Does AIDS kill women first? This is a lie, They just want to accuse us.	Gender
22	FGD3, 6	Carolina	How can a woman alone transmit AIDS when she stays at home to look after her household and kids.	Gender
23	FGD3, 3	Albertina	Not women's sex but men propagat e AIDS, men go out on Friday night with women and only come back on Sunday.	Transmission
24	FGD5, 5	Felisberto 23 ys Single	I have heard that you get AIDS from a virus and that this virus also appears in rotten food and injuries.	Contamination / food, injuries
25	FGD5, 3	Raimundo 31 ys Single	Could AIDS not be invented to reduce the number of people in this world? How do you explain why condoms are distributed for free? What kind of factory is this that can afford to produce condoms to offer?	Condom
26	FGD5, 3	Raimundo	AIDS only exist in poor countries and in blacks. I never saw a white person with AIDS, even on television. Only black people get AIDS through condoms that they receive for free.	Race / Condom
27	FGD5, 1	Ramos 31 ys Single	AIDS is like TB that you get eating with a sick person in the same plate and also through saliva of the sick. That is why they say that you don't have to share the same utensils.	Propagation / Saliva
28	FGD5, 4	Januario 34 ys Single	At the hospitals you see pamphlets with a sick person and then another with a healthy person who kisses the sick one. Would that mean that AIDS is not transmitted through kisses?	Propagation / Kisses
29	FGD5, 2	Santos 18 ys	Why do they only show black people with SIDA on tv? Would that be because white don't	Race

		Single	contract the disease? I even never saw a white person with TB.	
30	FGD5, 2	Santos 18 ys Single	Something is not clear in this, why do they say that a person who have persistent cough has AIDS and from thin people they say the same? We don't know anymore what AIDS is.	Analogy
31	FGD5, 4	Januario	Us blacks are not like whites. The only difference is that white people have money and when one falls sick the others are ready to help, they are well treated in good hospitals where they have their secrets. We blacks are not like this because if one is sick the others are prompt to spread the news as if it was a good one. White people have a different culture than ours.	Race
32	FGD5, 3	Raimundo	Even in the RSA where there are many whites, when I worked there, I never saw a white person with al the symptoms that you see in blacks. For this reason, I don't know if they get the disease or no.	Race
33	FGD5, 2	Santos	When a person goes to hospital to be treated for another disease than AIDS, they give him receipts to buy drugs but condoms they give him for free. Why don't they give drugs for free to recover from the disease he suffers at that moment instead.	Condom
34	FGD5, 4	Januario	When a person goes to hospital with TB they say he has AIDS.	Analogy
35	FGD5, 1	Ramos	AIDS has chosen the sexual way to enter into the organism. I say this because the way of transmission is woman's sex and as man cannot live without a woman he get contaminated.	Gender
36	FGD5, 4	Januario	There is a cure for HIV for those who have money, not for the poor.	Social difference
37	FGD5, 1	Ramos	I went to hospital for a bilharzias and there they told me I got an STD. They gave me an injection and condoms. I wondered if I got AIDS through the injection? They also told me I had to reduce the number of sexual partners but the truth is I only had one and this they wouldn't believe.	Analogy

38	FGD6, 1	Antonio 68 ys married	AIDS exists. Nowadays, a patient is considered as an AIDS patient as he loses weight and sometimes when he gets skin lesions.	Analogy
39	FGD6, 6	Carlos C 47 ys Married	What frightens me is that white people don't die of AIDS. AIDS is just a disease of the black people. That is what wonders me and makes me suspicious.	Race
40	FGD6, 5	Carlos D 69 ys married	I also believe that condoms transmit AIDS to the people who use them as (+ test).	Condom + test
41	FGD6, 3	Henriques	I also think that condoms provoke the disease otherwise I don't understand how a factory produces condoms to offer them to people.	Condom
42	Idem		In the past, people didn't die of AIDS because there were no condoms. Now that condoms exist to prevent the disease, people die more. This is not possible.	Condom
43	FGD6, 5	Carlos D	One infected person came to our country and spread the disease through the whole country having sex with every person in order just to spread the disease.	Origin in Mozambique
44	FGD6, 6	Carlos C 47 ys Married	In the 80ties in apartment *33 Andares* white people were seen having sex with Mozambican girls after giving them drugs. These women had sex with dogs that transmitted the disease to them. They in turn transmitted the disease to men.	Propagation in Mozambique through dogs
45	FGD6, 6	Idem	In poor countries in Africa there are not the same drugs as in other continents Asia, Europe and America because they say that we are numerous and they don't send them here so that we die more.	Race
46	FGD6, 5	Carlos D	AIDS is transmitted through the venomous of the dog that passed to persons.	Origin of AIDS
47	FGD6, 5	Carlos D	Contaminated person was sent to our country and transmitted AIDS sexually.	Propagation

48	FGD6, 5	Carlos D	Condoms also transmit AIDS (+ test).	Condom + test
49	FGD6, 6	Carlos C	White strangers make AIDS worse since they corrupt our girls with money and also give them AIDS.	Race
50	FGD6, 8	José 67 ys married	Men are responsible for the AIDS transmission as they seduce women.	Gender
51	FGD6, 9		Before there was no AIDS because there was no TV and we died less. Now that porno films exist, deaths are getting worse.	Propagation / TV
52	FGD6, 7	Sitoé 46 ys married	Limiting the disease won't be easy as factories continue to produce condoms. As we continue to use them, we won't be saved.	Condom
53	FGD7, 8	Florencia 20 ys single	They say that AIDS is transmitted sexually, bites of bees, but those don't get AIDS.	Propagation / bees
54	FGD7, 6	Zelia 15 ys single	I saw on TV a person who told he got AIDS but who was cured because he had a lot of money and they told him to protect himself in order not to get it again.	Cure / money
55	FGD7, 7	Carolina 17 ys single	At the universal church the priests say that they treat AIDS.	Cure / Church
56	FGD7, 8	Florencia 20 ys single	I know that AIDS got a treatment for those who have money.	Cure / money, via church
57	FGD7, 8	Florencia 20 ys single	A person with AIDS can also be treated at the universal church if one believes in GOD.	Cure / church
58	FGD7, 6	Zelia 15 ys	Not everybody goes to church. There are many sick people. If they went to church they wouldn't	Cure / church

		single	have AIDS and would be saved.	
59	FGD7, 8	Florencia 20 ys single	My friend told me that various people were cured at the headquarters of the universal church because the sick go there to talk with the priest and he asks all people to pray in favour of a cure of all AIDS victims.	Cure / church
66	FGD7, 3	Amina 20 ys single	It is not necessary to go to church for many years so that God cure the sick, it's just a matter of having trust and faith and one gets cured. For God it is not a question of luck.	Treatment / faith
61	FGD7, 3	Amina 20 ys Single	I want to know if AIDS and STD is the same thing. And which of both can be cured if it is not the same thing.	Analogy
62	FGD8,4	Ernesto 23 ys single	Some people have those black spots but after some months, the person get better. I don't know if this is AIDS.	Analogy
63	FGD8, 4	Ernesto	They say that AIDS has a treatment.	Cure
64	FGD8, 7	Sacur 19 ys Single	Condoms provoke the disease.	Condom
	FGD9		NO STEREOTYPES	
65	FGD10, 2	Salvador 32 ys single	Every body is responsible for oneself and must take care. Some people, however, do and then fate reaches them and they get the disease.	Transmission / bad luck
66	FGD10,7	José 38 ys single	People know about the existence of AIDS and they are not afraid as they never saw concrete case. We don't receive civic education about AIDS so that people don't believe in the existence of AIDS. That is why so many people are infected. I am one of those people who don't believe that sex, food and kisses are transmit AIDS. There can be another cause than sexual relations but they	Taboo

			don't say it. If it were sexually transmitted, one could use condoms his whole life and get AIDS all the same.	
67	FGD10, 6	Luis 26 ys single	I often hear that thin people have AIDS, I don't know if this is true and here in the district some thin people are already suspected.	Analogy
68	FGD10, 8	Africano 73 ys married	An old chap like me cannot get AIDS, only young people can get the disease.	Age
69	FGD10, 9	Albino 41 ys Married	I still don't believe in AIDS as there is not a concrete case of AIDS.	Analogy
70	FGD10, 9	Idem	In many cases, we neighbours say it is AIDS but the doctors don't say so.	Taboo
71	FGD11,2	Ricardo 63 ys married	Dogs transmit the disease. People are unhygienic, dogs wander at night and shit everywhere and here it is. People don't clean there houses well and there they get it.	Transmission / Dogs' excrements
72	FGD11, 5	Fransisco 59 ys Married	Too much poverty contributes a lot to the spread of this disease. Today the day women have the power and command and do what they want.	Gender
73	FGD11, 4	Armando 45 ys Married	We don't trust condoms because even using them one ends with the disease.	Condom
74	FGD11, 6	Alberto 47 ys Married	Those who migrate to the RSA die a lot of the disease. I don't know if they put drugs into the water or the virus, the truth is we are dying.	Propagation / water
75	FGD11, 4	Armando	Many people say that with a lot of money AIDS can be cured.	Cure / money