Mozambique's HIV/AIDS Pandemic

Grappling with Apartheid's Legacy

Carole J.L. Collins

Social Policy and Development
Programme Paper Number 24
February 2006

United Nations
Research Institute
for Social Development

This United Nations Research Institute for Social Development (UNRISD) Programme Paper has been produced with the support of the Royal Ministry of Foreign Affairs of Norway and UNRISD core funds. UNRISD thanks the governments of Denmark, Finland, Mexico, Norway, Sweden, Switzerland and the United Kingdom for this funding.

Copyright © UNRISD. Short extracts from this publication may be reproduced unaltered without authorization on condition that the source is indicated. For rights of reproduction or translation, application should be made to UNRISD, Palais des Nations, 1211 Geneva 10, Switzerland. UNRISD welcomes such applications.

The designations employed in UNRISD publications, which are in conformity with United Nations practice, and the presentation of material therein do not imply the expression of any opinion whatsoever on the part of UNRISD concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

The responsibility for opinions expressed rests solely with the author(s), and publication does not constitute endorsement by UNRISD.

ISSN 1020-8208

Contents

Acronyms ii

Acknowledgements ii

Summary/Résumé/Resumen iii
- Summary iii
- Résumé iv
- Resumen v

Introduction 1

The Scale of Mozambique's HIV/AIDS Pandemic 1
- Tracking the pandemic: Mozambique's unique prevalence pattern 2
- Factors affecting regional HIV prevalence levels 5

Structural Factors Shaping Mozambique's HIV/AIDS Crisis 6

Mozambique's Colonial Legacy and Links to Apartheid 7
- Skewed transport and commercial corridors 7
- The regional contract labour system and migrant labour 8
- Mozambique's public health system 9

South Africa's Surrogate War of Destabilization 10
- RENAMO violence: Targeting people 11
- RENAMO violence: Targeting transport corridors 12
- RENAMO violence: Targeting Mozambique's health care system 14

An Overlooked Source of Infection: Returning Refugees 15

The Cost of Donor Dependency: How the War Undermined Government Capacity and Political Autonomy 16

The Specific Impact of Structural Adjustment 17

Conclusion 18

Annex: Profile of Mozambique: Social and Economic Conditions 21

Bibliography 22

UNRISD Programme Papers on **Social Policy and Development** 25

Figures

Figure 1: Location of sentinel posts, 2004 4

Figure 2: Road corridors in Mozambique 8

Figure 3: Central corridor: Trucks parked at truck stops on three random days 9

Acronyms

AIDS	acquired immune deficiency syndrome
CUSO	Canadian University Service Overseas
FRELIMO	Frente de Libertação de Moçambique (*Mozambique Liberation Front*)
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (*German Agency for Technical Cooperation*)
HIV	human immunodeficiency virus
ICAD	Interagency Coalition on AIDS and Development
IDP	internally displaced person
IMF	International Monetary Fund
IOM	International Organization for Migration
IRIN	Integrated Regional Information Networks
NGO	non-governmental organization
RENAMO	Resistệncia Nacional Moçambicana (*Mozambique National Resistance*)
STD	sexually transmitted disease
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
US	United States
USAID	United States Agency for International Development
USDOS	United States Department of State
UZ/IDS	University of Zimbabwe/Institute for Development Studies
WHO	World Health Organization

Acknowledgements

The author would like to particularly acknowledge the materials, insights and other assistance provided by Julie Cliff of the Eduardo Mondlane University Faculty of Medicine in Maputo, Mozambique, and by Karen Foreit of The Futures Group in Washington, DC.

Summary/Résumé/Resumen

Summary

This study focuses on how apartheid, through its economic structures and wars of destabilization to preserve white minority rule, helped shape and deepen Mozambique's HIV/AID pandemic, and how this tragic legacy continues to this day.

Formal apartheid, and its efforts to destabilize black majority–ruled neighbours via proxy rebel movements, ended in Southern Africa in the early 1990s. Following the peace agreement in 1992, Mozambique achieved significant progress in economic and social reconstruction. But this progress is being undercut by a deepening HIV/AIDS pandemic significantly shaped and accelerated by the legacies of apartheid, and by the economic structures of colonial and white minority rule that continue to operate in the present.

This study analyses how Mozambique's HIV/AIDS pandemic was shaped by the complex interplay between multiple factors, all of which boosted the risk factors for HIV infection, in particular:

- the legacy of Portuguese colonialism (including the region-wide, low-wage migrant labour system and the paucity of public health services at independence);
- the violence and social chaos wrought by the apartheid-sponsored war from 1980 to 1992, which, through its massive disruption of family life, displacement of close to 40 per cent of all Mozambicans and destruction of transport and health infrastructure, crucially determined the geographic pattern and timing of the spread of HIV/AIDS across the country and undermined governmental capacity to respond to it;
- the necessity of relying on high HIV–prevalent neighbouring states to help defend Mozambique's infrastructure and for refuge from the chaos of war;
- the failure or inability to institute effective HIV prevention programmes among returning refugees; and
- the imposition of economic and other policies, under donor pressure, which have served to limit the access to basic health care that is fundamental to countering such a pandemic.

This study analyses how war-induced dependency on outside donors undermined the Mozambique government's autonomy in setting national health policy as well as its capacity to implement an effective national strategy. It also looks at how externally imposed structural adjustment conditions undercut Mozambique's response to the HIV/AIDS pandemic in various ways.

Mozambique's experience demonstrates the urgent need to initiate HIV/AIDS prevention programmes for refugees, internally displaced persons and soldiers before as well as following armed conflicts—or risk seeing recovery efforts undermined by a worsening HIV/AIDS pandemic. A high cost has been paid by Mozambicans for donor unwillingness to seriously redress, on the scale needed, the apartheid-wrought damage to Mozambique's health infrastructure.

But if donors and African governments are really serious about wanting to stem the rising tide of HIV/AIDS, they must begin to develop long-term alternatives to the region-wide low-wage migrant labour system, which continues to fragment family life and boost risk factors for HIV, and to the dominant export-led development model on which this system is premised.

Carole Collins currently works as an independent consultant and freelance writer on Africa policy issues. She has worked in southern Africa as a journalist, consultant and representative

for the American Friends Service Committee (1986–1990), and headed the US Jubilee campaign for debt cancellation in 1998–1999.

Résumé

Cette étude montre comment l'apartheid, par ses structures économiques et ses guerres de déstabilisation destinées à maintenir la minorité blanche au pouvoir, a contribué à déterminer et à aggraver la pandémie de VIH/Sida au Mozambique et comment le pays continue, aujourd'hui encore, à en subir les tragiques séquelles.

L'apartheid, sous sa forme officielle, et ses efforts pour déstabiliser les pays voisins gouvernés par une majorité noire en se servant des mouvements rebelles, a pris fin en Afrique australe au début des années 90. A la suite de l'accord de paix de 1992, le Mozambique a fait des progrès considérables sur le plan de la reconstruction économique et sociale. Mais ces progrès sont freinés par une pandémie de VIH/Sida qui va en s'aggravant et qui est déterminée dans une large mesure et accélérée par les séquelles de l'apartheid, et par les structures économiques du régime colonial et minoritaire blanc toujours en place actuellement.

Il ressort de l'analyse de l'auteur que la pandémie de VIH/Sida au Mozambique résulte de l'interaction complexe de facteurs multiples, qui tous augmentent les facteurs de risque d'une infection au VIH, notamment:

- les séquelles du colonialisme portugais (notamment le système économique appliqué dans toute la région, qui repose sur l'emploi de travailleurs migrants à bas salaires, et l'indigence des services de santé publique au moment de l'indépendance);
- la violence et le chaos social entraînés par la guerre de 1980 à 1992, qui était fomentée par l'apartheid et qui, en bouleversant la vie de milliers de familles, en déplaçant près de 40 pour cent de la population mozambicaine et en détruisant l'infrastructure des transports et de la santé, a déterminé les caractéristiques spatio-temporelles de la progression du VIH/Sida dans le pays et sapé les capacités d'intervention du gouvernement face à l'épidémie;
- la nécessité de compter sur l'aide de pays voisins, où le taux de prévalence du VIH était élevé, pour défendre l'infrastructure du Mozambique et pour trouver un refuge, loin du chaos de la guerre;
- l'incapacité d'entreprendre des programmes efficaces de prévention du VIH auprès des réfugiés de retour au pays ou le manquement à cette obligation; et
- l'imposition, sous la pression des donateurs, de politiques économiques et autres qui ont eu pour effet de limiter l'accès aux soins de santé élémentaires qui sont d'une importance capitale pour contenir une telle pandémie.

L'auteur analyse ici la situation du gouvernement mozambicain qui, dépendant de donateurs extérieurs à cause de la guerre, n'a pas pu définir en toute autonomie sa politique nationale de santé et se doter d'une stratégie nationale efficace. Elle étudie aussi les diverses manières dont l'ajustement structurel, dont les conditions ont été imposées de l'extérieur, a gêné l'action du Mozambique face à la pandémie de VIH/Sida.

L'expérience mozambicaine montre l'urgence d'entreprendre des programmes de prévention du VIH/Sida auprès des réfugiés, des personnes déplacées dans leur pays et des soldats, avant comme après des conflits armés, car le risque de voir les efforts de relèvement sapés par une aggravation de la pandémie de VIH/Sida est important. Les Mozambicains ont payé très cher le manque d'empressement des donateurs à réparer les dommages causés par l'apartheid à l'infrastructure sanitaire de leur pays et à financer des travaux qui soient à l'échelle des besoins.

Mais si les donateurs et les gouvernements africains veulent vraiment endiguer la montée du VIH/Sida, ils doivent se mettre à imaginer des alternatives à long terme au système régional d'exploitation des travailleurs migrants à bas salaires, qui continue à diviser les familles et à augmenter les facteurs de risque du VIH, et le modèle dominant d'un développement tiré par les exportations, qui a engendré ce système.

Carole Collins travaille actuellement en qualité de consultante et d'écrivain indépendant sur les politiques menées en Afrique. De 1986 à 1990, elle a travaillé en Afrique australe comme journaliste, consultante et représentante de l'American Friends Service Committee et a dirigé la campagne américaine de Jubilé pour l'annulation de la dette en 1998–1999.

Resumen

En este estudio se analiza, por una parte, la forma en que el apartheid, por medio de sus estructuras económicas y sus guerras de desestabilización para preservar a la minoría blanca en el poder, contribuyó a dar forma y profundizar la pandemia del VIH/SIDA en Mozambique y, por la otra, la manera en que este trágico legado ha continuado hasta el día de hoy.

El régimen del apartheid en Sudáfrica, y sus esfuerzos por desestabilizar, a través de movimientos rebeldes, a los vecinos de este país, gobernados por las mayorías negras, concluyó formalmente a principios de la década de 1990. Tras la firma del acuerdo de paz en 1992, Mozambique registró considerables avances en la reconstrucción económica y social. No obstante, este progreso se vio minado por la profundización de la pandemia del VIH/SIDA que los legados del apartheid contribuyeron a definir y acelerar, así como por las estructuras económicas coloniales y el régimen de una minoría blanca, factores que aún siguen vigentes.

En este estudio se examina cómo la conjunción de múltiples elementos dio forma a la pandemia del VIH/SIDA en Mozambique y agudizó los factores de riesgo de infección por el VIH, en particular:

- el legado del colonialismo portugués (incluido un sistema de mano de obra migrante de bajos salarios en toda la región y la escasez de servicios de salud pública al momento de lograr la independencia);
- la violencia y el caos social que trajo la guerra entre 1980 y 1992, que fuera promovida por el apartheid y que, a causa de la destrucción generalizada de la vida familiar, el desplazamiento de cerca del 40 por ciento de los mozambiqueños y la destrucción de las infraestructuras de transporte y salud, se convirtiera en un factor determinante del patrón geográfico y del momento de propagación del VIH/SIDA en todo el país y socavara la capacidad del gobierno para responder ante la enfermedad;
- la necesidad de tener que recurrir a estados vecinos con una alta prevalencia del VIH para defender la infraestructura de Mozambique y como refugio del caos de la guerra en el país;
- el fracaso o la incapacidad para instituir programas eficaces de prevención de la infección por el VIH entre los refugiados que regresaban al país;
- la implantación de políticas económicas y de otra índole (bajo la presión de los donantes) que han contribuido a limitar el acceso a la atención sanitaria básica, elemento fundamental en la lucha contra una pandemia.

En este estudio se analiza la forma en que la dependencia de los donantes externos inducida por la guerra socavó la autonomía del gobierno de Mozambique para establecer una política nacional de salud y su capacidad para ejecutar una estrategia nacional eficaz. También se aborda la manera en que unas condiciones de ajuste estructural impuestas desde el exterior minaron la respuesta del país a la pandemia del VIH/SIDA en diversas formas.

La experiencia de Mozambique demuestra la urgente necesidad de iniciar programas de prevención del VIH/SIDA entre refugiados, desplazados internos y soldados antes y después de los conflictos armados, so pena de correr el riesgo de que un empeoramiento de la pandemia del VIH/SIDA socave los esfuerzos de recuperación. Los mozambiqueños han pagado un alto precio por la renuencia de los donantes a reparar, con la seriedad y en la dimensión necesarias, el daño que el apartheid causara a la infraestructura sanitaria de Mozambique.

Pero si los donantes y los gobiernos africanos son realmente serios en sus intenciones de detener la creciente ola de infección por el VIH/SIDA, deben comenzar a desarrollar alternativas a largo plazo al sistema de mano de obra constituida por migrantes de bajos salarios en toda la región, que continúa fragmentando la vida familiar y sigue impulsando los factores de riesgo de infección, así como proponer opciones al modelo de desarrollo predominante orientado a las exportaciones, sobre el cual descansa dicho sistema.

Carole Collins trabaja actualmente como consultora independiente y escribe sobre temas relativos a la situación en África. Ha laborado en el sur del continente africano como periodista, consultora y representante del American Friends Service Committee (1986–1990); y presidió la campaña del Jubileo en los Estados Unidos para la cancelación de la deuda entre 1998 y 1999.

Introduction

Formal apartheid and its efforts to destabilize its black-ruled neighbours ended in South Africa in the early 1990s. Yet, the legacy of white minority rule continues to undermine the lives and health of ordinary people across southern Africa.

Mozambique's impoverishment under Portuguese colonial rule made it unlikely that it would escape the toll in human suffering wrought by the relentless spread of HIV/AIDS across Africa. But unique aspects of white minority rule and apartheid—the colonial skewing of transport systems and creation of a region-wide, low-wage migrant labour system—undercut stable family life and fostered conditions that made Mozambique even more vulnerable to the spread of HIV/AIDS. The apartheid-sponsored war waged by the rebel group Mozambique National Resistance (Resistência Nacional Moçambicana/RENAMO, also known as MNR) on newly independent Mozambique between 1980 and 1992 dramatically increased population mobility, a key risk factor for the spread of HIV/AIDS. Over 40 per cent of all Mozambicans were uprooted from their homes and villages by RENAMO's anticivilian violence. The war crucially reshaped the geographic pattern and timing of the spread of HIV/AIDS across the country.

RENAMO's anticivilian violence decimated rural clinics, seriously compromising Mozambique's capacity to monitor or respond to the HIV/AIDS pandemic. The war drained national coffers and boosted Mozambique's foreign debt burden and debt repayment costs. The result altered national budget priorities, forcing even greater diversion of scarce public revenues from health and education, and weakened the government's leverage with outside donors.

The concentration of Zimbabwe troops and internally displaced persons (IDPs) along critical transport corridors in central Mozambique due to the war significantly multiplied HIV risk factors. In addition, the post-1992 return of Mozambican refugees dramatically, and ironically, accelerated the spread of HIV/AIDS along and in rural areas near those corridors. Mozambique's experience highlights the urgent need to initiate HIV prevention programmes for refugees, IDPs and soldiers before as well as after civil or other armed conflicts. Otherwise, countries emerging from armed conflict—such as Angola and the Democratic Republic of the Congo (formerly Zaire)—risk, like Mozambique, seeing their recovery efforts undermined by a worsening pandemic (Garrett 2000).

Analysing this legacy of apartheid is not an abstract exercise. Donors have been unwilling to seriously redress, on the scale needed, the apartheid-wrought damage to Mozambique's health infrastructure and thus its capacity to respond to the escalating HIV/AIDS pandemic, even after peace has been achieved.

Donors have also ignored a key structural reason why HIV/AIDS continues to spread in Mozambique—and elsewhere in southern Africa—today: the continuation of the region-wide, low-wage migrant labour system beyond the formal end of apartheid. This system continues to fragment family life, thus helping sustain Mozambique's—and southern Africa's—HIV/AIDS pandemic. If donors and African governments are serious about stemming the rising tide of HIV/AIDS, they must begin to explore long-term alternatives to this migrant labour system—and to the dominant export-led development model on which this system is premised.

The Scale of Mozambique's HIV/AIDS Pandemic

Mozambique is one of nine African countries hardest hit by the HIV/AIDS epidemic (USAID 2002). By 2001, 15 years after the country's first AIDS case was diagnosed, over 1.1 million of Mozambique's then 19.2 million people were living with HIV or AIDS (UNAIDS et al. 2002). About 45 per cent of new infections were in the central region due to its larger population and higher HIV prevalence levels (National Institute of Statistics 2000). By the end of 2004,

Mozambique's HIV infection rate was 16.2 per cent (Republica de Moçambique 2005) and HIV prevalence in pregnant women was estimated at 14.9 per cent (USDOS 2005b). By 2005, approximately 500 Mozambicans, mostly young people, were being infected with HIV per day (UNAIDS 2005), and an estimated 470,000 AIDS orphans were in need of assistance (USDOS 2005a).

The United Nations Children's Fund (UNICEF 2004) calls HIV the country's greatest development challenge. High HIV/AIDS prevalence after almost two decades of war has eroded Mozambican hopes for rapid recovery. By 2010, the United States Agency for International Development (USAID) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) project that Mozambique's high HIV prevalence rates will

- cut life expectancy at birth from 43 to 36 years, rather than rising to over 50 as projected;
- cause 30 per cent to 40 per cent of Mozambican babies born to HIV-positive mothers to become infected;
- deprive 1.13 million Mozambican children of one or both parents due to AIDS; and
- leave Mozambique with 10.8 million economically active people, not 12.4 million as projected, with the majority of them either very young or very old (USAID 2002; UNAIDS et al. 2002).

HIV/AIDS has also started to push Mozambique's subsistence agriculture into long-term decline, posing an ominous challenge to its food supply and biodiversity. By 2020, Mozambique may lose over 20 per cent of its current agricultural labour force to HIV/AIDS (IRIN 2004c[1]).

By 2002, AIDS was the leading cause of death among Mozambican teachers at all levels of education and, by 2012, as many as 17 per cent of Mozambique's teachers will likely have died of AIDS, according to a 2002 Mozambique Education Ministry study (Agence France-Press 2002). By 2015, Mozambique's already high infant mortality rate will likely be 25 per cent higher than it would be in the absence of HIV/AIDS (USAID 2002). Young Mozambican women make up the bulk of those infected: infection rates of women between 15 and 19 years old are twice that for men of the same age; and of those between 20 and 24, the rate is four times that of men.

Tracking the pandemic: Mozambique's unique prevalence pattern

Mozambique's historical epidemiological HIV/AIDS profile appears to differ from that of most "typical" AIDS-afflicted African countries. Most countries with high prevalence rates have shown a similar "S" pattern of growth of the pandemic with three distinct stages (Foreit 1999):[2]

1. a slow growth stage with low initial HIV prevalence rates in the capital city (related in part to the relatively long HIV incubation period), followed by
2. a rapid growth stage with prevalence rates doubling every two years, as HIV spreads in urban areas and gradually to rural areas; and then
3. a levelling-off plateau stage as many HIV-infected individuals develop full-blown AIDS, become ill and die, disrupting economic life in local communities and leaving large numbers of children orphaned.

Existing data show that rather than peaking first in its capital city before spreading to rural areas—as in Zambia and Zimbabwe—Mozambique's highest prevalence rates during the 1990s

[1] Citing a recent Food and Agriculture Organization study conducted by Anne Waterhouse.

[2] Researchers are currently reassessing what is "typical", that is, whether more reliable, geographically balanced pre-1990 HIV/AIDS prevalence data for other African countries, if obtainable, would reveal patterns closer to Mozambique's. But large permanent troop concentrations and the degree of displacement of civilians by the war clearly seem to be key variables in Mozambique's pandemic (Karen Foreit, personal communication, 13 January 2004).

emerged in its central region, along and near Mozambique's two major transport corridors of Beira and Tete (Republica de Moçambique 2003; National Institute of Statistics 2000). This was the region most targeted by RENAMO violence during the 1980s, most dependent on Zimbabwe troop concentrations for protection and most traversed by IDPs and returning refugees after the 1992 peace agreement. By 1994, central Mozambique's infection rate was four to seven times higher than that of the southern region, which includes the capital Maputo (Republica de Moçambique 2003; Foreit 1999).

Transport corridors have raised HIV/AIDS levels in a number of African countries—for example, Uganda and Zambia—partly because the difficult and unsettled conditions of work, separation from families and prolonged stops due to border formalities and loading delays encourage truckers to use the services of sex workers along these routes. That said, the high prevalence levels found along Mozambique's two most vital transport corridors were markedly higher than expected.

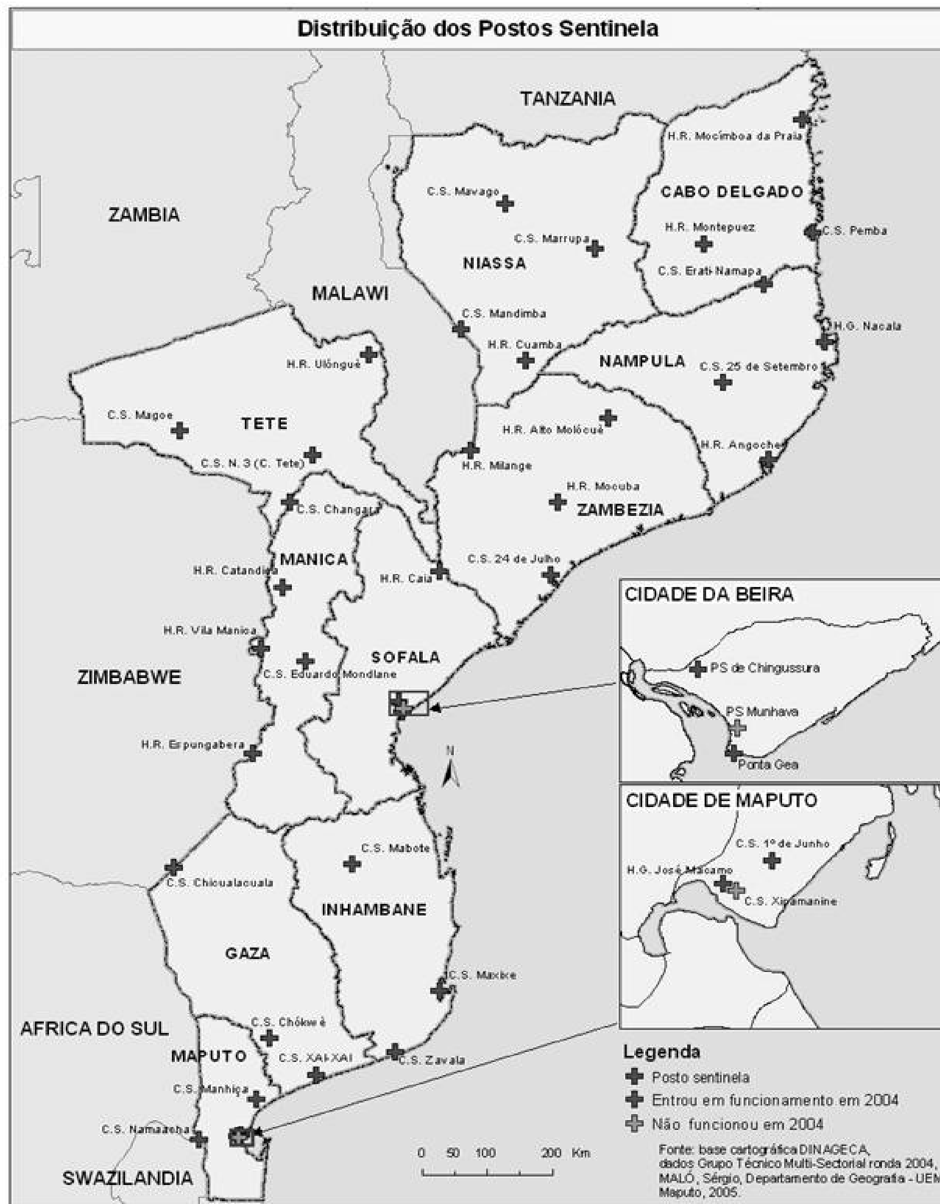
Policy makers wanted to know if Mozambique's regional differences in prevalence arose from specific regional epidemics beginning at the same time or at different times. The answer would carry different implications for future trends and policy responses in each region (Foreit 1999).

Finding answers was complicated by a nearly total lack of pre-1988 epidemiological data and by geographic imbalances—in part due to the war—of the data available before 2000 (Republica de Moçambique 2003). But extrapolations from the four phases of Mozambique's data collection efforts seem to support the second hypothesis.

- *Phase one: Data between 1988–1998:* Between 1988 and 1994, prevalence data were only available from Maputo's general hospital. Between 1994 and 1998, data were collected at three additional sentinel posts (*postos sentinela*), in the towns of Beira, Chimoio and Tete, along the two major transport corridors in Mozambique's central region. Early on, Mozambique chose the antenatal approach to surveillance of HIV prevalence at sentinel posts.
- *Phase two: 2000 surveillance round:* In 2000, the Ministry of Health expanded HIV data collection from four to 20 sentinel posts: 11 urban and nine rural, including seven northern sentinel posts (all previously unmonitored), eight central and five southern (National Institute of Statistics 2000). Quality control was enhanced to improve data reliability.
- *Phase three: 2001–2002 surveillance round:* In 2002, the Ministry of Health further expanded the number of sentinel posts to 36 (10 northern, 16 central and 10 southern).
- *Phase four: 2004 surveillance round:* In late 2004, the Ministry of Health reassessed Mozambique's HIV prevalence levels, also using data from 36 sentinel posts; the locations of two sentinel posts were shifted to provide greater geographic balance. The sentinel posts in Munhava and Xipamanine were closed, and there were two new ones opened in Marrupa and Chicualacuala (see figure 1).

All data collected between 1988 and 2002 appear in Republica de Moçambique (2003); all data for 2004 are drawn from Republica de Moçambique (2005). In addition to estimating the overall 2004 HIV national prevalence rate at 16.2 per cent, past and current data reveal several trends and clear regional variations.

Figure 1: Location of sentinel posts, 2004



Source: Republica de Moçambique 2005.

Southern region[3]

About one in four Mozambicans live in the southern region (CUSO 2002). Maputo hospital data from 1988 indicate that the city underwent a "rapid growth" stage between 1992 and 1998, after which HIV prevalence levels began to plateau.

The 2004 regional HIV rate among southern region 15–49 year olds was 18.1 per cent, two percentage points below the central region's rate. The region's highest provincial rates were in Maputo city and province (both 20.7 per cent) and Gaza province (19.9 per cent). Within Maputo province, high rates were found in the town of Namaacha bordering Swaziland (18.7 per cent), a major transit point for Mozambican miners traveling to South Africa. In Gaza, the

[3] This region bordering South Africa, Swaziland and Zimbabwe includes Gaza, Inhambane and Maputo provinces and the capital city Maputo as well the several key towns of Chokwe, Maxixe, Namaacha (on the South African border) and XaiXai.

port city of XaiXai had a rate of 27.7 per cent, and the city of Chicualacuala—on the border with Zimbabwe—had a rate of 21.4 per cent.

Rising prevalence levels in this region in part reflect increased commercial and migrant mineworker travel south since the 1992 peace agreement. An estimated 50,000 Mozambicans, most from the southern and central regions, currently work in South African mines, where HIV rates are very high. Many return home on annual leave infected with HIV and infect their wives. Maputo city had a 2004 infection rate of around 21 per cent. Inhambane, the province farthest from any major transport corridor, had the lowest 2004 rate with 11.7 per cent.

Central region[4]

The central region—home to 42 per cent of all Mozambicans, but also 52.2 per cent of those living with AIDS—had the highest 2004 regional rate for adults 15–49 years of age at 20.4 per cent, up from 16.7 per cent in 2002. Infection rates are exceptionally high in towns and transport junctions along the two corridors, and in adjacent rural areas (Raimundo 2003). Zambezia, the only province lacking major international transport routes, had the region's lowest prevalence rate in 2002 with 12.5 per cent. By 2004, this had risen dramatically to 18.4 per cent.

The Beira corridor from Zimbabwe to the sea runs through Manica province with 19.7 per cent and Sofala province with 26.5 per cent prevalence rates. Within Sofala, 2004 rates at sentinel posts in the Beira city district have ranged from 29.1 per cent to 34.4 per cent. Within Manica, the highest rate of 26.6 per cent was found in Chimoio, which hosted major contingents of Zimbabwe troops and a Zimbabwean Air Force base during the war (TransAfrica News 1987).

Tete province, whose transit corridor links Malawi, Zambia and Zimbabwe to Mozambique's seaports, had an infection rate of 14.2 per cent (21.7 per cent in Tete city) in 2002 and 16.6 per cent (25.8 per cent in Tete city) in 2004.

Manica, Sofala and Tete provinces suffered Mozambique's earliest dramatic rise in HIV infection rates, which rapidly increased from 1994 to 1998, but have levelled off somewhat since 2000. This levelling off indicates some maturing of the pandemic in these areas, as many infected people develop full-blown AIDS. The continuing rapid rise in Zambezia's rate—and to a lesser extent in Tete—reflects the continuing impact of the huge numbers of infected Mozambican refugees who returned to these provinces after 1992. Rising deaths among economically productive adults and growing numbers of AIDS orphans are straining the region's social, economic and health infrastructure.

Northern region[5]

The pandemic reached this region last, as reflected in the relatively lower and more slowly growing prevalence rates in the three northern provinces. Niassa, bordering Malawi, which hosted 65 per cent of the refugees who fled Mozambique during the war, had the highest 2004 provincial prevalence rate at 11.1 per cent, unchanged from 2002, followed by Nampula at 9.2 per cent and Cabo Delgado with 8.6 per cent. The region's highest rates are in cities along the border with Malawi (Mandimba with 10.7 per cent), towns along the rail line and main road linking Malawi to Mozambique's coast (Cuamba with 16.7 per cent, Nampula with 10.7 per cent, Montepuez with 10.3 per cent) and port cities (Pemba with 10.3 per cent).

Factors affecting regional HIV prevalence levels

Gender inequality, particularly the low socioeconomic status of women, has helped boost HIV prevalence rates generally in Mozambique (Arnaldo and Francisco 2004), and existing data

[4] This region borders Malawi, Zambia and Zimbabwe and includes Manica, Sofala, Tete and Zambezia provinces, the towns of Catandica, Chimoio, Espungabera, Magoe, Quelimane and Vila Manica and the cities of Beira and Tete.

[5] This region bordering Tanzania and Malawi includes Cabo Delgado, Nampula and Niassa provinces and the towns and cities of Cuamba, Mandimba, Nacala Port, Nampula and Pemba.

show that women are infected with HIV in significantly greater numbers than men (Raimundo 2003). Different regional infection rates also seem to reflect regional variations corresponding to the degree of gender inequality.

A region's lack of economic resources as well as degree of engagement in the regional migrant labour system and the apartheid-sponsored war appear positively correlated with higher HIV infection rates (Arnaldo 2004). RENAMO launched its most brutal, economically destructive and population-displacing anticivilian campaign in Manica and Sofala in early 1981 (Hanlon 1991; Maier 1992). The resulting massive uprooting of communities and families in Mozambique's central region, RENAMO's main operational zone in the early to mid-1980s, clearly appears to have contributed to higher prevalence rates.

Areas with high numbers of Muslims show a marked negative correlation with HIV prevalence levels (Arnaldo and Francisco 2004). Roughly 85 per cent of Mozambique's Muslim population lives in the northern region, which has experienced the lowest HIV infection rates as well as the least involvement in the regional migrant labour system. There is some research indicating that male circumcision, widely practised among Muslims in these regions, provides some protection against infection.

One should note that difficulties in monitoring prevalence rates caused by the disruption of war and in ensuring adequately representative distribution of monitoring sites, especially in rural areas targeted by RENAMO, may have resulted in understating the extent of infection in some areas. Arnaldo (2004) suggests that overrepresentation of sentinel posts in urban areas has likely led to underreporting in rural areas.

Structural Factors Shaping Mozambique's HIV/AIDS Crisis

What accounts for this distinctive pattern of regional variation in the stages and intensity of Mozambique's pandemic? Why did its regional epidemics begin at different times and grow the fastest in the central region?

To answer this, it is important to examine the factors that brought Mozambicans into contact with or protected them from HIV. These factors include

- the number of sexual partners and encounters;
- the probability of encountering HIV-infected partners;
- the frequency of exposure, given that HIV is difficult to transmit;
- the availability and use of protection, for example, condoms;
- the presence of other sexually transmitted diseases (STDs); and
- sexual practices that increase or decrease the risk of infection.

This paper argues that such seemingly "personal" factors have been negatively impacted by major macroeconomic structures and political developments in Mozambique's history. Some of these developments are:

- The legacy of Portuguese colonial rule and its links to apartheid, which shaped the development of Mozambique's transport corridors, patterns of labour mobility and the poor status of its health care system at independence, are key factors influencing the geographic spread of the HIV/AIDS epidemic and the availability of resources to combat it.
- The impact of white-ruled South Africa's war of destabilization against Mozambique from 1980 to 1992, with RENAMO anticivilian violence and attacks on infrastructure that decimated stable family life. As a result, almost five million

of Mozambique's then 16 million people were internally displaced (Cliff 1998) and another 1.7 million were forced to become refugees. This led to deployment of Zimbabwean troops and to exceptionally dense concentrations of civilians seeking security along Mozambique's main transport corridors, both of which helped boost risk factors for HIV infection. RENAMO destruction of health care facilities also decimated the country's key line of defence against the HIV/AIDS pandemic.

- The Cold War policies of the major Western powers that, despite their anti-apartheid rhetoric, explicitly supported white minority-ruled regimes in Africa as bulwarks against communism and the spread of Soviet influence. They consistently pressured Mozambique to jettison policies deemed too "socialist-oriented" and to adopt more "pro-free market" loan and aid conditions—for example, health care user fees—which, given Mozambicans' poverty, reduced the access of many to preventive care and treatment.[6]
- The failure or inability of the Mozambican government and its donors to plan adequately and pre-emptively for the impact that large foreign troop concentrations and massive refugee repatriation would have on Mozambique's prevalence rate.

Mozambique's Colonial Legacy and Links to Apartheid

Decades of popular resistance to white minority rule and a liberation war waged by the Mozambique Liberation Front (Frente de Libertação de Moçambique/FRELIMO), which was founded in 1962, finally ended Portuguese colonialism in June 1975. But 400 years of colonial rule had distorted Mozambique's socioeconomic development and left few institutional resources available to be deployed by the new FRELIMO-led government. The essentially extractive—rather than developmental—nature of the Portuguese colonial enterprise is revealed clearly in the skewed location of major transport and commercial corridors—roads, trains, oil pipelines—to serve the needs of colonial exporters rather than domestic populations; the economic dependence on low-wage migrant labour flows within Mozambique and to neighbouring South Africa and Rhodesia (later Zimbabwe); and the paucity of health care services and personnel at independence.

Skewed transport and commercial corridors

Mozambique's colonial rulers built most major roads and railways to run from the productive interior regions of the country and from neighbouring landlocked countries to port cities—Beira, Maputo, Nacala—along the Indian Ocean (Andersson 1992).

These transport routes provided vital outlets to the sea for Botswana, Malawi, Zambia and Rhodesia, underlining the interlocking and primarily extractive economic interests of southern Africa's white-ruled colonial regimes. Mozambique's only north-south railway line runs from Maputo north into Zimbabwe's southeast region. Very few routes built in the colonial era facilitated commerce between Mozambique's different regions.

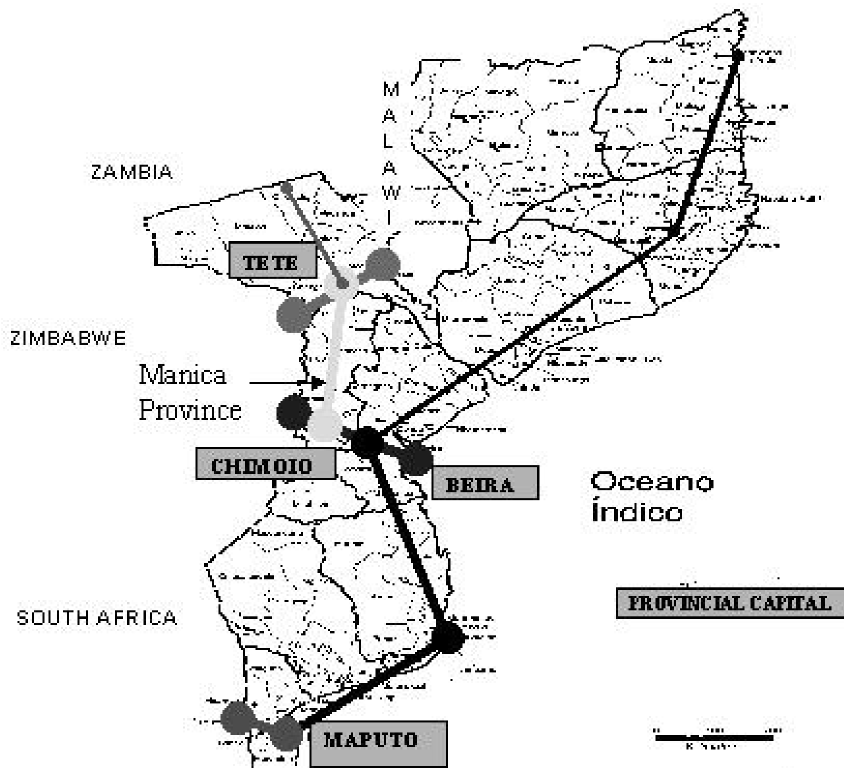
Transportation was a major component, along with migrant labour, of colonial Mozambique's economic links to South Africa. As early as 1917, a third of colonial Mozambique's revenue came from customs duties and shipping fees paid by South Africa (TransAfrica Forum 1984).

Figures 2 and 3 detail Mozambique's network of primary transport routes, including the two major commercial corridors, Beira and Tete, that became key vectors for the spread of HIV/AIDS. The Beira transport corridor, a road, railway and oil pipeline matrix stretching roughly 290 kilometres from Mutare in eastern Zimbabwe through Mozambique's provincial capital Chimoio to the Indian Ocean port of Beira, was largely developed to meet white-ruled

[6] They also provided major financial assistance to apartheid South Africa via international loans, indirectly helping to finance its war on Mozambique. When Mozambique sought a modest $200 million loan for essential goods in 1983, donors refused but did extend white-ruled South Africa a $1 billion International Monetary Fund (IMF) credit at the same time (Hanlon 1991).

and landlocked Rhodesia's need for an export outlet. The Tete transport corridor links Zimbabwe and Malawi by road through Mozambique's provincial capital of Tete, about half way between Zimbabwe's capital Harare and Malawi's capital Lilongwe (Andersson 1992). A link between the Tete and Beira corridors stretches to the Zambian border.

Figure 2: Road corridors in Mozambique



Source: Kwarteng and Cliff 2001. Adapted from a map produced by Ricardo Barradas, GTZ Truck Drivers' Project.

The regional contract labour system and migrant labour

White-ruled Mozambique, Rhodesia and South Africa developed similar African labour policies. Mozambique provided cheap migrant labour for South African mines from the 1850s and for Rhodesian farms from about 1900. Mine workers did not receive their wages directly. South Africa paid their wages to the colonial government in gold and workers received only a small portion in local currency. These partial wages, however, played an important role in the local economies of several southern provinces, especially Inhambane and Gaza (Andersson 1992; Epstein 2002).

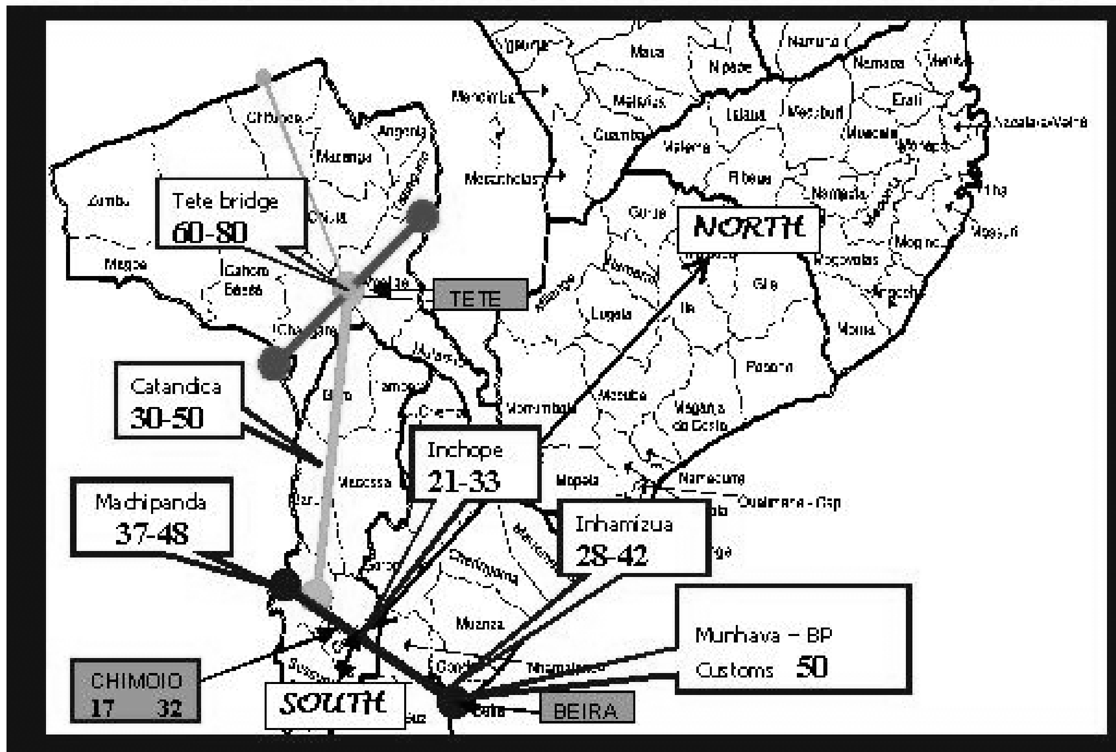
Mozambican workers suffered the same contract provisions, travel restrictions and work permit requirements as South Africa's black workers. They worked 11 months, returning home for only one month a year. They were barred from bringing their families to live with them near the mines. While wages were low, they were higher than most Mozambicans could hope to earn back home, so workers continued to seek jobs in South Africa and to a lesser extent in Rhodesia.

This brutal migrant labour regime, immortalized in song by South African jazz musician Hugh Masekela, became institutionalized across southern Africa.[7] Essentially a policy of "social re-engineering", it produced "an ideal template for HIV transmission by deliberately or otherwise

[7] The same pattern of 11 months of work and one month annual leave was largely replicated by Rhodesia's labour policy governing Africans forced to live in over-farmed communal lands when they sought work in mines or urban areas; it has largely continued since Zimbabwe's independence in 1980.

creating and deepening poverty and inequality" (UZ/IDS 2004a:4–5), especially between men and women, and encouraging a "dualization" of homes and sexual life.

Figure 3: Central corridor: Trucks parked at truck stops on three random days



BP = British Petroleum. **Source:** Kwarteng and Cliff 2001. Adapted from a map produced by Ricardo Barradas, GTZ Truck Drivers' Project.

Living in single-sex hostels and denied a normal, stable family life, migrant workers often sought sexual intimacy with sex workers, or acquired a "city wife" in addition to a "country wife". This multiplied male workers' number of sex partners, thus boosting the risk of contracting HIV. Many who became infected with HIV unknowingly infected their wives when they returned home on leave.[8]

Mozambique's public health system

A nation's public health system is critical to countering any pandemic. A 1993 World Bank study of 22 countries asserts that "roughly one third of the effect of economic growth on life expectancy came through poverty reduction and the remaining two thirds through increased public spending on health" (Lindelow 2002:8, quoting the World Bank study).[9]

Mozambique's colonial rulers spent almost nothing on health care for the African majority. At independence in 1975, Mozambique's under-five mortality rate approached 25 per cent. There was only one African among the roughly 519 doctors in Mozambique at independence, which dropped rapidly to 86 as most Portuguese doctors opted to leave (Andersson 1992). Missionary churches and traditional medical practitioners provided most of the little health care that was available.

[8] Another factor facilitating the spread of HIV has been male migrant workers' tendency to not use condoms with their wife when they return home, although many use them with sex workers.

[9] Thus, pressure since the late 1980s by international financial institutions and other donors on Mozambique to reduce its public sector health budgets and fund them from user fees rather than public revenue has reduced its capacity to respond to the pandemic.

Education and literacy also play key roles in responding effectively to a national health emergency. Portugal neglected basic education for Mozambique's African majority. About 95 per cent of Mozambicans were illiterate at independence, an estimated 70 per cent had no access to educational facilities at all, and only 1 per cent of the population, virtually all of them Portuguese settlers, had completed more than four years of schooling (Andersson 1992; Minter 1994).

Early FRELIMO health advances

From 1975, the new FRELIMO government placed high priority on extending basic health and education services to rural areas and among poor Mozambicans. Indeed, primary health care and education were cornerstones of its overall economic development programme (Andersson 1992), leading many to regard it as a model (Cliff 1998).

Despite limited resources, the new government substantially expanded health care (Minter 1994; Andersson 1992). Key measures of this progress include:

- increasing the number of doctors (from 86 to 300), health workers (from 2,000 to 3,600) and rural health outposts (from 326 to 1,195) between 1975 and 1985 (Lindelow 2002; Hanlon 1991). A 1982 World Health Organization (WHO) survey indicated that 81 per cent of rural children were seen at least once by a government health worker, an incredibly high proportion for Africa (Hanlon 1991), and a national vaccination campaign achieved a remarkable 96 per cent coverage rate in 1976;
- boosting the health budget from 3.3 per cent of state expenditures in 1974 to an annual average of over 10 per cent between 1976 and 1982 (Minter 1994); and
- reducing pharmaceutical import costs by 40 per cent, via competitive bidding from foreign suppliers on several hundred basic drugs.

But Mozambique still had a long way to go. As RENAMO began to escalate its war in 1982, "regular preventive measures were reaching less than half the population, and even fewer had access to curative medicine. The majority of doctors were still in the cities, and less than a third were Mozambican" (Minter 1994:22).

South Africa's Surrogate War of Destabilization

In 1974–1975, Rhodesian intelligence created RENAMO as a surrogate rebel movement to sabotage Mozambique's economic infrastructure (Flowers 1987),[10] in large part because of Mozambique's extensive support for liberation movements opposing white minority rule.[11] Days before Zimbabwe became independent in April 1980, RENAMO leaders were airlifted to South Africa and integrated into apartheid's regional military campaign against black-led neighbouring countries.[12] Post-1980 RENAMO attacks on Mozambique's transport infrastructure sought to thwart Mozambican and Zimbabwean efforts to achieve economic and political independence from South Africa.

RENAMO violence that ravaged Mozambique from 1980 to 1992 has been extensively documented.[13] The role of this violence in concentrating and accelerating the HIV/AIDS

[10] In 1977, the author interviewed several survivors of early RENAMO attacks on rural Mozambican markets in Gaza and Manica provinces.

[11] Mozambique openly backed the Africa National Congress of South Africa and from 1975 to 1980 hosted an estimated 150,000 Zimbabwean refugees, many of them members of Zimbabwe's two liberation movements, the Zimbabwe African National Union and the Zimbabwe African People's Union. In 1976, it imposed economic sanctions on South Africa called for by the United Nations (UN), costing an estimated $139–$165 million in economic losses in the first year alone (Andersson 1992).

[12] Based on the author's personal interview with a South African jailed for revealing the extent of the South African direction of RENAMO activities, Zimbabwe, 1988. For details of the transfer, see Minter (1994); Flowers (1987); and Vines (1991).

[13] Minter 1994; Hanlon 1986; Finnegan 1992; Hanlon 1987; Johnson and Martin 1986; Magaia 1988; Maier 1992; Vines 1991; and various UN reports and Mozambique Information Agency filings.

epidemic in central Mozambique is less well known. RENAMO attacks on major transport corridors led to the deployment of Zimbabwe troops along these routes for over a decade. RENAMO's anticivilian violence drove thousands of Mozambicans to the corridors. Inevitably, the proximity of large troop and IDP concentrations greatly increased the risk of becoming infected with HIV.

RENAMO violence: Targeting people

In 1983–1984, RENAMO began a new campaign—first in central Mozambique and later nationwide—to undermine the rural economy. RENAMO's goals, summarized in a captured document dated 24 February 1984, were to: (i) "destroy the Mozambique economy in rural areas"; and (ii) "destroy the communication routes to prevent exports and imports to and from abroad, and the movement of domestic produce" (Hanlon 1991:32).

As a result, by the early 1990s,

> about half of the nation's schools and a third of its health clinics had been damaged or destroyed. Agricultural fields and by-ways…were strewn with land mines. Mozambique had become first among the ranks of the world's poorest and aid-dependent nations…years of civil strife had weakened the social fabric and severely damaged the economic infrastructure of the country (World Bank 1997:1).

In Mozambique's central and northern provinces, RENAMO disrupted agricultural production, uprooted rural communities, conscripted fighters and porters and coerced women to service the sexual needs of its fighters.[14]

> Between 900,000 and 1 million people were killed during the conflict, which was characterized by direct attacks and use of terror against civilians, forced labour, forcible conscription of child soldiers, practices of forced relocation, extensive use of landmines and widespread destruction (Deng 1997:3).

The targeting of rural areas shaped the incipient HIV/AIDS pandemic in several ways.

War and isolation/displacement

RENAMO's war isolated some communities while displacing others, affecting risk factors in complex ways. War-induced isolation, especially in the north, initially may have limited exposure of some rural communities to HIV (Kwarteng and Cliff 2001), or possibly delayed the epidemic's onset in Mozambique compared to neighbouring countries. Some data show sharp regional HIV rate increases since peace was achieved in 1992, especially near Mozambique's borders and main transport routes (Bollinger and Stover 1999). The war displaced millions of Mozambicans, increasing their vulnerability to contracting HIV. By war's end in 1994, roughly 5.7 million people, over a third of all Mozambicans, had become displaced (*deslocados*), forced to flee their home villages and become IDPs or refugees in order to survive (World Bank 1997). They included more than 1.7 million exiled in neighbouring states and between 3.5 and 4.5 million internally displaced civilians (Deng 1997). Stable family life reduces the spread of HIV by limiting the number of sexual partners. RENAMO's war disrupted this stability. Of the 1.7 million Mozambican refugees who returned from neighbouring countries when the war ended, many came home infected with HIV or with AIDS.

War and gender

Women's lack of equal power to negotiate with men about where, when and how sex takes place increases risk of exposure (UNAIDS 2000). Colonial policies, by deepening gender inequality throughout southern Africa, made women even less able to negotiate equally with men. The war magnified Mozambican women's inequality even further. Many Mozambicans,

---
[14] See Gersony (1988) for Mozambican refugee accounts of forced labour.

especially women and children, were kidnapped and held captive in areas controlled by RENAMO.[15] The Carnegie Commission (1997) estimates about 10,000 children were coerced into serving as soldiers during RENAMO's 15-year war. Sexual abuse of such captives was common. Women were frequently forced to serve as concubines as well as cooks and porters for RENAMO soldiers. Rape became a routine tool of war for RENAMO soldiers. Among those refugees from RENAMO "control" areas interviewed by Gersony, "15 per cent had witnessed the systematic rape of women" (Andersson 1992:63; see also Maier 1992:35). A disproportionate number of war-displaced Mozambicans were women and children.[16] The excessive violence of this war also boosted the ratio of women to men. Since the war, men in the north and central regions reportedly have been taking more wives and sexual partners (Marlin 1998).

RENAMO violence: Targeting transport corridors

Since the early 1980s, RENAMO sabotaged roads, railway links and the Beira corridor oil pipeline, endangering Zimbabwe's strategic economic lifelines and effort to become less dependent on South African transport links (Cheru 1986). This slowed regional commerce severely, reducing Mozambique's revenue from its economically critical transport industry (Munkonoweshuro 1992).[17]

In 1981, Mozambique and Zimbabwe signed a mutual defence agreement. RENAMO's March 1982 attack on petrol tanks in Beira precipitated a joint decision to station a special task force of 1,000 Zimbabwe soldiers along the Beira corridor in November 1982 (Vines 1991), which was boosted to 3,000 in 1984, and to about 10,000 by 1985 (Accord 1998). These troops were largely tasked with defending the corridor's railway, road bridges, towns and the oil pipeline.

Despite some losses, Mozambique and Zimbabwe largely succeeded in keeping the corridors open. On the eve of the peace agreement, Zimbabwe was shipping roughly one-third of its freight through Beira (Meldrum 1991). Zimbabwe troops remained on the corridors until 1993, when they were replaced by UN troops.

The impact of Zimbabwe's troop presence

While Zimbabwean troops played a key role in defending Mozambique's infrastructure, they also helped boost HIV infection rates among Mozambicans. The quasi-permanent stationing of large numbers of Zimbabwe troops along the corridors had several serious effects. The war impoverished most Mozambicans. Many resorted to transactional sex to survive. Some economically desperate Mozambican women became prostitutes serving Zimbabwe troops, who were themselves separated from their families but with salaries that allowed them to purchase sexual intimacy. This increased the number of sexual transactions and diversity of partners among sex workers and their clients, both risk factors for HIV infection.

Epstein (2002) reports what a Mozambican doctor from Gaza told her:

> The railway line that goes through this town links Mozambique with South Africa and Zimbabwe. During the war in the 1980s, the trains were guarded by soldiers from those countries. There were shortages of food in those days and the relief supplies would come into Mozambique on those trains. Many of the women around here were starving, and they would sell their bodies just to eat. The problems started then.

As the number of troops rose in the early 1980s, so did the number of sex workers at truck stops and border towns but especially near troop cantonment centres such as Chimoio, in central

---

[15] Andersson 1992; Minter 1994; Gersony 1988.

[16] Women and children are generally estimated to make up about 75 per cent of displaced persons (ICAD 2001).

[17] In 1991, a RENAMO attack effectively blocked the Tete road linking Zimbabwe to Malawi, a lifeline for Malawi's food supplies. Malawi was forced to re-route food convoys via Zambia, a longer route that effectively doubled the freight shipment costs of using the Tete highway (Meldrum 1991).

Mozambique. Local purchases by the Zimbabwe military and its soldiers became a vital part of the local economy, on which many local Mozambicans depended for their livelihood.[18]

The limited data available make it methodologically difficult to separate out the precise impact that the three mobile population groups along the corridors—cantoned Zimbabwe soldiers, truck drivers plying the routes and IDPs who settled nearby for greater security—had in boosting central Mozambique's HIV levels. However, troops are known generally to increase the risk factors for becoming infected with HIV (*The Herald* 2002). This happens for several reasons:

- Soldiers, especially if posted far from their families, have a high risk of exposure to STDs, including HIV—generally two to five times higher than among civilians.[19] In times of conflict, the risk can sometimes be 50 times higher or more (UNAIDS 1998).
- Troops deployed far from their families regularly have intimate contact with sex workers and the local population, helping to spur the growth of local sex industries. Anecdotal information indicates this also occurred along the Beira corridor.
- Most Zimbabwe soldiers stationed in Mozambique were in the most sexually active age group (15–24 years old), hence at greatest risk for infection, and more conditioned by their military training or culture to engage in high-risk sexual behaviour (UZ/IDS 2004a).

Zimbabwe and Mozambique border towns were often awash with people delayed by border immigration and customs formalities and fees—for example, truckers, soldiers, migrant workers—and hence likely either to frequent local sex workers while waiting to cross or, in the case of female cross-border traders, to try to use sexual persuasion to avoid paying customs duties (UZ/IDS 2004a). These groups all faced higher risk of becoming infected. Soldiers and government officials posted in these towns also were implicated in high-risk behaviour, including intimidation and sexual exploitation of women traders and prostitutes as well as migrant workers (IOM et al. 2003).

Another likely factor in central Mozambique's high infection rate was the already high HIV prevalence among Zimbabwe soldiers sent to patrol the corridors, who in turn infected many Mozambican sex workers and other sexual partners.

Zimbabwe's adult HIV infection rate was estimated at nearly 20 per cent by the mid- to late 1980s. Zimbabwe's military had a three to four times higher HIV infection rate than Zimbabwe civilians, according to a 1997 UNAIDS study (UZ/IDS 2004a; UNAIDS 1998).[20] Although little reliable data exist on HIV prevalence among Zimbabwe troops,[21] in 1999, "it was estimated that 55 per cent of the approximately 36,000 soldiers in Zimbabwe were HIV positive" (UZ/IDS 2004b:62). In 1998, the Zimbabwe military also was estimated to have an STD rate of 80 per cent.[22]

---

[18] Zimbabwean dollars were particularly sought after as, unlike the devalued Mozambican metical, they could be used to buy goods in Zimbabwe that were unavailable in Mozambique. Informal women traders attracted by the commercial possibilities of access to "Zimdollars" were at high risk for HIV infection; many had to exchange sex for permission from authorities to travel or to gain access to transport.

[19] Bollinger and Stover (1999) note that sexual activities of peacekeeping troops from West Africa may have contributed to the more recent spread of HIV-2 in Mozambique.

[20] Even during peacetime, STD infection rates among soldiers are often two to five times higher than those for civilians they live amidst (UZ/IDS 2004b).

[21] In 1990, 21 per cent of one small group of 60 soldiers tested positive for HIV; 30 per cent to 50 per cent of a similar-sized group was afflicted with STDs (UZ/IDS 2004b).

[22] See Kirk (2000); ICAD (2001); and UZ/IDS (2004b).

Concentrating civilians along the corridors

Zimbabwe military protection made the corridors more secure places to live. As RENAMO attacks increased through the mid-1980s, hundreds of thousands of IDPs sought greater safety along the corridors. Many fled to Beira, the dilapidated port city at the end of the corridor. Originally designed to accommodate about 70,000 people, by 1991 it was home to almost half a million people, the bulk of them displaced by RENAMO attacks (Meldrum 1991).

After the Zimbabwe troops arrived in 1982, tens of thousands of IDPs settled in shantytowns along the two sides of the Beira to Machipanda corridor. By 1991, the corridor had attracted about 250,000 IDPs, huddled along a six-kilometre-wide strip controlled by Zimbabwean troops (Meldrum 1991). This long, thin strip of land became one of the most densely populated IDP camps in the country. The high concentration of impoverished people, few with stable family conditions, boosted the probability of transactional sex and multiple sex partners (IOM et al. 2003).

RENAMO violence: Targeting Mozambique's health care system

During the war, Mozambique's health care system became a prime military target (Pavignani and Durão 1997). RENAMO instructed its units to "try to capture teachers, nurses" to forcibly recruit them (Andersson 1992:57). By the end of 1988, at least 40 health workers had been killed, 43 kidnapped and 700 stripped of all their possessions explicitly because of their profession (Andersson 1992).

Rural districts were hardest hit. Health care workers increasingly rejected rural posts or training for such posts for fear of RENAMO violence—in 1980, Mozambique trained 303 village health workers; in 1985, only 33. Between 1982 and 1986, the ratio of doctors to rural inhabitants dropped from one doctor per 161,000 people to one doctor per 443,000 people (Andersson 1992). Whereas in 1982, 42 per cent of Mozambique's districts had a doctor, by 1987 this had declined to 18 per cent. By 1990, the government reported that 1,000 health clinics had been destroyed by RENAMO, the vast majority in rural areas (Maier 1992).

RENAMO destruction of health outposts particularly undercut the government's focus on preventive medicine—for example, vaccination and public health campaigns—and reduced the number of women receiving antenatal care. They also cut access to safe drinking water, as RENAMO poisoned wells and sabotaged water treatment plants. The result was reflected in worsening child mortality. In 1980, Mozambique's under-five mortality rate was 270 out of every 1,000 children; by the early 1990s, it had risen to 325.

By 1986, RENAMO attacks had largely reversed the health care gains of Mozambique's first decade of independence. Ultimately, RENAMO attacks destroyed or closed between 40 per cent and 50 per cent of Mozambique's health clinics and schools[23] (UNDP 2002; Lindelow 2002), denying approximately two million people access to previously accessible medical facilities. The Economist Intelligence Unit estimates that an additional one million people may have died during the 1980s due to loss of access to primary health care (Harris 1999).

Even more devastating was the extent of disruption of family life in rural areas. The massive scale of forced displacement of Mozambicans and loss of contact with other family members played a key role in changing patterns of sexual behaviour in ways that dramatically boosted the risk of contracting HIV.

[23] Similar attacks on educational services, facilities and personnel undermined the use of schools for preventive education to counter the HIV/AIDS pandemic. By the late 1980s, some districts saw 70 per cent to 90 per cent of their schools closed—Sofala, Tete and Zambezia provinces in Mozambique's central region were among the worst hit. Teachers were particularly targeted: by the early 1990s about 400 teachers had been killed, mutilated or kidnapped, 1,153 stripped of all possessions and an additional 618 were missing. Roughly 3,224 teachers were displaced by the rural violence in Mozambique. In 1990, the government estimated that 2,773 primary and secondary schools had been destroyed by RENAMO (Maier 1992).

South Africa's proxy war strengthened other factors known to play a role in "kick-starting a sexually transmitted HIV epidemic or driving it to higher levels".[24] The widespread displacement and deepening destitution of rural Mozambicans made regular use of condoms difficult and the cost of condoms beyond the reach of most; and the destruction of rural health outposts severely limited access to neonatal care, testing for HIV infection and HIV public education programmes.

An Overlooked Source of Infection: Returning Refugees

Many people escaped the war's violence and insecurity by fleeing Mozambique. An estimated 1,702,000 Mozambicans, over 10 per cent of the population, were forced to find refuge in neighbouring countries.[25]

Some of these host countries had the highest HIV prevalence rates in southern Africa at the time.[26] Unknowingly infected with HIV through liaisons with host nationals, many Mozambican refugees spread it further upon returning home (Bollinger and Stover 1999, citing a Population Services International study). Most refugees returned via one of the corridors, and some lingered in towns along these transport routes until their home areas had been de-mined.

The general insecurity of life in camps for Mozambican refugees raised the risks of contracting HIV[27] in various ways:

- refugees separated from wives or husbands by the war often sought sexual intimacy with other refugees or sex workers living near the camps, increasing their number of sexual contacts and partners;
- refugees were largely barred from work or other activities outside the camps—thus, with little to do, sexual activity often became the refugees' only recreation, and few refugees possessed money to purchase condoms; and
- limited access to water and health care services further undermined the refugees' capacity to prevent or limit HIV infection.

Mozambican refugees in Malawi—about 65 per cent of all Mozambicans who became refugees during the war—faced the additional threat of continued intimidation by RENAMO infiltrators. Supplies intended for refugees were sometimes diverted, via Malawi government trucks, to RENAMO; one source noted that RENAMO had its own security force of lookouts or spies (*mujibas*) in the refugee camps to monitor refugee and staff activities.[28] This intimidated camp residents, especially women with dependents, and made them more vulnerable to coercion of involuntary sex.

Virtually no HIV testing or monitoring of refugees was done, either on arrival at refugee camps or when repatriated. Virtually no HIV/AIDS education programmes were provided for refugees outside the country. A 66-page report from the United Nations High Commissioner for Refugees (UNHCR) on its entire Mozambique repatriation operation only mentions AIDS once in passing (UNHCR 1996). Given the paucity of HIV testing available in Mozambique at the

---

[24] See UNAIDS 2000:8 for a more complete list.

[25] These included Malawi (1.1 million refugees, or 65 per cent of the total), South Africa (250,000, virtually all without official refugee status), Zimbabwe (230,000), Tanzania (72,000), Swaziland (25,000), Zambia (24,000) and 1,000 in other countries (UN 1995).

[26] Mozambique's overall HIV prevalence rate of 13.6 per cent in 2002 was significantly below the rates estimated in 1997 for many of its neighbours, including Malawi (14.92 per cent), Zambia (19.07 per cent) and Zimbabwe (a sobering 25.84 per cent) (Link 2002). In 1994, 78 per cent of Malawi sex workers were estimated to be HIV-positive, as were 86 per cent of Zimbabwe's (World Bank 1999).

[27] The Church World Service estimates that refugees are six times more likely to become HIV-infected than those in stable communities (ICAD 2001).

[28] Personal interviews conducted in December 1989 with the UNHCR, Red Cross and Malawi Council of Churches staff working in Chifunga and Nyamithuthu refugee camps, and with the then Mozambican ambassador to Malawi, Amos Mahanjane, former head of Mozambique's national disaster assistance agency.

time, it is no surprise that returning refugees were not tested for HIV, although some testing of IDPs highlighted the potential problem (De Hulsters et al. 2003).[29] Some limited HIV and STD prevention programmes were also offered.

Mozambique's Ministry of Health and RENAMO's Health Department jointly initiated an STD and HIV prevention programme for soldiers being demobilized via the health posts in 49 quartering areas (29 FRELIMO and 20 RENAMO).[30]

While population movements in the postwar period contributed to increased risk of HIV and STD infections (De Hulsters et al. 2003), the extent to which migration helped boost HIV prevalence in Mozambique's specific regions and provinces is still a matter of some debate.[31]

Southern African governments only recently began to address the role of people crossing borders in spreading HIV (IOM et al. 2003). Specific mobile populations—military, transport workers, migrant mine and agricultural farm workers, informal traders, domestic workers and refugees/IDPs—are at particular risk of contracting or infecting others with HIV (Raimundo 2003).

The Cost of Donor Dependency: How the War Undermined Government Capacity and Political Autonomy

Total economic losses from RENAMO's war in Mozambique were about $15 billion (Carnegie Commission 1997), a huge cost imposed on an impoverished and devastated country.

Shortly after independence in 1975, FRELIMO had placed all health care facilities under government control and banned private medical practice. The government invested heavily in new health care infrastructure and personnel training. It dramatically expanded the number of rural health posts and clinics, from an estimated 326 at independence to almost 1,195 centres 10 years later (Lindelow 2002). By 1977, all in-patient care was free of charge, fees for outpatient care were nominal and large numbers of Mozambicans were vaccinated for the first time.

RENAMO violence not only destroyed clinics and schools, but also forced a shift in Mozambique's budget and programme priorities. The government had to divert resources to fund defence and the military, effectively "de-funding" health, education and other social services (Andersson 1992:86). In the first seven years of independence, Mozambique more than tripled the budget devoted to health care, to 11.2 per cent. By 1985, health spending dropped to 8.1 per cent, or $4 per person (Andersson 1992). Three years later, Mozambique was spending only 68 cents (less than $1) per capita on health (Maier 1992).

Lacking sufficient revenue to meet the basic food and other emergency needs of its over five million *deslocados* and *afectados,* Mozambique became increasingly dependent on foreign loans and bilateral aid to survive. By 1990, foreign aid financed 90 per cent of Mozambique's marketed and relief cereal needs (Maier 1992, citing UN and Mozambique government statistics). By 1992, foreign aid subsidized almost 60 per cent of all national health care expenditures, up from 29 per cent in 1986 (Cliff 1998). Five years after the war's end in 1992, foreign aid still made up 37.4 per cent of Mozambique's gross national product.

Such high dependency on foreign aid and loans exacted a heavy price. During the war, donors used "emergency aid" to gain leverage over and influence Mozambique to adopt more capitalist-oriented, pro-market economic policies and to reduce the government's role in public

[29] Personal communication, Julie Cliff, 22 June 2005.

[30] Personal communication, Julie Cliff, 22 June 2005.

[31] Raimundo (2003) argues that central Mozambique's high rate compared to other regions reflects the role of migration to and from high infection-rate countries as a key risk factor. Arnaldo and Francisco (2004) did not find a significant correlation but felt this might be due to the poor quality of available data and called for further research at the micro level.

services and the economy (Hanlon 1991:2). Financial lenders also imposed conditions on new loans to Mozambique, which further eroded the priority placed by the FRELIMO government on providing basic social services.

As a result of this pressure, in 1984 Mozambique joined the IMF and World Bank. In 1987, it adopted its first Economic Rehabilitation Program, a set of structural adjustment "reforms", which deregulated most goods and service markets. This spurred privatization and led to the reintroduction of health care fees that were eliminated a decade earlier (Hanlon 1991; Andersson 1992).

Both during and following the war, donors set up health programmes parallel to those of the government, weakening Mozambique's ability to better integrate its health care programmes (Cliff 1998) Many international non-governmental organizations (NGOs) acted unilaterally and ignored national programme guidelines, adding to the organizational chaos (Cliff 1998). International NGOs' preference for concentrating their health-related, and other, resources in specific provinces—for example, the Danish in Tete, the Dutch in Nampula, the European Union in Zambezia, the Italians in Sofala—helped undermine both national and local control and coherence of health programmes (Pfeiffer 2000). It has also undercut integration of Mozambique's national health care efforts, tending to create a "German NGO" strategy in one province, an "American NGO strategy" in another, for instance.

The government launched a national HIV/AIDS programme as early as 1988, following the first AIDS case diagnosis in 1986. But donors' financial and policy clout has tended to somewhat marginalize the Mozambican government and even local NGO participation in making decisions on how to best counter the HIV/AIDS pandemic.

The National AIDS Council, originally set up to coordinate the work of all Mozambican agencies and groups responding to the crisis, was undermined and Mozambicans were somewhat marginalized when, for a prolonged initial period, its meetings were conducted in English, not Portuguese. The Country Coordination Mechanism, a newer structure established by the UN to help coordinate all stakeholders' use of new resources from the Global Fund, initially conducted its meetings in English before shifting to Portuguese (Starling et al. 2005). Foreign donors' greater technical expertise has also tended to make Mozambicans feel marginalized (Starling et al. 2005). Donors' and international NGOs' greater resources have enabled them to "poach" competent but low-paid public health staff for their own programmes, weakening the Mozambique government's institutional capacity as staff leave in search of better salaries in the private or non-profit NGO sectors (Pfeiffer 2000; Starling et al. 2005:27).

Donors also introduced their own ideological baggage. For example, early on United States (US) bilateral aid funding could not be used for condom distribution, first because the US wanted this done by the private sector, not the Mozambique government, and later because USAID policy shifted to opposing any condom distribution in preference to programmes urging abstinence.

Hanlon (1991) sums up this process of reshaping Mozambique's social agenda—marked, inter alia, by the return of British and South African-owned plantations patrolled by private armies, foreigners dictating policies to ministry officials and Portuguese returning to reclaim their property—as a re-colonization leveraged by Mozambique's exceptional dependence on foreign aid.

The Specific Impact of Structural Adjustment

Economic structural adjustment policies pressed on Mozambique by the IMF, World Bank and a number of donor governments helped worsen the quality of health care and weaken the government's capacity to respond to the epidemic in specific ways (Cliff 1998).

Their insistence that Mozambique limit public health subsidies and shift from universal free care to a fee-based system compounded its HIV/AIDS crisis by reducing access to health care for its most impoverished and vulnerable citizens. While free neonatal care continues to be provided to pregnant women, they and others often cannot afford to pay for other basic health services.[32] Most spend their meagre income on unofficial, or illegal, payments to gain access to the same clinics, or seek treatment from traditional medical practitioners.

Lindelow (2002:74) uses regression analysis to simulate the likely impact of different policy changes on poor Mozambicans' access to treatment. He found that bringing people's projected incomes up to the poverty line would have little impact on increasing people's access to basic health care. Elimination of user fees at health outposts, however, would have a major impact, "increas[ing] the mean predicted probability of seeking care at a health post by more than 10 percent and concomitantly reduc[ing] the probability that the individual receives no care or self-treats". Lindelow found that even modest increases in user fees at public health care facilities led to a "large reduction in health care demand" and an increased probability that sick people would not seek treatment (Lindelow 2002:75). He concludes that "relatively small price changes would have a substantial impact on access to public health care, in particular for poorer households" (Lindelow 2002:78).

Initial postwar donor insistence that Mozambique repay all foreign debts, many contracted as a result of the war, forced the government to repay more in annual loan servicing costs than it spent on health care and education. At one point, the government had to repay up to $1 million a day in debt service, which otherwise could have been spent on health and education (Pfeiffer 2000). Structural adjustment policies that capped public salaries further undermined health care staff morale and the quality of health care. Nurses' monthly wages dropped from $140 in 1991 to $40 in 1996 (Cliff 1998). Many were forced to find a second job to make ends meet, reducing their hours of public service.

A key outcome of these policies was the de facto emergence of a three-tier system of care: (i) state-of-the-art care for the wealthier; (ii) very limited resources for public sector clinics in poorer areas; and (iii) increased reliance of the poorest on traditional healers with only the most limited resources and scientific knowledge to counter the HIV/AIDS pandemic.

Conclusion

Today, Mozambique's HIV/AIDS pandemic threatens to undermine the progress in economic and social reconstruction achieved since the war ended in 1992 (IRIN 2004b). This is due in great part to the continuing indirect effects of apartheid on Mozambicans' health status in the post-apartheid era.

As noted above, analysing this legacy of apartheid is not an abstract exercise. Mozambique's HIV/AIDS pandemic has grown out of a complex interplay between multiple factors, in particular:

- the legacy of Portuguese colonialism—especially the migrant labour system and poor public health resources at independence;
- the violence and social chaos wrought by the apartheid-sponsored war from 1980 to 1992;
- the necessity of relying on high HIV-prevalent neighbouring states for troops to defend its infrastructure and for refuge from the chaos of war;
- the failure or inability to institute effective HIV prevention programmes among returning refugees;

[32] Rural patients in the late 1990s were usually charged about $.10 for an outpatient consultation, urban patients about $.50 a visit and hospital in-patients about $1.00 a day (Lindelow 2002).

- the undermining of government strategy and policies by its growing dependency on outside donors and resources—such as loans and aid—to survive; and
- the imposition of economic policies under donor pressure, which have served to limit basic health care access fundamental to countering such a pandemic.

South Africa-sponsored destabilization created conditions ideal for accelerating the spread of HIV in Mozambique by massively disrupting normal family life and displacing almost 40 per cent of the population. The war concentrated the epicentre of Mozambique's HIV/AIDS crisis in its most heavily populated central region, where displacement was greatest, as well as along strategic transport routes. A key policy failure compounded this crisis.

The Mozambican government was unable, and donors also failed, to effectively adapt postwar recovery and reconstruction programmes to lessen the impact that returning refugees would have on HIV infection rates.[33] Returning from neighbouring countries with high HIV prevalence rates, these refugees unknowingly accelerated the spread of HIV along Mozambique's major transport routes and into their rural home areas and villages.[34]

The Mozambique government is not alone in this failure. South Africa also failed to plan pre-emptively to prevent the rapid spread of HIV by exiles returning from Mozambique, Zambia, Zimbabwe and other high HIV-prevalence countries of refuge. As a result, it now boasts the world's highest HIV adult prevalence rate.[35] These same issues face Angola and the Democratic Republic of the Congo, where endemic and continuing violence is fostering the development of new strains of HIV.

More robust preventive educational programmes initiated during the end stages of Mozambique's war, or even immediately following the 1992 peace accord, might have helped slow or significantly limit the returnee-related rise in HIV levels. Aggressive HIV/AIDS education and prevention programmes within the Zimbabwean and Mozambican militaries during the conflict would have helped even more.

After Mozambique's war ended, its donors were unwilling to seriously redress, on the scale needed, the apartheid-sponsored damage to Mozambique's health infrastructure. As a result, Mozambique's government remained crippled in its efforts to respond effectively to the escalating HIV/AIDS pandemic even after peace was achieved.

The war impoverished most Mozambicans. For many, transactional sex became a means of survival. The tragedy is that, today, "[t]hese people are so poor that sex has become part of their economy…In some cases, it's practically the only currency they have" (Epstein 2002).

Donors continue to ignore a key structural reason why HIV/AIDS prevalence continues to rise in Mozambique—and elsewhere in southern Africa—today: the continuation of the region-wide low-wage migrant labour system beyond the formal end of apartheid. This system continues to fragment family life, helping to sustain Mozambique's—and southern Africa's—HIV/AIDS pandemic.

As one researcher notes:

> all these regions…[still] send large numbers of migrant workers to South Africa…During the past century, the rural provinces of Mozambique…have sent millions of mine workers to the Witwatersrand. Today, some 40,000 from

---

33 In reviewing UNHCR reports about their Mozambican refugee operations, there is an almost startling lack of reference to HIV/AIDS levels among refugees.

34 Personal communication, Julie Cliff, 27 November 2003.

35 South Africa is also experiencing a demographic development unprecedented among developing countries: a drop in population growth to barely a third of the official estimate of 1.8 per cent per year, due largely to HIV and AIDS (IRIN 2004a).

> southern Mozambique alone [work there]. The miners sign yearly contracts, and may spend twenty years or more as migrant laborers traveling back and forth between the mines and their rural farms, hundreds of miles away. The migrant labor system in southern Africa has been blamed for many of the region's ills, including the disruption of family life and rural under-development. Now it is also being blamed for the spread of HIV (Epstein 2002).

Why? Because while Mozambicans continue to work in South African mines, just as during the apartheid era, they continue to be so poorly paid that they still cannot afford to live with their families while doing so, or find comparable alternative jobs in Mozambique close to their families. The central role played by the migrant labour system in Mozambique's economy, just as during white minority rule, still denies Mozambican workers a liveable wage sufficient to sustain stable family life and end the "dualization" of their family life and sexual life.

As a UN official noted in September 2004 in Maputo,

> Now more than ever, Mozambique, and the world, need a concept of development that is centred on human beings, in order to tackle absolute poverty and halt the spread of HIV/AIDS (Agência de Informação de Moçambique 2004).

As Epstein (2004) argues, "No public-health campaign [alone] can change the economic conditions that motivate transactional [sexual] relationships" and continue to foster the spread of HIV. If donors and African governments are serious about wanting to stem the rising tide of HIV/AIDS, they must begin to explore long-term alternatives to this migrant labour system—and to the dominant export-led development model touted by donors on which this system is premised.

Annex: Profile of Mozambique: Social and Economic Conditions

Mozambique, home to roughly 19.2 million people (UNAIDS 2000), is one of the world's most impoverished countries. About 70 per cent of Mozambicans survive on less than $1 a day (CUSO 2002). Between 69 per cent and 82 per cent of Mozambicans live in absolute poverty (Heltberg et al. 2001).

This poverty was aggravated by Portuguese colonial exploitation of Mozambique's considerable resources, both human and material (Andersson 1992). Portugal invested little in social services or institutions for Mozambique's black majority. The Mozambican colonial economy depended on providing services—transport and shipping—for its landlocked neighbours and producing a few key export commodities, for example, prawn fishing and cashews. However, neither provided direct benefits for the majority of Mozambicans (Heltberg et al. 2001). Thus, despite considerable agricultural, mineral, fishing and hydroelectric resources, Mozambique has consistently ranked among the bottom 10 countries in the United Nations Development Programme's (UNDP) annual human development index since it began to be issued in the early 1990s.[36] Four out of five Mozambicans today still live in rural areas, most of them surviving on subsistence farming. Data presented in the table below reflect the poverty in which most Mozambicans live today. Less than 40 per cent have access to health services. USAID (1998) estimates "average daily caloric intake in Mozambique is just 77% of daily requirements" and that as many as 30 per cent to 40 per cent of Mozambican children are affected by malnutrition.

[36] While Mozambique's ranking on the human development index has improved since 1994, recent gains are due almost exclusively to a sharp drop in adult illiteracy (CUSO 2002).

Bibliography

Accord. 1998. "Chronology of war and peace in Mozambique." *Mozambican Peace Process in Perspective*, Issue 3. Conciliation Resources in collaboration with the Arquivo Histórico de Moçambique. www.c-r.org/accord/moz/accord3/chronol.shtml, accessed on 23 April 2004.

Agence France-Press. 2002. "Mozambique-AIDS: AIDS seen killing 17 percent of Mozambican teachers by 2012." 24 April. www.afp.com/francais/home/, accessed on 1 September 2005.

Agência de Informação de Moçambique. 2004. *UNFPA Annual Report Launched*. 15 September. www.poptel.org.uk/mozambique-news/, accessed on 1 September 2005.

Andersson, Hilary. 1992. *Mozambique: A War Against the People*. St. Martin's Press, New York.

Arnaldo, Carlos. 2004. *Factores sócio-económicos associados com a percepção individual do risco de contrarir o hiv/sida em Moçambique*. Paper presented at the workshop on the determinants of HIV/AIDS in Mozambique, Centro de Estudos de População, Faculdade de Letras, Universidade Eduardo Mondlane, Maputo, 17 February.

Arnaldo, Carlos and António Francisco. 2004. *As características sócio-económicas dos distritos com postos de vigilância epidemiológica do HIV/SIDA e sua influência na taxa de prevalência do hiv em Moçambique*. Paper presented at the workshop on the determinants of HIV/AIDS in Mozambique, Centro de Estudos de População, Faculdade de Letras, Universidade Eduardo Mondlane, Maputo, 17 February.

Bollinger, Lori and John Stover. 1999. *The Economic Impact of AIDS in Mozambique*. The Policy Project, USAID Futures Group International in collaboration with Research Triangle Institute and the Centre for Development and Population Activities, September.

Canadian University Service Overseas (CUSO). 2002. *About Mozambique*. September. www.cuso.org.mz/mozambique.html, accessed on 5 January 2004.

Carnegie Commission. 1997. *Preventing Deadly Conflict*. Carnegie Corporation, New York.

Cheru, Fantu. 1986. "The politics of desperation: Mozambique and Nkomati." *TransAfrica Forum*, Spring, pp. 29–48.

Cliff, Julie. 1998. "Reconstructing health in post-war Mozambique." *Association of Concerned African Scholars Bulletin*, No. 50–51, Winter/Spring, pp. 1–3. http://acas.prairienet.org/bulletin/acasbulletin5051.pdf, accessed on 7 July 2005.

De Hulsters, Brigitte, A. Barreto, R. Bastos, A. Noya, E. Folgosa and L. Fransen. 2003. "Geographical focusing: An intervention to address increased risk for sexually transmitted diseases during repatriation and resettlement in post-war Mozambique." Letter in *Sexually Transmitted Infections*, Vol. 79, No. 1, February, p. 77. http://sti.bmjjournals.com/cgi/content/full/79/1/77, accessed on 14 July 2005.

Deng, Frances M. 1997. *Profiles in Displacement: Mozambique*. Addendum report of the representative of the Secretary-General, Commission on Human Rights resolution 1996/52, United Nations Economic and Social Council, E/CN.4/1997/43/Add.1. 24 February. www.hri.ca/fortherecord1997/documentation/commission/e-cn4-1997-43-add1.htm, accessed on 23 April 2004.

Epstein, Helen. 2004. "The fidelity fix." *New York Times*, 13 June. www.ph.ucla.edu/epi/faculty/frerichs/fidelityfix.html, accessed on 24 July 2005.

———. 2002. "The hidden cause of AIDS." *New York Review of Books*, Vol. 49, Nos. 8 and 9 May. www.nybooks.com/articles/15371, accessed on 26 July 2005.

Finnegan, William. 1992. *A Complicated War: The Harrowing of Mozambique*. University of California Press, Berkeley.

Flowers, Ken. 1987. *Serving Secretly*. John Murray, London.

Foreit, Karen. 1999. *Some Considerations for Developing a Strategic Approach to the HIV/AIDS Epidemic in Mozambique*. Discussion draft, The Policy Project, Washington, DC. June.

Garrett, Laurie. 2000. "Allies of AIDS: Among warring factions in Congo, disease is mutating." *Newsday*, 9 July, p. 24.

Gersony, Robert. 1988. *Summary of Mozambican Refugee Accounts of Principally Conflict-Related Experience in Mozambique*. Bureau of Refugee Programs report, United States Department of State, Washington, DC. April.

Hanlon, Joseph. 1991. *Mozambique: Who Calls the Shots?* James Currey and Indiana University Press, London.

———. 1987. *Apartheid's Second Front: South Africa's War Against Its Neighbours*. Penguin Books, London.

———. 1986. *Beggar Your Neighbours*. Catholic Institute for International Relations in association with James Currey, London.

Harris, Geoff. 1999. *External Financial Resources and Mozambique's Recovery from War 1986–1995*. Working Paper No. 4, Southern African Centre for Defence Information (SACDI) Defense Digest. http://ccrweb.ccr.uct.ac.za/archive/defencedigest/defdigest04.html, accessed on 15 July 2004.

Heltberg, Rasmus, Kenneth Simler and Finn Tarp. 2001. *Public Spending and Poverty in Mozambique*. Discussion Paper No. 2001/63, UNU/WIDER Project on New Fiscal Policies for Growth and Poverty Reduction, Helsinki.

The Herald. 2002. "Long distance truck drivers among major contributors to spread of HIV/AIDS." 18 March. Harare.

Integrated Regional Information Networks (IRIN). 2004a. *South Africa: Population Shrinkage Caused by HIV/AIDS*. United Nations Office for the Coordination of Humanitarian Affairs, Geneva.

———. 2004b. *Mozambique: AIDS Threatens Development and Life Expectancy*. United Nations Office for the Coordination of Humanitarian Affairs, Geneva.

———. 2004c. *Mozambique: HIV/AIDS Threatening Subsistence Agriculture*. United Nations Office for the Coordination of Humanitarian Affairs, Geneva.

Interagency Coalition on AIDS and Development (ICAD). 2001. *HIV/AIDS and Displaced Persons*. Ottawa, Canada.

International Organization for Migration (IOM), CARE and the Swedish International Development Cooperation Agency (Sida). 2003. *Mobility and HIV/AIDS in Southern Africa: A Field Study in South Africa, Zimbabwe and Mozambique*. September. www.iom.int/en/PDF_Files/HIVAIDS/Southern_africa_hiv.pdf, accessed on 31 January 2004.

Johnson, Phyllis and David Martin (eds.). 1986. *Destructive Engagement: Southern Africa at War*. Zimbabwe Publishing House, Harare.

Joint United Nations Programme on HIV/AIDS (UNAIDS). 2005. *UN Programme Gives Young People a Voice in Mozambique*. www.unaids.org/en/Media/Feature+stories.asp, accessed on 14 August 2005.

———. 2000. *AIDS Epidemic Update: December 2000*. www.unaids.org/wac/2000/wad00/files/WAD_epidemic_report.htm, accessed on 19 February 2004.

———. 1998. *AIDS and the Military*. Best Practices Collection. May. www.worldbank.org/wbi/aidsleadership/dls_AIDS_military_may14.pdf, accessed on 19 December 2003.

Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Children's Fund (UNICEF) and World Health Organization (WHO). 2002. *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections: Mozambique, 2002 Update*. www.who.int/emc-hiv/fact_sheets/pdfs/Mozambique_EN.pdf, accessed on 5 April 2004.

Kirk, Paul. 2000. "60% of SA army may be HIV-positive." *Mail and Guardian* (Johannesburg), 31 March. http://allafrica.com/stories/200003310134.html, accessed on 19 February 2004.

Kwarteng, Tamara and Julie Cliff. 2001. *Sex Workers in Manica Respond to HIV/AIDS*. Mid-Term Project Review. Electronic draft provided by authors. December.

Lindelow, Magnus. 2002. *Health Care Demand in Rural Mozambique: Evidence from the 1996/97 Household Survey*. Discussion Paper No. 126, International Food Policy Research Institute, Food Consumption and Nutrition Division, Washington, DC. February. www.ifpri.org/divs/fcnd/dp/papers/fcndp126.pdf, accessed on 31 January 2004.

Link, Derek with Mark Harrington. 2002. *Exploring the American Response to the AIDS Pandemic*. Treatment Action Group, New York.

Magaia, Lina. 1988. *Dumba Nengue: Run for Your Life*. Africa World Press, Trenton, NJ.

Maier, Karl. 1992. *Conspicuous Destruction: War, Famine and the Reform Process in Mozambique*. Africa Watch report, Human Rights Watch, New York.

Marlin, Robert P. 1998. "Violence, gender and illness in post-war Mozambique." *Association of Concerned African Scholars Bulletin*, No. 50/51, Winter/Spring, pp. 4–6, http://acas.prairienet.org/bulletin/acasbulletin5051.pdf, accessed on 7 July 2005.

Meldrum, Andrew. 1991. "Railway of refuge." *Africa Report*, Vol. 36, No. 3, May-June, pp. 63–66.

Minter, William. 1994. *Apartheid's Contras: An Inquiry into the Roots of War in Angola and Mozambique*. Witwatersrand University Press, Johannesburg and Zed Books, London.

Munkonoweshuro, Elipha G. 1992. *Zimbabwe: Ten Years of Destabilization: A Balance Sheet. Vol. 4, Africa: The Wakening Giant Series*. Bethany Books, Stockholm.

National Institute of Statistics. 2000. *Demographic Impact of HIV/AIDS in Mozambique (Update 2000)*. Ministry of Health, Maputo.

Pavignani, Enrico and Joaquim Ramalho Durão. 1997. *Aid, Change and Second Thoughts: Managing External Resources in the Health Sector in Mozambique*. Ministry of Health, Maputo. www.sti.ch/pdfs/swap289.pdf, accessed on 15 July 2005.

Pfeiffer, James. 2000. "Health care and privatization: Lessons for East Timor from Mozambique." *The La'o Hamutuk Bulletin*, Vol. 1, No. 3, 17 November. www.pcug.org.au/~wildwood/ LHBMozam.htm, accessed on 29 July 2005.

Raimundo, Inês Macamo. 2003. *Migração e HIV/AIDS em Moçambique: Explorando a questão migração e HIV/SIDA na região centro de Moçambique*. Paper prepared for the workshop on the determinants of HIV/AIDS in Mozambique, Centro de Estudos de População, Faculdade de Letras, Universidade Eduardo Mondlane, Maputo, 17 February.

Republica de Moçambique. 2005. *Divulgação de dados de vigilância epidemiológica do HIV-Ronda 2004*. Press conference on *Relatório sobre a revisão dos dados de vigilância epidemiológica do HIV-Ronda 2004*. August 2005. Grupo Técnico Multisectorial, Ministerio da Saude, Maputo.

———. 2003. *Relatório sobre a revisão dos dados de vigilância epidemiológica do HIV-Ronda 2002*. Direcçao National de Saude, Programmes Nationale de Controle das DTS/HIV-SIDA, Ministerio da Saude, Maputo.

Starling, Mary, Ruairi Brugha, Gill Walt, Julie Cliff and Benedita Fernandes. 2005. *Global Fund Tracking Study: Mozambique Country Report*. January. www.share-net.nl/assets/images/ Mozambique_GF_Tracking.pdf, accessed on 1 July 2005.

TransAfrica Forum. 1984. "Mozambique: Destabilisation and historical dependency." *Issue Brief*, Vol. 3, No. 3, June-July, pp. 1–2.

TransAfrica News. 1987. "Mozambique." Vol. 6, No. 2, p. 5.

United Nations (UN). 1995. *The United Nations and Mozambique, 1992–1995*. UN Department of Public Information, New York.

United Nations Children's Fund (UNICEF). 2004. *Latest News: Life Skills for Out of School Children: My Future is My Choice*. 15 January. www.unicef.org/mozambique/ latest_news_15Jan04_04.html, accessed on 14 March 2004.

United Nations Development Programme (UNDP). 2002. *Human Development Report 2002: Deepening Democracy in a Fragmented World*. Oxford University Press, New York.

United Nations High Commissioner for Refugees (UNHCR). 1996. *Evaluation of UNHCR's Repatriation Operation to Mozambique*. UNHCR, Geneva.

United States Agency for International Development (USAID). 2002. *HIV/AIDS in Mozambique: A USAID Brief*. July. www.synergyaids.com/documents/Mozambique_final.PDF, accessed on 14 January 2004.

———. 1998. *Congressional Presentation, FY 1999*. USAID Section on Mozambique, Washington, DC. www.synergyaids.com/documents/Mozambique_final.PDF, accessed on 14 January 2004.

United States Department of State (USDOS). 2005a. *Country Profile: Mozambique*. Office of the US Global AIDS Coordinator, USDOS, Washington, DC. www.state.gov/s/gac/rl/cp/50727.htm#one, accessed on 14 August.

———. 2005b. *Focus Country Operation Plans for Fiscal Year 2005: Mozambique*. www.state.gov/s/gac/rl/or/44535.htm#mozambique, accessed on 9 July 2005.

University of Zimbabwe, Institute for Development Studies (UZ/IDS). 2004a. *Summary: Zimbabwe Human Development Report 2003: Redirecting Our Responses to HIV and AIDS*. University of Zimbabwe, Harare.

———. 2004b. *Zimbabwe Human Development Report 2003: Redirecting Our Responses to HIV and AIDS*. Final Report. University of Zimbabwe, Harare.

Vines, Alex. 1991. *RENAMO: Terrorism in Mozambique*. Centre for African Studies, University of York and James Currey, London and Indiana University Press, Bloomington.

World Bank. 1999. *Confronting AIDS: Public Priorities in a Global Epidemic*. Revised edition. Oxford University Press, New York.

———. 1997. *War-to-Peace Transition in Mozambique: The Provincial Reintegration Support Program*. Findings: Africa Region, No. 90, July. Oxford University Press, New York.

UNRISD Programme Papers on **Social Policy and Development**

PP SPD 24 **Mozambique's HIV/AIDS Pandemic: Grappling with Apartheid's Legacy**
Carole J.L. Collins, February 2006

PP SPD 23 **Targeting and Universalism in Poverty Reduction**
Thandika Mkandawire, December 2005

PP SPD 22 **Transforming the Developmental Welfare State in East Asia**
Huck-ju Kwon, September 2005

PP SPD 21 **The Politics of Welfare Developmentalism in Hong Kong**
Eliza W.Y. Lee, August 2005

PP SPD 20 **Política social y reforma social "a la tica": Un caso paradigmático de heterodoxia en el contexto de una economía periférica**
Manuel Barahona, Ludwig Güendel y Carlos Castro, agosto 2005

PP SPD 19 **The Adult Worker Model, Gender Equality and Care: The Search for New Policy Principles, and the Possibilities and Problems of a Capabilities Approach**
Susy Giullari and Jane Lewis, April 2005

PP SPD 18 **"Globalization" and Social Policy in a Development Context: Regional Responses**
Nicola Yeates, April 2005

PP SPD 17 **The Developmental Welfare State in Scandinavia: Lessons for the Developing World**
Stein Kuhnle and Sven E.O. Hort, September 2004

PP SPD 16 **Late Industrializers and the Development of the Welfare State**
Christopher Pierson, September 2004

PP SPD 15 **Global Capitalism, Deflation and Agrarian Crisis in Developing Countries**
Utsa Patnaik, July 2003

PP SPD 14 **Agrarian Change, Gender and Land Rights: A Brazilian Case Study**
Julia S. Guivant, June 2003

PP SPD 13 **Reworking Apartheid Legacies: Global Competition, Gender and Social Wages in South Africa, 1980–2000**
Gillian Hart, December 2002

PP SPD 12 **Women's Employment and Welfare Regimes: Globalization, Export Orientation and Social Policy in Europe and North America**
Ann Shola Orloff, June 2002

PP SPD 11 **Agrarian Reform, Gender and Land Rights in Uzbekistan**
Deniz Kandiyoti, June 2002

PP SPD 10 **Agrarian Change, Gender and Land Reform: A South African Case Study**
Cherryl Walker, April 2002

PP SPD 9 **Gender and Education: A Review of Issues for Social Policy**
Ramya Subrahmanian, April 2002

PP SPD 8 **Dynamique de la politique sociale en Côte d'Ivoire**
Francis Akindès, juillet 2001

PP SPD 7 **Social Policy in a Development Context**
Thandika Mkandawire, June 2001

PP SPD 6 **Breaking the Mould: An Institutionalist Political Economy Alternative to the Neoliberal Theory of the Market and the State**
Ha-Joon Chang, May 2001

Continued

PP SPD 5	**Les politiques sociales en Afrique de l'Ouest: Quels changements depuis le Sommet de Copenhague? Synthèse des études de cas (Bénin, Burkina Faso, Côte d'Ivoire, Mali, Sénégal)** Momar-Coumba Diop, avril 2001
PP SPD 4	**AIDS in the Context of Development** Joseph Collins and Bill Rau, December 2000
PP SPD 3	**Empirical Inquiries and the Assessment of Social Progress in Western Europe: A Historical Perspective** Jean-Michel Collette, June 2000
PP SPD 2	**Social Indicators and Welfare Monitoring** Gøsta Esping-Andersen, May 2000
PP SPD 1	**External Dependency and Internal Transformation: Argentina Confronts the Long Debt Crisis** Jorge Schvarzer, May 2000

Printed in Switzerland
GE.06-00252-February 2006-1,100

UNRISD/PPSPD24/06/1