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GENDER, SEXUALITY AND VAGINAL PRACTICES

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TECHNICAL NOTE

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Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CRDS	Centro Regional para o Desenvolvimento da Saúde (Regional Centre for Healt Development)
GFR	Global Fertility Rate
HIV	Human Immunodeficiency Virus
IDS	Indice de Desenvolvimento Ajustado aos Sexos (Sex Adjusted Development Index)
IMR	Infant Mortality Rate
INE	Instituto Nacional de Estatística (National Statistics Institute)
MoH	Ministry of Health
NGO	Non-Governmental Organisation
OMM	Organização da Mulher Moçambicana (Mozambican Women's Organization)
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection Joint
UNAIDS	United Nations Programme on HIV / AIDS
WHO	World Health Organization

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Executive Summary

The "Study on Gender, Sexuality and Vaginal Practices" was conducted in South-east Asia (Thailand and Indonesia) and southern Africa (Mozambique and South Africa). It was coordinated by the WHO Department of Reproductive Health Research, Gender and Rights, Geneva. In Mozambique the study was conducted in collaboration with the Ministry of Health (MoH), the Regional Centre for Health Development (Centro Regional para o Desenvolvimento da Saúde - CRDS), the Provincial Directorate of Health in Tete, WHO Mozambique, the International Centre for Reproductive Health (ICRH) and the University of Ghent (Belgium).

The study had two phases. Phase 1, ethnographic work, took place in 2005 and the results are presented in this paper. Based on these results, there was a second (quantitative) phase with a questionnaire survey of a representative sample of women in Tete province.

The ethnographical research was conducted in four locations in Tete province: two rural and two urban areas in Tete town and Changara district. This district was chosen because it lies along an important transport corridor between Beira, Malawi and Zimbabwe. In Tete town, the provincial capital, Filipe Samuel Magaia neighbourhood and a semi-urban area (M'padue) were selected. In Changara district a neighbourhood in the capital and a rural area in Chipembere locality were selected.

Data were collected using semi-structured interviews with an interview guide covering the main topics based on WHO guidelines. The study was conducted mainly from a female perspective. A total of 103 people participated in the study, 25 men and 78 women. There were seven focus group discussions, 20 individual interviews with key informants, 18 in-depth interviews and four reference group discussions. The discussion groups usually comprised five to nine people and were homogeneous in terms of occupational category and sex.

The study found that women use a variety of natural and synthetic, traditional and modern products - inserted into the vagina or ingested - for cleansing purposes, to treat disease, to change the way they feel their body and to prepare for sexual intercourse. In addition, most women had lengthened their *labia minora* since childhood, changing their bodies in line with aesthetic criteria, their notions of femininity and sexual pleasure.

Some of these practices, such as cleansing the vagina with soap and two fingers, can occur throughout their lives or for specific events. It should be noted that many women use various practices simultaneously. Sexually active women who are not pregnant or nursing a baby perform these acts more than others.

It was found that sexuality is not monolithic and imposed on an individual. It is subject to negotiation and change during a woman's life cycle producing what we would describe as multiple and contextual sexualities. Deconstructing colonial and postcolonial notions of the "other", the view that African sexuality is promiscuous and based on the dichotomy model of male sexual pleasure and a woman's reproductive sexuality, the study shows how people build sexuality around contextually specific notions and practices. Vaginal practices are thus part of a woman's socialisation process that has various components: sexuality, health, reproduction and life in general. Metaphors and notions such as closed/open, dry/wet, hot/cold, heavy/light, life/death, wealth/poverty, sweet/not sweet are gender symbolism/symbols related to the hygiene, health, well-being, eroticism, reproduction and aesthetic concepts that inform sexual practices.

The study shows that certain vaginal practices are incompatible with condom use and highlights their negative impact on the possible use of microbicides. It also calls attention to the need for more detailed studies on these practices to identify their prevalence in other provinces in the country. In addition, given the evidence that some practices, especially intra-vaginal cleansing, are harmful because of their association with STI and HIV/AIDS, the study recommends that the matter should be addressed in public health policies and prevention strategies.

CHAPTER I

BACKGROUND AND CONTEXT

1. Context and justification

"Vaginal practices" is a term that describes a variety of interventions in the vagina at different times in a woman's life and for a variety of reasons. They can include modifications (incisions, elongation, removal) to the hymen, the vaginal *labia minora* or maiora, the clitoris or the vaginal area. Other practices include interventions on the size of the vagina, the temperature, lubrication, moisture and consistency by steaming and the application or ingestion of different substances and/or medicines. The reasons for these practices include, but are not limited to, the sexual satisfaction of one or both partners, personal hygiene, health and well-being, the socialisation of a woman's body and fertility (Van de Wijgert et al., 2000a, 2000b; Brown and Brown, 2000).

Many interventions have been mentioned in the literature in various countries in Asia, Africa and the Americas. However, except for excision and infibulation , that are specific to Africa (Hosken, 1979; Lewis, 2004), few have been properly documented and studied, in particular their possible implications for concepts linked to sexual pleasure and their consequences for sexual and reproductive health.

Many practices are traditional and done at home, with knowledge transmitted orally within restricted groups, and involve local products and actors. Other practices are conducted under the control of a traditional healer and involve manufactured products widely advertised in the media. What is done and discussed varies from country to country and from season to season.

Studies have shown that there is an increased risk of irritation and inflammation of the sexual organs of both partners and the transmission of disease (Brown et al., 1992, 1993a, 1993b; Cohen et al., 1995; Baleta, 1998; Dallabetta et al., 1995; Kun, 1998; Beksinska et al., 1999; La Ruche, 1999; Orubuloye et al., 1995; Brown and Brown, 2000; Myer et al., 2004). However, little is known about variations within the same culture or among different groups of women with different characteristics (Awusabo-Asare, 1993; Green et al., 2001; Bagnol, 2003). A recent meta-analysis of intra-vaginal practices shows that they are harmful to a woman's health because they are associated with a higher prevalence of STI and HIV/AIDS (Low et al., 2010).

[1] The African Union's Maputo Protocol on female genital mutilation requiring its members to ban this practice, was adopted in Mozambique in 2003.

This study and those carried out under the same project in Thailand (Chonburi), Indonesia (Yogyacarta) and South Africa (KwaZulu Natal) indicate a high prevalence and a large proportion of women performing various vaginal practices (Bagnol and Mariano, 2008a, 2008b, 2009a, 2009b; Scorgie et al., 2009, 2010; Mariano and Bagnol, 2009; Martin Hilber et al., 2010a, 2010b). Overall, it has been found that these practices are more widespread in Africa than in Asia (Martin Hilber et al., 2011).

More and better knowledge of the subject would help to provide appropriate messages or develop alternatives to ensure the protection and sexual pleasure of both partners. It could also help the development of contraceptives or technologies that take into account such practices.

1.1 Context, background and justification

Over the last decade, various institutions and Non-Governmental Organisations (NGOs) in Africa and Mozambique in particular, have done a lot of research on sexuality and issues related to HIV/AIDS. However, despite growing efforts to promote changes in attitudes and practices in order to fight the spread of HIV/AIDS, there is growing awareness that little is known about sexual and reproductive health, and in particular its foreplay component. It has also been found that, despite some improvement over the last decade, prevention and treatment are currently insufficient and have little impact (UNAIDS/WHO, 2003). This raises this question: do we have sufficient knowledge about sexuality and reproductive health to develop appropriate, culturally sensitive messages with participation by all parties concerned?

Analysing research output on Sexual and Reproductive Health, STD and HIV/AIDS in Mozambique, Arthur and Osório (2002) state that most of these studies are extremely limited in terms of ethnographic research and thorough analysis of the cultural context. According to these researchers, this is mainly due to the relatively short time spent on studies and field work and the lack of funds for in-depth studies. In addition, most research to date has focussed on projects and a medical perspective linked to the prevention of STI/HIV/AIDS such that it has not been possible to capture the complexity of sexuality as a social, cultural and historically constructed reality. In addition to knowing the number of partners and the frequency of sexual relations with and without a condom, information is needed on people's

sexual preferences and the possibility of negotiating the sexual relationship (Parker and Gagnon, 1995:14).

Some studies look at practices involving the vagina, such as drying and tightening, (Mahomed et al., n.a.), stretching the vaginal *labia* (OMM, 1983; Arnfred, 1989, 2003; Ironga, 1994; Enoque, 1994; Bagnol, 1996, 2003), extracting impurities through incisions (*masale* or *masungo*), curing and treating infertility (Mariano, 2001), ritual deflowering practices (Bagnol, 1996; Dava et al., 1999) or testing virginity (Bagnol, 2004), practices linked to notions of cleansing and purification involving sexual encounters with casual partners, ritual cleansing following STD treatment (Bagnol, 1998) or ritual cleansing after the death of a relative.

There is information suggesting that some of these practices - such as the use of vaginal products for various purposes (daily or post-coital hygiene) or purification rituals following a death - could be widespread or highly localised such as deflowering rites and virginity testing. However, no research has examined specifically and in detail practices linked to notions of transforming a woman's body, the concept of sexual pleasure, notions of vaginal hygiene or ritual purification/cleansing.

The purpose of this study, the result of fieldwork conducted in 2005 in Tete province, is to help improve knowledge about a variety of vaginal practices and women's sexuality in general in the province, more specifically in the provincial capital and Changara district.

1.2 Objectives of the study

According to the WHO protocol, the general objectives of the study are:

- To identify, better understand and document vaginal practices related to women's sexuality and sexual health. A guiding question for this objective is how women themselves perceive the impact of these practices on their sexual health and well-being;
- To describe the broader social context in which these practices are carried out including, for example, the gender system, economy, culture, historical setting, religion and medical institutions;
- To understand the motivations, intent, perceptions and experiences (beneficial and detrimental) of individual women who have undertaken vaginal practices;
- To obtain reliable estimates of the prevalence of specific vaginal practices among a specific major social group in each country.

The purpose of the study was to address the following questions:

- What vaginal practices (efforts to modify, cut, dry, cleanse, enhance, tighten, lubricate or loosen the vagina, *labia*, clitoris or hymen) are found among women in the study communities?
- What is the prevalence and frequency of these vaginal practices within each study populations?
- What are the reasons women undertake these vaginal practices?
- What impact do these practices have on the sexual and reproductive health of women and men?
- What impact do these practices have on women's and men's self-perceived sexual and reproductive health?
- To what extent are the practices promoted or opposed by women's sexual partners, or by other members of the community, including traditional and modern health service providers?

This study is a continuation of the above-mentioned research on sexual practices in Mozambique by various authors. However, the research field was limited to as yet unknown areas linked in particular to practices that have a specific impact on the vagina.

In order to discuss these subjects appropriately with women and men, the research team sought to obtain a broader understanding of notions of sexuality and treatment linked to sexual or relational problems between partners. Notions of eroticism, pleasure and sexual desire were also investigated by the team. It tried to obtain a picture of women's views and also those of men. Some interventions carried out by men were also identified, although these were not highlighted or covered in detail in the description and analysis.

1.3 Expected results

According to the protocol it was expected that the study would produce sufficient, in-depth data that would:

- Contribute to policies on STI, HIV/AIDS and sexuality at all levels;
- Influence the development of microbicides and condoms;
- Contribute to the preparation of relevant messages on preventing STI and HIV/AIDS;

- Build awareness on vaginal practices and people's understanding of sexuality and pleasure.

1.4 Review of international literature

The international literature review focuses in particular on practices similar to those found in Mozambique. Information on female genital mutilation in many countries in central Africa and neighbouring countries such as Tanzania were disregarded, although there is anecdotal evidence of such practices in Cabo Delgado province.

Various products are used to enhance the sexual pleasure of men or both partners (Hull and Buiharsana, 2001) by reducing the size of the vagina and its lubrication, thereby increasing friction and the man's sexual pleasure. These practices are known in Africa, the Dominican Republic, Southeast Asia, Haiti, Qatar, Melanesia and the United States of America. There is more information on the situation in Africa than other continents (Morar and Karim, 1998; Kun, 1998; Runganga et al., 1992; Brown and Brown, 2000; Reed et al., 2000; Braunstein and Van de Wijert, 2002).

In his book on the sexuality of the Beti in central-south Cameroons, Ombolo (1990) explains that a large vagina is considered a serious problem. People speak with revulsion about "an abyss", "a hole", or that "the penis swims around without touching the walls" (Ombolo, 1990: 51-52). The author believes that this attitude is frequent in Sub-Saharan Africa and cites Kashamura (1973:115) who, referring to the Great Lakes region, says that a large vagina is the subject of ridicule. The desired vagina must be "narrow and hot" (Ombolo, 1990: 52). When there is too much water, the Beti use a preparation made from the bark of a mimosa-type plant (pedptademia africana) that is known to help remove excess vaginal secretions. In the Democratic Republic of Congo women also insert small balls made of ground leaves into the vagina 12 hours before intercourse (Brown et al., 1992).

Similarly, women in Indonesia drink manufactured potions, known commercially as *jamu*, to tighten the vagina and increase their partners' sexual satisfaction. These medicines have existed for a very long time both to improve sexual performance and for hygiene and health; they are very popular and are preserved by the Sultan's court. In Thailand too, there is a wide variety of products to dry or tighten

the vagina, prepared by large companies and distributed in shops throughout the country. Women use these products prior to sexual intercourse to alter the characteristics of their vaginas.

There are indications of a greater risk of inflammation and irritation of the sexual organs of both partners and modification of the woman's vaginal flora (Brown and Brown, 1993a; Cohen et al., 1995; Baleta, 1998; Kun, 1998; Myer et al., 2004). However, some studies also suggest that different products can have completely different effects, some limited while others increase the risk of transmitting disease (Myer et al., 2005). The combination of these practices and implants in the penis, as in Southeast Asia and the Pacific, may increase health risks for both the woman and man.

Studies in Thailand on modification of the vaginal mucosa of sex workers due to the use of various products indicate susceptibility to STIs and HIV/AIDS (Cohen et al. 1995; Kilmarx et al., 1998; Chaikummao et al., 2004, McClelland et al., 2006a, 2006b).

Various studies on KwaZulu Natal (South Africa), that has one of the highest HIV/AIDS prevalence rates in the world, analyse the possible connection between these rates and the high prevalence of vaginal practices (Baleta 1998; Morar and Karim 1998; Beksinska et al., 1999; Myer et al., 2004; Smith et al., 2002). A recent meta-analysis of intra-vaginal practices indicates that cleansing the vagina with soap and other abrasive products is not benign (Low et al., 2010). Studies also show that the use of vaginal products is related to a preference for unprotected sexual relations.

Daily or regular hygiene practices using a variety of products can be found in various countries and on different continents (Joesoef et al., 1996; Preston-Whyte, 2003; Utomo, 2003). The reasons why women use them include the need to eliminate menstrual blood, semen, vaginal secretions or odour. Increased susceptibility to infection due to changes in the vaginal flora has been mentioned by some authors (Braunstein and Van de Wijert, 2002). Ombolo (1990) explains that the personal hygiene of young girls is subject to close scrutiny by the mother in order to "disinfect and remove odours":

> *The woman cleanses the vagina with a warm infusion of the bark of a tree* (guibourta tessmannií)*; she can also occasionally drink half a cup of this potion. Similar vaginal cleansing can be done with an infusion of* baillonnella

> toxisperma bark *and* alchornea cordata *leaves. Beti women also insert fresh tobacco leaves rolled into small balls, and dried* bridelia micrantha *leaves into their vaginas as a disinfectant. It was said that all these substances stop the female genital organs from being dirty and smelly (Ombolo, 1990:149-50).*

Elongation of the vaginal *labia minora* is practised by some groups in southern Africa (Parikh, 2005). It is found among the Venda in South Africa, throughout the centre and north of Mozambique (Arnfred, 1989, 2003; Ironga, 1994; Enoque, 1994; Bagnol, 1996, 2003; Geisler, 2000), among the Makonde in the south of Tanzania, the Shona in Uganda (Parhik, 2005) and in Zimbabwe (Aschwanden, 1982: 77; Gelfand, 1979:19).

Early 19th century authors thought that elongated *labia* were a natural anatomical feature of the Khoisan, called apron. According to studies at the time, the average size of the vagina *labia* was 7.5 cm (Baker, 1974). At 19.3cm the *labia* of Sarah Bartman, the "Hottentot Venus" was the subject of immense curiosity and controversy (Fauvelle-Aymar, 2002, 2004). If elongated *labia* were a natural feature among the Khoisan then perhaps it was replicated by other groups in the region but using traditional methods.

Parikh (2005) explains how, in Uganda, a paternal aunt was traditionally responsible for advising a girl on how "to prepare and sexualise the young girl's body, teaching her how to lengthen her *labia minora*" (Parikh, 2005:131). The author explains that, although the girl's sexuality was being prepared primarily to satisfy male pleasure and desires, satisfaction of the young girl's desires was not ignored (Parikh, 2005:132) and that pulling the *labia minora* was considered to be something that increased the woman's sexual desire and the pleasure of masturbation (Parikh, 2005:139), as can be seen from the author's description:

> *Pulling was a key part of the preparation of the female body for sexual activity with her husband and childbirth. During an interview with Norah, a traditional midwife in her late sixties, she gave me a common explanation: "Long ago they used to say that if you had not gone into the bush to pull you couldn't give birth. In reality," she continued, "pulling is useful because, if you have never done it, when you start to give birth the child sees that what is coming is a very open place and will be afraid to come out. And men did not like having sex with a woman who had never pulled. For a*

> *man, entering a woman who had never pulled was like entering a house without a door." As in Norah's case, the elderly usually explain that the vagina needs a cover and present the image of a gate by associating both with modesty. As Norah suggests, pulling was also closely associated with the idea of fertility, linking the transformation of the external genitalia with their reproductive capacity [...]. The girl received a stern warning that if she did not pull she could not give birth or would have problems during labour (Parikh, 2005:133).*

Parikh's description also refers to the role of belts made of small beads, movements before and during sexual intercourse and the sounds and attitudes taught by the *ssenga* (aunt):

> *Bedroom tricks' included the bedroom dance, or the movements of the hips, during preparation and during intercourse. For the bedroom dance it was important to wear beads around the waist and use them properly. Of considerable sexual significance, the beads around the waist undoubtedly aroused the man. The aunt also gave the girl a cloth to clean up after having sex. Along with information about its proper use came the stern warning that if her husband found her with the cloth, when not in the room with him, it would be sufficient evidence to accuse her of adultery. Another important lesson involved her correct bodily hygiene that included how to get rid of odour and the use of herbs and other vegetation (Parikh, 2005:134-5).*

The Karanga of Zimbabwe also lengthens the *labia minora*. Explaining the importance of stretching the *labia minora* in building the female identity in Africa, Aschwanden (1982: 77) asserts that a woman who has not pulled her *labia* is called "cold, or even a man". According to the author, the practice intensifies the sexual pleasure of the man and the woman, providing greater stimulation for the clitoris. Elongated *labia* "keep the vagina warm and support the penis". Aschwanden (1982) explains that these practices are part of a broader preparation of sexuality that also includes tattooing the woman's body to increase sexual pleasure. Gelfand (1979:19) describes the process for lengthening the *labia minora* of Shona girls in Zimbabwe. He explains that the process starts before the onset of menstruation and that young girls use oil to facilitate it.

Aschwanden (1982; 1887; 1989) states that small balls made of ground bark powder are placed in the vagina to trigger menstruation. He describes a similar system

Strings of beads used by the women around their hips, erotic in function. These adornments are an important element of femininity

used by the Karanga. For example, the bark used to bring on menstruation comes from a tree with a fruit that looks like an orange, with a shape similar to a girl's breasts and this makes the tree a female symbol. The bark chosen for the preparation comes from branches that touch each other. It is this friction that they try to produce in the vagina to enable the uterus to open and produce menstruation (Aschwanden, 1982: 91-92). In various publications the author describes metaphors relating to sexuality and sexual organs (Aschwanden, 1982, 1987, 1989). The author draws a parallel between the uterus and pans, or fire and sexuality: "It ensures that your home has fire. By fire the Karanga mean the uterus, love and children" (Aschwanden, 1982: 149). Another analogy mentioned by the author is the similarity between the vagina and the well or water source that never dries up, a symbol of fertility (Aschwanden, 1982:179).
Eppretch (2004) notes that women in Zimbabwe use love potions (mupfuhwira) to ensure sexual relations with their husbands and to stop them from having an erection with other women. He speaks of the importance of the sexual relationship and semen in helping a woman to be biologically and spiritually healthy (Eppretch, 2004:30).

1.5 Review of literature on Mozambique

Studies in Mozambique over the last 20 years have identified various practices of a sexual nature[2]. One of the first collections of documents on sexuality arose from the work of the Extraordinary Conference of the Mozambican Women's Organisation (OMM) held in 1983 and the survey of practices that, at that time, were consi-

dered primitive by FRELIMO.

The report by OMM in Tete (1983) states that lengthening the vagina's *labia* is useful because "during coitus they increase the man's sexual pleasure and later when the woman is older the *labia* are used to strengthen the width of the vagina"[3]. Analysing initiation rites and practices intended to lengthen the *labia* or increase the size of the penis, the same report states that "both boys and girls must not use products that harm their health and sexual organs" (OMM, 1983).

In Mozambique lengthening the vaginal *labia* occurs mainly in the centre and north of the country. Various authors (Arnfred, 1989, 2003; Ironga, 1994; Enoque, 1994; Bagnol, 1996; 2003) have studied the lengthening of the *labia minora* in Nampula province. While Bagnol (2003) analysed the implications of the practice for homo-attraction and gender roles, Arnfred (2003) emphasised the importance of detailed participatory ethnography in order to avoid preconceived western models that condemn the practice as genital mutilation. Some authors refer to this practice as being requested by men because it emphasises sexual pleasure (Raimundo et al., 2003) or, along the same lines, they feel that its absence can justify divorce (Ironga, 1994).

The data show that women throughout the country use a variety of agents (Dettol, Savlon, a special stone called "sulphur" or "incense", a mixture of water, salt, lemon and vinegar) or follow the recommendations of traditional healers on mixing unspecified plants, roots and other ingredients. A strong sign that these products are in fact being used is that they are on sale in many markets in the country and even in the Maputo city central market. They are used to dry, cleanse and/or tighten the vagina. Some authors refer to men's preference for a narrow vagina: "The minor's (in age) vagina is very narrow and the man's pleasure is greater" (Bagnol, 1997). One study on STI in Tete province explains that vaginal products are used to increase the man's sexual pleasure to the detriment of a woman's (Mahomed et al., n.a.: 27). The authors also explain that people seek the assistance of both health units and traditional healers for sexually transmitted infections and other aspects of sexuality. As some infections are thought to have a spiritual and magical origin, traditional healers are responsible for purifying (male and female) patients.

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[2] See also published data relating to this study (Bagnol and Mariano, 2008a; 2008b, 2009a; 2009b; Mariano and Bagnol, 2009).

[3] The document is referring to the possibility of putting the *labia* inside the vagina to reduce the hole.

Other interventions on female genitalia include extracting "impurities" by making a small excision between the vaginal orifice and the anus in cases of infertility or frequent miscarriage. The purpose of this intervention is to cure a disease known in the south of Mozambique as *kutsamiwa* or *xilo* (Mariano, 2001) and in Tete province as *masale* or *masungo*.

Another practice in central Mozambique is virginity testing (Bagnol, 2004:20). The author explains that in Gorongosa the girl is examined by relatives every month to check her virginity.

The practice of deflowering during initiation rites has been identified in Mucubúri district, Nampula province, in Cuamba district, Niassa province (Bagnol, 1997), and in Zambézia province (Dava et al., 1999). Bagnol quotes a 35 years old woman who spoke about the practice:

> *The rites in my area are very different from those in coastal or other areas. In addition to teaching, the elderly simulate sexual intercourse with a clay penis without any lubrication. It is very painful and traumatic for girls, who become afraid of men and of having sex. They learn that sexual pleasure is for men, that we must always accept the man and that the purpose of sex is to have children. In the countryside, elderly women, in their youth have experienced a violent form of sexuality (Bagnol, 1997).*

Raimundo and colleagues (2003) relate health issues and the eventual transmission of STIs to the fact that the same clay or wooden penis for these rituals is used for different girls.

There is also reference to practices linked to notions of cleansing and purification involving a sexual encounter with casual partners, such as ritual cleansing after treatment for STD (Bagnol, 1998) or ritual cleansing after the death of a relative. One practice in Zambézia province called *okeka*, involves sexual relations with a casual partner after taking medication as part of treatment for STD. Usually recommended by traditional healers for cleansing and purification (Bagnol, 1998), this therapeutic process requires a more profound understanding given its potential contribution to the transmission of STI. Other purification practices, such as *kupita kufa* that involves a sexual encounter with casual partners for ritual cleansing after death, have also been recorded. Anecdotal information from Cabo Delgado province also points to excision in the vaginal area.

Information related to the prevalence of vaginal practices arising from this study has already been published (Martin Hilber et al., 2011). Initial data (Table 4) show that at the time of the research in 2005, 63% of women in Tete province washed the outside of the vagina and 92% washed the inside as part of their daily hygiene routine (Martin Hilber et al., 2011). Most women - 60% - inserted products into the vagina to tighten or dry it or to treat disease. The vast majority had elongated *labia minora* and 65% actively engaged in this practice at the time. A smaller proportion of women took products to affect the condition of their vaginas (39%) and had excised or incised "impurities" in the perineal area (25%). In order to treat infections and prepare for the sexual act, 10% of women fogged and steamed their vaginas (Martin Hilber et al., 2011). The paper develops the motives, the products used, the frequency and the effects (desired or otherwise) presented by women during the ethnographic research.

Although some of these practices in Tete province have been documented by this study, (Bagnol and Mariano, 2008a, 2008b, 2009a, 2009b; Mariano and Bagnol, 2009; Martin Hilber et al., 2010b, 2011) their prevalence in other parts of the country is unknown.

2. Mozambique and Tete: description and socio-demographic profile

Following the country's independence in 1975 after ten years of armed national liberation struggle against Portuguese colonialism, from 1981 to 1992 the country faced another war that led to the death of over a million people, forced one and a half million people to seek refuge outside the country and displaced some four million people within the country. Due to this war and various natural disasters Mozambique's social infrastructure was destroyed, especially the health network, and it became one of the poorest countries in the world. Following the signing of peace agreement in 1992 and general multi-party elections in 1994, there has been substantial progress in consolidating democracy and fighting poverty.

Village in Changara District

2.1 Socio-demographic profile of Mozambique

Mozambique has an area of 799,380 km2 and 20,579,265 inhabitants. The urban population accounts for 30% of the total, the masculinity rate is 93 (Instituto Nacional de Estatística (INE, 2010), 44% of the country's population are children under 15 years of age and 53% are between 15 and 64 years of age (INE, 2002).

In recent years primary school enrolment has grown from less than half to two thirds of school-age children with the largest expansion in rural areas, although there is still a big difference between rural and urban areas. Only 39% of the population has access to potable water (Governo de Moçambique, 2004).

The health of the Mozambican population in general is precarious. This is due to economic and social factors and the limited assistance provided by the weak health network, with an average one health unit for 15,000 inhabitants (INE, 2004). Only half the population has access to health care provided by the National

A woman washes clothes in the Zambezi River, near the City of Tete

Nyao dance
(Changara district seat)

Health Service and 70% take over an hour to reach the nearest health unit. This is detrimental for women and children in particular in situations of endemic diseases, childbirth and postnatal assistance (INE, 2002). Some people in rural areas have to walk more than 30 km to reach a health unit that often does not provide the appropriate and desired service because it is poorly equipped and its staff do not have the appropriate training to deal with even common diseases (Ministério da Saúde, MISAU, 2004).

The country's global fertility rate (GFR) is 5.5 children per woman: 6.1 in rural areas and 4.4 in urban areas. The infant mortality rate (IMR) is 124 per thousand children under one year of age, while the under-five mortality rate (U5MR) is 178 (MISAU, 2004). The population's nutritional status as demonstrated by low birthweight, fell from 9% to 7% over the 1999/2003 period. The stunting rate also fell from 12% to 10% over the same period (Governo de Moçambique, 2004).

In 2000-2001, 75% of pregnant women received antenatal assistance: 69% in rural areas and 92% in urban areas (MISAU, 2002). Some 85% of women who had access to this assistance had three or more consultations and around 71% were vaccinated against tetanus. Only 40% of the women interviewed knew what kind of vaccine they had received. Only 49% of women gave birth in a health institution. The same document states that 60% of births by adolescents aged between 12 and 14 years took place at home. The country's central and northern provinces had the lowest percentages of births in a health institution: Zambézia (28%), Cabo Delgado (29%) and Nampula (35%) (MISAU, 2002).

The main features of Mozambique's epidemiological situation are transmissible infectious and parasitic diseases; cases of HIV/AIDS are rising constantly and malaria has substantial weight.

According to INE data on 2000-2001, 46% of the population had had malaria and 2.4% suffered from tuberculosis. In 1997 tuberculosis was the main reason for hospital admissions in the country's rural hospitals (MISAU, 2001).

The prevalence of HIV/AIDS among adults aged between 15 and 49 years is 11.5% (13% in women and 9% in men). Prevalence is higher among people living in urban (16%) than in rural (9%) areas (MISAU, 2010:11).

2.2 Socio-demographic profile of Tete province

Tete province lies in Mozambique's central region and covers an area of 100,724 km2. To the North it shares a border with the Republics of Malawi and Zambia; to the South with the Republic of Zimbabwe and the provinces of Manica and Sofala; to the West with the Republics of Zambia and Zimbabwe and to the East with the Republic of Malawi and Zambézia province.

Tete province comprises 13 districts, including Tete town, and these are further subdivided into 33 administrative posts with 102 localities. Two district capitals and the provincial capital have municipality status: Tete, Songo and Moatize. The River Zambezi divides Tete province into two agro-climatic regions: North of the River Zambezi, comprising the districts of Zumbo, Marávia, Chifunde, Macanga, Angónia, Tsangano, Chiúta, Moatize and Mutarara and South of the River Zambezi, comprising the districts of Mágoè, Cahora-Bassa, Changara and Tete town (Governo Provincial de Tete, 2005: 2).

The province has 1 489 843 inhabitants: 48% are under 15 years of age and 49% are adults (Governo da Província de Tete , 2005: 8). The female population is in the majority, with roughly 52%.

Approximately 87% of people live in rural areas. Tete is considered one of the country's poorest provinces with 82% of its population living below the poverty line (Governo da Província de Tete, 2005: 8). In the areas where this study took place most people obtain their water from the River Zambezi and only Tete tow has electricity.

TABLE 1

DEMOGRAPHIC CHARACTERISTICS OF TETE PROVINCE	
Population density (inhab/km2)	13
Gross birth rate (per thousand)	47.1
Gross mortality rate (per thousand)	20.5
Infant mortality rate (per thousand)	127.4
Global rural fertility rate	6.8
Global urban fertility rate	6
Life expectancy (years)	42.8
Low weight at birth (%)	31.2
Masculinity rate (%)	93

Source: Governo da Província de Tete, 2005

Tete has a variety of ethno-linguistic groups most people have Cinyanja (46.5%) as their mother tongue, followed by Cinyungwe (27.5%) and Cisena (11.4%)(INE, 2007). It should be noted that the Cinyungwe and Cisena have a patrilineal system where transmission rights, succession and inheritance rights pass through the male line.

TABLE2

SOCIO-ECONOMIC CHARACTERISTICS OF TETE PROVINCE	
Inhabitants per household	4.2
Rural	4.5
Urban	4
Illiteracy rate (%)	67
Women	81
Men	50
Economically active population (%)	68
Women	65
Men	72
Access to health services (%)	11
Access to potable piped water (%)	4

Most of the province's population hold traditional beliefs in the form of ancestor worship, and the remainder profess religious faiths: around two fifth of the population say they have no religion, one fifth is Catholic, less than one fifth belong to the Zion church, one tenth are Protestant/Evangelical, and the remaining are Jehovah's Witnesses and Muslims (Instituto Nacional de Estatística, 2007).

Exogamous marriage is common as is polygny, especially in rural areas. Data on the population over 12 years of age show that 31% are single, 16.6% are married, 43.8% live in a marital union, 3.3% are separated and 3.3% widowed (Instituto Nacional de Investigação, 2007; Gujral et al. (2004:37) state that 24.7% of men have more than one wife.

Tete province has an adult HIV/AIDS prevalence rate of 7% (MISAU, 2010:7). Recent studies on STI in the province mention plants being inserted in the vagina "to reduce lubrication and increase friction" (Mohamed et al., n.a.: 27). Although there is no evidence of a correlation between specific vaginal practices and STI, the existence of both in high STI prevalence areas warrants further investigation.

The research assistant interviews a woman (Village of Chipembere, Changara District)

3.Research methodology

This study was approved by the Mozambican National Bioethics for Health Committee through Note Ref:i6i/CNBS/io of 14 May 2010 and by the WHO Ethics Committee.

3.1 Data collection techniques

A variety of data collection techniques were used to gather information: literature review and analysis of national, regional and international documents, semi-structured interviews, focus groups, individual interviews and in-depth interviews with key informants.

The literature review and analysis covered studies on ethnographic and medical aspects in Mozambique and elsewhere i.e. countries in Africa and Asia. Despite access to a lot of documentation there were few studies directly related to the spe-

cific situation of Tete province or Mozambique.

Interviews were based on guides adapted from documents contained in the WHO international protocol. There were three interview guides: for key informant interviews, in-depth interviews and focus groups. The guides started with general questions and then moved on to more specific ones that focused on the research objectives. In order to ensure that the original content was fully respected, the three guides were translated into Cinyungwe by the research assistants during their training. All interviews were translated and written up in their entirety.

3.2 Training research assistants and the pilot study

The research team comprised two researchers and three research assistants (two women and one man) with experience in qualitative research on socio-cultural aspects of the human condition. The research assistants came from the Research Unit of the Institute for Social Communication and the Tete Provincial Directorate of Health.

Training the assistants and pre-testing the research instruments ran from 25 to 30 July 2005. During the course participants discussed the content of the guides to ensure cognitive uniformity among the team members. The interviewers were trained in research methodology and told to ensure secrecy and confidentiality and respect the comments, values, beliefs, decisions and options of respondents. Training covered the following subjects: qualitative survey methodology, gender relations, sexuality, local significance and definition of sexual pleasure and satisfaction, and the identification and classification of the vaginal and sexual practices known to the team. In practical terms, training was a continuous process from the moment it started up to the conclusion of the interviews. In addition to daily discussions the team had weekly meetings to summarise and discuss the interviews, systematise the data and thus update the research methodology.

A pilot study was conducted in M'padwe neighbourhood in Tete town to test the three interview guides. The pilot study also served to familiarise the assistants with the fieldwork routine and to identify possible difficulties in translating and transcribing the taped interviews. It was found that the methodology was valid for the study's objectives in that it enabled highly reliable, qualitative information to be gathered in an agreeable respondent-researcher environment.

3.3 Fieldwork and interviews

Fieldwork ran from 1 August to 20 September 2005 in the two administrative areas selected (Tete town and Changara district) and took place in collaboration with the local authorities (District Administrator, community leaders, neighbourhood secretaries, OMM, and the District Directorate of Health).

Local leaders in the various study locations were focal points for:

- Identifying where to set up the team's camp in Chipembere and Changara town;
- Presenting and introducing the team to key people in the community;
- Reconnaissance in the district capital and some villages, with the support of local authorities;
- Explaining the research process to community leaders and traditional healers and requesting their assistance in identifying and selecting the people to be interviewed;
- Setting up interviews and finding somewhere to meet.

Local leaders were usually the first to be interviewed in order to familiarise them with the research content and to get their help in identifying informants. The interviews were held in places - usually the respondents' homes - that guaranteed a private, confidential and calm environment and ensured the most privacy. Sometimes they took place in public spaces chosen for this purpose. Some individual interviews took place in a location close to the research team's camp where informants went to guarantee privacy and confidentiality.

Two members of the research team were present during the interviews. The interviews were always conducted by the researchers themselves, in some cases directly in Portuguese or with an assistant of the same sex as the respondents to facilitate communication.

Symbolism was used to explore aspects that related sexuality to the material culture and gender roles. For example: a mortar and pestle was associated with sexual intercourse, a clay pot was associated with the uterus, the vagina with the house. Pictures in a book and/or a laptop showing the vagina or the elongated *labia* were used to stimulated discussions with individuals or groups of men and of women. Samples of plants or roots also served as basic instruments for discussing and analysing vaginal products.

The acquisition of "love and sex" medicines sold in Kwachena market in Tete town

permitted discussions about vaginal products and their classification. There was also direct observation of customers and the kind of products being sold.

The researchers used participatory observation to understand and analyse a number of vaginal practices. Sometimes they played the role of "sexual initiates" and the respondents, experienced women, acted as traditional birth attendants or godmothers. This method produced greater interaction between researchers and respondents, creating a climate of confidentiality and heightened interest in transferring knowledge, recreating situations known to the respondents and putting them at ease. The researchers attended medical consultations and heard the explanations provided by nurses, gynaecology and obstetrics specialists in order to understand the perceptions of health personnel. The activities of some traditional healers were also observed to identify the kind of customer and classify the vaginal products used for sexual preparation, attraction and eroticism, childbirth, abortion and the treatment of STIs.

3.4 The sample

The study took place in four locations in Tete province, in the capital of the same name and Changara district. Tete and Changara were selected because they lie along an important transport corridor between the town of Beira, Malawi and Zimbabwe that has a high prevalence of HIV/AIDS. In Tete town an urban neighbourhood (Filipe Samuel Magaia) and a semi-urban area (M'padue) were selected. Two locations in Changara district were also selected (district capital and Chipembere, a very isolated rural area far from the main road).

TABLE 3

INTERVIEWS	NUMBER
Key informant interviews	20
In-depth interviews	18
Focus groups	7
Reference groups	4

One hundred and three people participated in the study: 25 men and 78 women. The key informants were men and women, community leaders, neighbourhood secretaries, traditional birth attendant, potters, nurses and gynaecologists. In a

Josefa, a traditional healer (Tete City, Filipe Samuel Magaia neighbourhood)
Basket with various products in the her house
Medicines (*mankwala*) in her house

first phase, community leaders, neighbourhood secretaries, OMM women and staff in the District Directorate of Health were chosen as key informants. Using the snowball technique they then invited other people who fit the researchers' criteria (age, sex, knowledge and experience of vaginal practices).

There were in-depth interviews with people selling vaginal products, sex workers, potters, women with children and traditional healers of both sexes. The discussion groups usually contained from 5 to 9 people and were homogeneous in terms of professional category and sex. Respondents in general had the following characteristics:

- Adult men aged between 18 and 70, peasants, married with children;
- Adult women aged between 18 and 70, peasants, married with children;
- Girls aged between 18 and 20, secondary school pupils, single, no children;
- Young men aged between 18 and 20, secondary school pupils, single, no children;
- Traditional birth attendant or other women who provide treatment or advice during these practices, aged between 30 and 70, widows and married with children;
- Sex workers aged between 18 and 30, single and with children;
- Community leaders and neighbourhood secretaries, aged between 30 and 72, married with children;
- Traditional healers, men and women aged between 30 and 45, single and married with children;
- Male and female nurses aged between 25 and 45, married with children;
- Doctors and gynaecologists of both sexes aged between 40 and 60, divorced and single, with children.

3.5 Informed consent

Before the interviews took place the researcher explained the objective of the study and requested permission to tape the conversation. The presentation of the team, the study objectives and reading the consent form in Cinyungwe and Portuguese took on average 20 to 30 minutes.

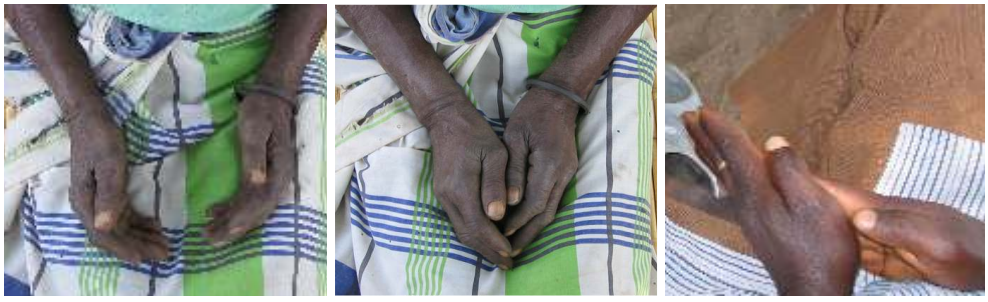
The consent form was usually read one or more days prior to the interview. This enabled the participants to prepare themselves and get to know the objectives of the study. It also enabled the women to choose the most appropriate place and time for them to speak freely, with privacy and confidentiality. However, some

interviews took place immediately following the reading of the consent form, mainly in the case of people who spoke Portuguese and participants with a certain level of education (nurses, students and doctors).

Sometimes respondents did not turn up for the interview on the agreed day because they forgot or because they were busy with other activities. Some people didn't understand the consent statement because it contained technical terms.

Except for one person who refused, all consent statements and interviews were taped with the prior written authorisation of the participants. In order to organise the data, each tape contained the date, place and interview code. Transcriptions did not mention the name, only the code number and personal data (age, sex, marital status, whether a polygamous marriage or not, number of children and other demographic characteristics). An additional five people, not part of the initial research team, were hired to translate the tapes and transcribe them in writing. Data analysis was done manually; only relevant aspects were typed up.

The entire population, women in particular, expressed their interest and willingness to participate in the study. Most were willing to discuss frankly intimate aspects of sexuality. In many instances the women wanted to demonstrate the kinds of manipulation or practices that exist and proved to be extremely candid when explaining the products and showing the plants or potions they use. Many shared information on the sexual education they had received such as movements, positions, massage, how to treat and speak to a partner. However, the initial reaction of the OMM group of women was to refuse any discussion linked to sexuality because these were women's secrets and also because they thought they should receive compensation for communicating their knowledge and experience.



Gestural communication. A woman explains that when the vagina isn't treated, it stays open, air comes in and the body becomes light. The vagina is closed when it is treated with the medicines (*mankwala*). The closed vagina creates a favourable situation for friction at the time of penetration

The interviews lasted between 45 minutes and three and a half hours. Some were spread over various meetings, usually in the case of in-depth interviews and especially when monitoring traditional healers. Women selling vaginal products in Kwachena market, who are at the same time are also traditional healers, Mozambicans and Zimbabweans, participated in the whole research programme.

As a token of appreciation, all study participants received soap and biscuits. Participants who lived in distant localities received money for transport or travelled in the research team's car.

3. 6. Fieldwork constraints

The team's work environment was positive, of crucial importance for obtaining a vast amount of detailed information. In almost every case there was an atmosphere of familiarity and intimacy between interviewers and respondents and this was an important and necessary factor for detailed discussions and for clarifying some of the discussion topics.

Sometimes the opinions of various informants, including health staff, differed. Direct observation was required to overcome this impasse. As the research protocol did not include clinical observation and taking photographs this was a major limitation on obtaining more detailed information on some aspects. In addition, the absence of a digital camera meant that, even during interviews, it was not possible to take photographs to help identify products (roots, plants etc) that could then be shown to other informants in order to confirm and complete information more quickly. The collection of gestures complemented, integrated and reinforced verbal language. However, although it was found that body language is a valid instrument and an analytical document for ethnographic research, it could not be explored completely for ethical reasons. The absence of a digital recorder was also a disadvantage when discussions were in Portuguese and when the team or researchers exchanged ideas. This equipment would have enabled discussions to be stored immediately in electronic files in computers for later use as elements in the analysis.

The main language of communication was Cinyungwe. However, many informants spoke other languages (Cinyanja, Cisena, and Portuguese). The language issue and understanding the language used were problematical because the cultural diversity in a discussion group sometimes limited the Cinyungwe-speaking translator's comprehension of the whole. The absence of a linguistics specialist to analyse basic concepts and interpret signs and symbols was a disadvantage.

CHAPTER II

PRESENTATION OF THE RESULTS

From an anthropological perspective the body, sexuality, eroticism and health are not natural objects but rather historical products i.e. cultural constructions that vary according to socio-cultural contexts. Consequently, even the most obvious "data" such as a person's natural sexual characteristics are shaped by social practices and cultural meanings. Ethnographic and historical research and studies by second generation feminist researchers have shown that there are many different notions of sexuality, ways of being or of feeling as a man or a woman and of incorporating social values.

Not all human cultures have developed an abstract notion to define the body as an individual, biological entity, and the basic concept of health and illness can vary. Anthropology is aware of this and adopts a critical methodology of the cultural, political and historical type. It contextualises perceptive processes and the way the relationship between the body and the world is understood and contributes to reflections on the experience of living in a society. This is the context and these are the assumptions underlying the fieldwork and the results presented here.

1. Constructing gender and concepts of sexuality and health

Speaking about sexuality is intellectually challenging because it requires reflection on an area where thought and life intersect in a complex correlation. It is also an area that arouses heated debates on the dichotomies of nature and culture. The body, sexuality, health and disease can be regarded as conceptual machines that attempt to capture real-life experience in an abstract definition or representation.

Over the last few centuries studies and notions of sexuality have evolved from an essentially religious concept to more of a medicalised one (Foucault, 1994). These ideas had a profound influence on the way sexuality was studied and contemplated, and contributed in particular to questioning what "normal" sexual behaviour was and what was a disease. For a long time masturbation and homosexuality were considered a disease or deviant behaviour. In recent decades, with feminist, gay, lesbian and postcolonial studies, sexuality concepts have evolved, producing other ways of interpreting and analysing sexuality and "liberating" sexuality from religion, medicine and the colonialist vision. Through their experience of homoerotic attraction authors of both sexes have shown how earlier analyses were based on the assumption that heterosexuality is universal. Post-colonial authors of both

sexes exposed the ethnocentric view and the male bias in many of the ways that the unfamiliar behaviour of "others" was viewed and understood. Perceptions of the body, health and disease are concepts that act symbolically and physically on living bodies and are thus inseparable from social and cultural fields and the historical forces that are actively engaged in defining them.

Sexuality is not just the sexual act itself because the entire socialisation process from birth to death and the various influences that affect individuals determine their sexuality. Family, friends and neighbours as well as institutions determine and control not only how sexuality is perceived, but also how this happens and the role of each actor involved. The Catholic Church is one of the institutions that has had, and tries to have, the greatest interest in and control over sexuality (forbidding masturbation, contraceptives for birth control, condoms to prevent HIV/AIDS, abortion, divorce and homosexuality).

In the society studied in Tete province, after a woman reaches menopause she no longer has sexual intercourse because it is feared that disease and death will arise from the sperm accumulated in her abdomen when it is no longer being ejected by menstruation. This shows how ideas about sexuality are inter-connected with ideas about health and the extent to which they are specific to this context.

Notions about the body (odour, hygiene, aesthetics etc), erotic desire, love, sexual practices and ideas about health vary from place to place according to a variety of factors that include social class, ethnic group, religious belief, sex and age. Historians have shown that these ideas evolve over time and are intrinsically linked to political, social and cultural transformations. For example, homophobic societies shape the behaviour of people through homo-erotic attraction. Belonging to a religious group can ban the use of a condom or cause sexual practices that are considered inappropriate to be abandoned. In Western society notions of the beauty and health of a woman's body tend to emphasise a slender figure whereas in some parts of Africa a stout body is often desired in order to comply with aesthetic and health standards. Another example, this time linked to State policies, can be found in China where birth control policies limit the number of children to one per couple and thus dictate the reproduction rules between partners. Body, desire, love, sexuality, health, relations between men and women are thus social constructs that have evolved, are evolving and will continue to evolve. Institutions and the people with whom individuals interact define how they think about their sexuality, how they express it and with whom they have sex.

This means that in order to understand and analyse the sexuality of different human groups we have to try and understand certain concepts in the contexts in which these groups live and that determine individual standards of behaviour. We must also understand the power relations between them because these determine sexual options, desires, sexual pleasure and the possibility of negotiating them with partners (Parker and Gagnon, 1995:15).

1.1 Constructing gender

According to the standard definition "Gender is a constitutive element of social relationships based on perceived differences between the sexes and gender is a primary way of signifying relationships of power" (Scott, 1989: 28-50) or it is the term used to "describe the set of qualities and behaviours of men and women that are expected by their societies" (Menon-Sen, 1998). The power relations that embody gender relations are fundamental for understanding and analysing sexual relations and all practices relating to them.

Socialisation: a female child plays at carrying another child on her back

1.1.1 Socio-economic differences between men and women produce different kinds of sexual behaviour

Men and women do not always have an equal and equitable relationship when they negotiate or initiate a sexual relationship. A wide variety of interconnected factors establish hierarchical power relations between men and women, usually unfavourable

to the latter, that influence the sexual behaviour of both. As a woman is frequently in a less favourable economic and social position than her male partner she does not always have the same possibility of negotiating the sexual relationship or rejecting it.

As they have less access to all kinds of resources women, especially young women, are placed in an inferior social and economic power situation in society and individually within the family and the couple. The reasons for these inequalities stem from ideological, symbolic, legal and practical aspects and mean that women have less access than men to education, land ownership and employment, among other aspects.

Cultural and social values assign different sexual roles to men and women. They define the type of sexual relationship, its frequency, the type of partners and on the whole give men more freedom, initiative and possibility of varying their partners than women. It is often through seduction and by keeping the man in the home that women obtain some form of sustenance. However, governed by the same cultural matrix, the complementary aspect is that the man is often socially obliged to have various sexual partners who also receive some kind of support when he has a sexual relationship with them. His virility and sexual prowess are a source of concern and result in numerous practices that will be discussed later.

1.1.2 Being a man and becoming a woman

Children of both sexes in Tete learn very early how to behave as men and women and go on building their belonging to the male or female gender. Learning to feel that you belong to one or another gender is a long process that begins at birth and continues during sexual socialisation. Gender identity is built on the relationships that each person establishes with his/her family and society. Added to this is a growing awareness of their own bodies. A person's anatomy is important for the development of this "feeling of belonging" to the male or female gender, but by itself is insufficient. In the areas studied in Tete province, a girl only becomes a woman when her body is transformed by lengthening the *labia minora*. The women and men interviewed, of all ages, agreed that this process is essential in order to become a woman. One traditional birth attendant in M'padwe neighbourhood on the outskirts of Tete town explains:

> *This is what we do. When the girl's breasts start to grow, we look for a godmother to teach her how to do* puxa-puxa *(pull-pull to lengthen the*

> *labia) because a female child cannot avoid doing it. It's good for her. You're a woman so you can't remain the same as when you were born (…). It's good to do it because you're a woman. We women, what do we have? We have a hole! It can't stay like that - just a hole! It must have that (lengthened labia) to close the hole. (MPD3-p. 1-2, Traditional birth attendant, widow, 60 years of age, M'padwe, August 2005).*

This means that the biological body must be transformed to correspond to the social body of the female gender. One group of women interviewed reported what a man would say if he found a woman without elongated *labia*:

> *We do this (lengthening the labia) so that we can give pleasure in our home, to show that we're rich, we're rich. (…) For a woman it's also life. (When she is praised she is convinced that there is also wealth in her body). There are other women, our daughters, who remain the same as when they were born and do not stretch their labia. When they are at home their husbands say: "What can you give me? Just a hole! Did your mother only know how to cook maize meal for you? Didn't she have anything else to do? Is eating all you know? You're not even alive!" Then when the man meets a woman with lengthened labia he says: "You've got life" and the woman feels at ease because she has life. But when a woman doesn't do it the man makes fun of her: "What have you got? Just a hole!" They say she only has a hole because she doesn't have* labia minora*. (…) Men take hold of it and press against it in order to insert their sex organ. (…) Men prefer life. (…) It arouses a man when they lie down on the mat to do it." (CHI9- p. 4, Focus group of traditional birth attendants , widows, wives of polygamists - Chipembere, August 2005).*

Associating the *labia minora* with life - sexual life, reproductive life, a woman's individual, psychological and sexual health - shows the importance of lengthening the *labia* if she is to "to be and to feel like a woman". So when they say that a woman "has life" or is "rich", they are alluding to the potential of the sexual process, taking into account reproduction. The process used and the various motivations linked to the practice will be analysed later.

In contrast, a boy does not modify his body in any way in order to become a man; hence expressions such as "being" a man and "becoming" a woman. In the locations studied there was no male circumcision or any formal rites of passage to adulthood[4]. Only a girl must submit herself to a transformation that is perma-

nently inscribed on her body in order to respond to local cultural criteria of femininity.

The "natural" body of a female child in Tete must be transformed in order for her to become a woman. This situation recalls Simone de Beauvoir's statement in her book "The Second Sex": "One is not born a woman, one becomes a woman". With this statement the author summarised the notion that the feminine is defined in the light of to the male norm, where the body of the man and being a man is presented as the universal being. Similarly, according to Judith Butler (2005) gender must be understood as "the instrument for production and the establishment of the sexes themselves.

Consequently, gender is not the outcome of culture, and sex is not the outcome of nature. Gender is also the set of discursive/cultural means whereby a 'sexual nature' or 'natural sex' are produced and established within a 'prediscursive' framework that precedes culture, like a politically neutral surface over which culture intervenes later" (Butler, 2005:69). So in Tete, this "naturalisation" (to use Butler's term) of a woman's biological body into a female being occurs when the girl is about 8/10 years of age. By transforming her body the girl develops intimate knowledge of her sexuality together with other women of various ages, but essentially with other young girls of her own age.

> *They pull each other so that it will not hurt, among friends, one in front of the other. And they pull each other at the same time for 30 minutes. They do it every day. They pull each other when they are young, only those who are not married. (Mother and Child Health nurse, Tete Provincial Hospital - September 2005).*

So although learning is guided by an older woman who demonstrates how to pull the girl's *labia*, it is subsequently done by girls of the same age who continue the practice for months. It is however, interesting to note that in this process of officially becoming a woman in order to have sex with a man and learning heterosexual norms, a girl is initiated into masturbation and homoerotic attraction.

> *When girls or women do pull-pull they experience sexual pleasure (...) when they are grown up. It's also fun and she can masturbate alone when*

[4] Nevertheless, some practices involving lengthening a man's penis have been identified in Tete but they are not related to any kind of rite of passage to adulthood, nor are they coercive as are the vaginal practices carried out by women.

there is no man by her side. When she is a little girl she doesn't know anything, so she doesn't feel any pleasure (...) When she is about 15 years old and starts to do it, she feels pleasure. (CH13, Potter, about 45 years old, Chipembere, August 2005).

When the other girl pulls you feel aroused (sexually) (...) when you pull a lot it makes you feel good (...) the finger also works when you're alone. (CH16 - p. 20, Midwife, married, 3 children, Chipembere, August 2005).

As the respondents point out, pull-pull enables them to develop homoerotic attraction that can either be limited to childhood or adolescence, can continue throughout their lives, or can be an occasional experience (Bagnol, 1996). So at the same time that they are taking on a gender identity another, entirely different, process is at work that should not be confused with it, that of seeking an affective-sexual identity and the performance of an affective-sexual role. The affective-sexual orientation is the ability to choose the person you will love or with whom you will have a sexual relationship, whether of the same sex or not. This orientation can be fundamental or circumstantial and is not always clear in the adolescent phase. Even when adults, people can "be permanently" heterosexual, "be occasionally" heterosexual, "be permanently" homosexual or "be occasionally" homosexual, depending on the period in her life, the psychological moment or the social circumstances. Not everyone that you choose to love will be the person with whom you make love.

It is interesting that when women masturbate each other or have sexual pleasure together during their preparation it is often not considered as such or talked about. This situation warrants more specific study. But we can put forward the hypothesis that as these forms of pleasure between women do not involve penetration they are not considered to be part of their sexuality. Is the fact that women pull their *labia minora* an expression of their subordination and of their being conditioned to satisfy the sexual pleasures of men? Does a woman express a form of power in this process? How is female, homoerotic pleasure linked to the heterosexual norm? These are questions that could/should be addressed after more profound research.

In her article "Facts of Life or the Eroticization of Women's Oppression? Sexology and the Social Construction of Heterosexuality" Margaret Jackson shows how, until the advent of feminist criticism, sexologists - most of whom were men - legitimised myths about sexuality. The first myth to receive pseudo-scientific support was that men have an extremely strong and uncontrollable sexuality that justifies

violence and sexual abuse. The second myth supported by the literature is that women must be taught how to serve men sexually (Jackson, 1987:70). The author explains that when a woman is taught to behave sexually with a man, the penis is considered crucial for female pleasure and this imposes the heterosexuality norm. These myths affirm a social relationship system where the supremacy of the penis and heterosexuality become natural, and male domination and female subordination are institutionalised and sexualised.

The situation encountered in the study area is rather complex because through her apparent preparation for heterosexuality a woman discovers various forms of sexual satisfaction including masturbation and homoeroticism. The apparent preparation for heterosexuality includes an undeclared and unacknowledged preparation for other forms of pleasure. Could it be that, as presented in discourse, this suppression of all tendencies that are not strictly heterosexual is a recent phenomenon arising from religious influence in the region? More in-depth research on the evolution of sexuality there and discourse on this subject is required for a better understanding of whether there has been a move from the supremacy of the vagina to a more complex situation where the penis gradually occupies greater symbolic space and determines sexual and social power relations.

1.2 Concepts of sexuality and sexual and reproductive health

Notions of closed/open, wet/dry, cold/hot, light/heavy, skin together/skin apart are important for understanding phenomena linked to sexuality and reproductive health in the context of this study (Bagnol and Mariano, 2008a, 2009b). Sexuality is linked to the possibility of procreation and to notions of pleasure for both partners. In this sense, the aim of all practices related to sexuality or sexual health is to prepare for sexual relations.

The notion of health is understood in a broad sense that includes both the absence of illness and discomfort and also happiness in the home and the family's well-being. "Well being", "feeling good", "feeling strong", are recurring expressions in women's discourse when they talk about how they feel when they use *mankwala* ya *kubvalira*. The women interviewed also said that when they do not have the "treatment", their bodies remain "light", "without strength". This shows how the notion of health is linked to a practice that is rooted in a specific understanding of the body, a specific way of feeling about herself and feeling her body, as one of the respondents explained:

> *(A woman who uses* kubvalira*) feels that she is heavy. And in fact she really is heavy. She feels that she's a person. (…) She feels this way because when she walks, even if she is not going to have sex, she feels that she is heavy (…). Feeling heavy refers to joining with her husband. He feels good and so does she. After a short while they want to join together again. (MPD6-p. 7-8, traditional healer, M'padwe August 2005).*

According to respondents, certain conditions are required in order to conceive a child. There must be a certain amount of moisture, the retention of the woman's and the man's liquids, and also some heat in order to do the "cooking" that will lead to conception. A woman's reproductive organs are compared to a covered cooking pot. The vagina's *labia* are the wood that feeds the fire that permits the "cooking".

The metaphors linked to sexuality and reproduction refer essentially to the preparation of food and nourishment. Sexuality is often compared to the act of eating. When a person eats her belly is full. Similarly, when a woman becomes pregnant her belly is full. These metaphors are common in Southern Africa and have been documented in various studies (Gregory, 1982; Biesele, 1993; Bagnol, 1997; Feliciano, 1998; Moore, 1999; Mariano, 1998, 2001).

2. The various practices

Vaginal practices comprise a wide variety of cuts, surgery or any other kind of intervention to modify the vagina. They also include the use of many different traditional and modern products to dry, tighten, lubricate and cleanse the vagina.

TABLE 4

SUMMARY OF THE CHARACTERISTICS OF VAGINAL PRACTICES

Pratice	Current prevalence*	Reason	Who do it	Frequency
Lengthening the vaginal *labia*	65.1%	- to prepare for sexual intercourse - to become and to feel like a woman - to satisfy her sexual partner - to stimulate erection and hold on to her partner - for sexual satisfaction and to feel good - for the body to have weight and strength - to close the vaginal orifice - to make the body beautiful - to keep the vagina hot - to squeeze the sexual partner's penis	All women from 8/12 years of age	During childhood and for maintenance following childbirth
External cleansing of the vagina	63.1%	- hygiene	All women	Very often, daily
Cleansing inside the vagina	91.7%	- hygiene - so that a woman feels good, pretty and "prepared"	All women	Very often, daily
Cutting the pubic hair	Not available	- to maintain hygiene - erotic games between partners - to increase friction during the sexual act	Most women	Weekly
Excision and incision in the perineal area	24.7% (done in the past)	- treatment for infidelity or the death of a child	Women with infertility problems and when a child dies	Average and regular, daily or weekly
Insertion and use of vaginal products	60,2%	- to tighten the vagina before and after sexual intercourse and after childbirth - to dry and heat the vagina - to reduce/diminish the vaginal orifice - so the penis does not come out during the - sexual intercourse - to treat *masale* and STIs	Women of fertile age. They interrupt in the third month of pregnancy until after childbirth	Irregular to regular, daily or weekly
Ingesting potions	38. 8%	- to tighten - to have a hot body - to have and/or increase sexual desire - to open the cervix and facilitate childbirth		
Inserting cassava sticks into the vagina	Not available	- to cause an abortion childbirth	Pregnant women	Rare
Steaming/ fogging	10.0%	- to lengthen the *labia*	Women who want longer *labia*	Rare

*(Martin Hilber et al., 2011)

2.1 Overview of the various practices

The current prevalence of vaginal practices (Martin Hilber et al., 2011) and women's reasons are presented in the table below that is followed by detailed information on them.

2.1.1 Elongation of the vagina's *labia minora*

Known locally as *kukhuna, kupfuwa* or *puxa-puxa* (pull-pull), as explained above stretching the *labia minora* is a common practice among women in Tete province. Lengthening the *labia minora* is part of their initiation into female sexuality, a practice directly linked to a woman's sexual activity. It is an integral part of how she perceives her body, the significance of being a woman and what constitutes a satisfactory sexual relationship for a man and for a woman. It is the preliminary instruction activity for sexuality and marriage, guided by older women called godmothers who are usually chosen by the adolescent's mother or aunts. They are paid for their teaching and for monitoring how elongation is proceeding.

As soon as a young girl's breasts start to grow her godmother teaches her that in order to "be" and to "feel as a woman" she must lengthen her *matingi* (*labia minora*). She is taught that the *matingi* is "the man's toy" and that if he cannot find it she will not be able to hold on to him. At first the godmother shows how to lengthen them, pulling the girl's *matingi*, then later the girl does it herself. The godmother monitors the girl in order to ensure that she is doing it correctly. The *labia* are massaged and stretched from top to bottom with the tips of the thumb and the index finger of each hand. An oily substance extracted from the nut of the castor plant called *nsatsi*[5] is used, or the fruit of the *nthengeni*[6] that grows locally and can be bought in markets or from traditional healers, already prepared or not. The nut is burnt and pounded to extract the oil used in lengthening the *labia*. Sometimes the oil is mixed with a type of rubber (the kind used to make catapults) chewing gum or burnt bats' wings ground to a powder. Nowadays women use Johnson's baby oil and Vaseline bought in shops or even cooking oil. Chewing gum or bats' wings are used to prepare oil to lengthen the *labia* because both are elastic,

[5] *Nsatsi* is a fruit with a seed that produces medicinal oil (castor oil). Women apply it both externally and also inside the vagina.

[6] A plant that produces a fruit of the same name. Its seed is used to produce oil to lubricate the vagina, pull the *labia* and lengthen the clitoris. It is much sought after by women as it has a wide variety of functions.

Nthengeni (sour plum/*Ximenia Caffra Sond*) fruit. The various grains symbolise the fertility desired by the women. The seeds are used in the preparation of the oil for elongating the labia minora.
Powder used to insert into the vagina. Grains of sour plum and castor-oil plant, ground in small two clay containers (*mbale)* to prepare the oil for elongating the labia minora

the characteristic to be achieved through elongation - the elasticity of the *labia*. The process can last various months until the ideal size has been achieved, which varies from woman to woman. The godmother monitors the elongation of the girl's *labia* and decides when it should end.

Elongation of the *labia minora* is linked to the basic notion of femininity. The main reason for lengthening the *labia* is so that the *matingi* close the vaginal orifice that has been naturally open since birth, and is also opened by regular coitus and after childbirth. However, it is also a fundamental element in preparing for coitus and foreplay by partners, helping to increase pleasure in the sexual relationship for both the man and the woman. Some of the statements by male and female respondents mention the purpose of lengthening the *labia*:

> *For some men it's a toy, (…) first he says let's play; he takes the dish (containing the castor oil), heats it and starts doing pull-pull. Then, when we are going to have sex, as he pulls it grows a few centimetres (…); the man pulls and when we are about to have sex he only holds it as a game (…) to arouse sex. (TET - p7. 8, traditional healer, Tete August 2005).*

> *(If a woman does not have long* labia*) she will not be able to hold on to her husband. In the old days that wasn't good. You must have pull-pull.... it's good (to have), because those men or boys, when you have your husband (…) because a man usually does not have just one woman and as his wife I can keep my husband for myself, but only to cook. But when he wants to*

> *play he has another woman. And there, with that woman, he finds those long labia (…) and when he comes back to you he will only find a hole! No long* labia*! In the old days that wasn't good. But today it's no longer a problem. (MPD3 - p. 12, widowed traditional birth attendant, 60 years old, M'padwe, August 2005).*

References to elongated *labia* often use the metaphor of the "door". Before having sex partners must open the "door"; "the man cannot enter just like that". These aspects are frequently mentioned to illustrate the importance of a woman being "closed", perhaps as a form of protection and as a possibility of "playing" (erotic games) before penetration.

2.1.2 Using products or medicines in the vagina

In addition to lengthening the *labia* in order to close the vaginal orifice that is considered "open" due to frequent coitus and following childbirth, women in Tete also use various products or medicines to close, tighten or reduce the vaginal canal.

> *A woman who lies with a man for the first time loses her virginity in the first encounter and after many times (sex) it becomes wide, expands, so she'll (…) look for medicine (…)* kubvalira *to try and reduce her vagina. When she wants to have sex she puts a bit of the medicine in her vagina and it shrinks so that she's like a virgin; that's what we call* kubvalira*. (CHA5 -p. 21, male focus group, Changara, September 2005).*

These products are called *mankwala ya kubvalira* meaning "remedy for women to be well, pretty, prepared". And in the particular context of this research, *kubvalira* was also referred to as meaning "inserting", "using, placing something, placing it inside". So when a woman has these products in her vagina she feels good and pretty.

The *mankwala ya kubvalira* are produced locally using dried, ground leaves, roots, tree bark and lemon. They are then placed in the vaginal orifice with the point of the finger, in underwear or within the vagina. Sexually active women of fertile age usually use mankwala ya *kubvalira*. Many use them following childbirth to close the vagina as quickly as possible so they can resume sexual relations with their partners. The notion of well-being is constantly repeated in women's discourse to describe how they feel when they use mankwala ya *kubvalira*. Respondents also said that if they do not have this "treatment" their body

becomes "light" and "weak"; it remains "open", with "water", with "air" and during the sexual act it makes a noise and is uncomfortable. This shows how the perception of health is rooted in a specific understanding of the body, or way of feeling themselves and their body.

The various explanations for using vaginal products include the association between virginity and a narrow vaginal orifice. They use these products to close the vagina and increase friction, to enhance abrasion during penetration and sexual intercourse, and also so that the penis does not come out during a sexual encounter. Many male and female respondents used the expression "to be like a virgin", the ideal condition for the most satisfactory sexual relationship. These products are also used to retain sperm in the vagina.

The *mankwala ya kubvalira* are usually provided by the woman's relatives (godmothers, aunts, grandmothers) or by male/female traditional healers. They can also be found in Kwachena market in Tete town and obtained from Zimbabwean or Mozambican hawkers in the street and in rural areas. They can also be prepared from vege-

The research assistant (left) and the researcher (centre) classify and collect the vaginal products sold in Kwachena market (Tete City)

tables at home by relatives, neighbours and users themselves. The locally produced mankwala are made of leaves, roots, dried bark ground into a powder and placed in underwear, on the surface of the vaginal orifice using the top of the finger, or inside the vagina.

There is also a kind of "vaginal ovule" made with natural substances similar to those mentioned above and mixed with egg to form little balls. Egg is used in the preparation of these products because it is closed and that is the expected outcome. Many treatments are based on this line of thinking: by manipulating the analogy the aim is to obtain the desired result (Feliciano, 1998: 297-323). The wide range of *mankwala ya kubvalira* also includes commercial products for domestic use such as Colgate toothpaste, Vicks ointment, salt, lemon, vinegar, tea and Dettol.

In recent years, more or less since 2001, new products have appeared that are considered "modern", "used by whites" or "by Zimbabweans". They come from Zimbabwe and are sold in markets and by hawkers. These mankwala ya *kubvalira*, that include stones and powder (copper sulphate and alum) are becoming very popular among women even though they are said to be harmful to users.

All the sexually active women we interviewed used mankwala ya *kubvalira*, although one respondent said that pregnant women do not use it after some months of gestation:

> *(…) When a woman knows she's pregnant she usually doesn't apply it because the door will become smaller. It will be difficult for the child to come out. (…) The pathway is closed. We use medicines to contract the body (vagina). If they continue to put these medicines when they're pregnant the vagina contracts and they'll have a difficult birth. (…) The path will be small. The baby will not come out easily (…). As soon as she's in the second, third or fourth month she must stop applying it. She can't insert it any more. But she continues to lie on the mat (to have sex) and only stops from the sixth month. (MPD3 , traditional birth attendant, 60 years of age, M'padwe, August 2005).*

After a child is born, even if she has not resumed sexual relations with her partner, a woman must resume the *mankwala ya kubvalira* treatment. She must use it "to help close" the vagina.

> *After giving birth and until the umbilical cord falls and the end of the period known as* cimpswade *at about 3 months, when the child starts to sit up, a*

> *woman will use medicine twice a week. When the child starts to crawl she uses the medicine every week. (CHI3 - p. 7, potter, about 45 years old, Chipembere August 2005).*

So the frequency of using vaginal products can vary; it can be daily or weekly depending on need and the effectiveness of the product or medicine. Some respondents said that as women stop having sex during menopause they often no longer use these products. Some, however, continue to use them in order to "be well", have "weight" and "strength when they walk", although this does not appear to be widespread. As certain churches ban the use of traditional medicines some women stop using them in order to comply with these rules.

When there is sexual competition with other women, in both towns and in rural areas, or if a woman's husband has various wives or lovers, she uses vaginal products more often in order to "keep" him at home. According to most women, inserting mankwala, applying it to the vagina or ingesting it improves her sexual performance when she is worried about retaining an unfaithful or polygamous partner. Sex workers also use vaginal products frequently in order to ensure that they provide satisfactory sexual services and so that a sexual partner "does not suspect that they have just had a relationship with another man".

Mankwala ya kubvalira is used for a variety of reasons, the most important being that already mentioned: to close the vagina. However, both the men and women interviewed mentioned other reasons: the vagina must be tight, dry and hot to allow for friction and sexual pleasure for both partners during a sexual relationship and the woman's well-being.

According to the opinions gathered on sexual preparation focused on the vagina, a woman cannot remain "open", "wide" because when the man penetrates he must have a little "difficulty" and "feel the flavour". The purpose of medicines is to "strengthen" her so that she does not have "water" and doesn't "make a noise". In addition to medicines "to make her sweet", others are used to dry the vagina and reduce it, to warm the body and the vagina and thus stimulate sexual arousal.

To some extent the search for heat, sweetness, friction implies a "nyama na nyama" ("skin to skin" without a condom) relationship that is considered the most satisfactory. For some male and female respondents using vaginal products is the absolute opposite of using a condom. They say that when they use vaginal products there can be no condom in the sexual relationship so there can be more direct contact between the vagina and the penis and greater sexual pleasure. Some peo-

ple, however, including sex workers say that it is possible to use makwalaya *kubvalira* and a condom at the same time.

2.1.3 Douching and cleansing the vagina with a variety of products

The vagina is washed and cleansed daily in a number of ways, with soap and a wide variety of other products. Sometimes it is done several times a day. The aim is to guarantee a woman's daily hygiene and it also takes place after sexual intercourse. Cleansing involves a circular movement with a finger of the left hand inside the vagina in order to remove vaginal secretions, sperm and products and to eliminate vaginal odours. Women wash themselves with water and soap, salt, lemon, vinegar, tea or Dettol as well as other vegetable based products. It can be done in association with vaginal medicines or as a substitute to try and tighten the vagina. Cleansing can also be done by inserting paper handkerchiefs, toilet paper, napkins or pieces of cloth used specifically for this purpose.

The reasons for washing and cleansing the vagina are associated with *kubvalira* practices. Between one sexual relationship and the next, in order to remove sperm from the vagina a woman usually cleans inside with a cloth and can also be cleaned by her partner. The same cloth can be used to clean his genitals. The aim is to remove excess "water" from the vagina; this is important in order to have repeated coitus. Some respondents explained that this washing method is taught in health facilities.

Many women clean their vagina for therapeutic purposes, in order to reduce secretion and contract the uterus and vagina following childbirth. Specific medicines are used for this purpose, usually recommended by male and female traditional healers, traditional birth attendants or relatives and neighbours. Women's reasons are the same irrespective of the context (rural and urban), level of education, age and social strata.

2.1.4 Cutting the pubic hair

Cutting the pubic hair ensures a woman's beauty and hygiene. In rural areas it is cut by the godmother when a girl has her first menstruation. Later, during the woman's life cycle she cuts or shaves the hair regularly. Sometimes her partner does it as part of an erotic game. Cutting a partner's hair is a lover's way of expressing affection but it may also be a form of control: the husband asks his wife "who

shaved you or who did you shave for?" if she has shaved in his absence.

According to a traditional healer, shaving the hair makes a woman "look like a child". The concern to look like a child or to have a tight vagina like a virgin highlights men's preference for young girls.

2.1.5 Ingesting sexual stimulants

There are three kinds of sexual stimulants:

> *"to be ingested, to put in porridge and to put inside the vagina". (MPD8-p. 16, focus group of women with children, M'padwe, August 2005).*

As the objectives are similar to those of *mankwala ya kubvalira* there is a range of products and/or medicines that women take to give the couple greater sexual pleasure. Sexually active women who are not pregnant use them, prepared essentially from vegetable substances (*m'puphwa*[7], *nsyio*[8]) that are added to solid or liquid food. Compared to the mankwala ya *kubvalira* that are used regularly, ingested medicines such as these are used irregularly and occasionally.

The mankwala that are ingested to affect the condition of the vagina and the reproductive apparatus can also include potions that are mixed with food or drink. The objective is to facilitate dilation of the cervix during preparation for childbirth. In addition, after birth a woman massages her stomach and takes potions to facilitate expulsion of the afterbirth and reduce the vaginal orifice. The medicines used to close the uterus and the vagina after childbirth are considered highly potent and effective. According to a group of male respondents, most women use such products both during pregnancy to prepare for birth and in the period immediately after birth in order to resume satisfactory sexual relations as quickly as possible:

> Kubvalira *is a medicine that a woman usually puts on her sexual organs; when they are wide after childbirth a woman puts the* kubvalira *in order to make them the same size as before (…) so that she's like a virgin. (CHA5 - p. 21, male focus group, Changara, September 2005).*

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[7] *M'puphwa* is a plant that grows on river banks. It is mixed with mulumbi (a brown cereal) or from the husk of the plant. The mixture is then pounded to produce a powder that is placed in the vagina "to remove the water (…) to make it dry (…) to tighten and dry it."

[8] Nsylo is a plant used to make a special kind of medicine. It is pounded in a mortar together with a chicken's egg and made into little balls that are inserted in the vagina to dry and tighten it.

Another objective of some ingested products is to create a sensation of heat in the body in general "as if you had a malaria fever".

> *A woman's natural body (…) is cold. She was born like that; it's cold there inside her vagina, that's when she starts to ask for medicines, to see if she can put an end to this cold feeling. (…) When the man (…) penetrates he feels it is cold, cold, cold (…) he says ah! This is no good, but if it is warm all he has to do is to move two or three times and he will immediately ejaculate, he feels that it is a good body, the vagina is hot. (CHI8- p. 9, potter, widow 70 years old, had 11 children, 3 of whom died from AIDS, Chipembere, August 2005).*

Mankwala are ingested by both men and women. Men also take a wide variety of substances to ensure an erection and increase their sexual performance. The products ingested by men are usually intended to stimulate an erection, increase sexual potency, to have coitus several times during a single night, to please the woman and to feel more pleasure.

2.1.6 Inserting cassava sticks into the vagina to bring about an abortion and porridge to delay birth

Some women, most of them Mother and Child Health nurses, said that cassava sticks can be inserted in the vagina to bring about an abortion.

A few informants said that some women also insert balls of cooked maize porridge to delay birth while they are on their way to hospital. This was confirmed by nurses who said they had seen women in labour with porridge in the vagina.

2.1.7 Virginity tests

Virginity, known locally as *udende* in both Nyugwe and Nyanja, is a sign of the integrity of adolescents and young girls. Virginity is so important for girls that they must be constantly watched in order to preserve it. For this reason they are not allowed to eat certain kinds of food, such as eggs, sugar, sorghum and millet because "they eat the virginity" of girls. In rural areas there are tests for adolescents and young girls as illustrated by some of our respondents.

> *If she has* udende *(virginity) we can usually see it. We take her to the river, tell (the girl) to undress, take off her underwear and bathe. She lies on her back and we tell her to open her legs and we look into the vagina. If she is a*

> *virgin you can see a kind of white lid in the vagina and if she is not a virgin the vagina is a reddish colour and has no lid. (FSM3- p. 4, traditional healer, widow, seven children about 50 years old, Tete August 2005).*
>
> *The godmother who taught the girl to do pull-pull, the boy's godmother and one of his aunts (...) invite the girl to bathe and then tell her to sit with her legs bent and open and without underwear. It is the man's aunt who checks. If she is a virgin then immediately she sings* nthungulu *(satisfaction) (...) and the others sprinkle flour on her head. (CHA4- p. 34, widow, Changara, September 2005).*

In additional to virginity tests for single girls, young brides are also subject to this ritual when they marry to confirm that the grooms are in fact the first men to have sexual intercourse with them. One of the moments in the marriage ceremony, after the first wedding night, consists of presenting a white sheet stained with the blood of the young bride. The girl's reputation and that of her parents depend on her virginity and can also be related to the amount paid in brideprice. "You will pay more when the woman is a virgin, when she is not a virgin you do not pay much and may not even pay anything ", said one community leader.

2.1.8 Treatment to restore virginity

Women who are already sexually active or married also try to appear virgins, with a tight and dry vagina like that of a child, by using various products and medicines. Virginity is "restored" using both some of the above-mentioned *mankwala ya kubvalira* and also a wide variety of other mankwala. Chicken eggs mixed with certain plants were mentioned as being effective for restoring virginity.

> Batanani *means becoming a virgin again (...) you take a plant, scrape it and leave it in the sun to dry, then later in the day you pound it, make-a porridge and eat it. Even a mother who already has a child can become a virgin again, although the man can ask how she became a virgin again if she already has a child (...)* Batanani *means put it together, hold it, and is placed inside the vagina; it is also used to treat wounds or a fracture. (TET6-P. 18-19, Traditional healer, Tete August 2005).*

Another method involves using a snail:

> *Take the snail, mix it with medicines* (nkuia nkona) *tell the girl to lie on her back and put some drops into her vagina (...), when it dries (...) she is virtually dry. You put some drops of the snail liquid with some leaves from*

the kubvalira *plant into the girl's vagina and by the end of the day it's closed. (...) [when she has sex] a little bit of blood comes out but it isn't her own blood, it's a kind of beaten egg or egg yolk. (...) It's only to close, not to produce blood, and when the man penetrates he feels a tight vagina. (CHA3- p. 31-32, Focal group of traditional healers, Changara, September 2005).*

It is believed that some girls "play around with a lot of boys" and when they want to find someone to marry they have this treatment to restore their virginity.

Sometimes mothers seek medicine for their daughters when they suspect that they are no longer virgins, because they want to preserve their reputation with their future husbands.

2.1.9 Steaming and fogging the vagina

Another common practice among women is to lengthen the *labia* by steaming and fogging (*Kucita bafu* in Nyúngwe or *Kucita bafa* in Nyanja). Steaming involves the woman sitting by the fire with a pan containing bark, roots, seeds or leaves of certain trees. When it boils the pan's contents produce steam and heat. In order to steam her vagina the woman stands by the preparation with her legs open so that the steam can lengthen her *labia*.

Stretching the *labia* by steaming is an alternative to using fingers, mainly among adolescents who refuse to do it that way because of the pain.

There are various ways of lengthening the labia*: one involves digging a small hole, placing a little burning charcoal and then the medicine on top of that. The person crouches and covers herself from the waist down. She continues to kneel as long as there is medicine on the fire, and coughs a little (...) if she coughs a lot they (the vaginal* labia*) come out a lot, [the* labia minora *lengthen]. (...) The smoke enters (the vagina) and the* labia *lengthen. (FSM4- p. 4, traditional healer, married, five children, about 40 years old, Tete August 2005).*

Many children refuse to pull [the labia*] by hand because it's painful so traditional healers have adapted a root. We take a burning coal, the girl sits with her legs open, you put the root on the coal and it starts to smoke. When the smoke rises it hits the* labia minora *and they immediately come out. We also have another root that we grate and put in the sun to dry; when it's dry you take a piece of paper and make a cigarette that we give to the girl to smoke;*

she must inhale the smoke; after inhaling we tell the girl to cough and as soon as she coughs the matingi *come out. (TET6- p. 1-2, traditional healer, Tete August 2005).*

Steaming and fogging are not as common as manual elongation of the *labia*. People usually prefer the pull-pull method because, according to respondents, it is feared that fogging and steaming might make the *labia* grow a lot. With elongation by hand it is easier to control their size.

2.1.10 Excising and incising "impurities" in the perineal area

Women in Tete also excise and incise "impurities" in the perineal area (between the vaginal orifice and the anus). If a baby is stillborn, if babies are born but do not survive very long, if they are always ill, or if "their eyes are always closed", they say that mothers of these children have an illness called *masale*. This illness can affect both men and women:

There are two or three types of masale*: for a man and for a woman and it lies between the vagina and the anus. It causes many problems for childbirth and you can even say "I've been bewitched" although this is not the case. If a woman has* masale *(…) the child is always sick and, indeed older people can discover why the child's eyes are always closed, and when it is discovered they have it cut out. (TET6 p.24, traditional healer, Tete August 2005).*

Masale often takes the form of spots. Women itch and scratch them, making them burst and bleed. During labour and at birth the child touches the spots and, they say, becomes ill or can even die. The treatment for *masale* is to eliminate them by cutting them open:

We usually get rid of them with a blade very early in the morning, (…) you take a new blade and cut that thing (…) we usually apply that medicine, a mixture of chinkhundo*,* m'pherangira *and* khoma la nsika*. (FSM5 p.46-49, traditional healer, married, 11 children, Tete, August, 2005).*

If you do not want to cut, you can rub the affected part with an appropriate *mankwala ya kubvalira*.

3. Perceptions of the impact of vaginal practices on sexual experience and satisfaction and on sexual and reproductive health

The various vaginal practices described above have an impact on sexual experience and satisfaction and on the sexual and reproductive health of women and men, although they have different perceptions of this impact. Similarly, the perceptions of traditional doctors and health personnel also differ.

3.1 Women's perceptions of the impact of these practices on their sexual and reproductive health and their sexual satisfaction

Women tend to feel that the various vaginal practices are not harmful to their health. On the contrary, they are considered essential and thus unavoidable to guarantee their sexual satisfaction, the satisfaction of their ego, their "well-being" and that of their partners. The "minor" collateral effects of these practices are not "negative" for either their sexual experience and satisfaction or their sexual and reproductive health.

The vast majority of men and women interviewed explained that the *mankwala ya kubvalira* is essential for a satisfactory sexual relationship for both a woman and her partner. A woman "who has not prepared herself" is considered to be watered down and for her partner the sexual relationship is like penetrating "a glass of water". This means that there is no sensation of pleasure. For both the man and the woman this practice is profoundly rooted in "tradition" and the concept of sexuality and sexual pleasure.

Referring to the "minor" negative effects women stated that some of the products used to lengthen the labia minora and the act itself sometimes cause lesions and that it is a painful process. Lacerations can also occur when the sexual partner "plays" with the *labia*, pulling them without using oil. Nevertheless, women feel that pull-pull is necessary.

They also mentioned difficulties during childbirth if a woman continues to use *mankwala ya kubvalira* while she is pregnant. Uterus pains and lesions for both a man and a woman during a sexual relationship were mentioned in cases where modern products are used, when they are prepared incorrectly and when women do not follow the recommended dose or do not remove them from the vagina when "they lose strength".

There is a kind of blue medicine that comes from Zimbabwe and is sold in Kwachena market. After I bought it I bathed, inserted it and after a while my vagina became swollen and water started coming out, and the same day (another) woman appeared in the hospital with these problems. She had used a lot of it, completely stuffing her vagina, and her belly became bloated; it was swollen and she died. (MPD 11 p.25, woman, single, no children, M'padwe, September 2005).

I know about a medicine from Zimbabwe, kubvalira *I bought it, inserted it and immediately started to moan. I was ill right away. That day I had to take a fan and direct it at my vagina. On the following day there were scales, flaking and a white substance. I spent a week without having dinner with my husband. It was salt from Zimbabwe; little stones (....) they damage the uterus. (TET4 - p.24, Focus Groups, OMM women, Tete, August 2005).*

Women in both rural and urban areas believe that products (stones and powder) sold in Kwachena (the local market) are the only ones that cause trouble because many women have experienced shedding of the vaginal mucosa, vaginal lesions, burning, swelling and a rise in vaginal secretions when they are used. In addition, women also say that when they use these "foreign products" a man can also have lesions on his penis due to the penetration effort needed and friction during sexual intercourse.

No respondents other than female activists and health providers felt that there was any connection between lesions arising from vaginal practices and the possibility of transmitting STI and HIV/AIDS. It was also found that most do not use a condom because *kubvalira* requires unprotected sex in order to permit direct contact between the vagina and the penis and obtain more sexual pleasure. *Kubvalira* means seeking more friction, which can mean "blood with blood". For these women, a condom and its lubricant produce precisely the opposite effect of *kubvalira*. Others, however, including sex workers, explained that it was possible to use both products and a condom simultaneously.

There is a widespread belief among women that vaginal practices are positive. They believe that if they do not use makwala ya*kubvalira* it will have a negative impact on their health, understood in the broad sense as the absence of illness and discomfort as opposed to a happy home and the wellbeing of the family.

(In a polygynous marriage) when a woman has water in her vagina, it can mean the end of the marriage. If she remains (in the home) she is merely a

kind of doll in the house (…) The problem of a woman's water is the worst; it has destroyed many homes. (CHIg- p.g, traditional birth attendant, Focal Group; widows, women in a polygenic marriage Chipembere, August, 2005).

In other words, between on the one hand the undesired effects of vaginal products and on the other hand guaranteeing the family's well-being, women opt for the latter.

3.2 Men's perception of the impact of these practices on their sexual and reproductive health, their sexual satisfaction and experience

For men, as for women, vaginal practices are necessary and have no negative impact on sexual and reproductive health. Moreover, a condom is seen as having an undesired effect on the objective of *kubvalira* and is thus undesirable.

Using a condom with kubvalira *doesn't work because the woman's body (….) won't be tight, it will feel like water. A condom has that liquid. If you put your penis in the vagina it will get the* kublavira *that dries the vagina. If you use a condom it gets wet, precisely the opposite of the real thing. (MPD - p.28, male focus group, M'padwe, August 2005).*

If the function of various practices is to leave the vagina tight and wet, it is completely understandable that men do not use a condom because it will lubricate the vagina, thus having the opposite effect.

3.3 Male and female traditional healers' perceptions of the impact of these practices on sexual and reproductive health

Both male and female traditional doctors think that the makwala ya *kubvalira* can be harmful to the sexual and reproductive health of women and men. Nevertheless, they feel that negative effects are only due to products that are "foreign", "modern", "for white people" or using local traditional products without knowing the recommended dose.

There is one kind (of medicine), a powder such as soda or salt that causes pain in a woman's uterus whereas traditional medicines have no negative effects. (CHA3 p.30, focus group of traditional healers, Changara, September 2005).

Medicines can cause problems - all medicines must be measured. That's why we make recommendations when we provide them; we talk about doses and when they should be taken or applied. Especially the minerals: if you apply them in the morning and only remove them in the afternoon, the vagina becomes full of water. (FSM7 p.25, female traditional healer, widow with 4 children, 38 years of age, Tete, August 2005).

So for most of the men and women interviewed, vaginal practices involving the use of traditional local medicines only have a negative impact on sexual and reproductive health when they are not used properly:

There are no consequences. (MPD4 p.14, male traditional healer, about 60 years of age, M'padwe August 2005).

No spots, no sores, no lesions, no itching. (MPD4 p.14, female traditional healer, M'padwe August 2005).

Male and female traditional doctors also agreed with the opinion of most women and men, that using a condom counteracts the intended effect of the *kubvalira*, as stated by one of the female traditional healers interviewed:

A condom is no good when you have kubvalira*, because the man won't feel any pleasure (...) blood has to meet blood. (FSM9, female traditional healer, with 4 children, about 60 years of age, Tete August 2005).*

3.4 Health personnel's perception of the impact of these practices on sexual and reproductive health

According to meetings with health personnel, clinical observations frequently find women with residue from vaginal products or vaginal complications and discharge that can be caused by these substances.

After the stones are inserted there has been a reaction, a constant discharge. When women arrive at the health post they say they have STD but they don't. I ask questions and try to explain to the person that she should not use that. It isn't STD. And sometimes they spend more money and are never cured. (...) Roots can cause lesions inside and outside the vagina and this is dangerous... with these lesions they are easily infected with STD and HIV/AIDS. (MPD2-p.8, male health provider).

Gynaecologists point to various consequences of these vaginal practices such as early menopause, atrophy of the uterus and ovaries, vaginal lacerations, flaking of the vaginal wall, destruction of vaginal flora, cervical cancer and greater vulnerability to STI and HIV/AIDS.

Health staff feels that daily hygiene that involves using the fingers to washing inside the vagina with soap and water results in nails causing scratches or infections due to the dirt introduced by the fingers or the cloth used. Destruction of vaginal flora was another consequence mentioned.

Despite their awareness of the high prevalence of women using vaginal products and their effects on sexual and reproductive health, there is little discussion on this subject among health personnel.

Conclusions

The purpose of this study was to identify, document and understand vaginal practices related to the sexuality and sexual health of women, to understand why they do this and their perceptions of the impact on their sexual health based on research in Tete province in the centre of Mozambique.

The study data show that there is a large variety of vaginal practices in Tete carried out by women themselves at various moments in their life cycle and with different functions. These practices express a particular way of conceiving a woman's sexual identity, sexual pleasure, health, well-being and sexuality that is rooted in a broader relational universe, in a whole set of relationships that can only be understood when they are all linked together.

According to these women, the essential purpose of vaginal practices is to "hold on to" their sexual partners, improve personal hygiene and self esteem, guarantee their well-being and improve their own sexual performance and satisfaction and that of their partners. Vaginal practices enable a woman to meet society's aspirations for her. Sexual partners are "held on to" when women provide a satisfactory response to their expectations and those of society, when they are able to mould their body in line with society's expectations. Only by shaping their body to fit the image that is expected by society can they "become women" and feel good.

Good sexual performance means that the man must feel that the vaginal orifice is narrow. "Apparent virginity" is a precondition not only for a woman's satisfactory sexual relationship, but also a man's. After frequent coitus and after childbirth the local perception is that the vaginal orifice has become open and wide, and needs to be closed and tightened. Interventions to achieve this include lengthening the *labia* (*kukhuna*, *kupfuwa* or pull-pull), inserting products and/or vaginal medicine (mankwala ya *kubvalira*) and ingesting sexual stimulants (mankwala) that also heat and dry the vagina.

If a woman is to feel good and pretty she must intervene in her body. She must also cleanse her vagina every day and transform it in preparation for the sexual act. She uses water and soap, salt, lemon, vinegar, tea as well as vegetable and chemical-based products. Women also insert their fingers, paper handkerchiefs, toilet paper, napkins or cloth. They shave their pubic hair, and this also serves as an erotic game with the partner.

Other practices identified and documented involved the insertion of cassava sticks into the vaginal channel to bring about an abortion, inserting balls of maize porridge to delay delivery while travelling to hospital, and applying ball-shaped medicine to dilate the cervix and facilitate childbirth.

According to the people interviewed the various vaginal practices only have positive effects. The undesired effects mentioned occurred mainly in cases where the products and/or medicines used are modern ones from Zimbabwe as opposed to traditional ones, and when women do not know enough about the products and how to use them correctly.

Most of the people interviewed - except health workers, activists and doctors - did not associate the lacerations caused by these practices with the possibility of transmitting STI and HIV/AIDS. Respondents felt that the search for the "heat", the "sweetness" of friction implies having a "skin to skin" relationship. This is why the use of vaginal products is considered incompatible with using a condom. Products ingested to dilate the cervix and increase contractions prior to childbirth were also mentioned as having a positive effect, probably because the delivery runs smoothly. This points to the need to study in more detail the substances used and the appropriate dosage and thus observe bio-medical principles in "traditional" curative practices.

Cultural (re)construction of the body and female identity

In Tete, the female body and identity must be (re)constructed. Identity is built on relationships within the family and society and also a girl's growing perception of her body. Consequently, in the areas studied, a girl only becomes a woman through the transformation of her body, by lengthening the *labia*.

The "appearance of virginity", with a tight and dry vagina, is a fundamental aspect of the reconstruction of the female identity expected by men and by women themselves (godmothers, mothers, women responsible for the socialisation of younger

girls). It is also a fundamental aspect in guaranteeing a healthy and lasting relationship between a couple. By (re)constructing her body, a woman is "preparing" to take on her role as a sexual partner, guaranteeing the sexual satisfaction of her partner and "hanging on to him". Consequently, the various vaginal practices that shape the female sexual identity are essential elements not only in differentiating between male and female, but also in differentiating between the woman who is "prepared", "has weight" and the woman who is "not prepared", "without weight" and is thus rejected.

Our data show that these practices constitute a social and cultural imperative, a virtually absolute rule that drives women to consider their transformed bodies as a value. They are the social and cultural meanings attributed to a woman's body (elongated *labia*, a dry and tight vagina) that define the ideal woman, the woman's sexual identity. This necessarily means that how a woman is regarded is based on social and cultural meanings that mesh with their physical and biological constitution. A woman's body is simultaneously an object of symbolism and a set of cultural meanings that are encapsulated in women's bodies.

Female genital mutilation?

According to the women interviewed, with the exception of one practice related to treating infertility (*masale* or *masungo*), the various vaginal practices identified in Tete are not considered to be a "problem" or detrimental to their health. They are considered a necessary and indispensable strategy for "feeling good" and "holding on to their partners".

Nevertheless, these vaginal practices are among those considered to be "harmful to the health" of women and related to female genital mutilation (OHCHR et al. 2008). Although we do not feel that these practices fall into the mutilation category (Bagnol and Mariano, 208a, 209b) some of them can be harmful (invasive) to the sexual health of the women concerned and their partners (Low, 2011).

Data from this study show that some of the vaginal practices are harmful to the sexual and reproductive health of women and have negative implications for preventing and controlling HIV/AIDS. In addition, there is the pain and the potential heightened risk of HIV/AIDS infection as a result of, for example, excising and incising" impurities" in the perineal area, and the use of makwala ya *kubvalira* inhibits condom use.

Against the trivialisation of culture

Although vaginal practices are a social and cultural imperative, they must also be seen as the outcome of the personal projects of the women who practice them.

The context in which these practices take place must be understood in order to assess the different kinds of risks inherent to them. In addition to risks related to sexual and reproductive health there is also the "danger" of rejection and discrimination against women who do not perform these practices. This means that the complex and constant dynamic nature of the cultural context of vaginal practices must be studied and understood better, in order to avoid trivialising the cultural motivation that informs them and gives them meaning.

All interventions on a woman's body, whether for personal hygiene or for aesthetic purposes, or that lead to heightened sexual satisfaction, do not involve merely the simple transformation of the physical body. In particular, they result in women gaining a social position and a socio-cultural body that meets the expectations of her group. This process of interfering with her physical body is a case of conditioned intentionality. Women's actions conform to what is seen as their natural position in the relation between the sexes and increase their vulnerability to STI, HIV and other problems related to their sexual and reproductive health but, they also achieve their personal projects. Consequently, and as stated by Sahlins (1987) people are responsible for what their own culture may have done to them, because even if there is always an a priori system of interpretation, there is also the life they want for themselves.

Although health personnel are aware that many women interfere with their bodies through vaginal practices, and despite their effects on sexual and reproductive health, their discussion of this subject is still minimal and there are virtually no studies on these practices. None of the practices identified and described here have been studied in detail in Mozambique in order to understand them and learn about their impact on the transmission and prevention of STI and HIV/AIDS, including the use of condoms and microbicides. Clinical monitoring is required to test/confront and undertake biochemical analysis of the products used to assess the impact of these practices on the prevalence of STI and HIV/AIDS. In other words, there is a need for more multidisciplinary research on the subject and discussion of the results.

ANNEXES

ANNEX 1 Glossary of vaginal pratices and male sexual pratices

NYÚNGWE	NYANJA	ENGLISH
Batanani		Come together, hold on to each other
Cimwemwe		Smile
Ci phata mbolo		Squeeze the penis
Kubvalira	*Kubvalira*	To get dressed, apply. In this context the word was used with the sense of "to prepare"
Kucita bafu	*Kucita bafa*	Steaming. Treatment with air/fogging
Kukhuna	*Kukuna*	Pull-pull. The action of pulling the vagina's *labia*. It is a polysemic word covering all practices intended to lengthen the labia minora
Kupfuwa	*Kufuyia*	To make grow, take care of
Ku likha dende		To restore virginity
Ku tambisa madoda		To make a man dance
Mankhwala	*Mankhwala*	Remedy, medicine, poison
Mankhwala ya kubvalira	*Mankhwala yakukongoletsa*	Medicine that makes a woman feel good/pretty/prepared
Mary pa mbedi		Maria in bed
Matinji	*Matinji*	Vaginal labia minora
Nkoteko	*Nkoteko*	Love witchcraft
Nsana wa mbuia		Old woman's backbone
Nyama na nyama		Flesh on flesh or skin on skins (alluding to sex without a condom)
Tapi tapi		Sweetness
Udende	*Ubuthu*	Virginity

ANNEX 2 Products and processes related to elongation of the vaginal *labia* (*kukhuna, kupfuwa*, pull-pull)

PRODUCT	TIPE OF SUBSTANCE	PREPARATION	HOW IT IS USED	OBSERVATIONS
Cacoe	Vegetation, roots	Roots dried and pounded	Burnt for steaming or made into a cigarette to make the woman cough and in so doing lengthen her vaginal *labia*	Not used much because the *labia minora* tend to become too long; the l abia become redder
Cassinyemba	Vegetation, roots	Roots dried, pounded and mixed with *nthengeni* or *nsatsi*	Fingers covered with oil pull the vaginal *labia*	Causes itching but produces elongation
Cikossorossa (Ndau)	Vegetation, leaves		Leaves smoked to produce a cough	
Citautau (something elastic in Nyugwe)	Vegetation, roots	Roots dried, pounded and mixed with *nthengeni*	Vaginal *labia* pulled	Not used much because the *labia minora* tend to become too long
Cithonge	Vegetation, leaves		Leaves smoked	The leaves have the same shape as the vaginal *labia*
Kasausau	Vegetation, roots	Mixed with roots of *nsatsi*, *nthoie* and *nthengeni*	Vagina covered with a cloth and fogged, with a slight cough once to help the vaginal *labia* come out; only done once	
Nguledede	Vegetation, leaves	Leaves burnt and milled together with *nthengeni*	The tips of index fingers oiled and vaginal *labia* pulled.	
Nsatsi	Vegetation, castor seeds used to produce oil	Seeds husked, toasted or burnt then milled to extract oil		Kept in a small clay or wooden pot (*mbaie*)
Nsika	Vegetation, roots	Roots are washed and soaked in water	Drunk twice a day (morning and night) for two days	
Ntarena	Vegetation, *ntalala* plant	Grated and dried	Rolled into a cigarette, smoked and the smoke is swallowed to cause coughing and make the vaginal *labia* come out	
Nthengeni	Vegetation, fruit of the *nthengenia* tree	Husked, toasted and milled to extract oil	Tips of index fingers are oiled and the vaginal *labia* pulled; only done every two days to let the body rest as it is painful	
Nthoie	Vegetation, roots	Reduced to a powder	Rubbed on vaginal *labia* every two days for a week	
Ti-nyemba	Vegetation, seeds; especially beans	Oil is obtained from the milled seeds	Tips of index fingers are oiled and the vaginal *labia* pulled for a few minutes	Girls who have not started menstruation do it on alternate days until the desired size is achieved
Ulunzu	Vegetation, roots of an aquatic plant	Roots are dried and then burnt	Steaming	
Nyankhe mwa lemwa	Animal, bat's wings	Wings are burnt and the ash mixed with *nsatsi* or *nthengeni* oil	Tips of index fingers are oiled and the vaginal *labia* pulled	
Rubber	Artificial rubber (inner tube)	Burnt, melted and mixed with *nthengheni* or *nsatsi*	Fingers covered with oil and vaginal *labia* pulled	
Vaseline	Manufactured, ointment		The tips of the index fingers are oiled and the vaginal *labia* pulled	Used by girls in towns

ANNEX 3 Products and process related to practices to tighten, dry, heat and sweeten the vagina (*kubvalira or mankwala ya bvalira*)

PRODUCT	TIPE OF SUBSTANCE	PREPARATION	HOW IT IS USED	OBSERVATIONS
Cihobvo	Vegetation, leaves	Leaves pounded and made into small balls	A small ball is inserted into vagina in the morning and left to dissolve inside the vagina	To dry, heat and close the vagina
Cissiu	Vegetation, roots and bark of a tree	Husked, pounded and made into small balls	The small ball is inserted into the vagina once a day	To dry the vagina and strengthen the body
Kapinimini	Vegetation, leaves	Leaves pounded and made into porridge	Ingested in porridge	To sweeten the vagina
Katungulu + khombokole	Vegetation, roots (tubercules)	Peeled, dried, milled and added to porridge with sugar, salt and *khombokole*		To heat the vagina
Mulumbi	Vegetation; cereal	Reduced to powder, mixed with *mpuphua*	Finger used to insert powder into vagina	To tighten and dry the vagina
Mzunga/ tsokotsoko or *bzigolomva ya nsiyo* (balls of *nsiyo*)	Vegetation,fruit of the *nsiyo* (a tree with thorns), roots	Roots are ground or pounded, the powder is mixed with water and a little sugar and made into small balls	A small ball is inserted into the vagina once a day, at any time and stays there for 2-3hours; washed after 6/8 hours.	To dry the vagina
Ngugudza		Pounded and mixed with toasted maize	Eaten in porridge	To dry the vagina
Nsana wa mbuia (old woman's backbone)	Vegetation, roots, leaves	Roots are peeled, dried, pounded with fresh leaves and made into small balls	Put on the surface of the vagina	To dry the vagina
Nseketsi + kapinmini	Vegetation, roots, leaves			
Nsiyo + nkuio + nthengeni	Vegetation, fruit,bark,roots	Dried, pounded, mixed with sugar, salt and egg to make small balls	A ball is inserted into the vagina	To close the vagina and for healing wounds
Ntcegerume	Vegetation,roots		Drunk	
Nthengheni	Vegetation,roots			To close and heat the vagina
Nyankaphete	Vegetation, leaves	Placed in hot water		To close the vagina
Nyankuku	Vegetation, roots with a reddish colour	Chewed	Inserted in the vagina that is then washed with salty water	To dry and close the vagina
Tapi-tapi *(Sweetness)*	Light green powder			To close, sweeten and heat the vagina
Thobve	Vegetation; plant similar to okra			Makes the vagina good
Ci phata mbolo (squeezes the penis)	Mineral, stones and minerals	Milled into a powder	Powder inserted into the vagina with the finger; once a day before sexual intercourse	To dry and close the vagina
Khamandara	Mineral, stones and minerals		Tip of finger used to insert powderinto vagina that is washed after 2 hours; every day, 2 hours before sexual intercourse	To dry the vagina
Pula	Yellow powder			
Salt		Salt diluted in hot water	Washing the vagina	To wash and close the vagina
Virgin salt	Mineral, stones, crystals, salt	Reduced to a powder that is diluted in water	Vagina is washed using the fingers, or it is placed directly without being diluted shortly before the sexual act	To close and dry the vagina. Said to have a negative effect: scaling and more water in the vagina

Annex 4 Products and processes related to virginity, love potions (*nkoteko*), treating STI, childbirth and abortion

PRODUCT	TIPE OF SUBSTANCE	PREPARATION	HOW IT IS USED	OBSERVATIONS
Batanani (Coming together, holding each other)	Vegetation, roots	Milled into a powder	Mixed with porridge and eaten once a day for two days	To become a virgin again; a type of healing product used to cure fractures
Ku-funga		Medicine mixed with a raw chicken's egg	Inserted into the vagina	To close, to restore virginity with bleeding
Ku-likha dende				Virginity testing of a girl
Mitsanya	Vegetation,fruit of a tree containing a sticky substance	Fruits are pounded,made into small balls and then dried	A ball is inserted into the vagina, one ball a day every day	To feel good, have strength and feel a woman, to become like a virgin
Mpfumba-sana	Vegetation, roots		Eaten in the evening	To close the vagina, appear a virgin
Cinama	Vegetation, roots, flowers	Roots milled into a powder, mixed with a small piece of finger nail and added to food	Given to a man to eat once	To be lucky in love
Nkoteko	Animal, heart of a lizard		Rubbed on the thighs and the vagina, with Incisions on the forehead, chin and sometimes thighs and pubic area	To attract, conquer and domesticate a man, to prevent him from having sex with another woman, making him impotent
Cinyai (Spider's web)	Animal, spider's web	Smoked with kitchen smoke and ground with salt	Drunk with water or eaten in porridge	To close the vagina properly, to be like a woman; to protect a man who has sex with a menstruating woman; to treat hernia and colic
Dettol	Manufactured, chemical/pharmaceutical product	Diluted in hot water, put half a bottle cap using cotton wool	Washing the vagina	Hygiene/Cleansing after childbirth and before the sexual act
Blue stone (copper sulphate in powder form)	Manufactured, pharmaceutical product		Put on to cotton wool used to wipe inside the vagina that is then washed with water; or it is dissolved in water and the vagina washed; from once a day to once a week	Medicine to make a woman well, pretty, prepared; to clean and close the vagina, treatment for STI, vaginal secretions and *masale*
Cengerume	Vegetation, roots	Roots are cut up, left to soak in water and mixed with *cimbumbum*	It is drunk	To treat STI
Cimbalam-bize	Vegetation, sap of a spiky plant that grows along river banks		Sap is used to treat wounds	To treat STI
Cimbum-bum	Vegetation, roots of the paw-paw	Roots are cut up, left to soak in water and mixed with cengerume	It is drunk	To treat STI
Gona nibwino	Vegetation, leaves	Leaves are pounded, mixed with water and made into small balls	Drunk four times in the morning and evening	To induce/bring about an abortion
Mpsototo	Vegetation, leaves			To clean the vaginal loquia after childbirth
Garlic	Vegetation, garlic	Skin a piece of garlic	Inserted in the vagina	To treat discharge
Cimwemwe (smile)	Vegetation, roots	Roots are reduced to powder and mixed with the hearts of a couple of pigeons	Given to the man to eat	

ANNEX 5 Products and processes related to male sexual practices (growth of the penis, sexual potency and *likango*)

PRODUCT	TIPE OF SUBSTANCE	PREPARATION	HOW IT IS USED	OBSERVATIONS
Cissiu	Vegetation, roots, bark	Peeled and pounded to powder	Eaten mixed into porridge once a day	Makes the penis grow
Mbvumbo	Vegetation, fruits, roots	A small piece of the fruit is cut off and soaked in water to be drunk, or mixed with porridge; roots can be used	It is drunk or eaten every day for a month	Makes the penis grow
Nganganga	Vegetation, fruits, bark	The fruit or skins are cut up and pounded	Eaten mixed with toasted and milled maize	To facilitate a man's erection; to have strength
Vuka-Vuka	Vegetation, skin of root	Reduced to a powder, mixed with toasted maize and made into porridge	It is eaten	To increase a man's sexual potency

Bibliography

ARNFRED, S. (1989). Notes on Gender and Modernization. Paper presented at ROAPE Conference, Warwick.

ARNFRED, S. (2003). Contested Construction of Female Sexualities: Meanings and Interpretations of Initiation Rituals. Paper presented at the Conference on Sex and Secrecy. Johannesburg 2003.

ARTHUR, M. J. and OSÓRIO, C. (2002). Saúde Sexual e Reprodutiva, DTS, HIV/SIDA: Moçambique, Revisão da Literatura. Maputo: UNFPA.

ASCHWANDEN, H. (1982). Symbols of Life. Gweru: Mambo Press.

ASCHWANDEN, H. (1987). Symbols of Death. Gweru: Mambo Press.

ASCHWANDEN, H. (1989). Karanga Mythology. Gweru: Mambo Press.

AWUSABO-ASARE, J. K .A. and AGYEMAN, D.K. (1993). Women's Control over their Sexuality and the Spread of STDs and HIV/AIDS in Ghana. Health Transition Review, 3: 69-84.

BAGNOL, B. (1996). Assessment of Sexual Orientation in Maputo and Nampula. Maputo: Royal Netherlands Embassy. (Consultancy report).

BAGNOL, B. (1997). Appraisal of Sexual Abuse and Commercial Sexual Exploitation of Children in Maputo and Nampula. Maputo: Royai Netherlands Embassy. (Consultancy report).

BAGNOL, B. (1998). Pesquisa Qualitativa sobre DTS/SIDAem Quelimane, Maganja da Costa e Pebane. Maputo: Action Aid. (Consultancy report).

BAGNOL, B. (2003). Identities and Sexual Attraction: Female Adolescent Rituals in Northern Mozambique and Healers in Southern Mozambique. Paper presented at the 4th International IASSCS Conference. University of the Witwatersrand. Sex and Secrecy Conference. Johannesburg 22-25 June.

BAGNOL, B. (2004). Avaliação da Área Temática sobre Violência e Abuso Sexual de Crianças. Maputo: Save the Children Norway.

BAGNOL, B. and CABRAL, Z. (1998). Assédio e Abuso Sexual nas Escolas. Maputo: Ministério da Educação, ONP/SNPM, Embaixada do Reino dos Países Baixos, Embaixada do Reino da Dinamarca.

BAGNOL, B. and MARIANO E. (2008a). Elongation of the Labia Minora and Use of Vaginal Products to Enhance Eroticism: Can these Practices be Considered FGM? In: "Female Genital Cutting in the Past and Today". The Finnish Journal of Ethnicity and Migration FJEM, 3(2): 42-53-

BAGNOL, B. and MARIANO E. (2008b). Vaginal Practices: Eroticism and Implications for Women's Health and Condom Use in Mozambique. Culture, Health & Sexuality, 10: 573-585.

BAGNOL, B. and MARIANO E. (2009a). Cuidados Consigo Mesmo, Sexualidade e Erotismo. Physis, 19 (2): 387-404.

BAGNOL, B. and MARIANO E. (2009b). Politics of Naming Sexual Practices. Outliers, a Collection of Essays and Creative Writing on Sexuality in Africa, 2.

BAKER, R. J. (1974). Race. London: Oxford University Press.

BALETA, A. (1998a). Concern Voiced over "Dry Sex" Practices in South Africa, The Lancet, October 17, 352-1292.

BEKSINSKA, M. E., REES, H. V., KLEINSCHMIDT, J. and MCLNTYRE, J. (1999). The Practice and Prevalence of Dry Sex among Men and Women in South Africa: a Risk Factor for Sexually Transmitted Infections? Sexually Transmitted Infections, 75:178-180.

BIESELE,M.(1993).Women like Meat. The Folklore and Foraging Ideology of the Kalahari Juhoan. Bloomington: Indiana University Press.

BRAUNSTEIN S. and van de WIJERT J. (2002). Cultural Norms and Behavior Regarding Vaginal Lubrication during Sex: Implications for the Acceptability of Vaginal Microbicides for the Prevention of HIV/STIs. New York: Population Council.

BROWN E J. and BROWN, R. C. (2000). Traditional Intravaginal Practices and the Heterosexual Transmission of Disease a Review. Sexually Transmitted Diseases, 27(4): 183-187.

BROWN E, J., AYOWA, O. B. and BROWN, R.C. (1992). Vaginal Inflammation in Africa. New England Journal of Medicine, 32(7): 572.

BROWN, E. J., AYOWA, O. B. and BROWN, R. C. (1993a). Dry and Tight: Sexual Practices and Potential AIDS Risk in Zaire. Social Science and Medicine, 37: 989-994.

BROWN E J., AYOWA, O. B. and BROWN, R. C. (1993b). The Use and Physical Effects of Intravaginal Substances in Zairian Women. Sexually Transmitted Disea-

ses March-April, 20(2): 96-9.

BUTLER, J. (2005). Trouble dans le Genre (Gender Trouble). Pour un Féminisme de la Subversion. Paris: Éditions de la Découverte.

CHAIKUMMAO, S., UTHAIWORAVIT, W., MEDTANAVYN, T., MANOPAIBOON, C., KILMARX, P. H., BRAUNSTEIN, S., SRIVIROJANA, N., SIRAPRAPASIRI, T., TAPPERO, J. W. and MC LEAN, C. A. (2004). Recruitment for a Trial of Microbicide Safety and Acceptability among HIV-infected Women, Thailand. Abstract 02576 - Microbicides 2004 Conference, 28-31 March, 2004. London: Hilton London Metropole.

COHEN, C. R., DUERR, A., PRUITHITHADA, N., RUGPAO, S., HILLIER, S., GARCIA, P. and NELSON, K. (1995). Bacterial Vaginosis and HIV Seroprevalence among Female Commercial Sex Workers in Chang Mai, Thailand. AIDS, 9:1093-1097.

DALLABETTA, G. A., MIOTTI, P. G., CHIPHANGWI, J. D., LIOMBA, G., CANNER, J. K. and SAAH, A. J. (1995). Traditional Vaginal Agents: Use and Association with HIV Infection in Malawian Women. AIDS, 9:293-297.

DAVA, F. and ZANDAMELA, I. (1999). Cultura, Saúde Sexual e Reprodutiva em Moçambique. Maputo: Instituto de Communicação Social.

ENOQUE, M. A. (1994). Mulheres Maniyka Contam... Sexualidade e Família. Maputo: INDE/FNUAP/UNESCO.

FAUVELLE-AYMAR, F. (2002). L'Invention du Hottentot. Paris: Publications de la Sorbonne.

FAUVELLE-AYMAR, F. (2004). De la Réapparition des Khoesan dans 1'Afrique du Sud Post-apartheid: Invention de la Tradition et Réconciliation Nationale. In:GUILLAUME, P., PÉJOUT, N.e KABWE- SEGATTI, A. W. (eds). L'Afrique du Sud Dix Ans Aprés. Transition Accomplie?Johannesburg: IFAS. Paris: Karthala.

FELICIANO, J. F. (1998). Antropologia Económica dos Thonga do Sul de Moçambique. Maputo: Arquivo Histórico de Moçambique.

FOUCAULT, M. (1994). História da Sexualidade I: A Vontade de Saber.Lisboa: Relógio d'água Editores.

GARLAKE, P.(i995). The Hunter'sVision. London: British Museum.

GEISLER, G. (2000). Women are Women or How to please your Husband. Initiation Ceremonies and the Politics of "Tradition" in Southern Africa. In: GODDARD, V. A. (ed.). Gender, Agency and Changes. Anthropological Perspectives. London: Routledge. 56-85.

GELFAND, M. (1979). Growingup in Shona Society from Birth to Marriage. Harare: Mambo Press.

GOVERNO DE MOÇAMBIQUE (2004). Review of the Economic and Social Plan for 2003. Maputo: Governo de Moçambique.

GOVERNO DA PROVINCIA DE TETE (2005). Plano Estratégico de Desenvolvimento 2005-2010. Tete: Governo da Província de Tete.

GREEN, G., POOL, R., HARRISSON, S., HART, G. I., WILKINSON, I., NYANZI, S. and WHITWORTH, J. A. (2001). Female Control of Sexuality: Illusion or Reality? Use of Vaginal Products in South West Uganda. Social Science and Medicine, 52:585-598.

GREGORY, A. C. (1982). Gifts and Commodities. London: Academic Press.

GUJRAL, L. FERNANDES, B., WESTPHAL, B. V., MBOFANA, F., FRANÇOIS, I., MATSINHE, C., LANGA, Q., MARIANO, E. and GUNE, E. (2004). Resposta dos Agregados Familiares face ao HIV/SIDA - Um Estudo de Base - Província de Tete: Changara, Magoe, Cidade de Tete, Angonia. Ministério da Saúde/ Direcção Provincial de Saúde de Tete, DANIDA.

HOSKEN, P. F. (1979). The Hosken Report. Second enlarged edition. Genital and sexual Mutilation of Females. New York: Women International Betwork News (WIN).

HULL, T. H. and BUDHIHARSANA, M. (2001). Male Circumcision and Penis Enhancement in Southeast Asia: matters of pain and pleasure. Reproductive Health Matters, 9(18): 60-67.

Instituto Nacional de Estatística (2002). Dados do QUIBB 2000-01. Maputo: INE.

Instituto Nacional de Estatística (2004). Moçambique em Números 2003. Maputo: INE.

Instituto Nacional de Estatística (2007). III Recenseamento Geral da População e Habitação 2007. Indicadores Sócio-Demográficos. Província de Tete. Maputo: INE. http://www.ine.gov.mz/censo2007/censo2007/rdcenso09/Tete/ (consulted on 16/01/2012).

Instituto Nacional de Estatística (2010). Dados Preliminares do III Recenceamento Geral da População e Habitação 2007. Maputo: INE. www.ine.gov.mz.

IRONGA, I. (1994). Mulheres Chuabos Contam... Sexualidade e Família (micro estudo exploratório). Maputo: INDE/FNUAP/UNESCO.

JACKSON, M. (1987). "Facts of Life" or the Eroticization of Women's Oppression? Sexology and the Social Construction of Heterosexuality. In: CAPLAN, P. (ed.). The Cultural Construction of Sexuality. London: Routledge.

JOESOEF, M.,SUMAMPOUW, H., LINNAN, M.,SCHMID, S., IDAJADI, A. and St LOUIS, M. (1996). Douching and Sexually Transmitted Diseases in Pregnant Women in Surabaya. Indonésia, American Journal of Obstetrics and Gynecology, 174:115-119.

KUN, K. (1998). Viewpoint: Vaginal drying Agents and HIV transmission. Family Planning Perspectives, 24(2)

LA RUCHE, G., MESSOU, N., ALI-NAPO, L., NOBA, V., FAYE-KETTE, H., COMBE, P., BONARD, D., SYLLA-KOKO, F., DHEHA, D., WELFFENS-EKRA, C., DOSSO, M. and MSELLATI, P. (1999). Vaginal Douching: Association with Lower Genital Tract Infections in African Pregnant Women. Sexually Transmitted Diseases, 26: 191196.

LEWIS, S. (2004). Notes for Press Briefing by Stephen Lewis, UN Secretary-General's Special Envoy for HIV/AIDS in Africa, May 1923, 2004.

LOW, N., CHERSICH, M. F., SCHMIDLIN, K., EGGER, M., FRANCIS, S. F., VAN DE WIJGERT, J. H, HAYES, R. J., BAETEN, J., BROWN, I., DELANY- MORETLWE, S., KAUL, R., MCGRATH, N., MORRISON, C., MYER, L., TEMMERMAN, M., VAN DER STRATEN, A., WATSON-JONES, D., ZWAHLEN, M. and MARTIN HILBER, A. (Accepted in 2011). Intravaginal Practices, Bacterial Vaginosis and HIV Infection in Women: Individual Woman Data Meta-analysis. Pios Medicine.

MAHOMED, A.; COUTINHO, P. and SANTOS, B. (n.a.). Envolvimento do Parceiro no Despiste e Tratamento das ITS em Mulheres Grávidas. Relatório Draft. Maputo: Ministry of Health.

MARIANO, E. (1998). Concezione Inerenti alia Sterilità delia Donna e alia Infertilità delia Terra Presso la Comunità Rurale di Djabissa dei Distretto di Matutuine, Província di Maputo - Mozambico. Tesi di Laurea in Lettere. Universita di Génova.

MARIANO, E. (2001). Childlessness: Whom to Blame? How to Cope? Symbolic Representations and Healing Practices among the Shangana of Southern Mozambique. Master Thesis. University of Bergen.

MARIANO, E. and BAGNOL, B. (2009). Intervenções Praticadas sobre o Corpo da Mulher e o Impacto na sua Saúde Sexual e Reprodutiva. Revista Médica de Moçambique, 10:27-36.

MARTIN HILBER, A., CHERSICH, M. F., VAN DE WIJGERT, J. H. H.M., REES, H. and TEMMERMAN, M. (2007). Vaginal Practices, Microbicides and HIV: What do we Need to Know? Sexually Transmitted Infections, 83(7): 505-508.

MARTIN HILBER, A. M., FRANCIS, S. C., CHERSICH, M., SCOTT, P., REDMOND, S., BENDER, N., MIOTTI, P., TEMMERMAN, M. and LOW, N. (2010a). Intravaginal Practices, Vaginal Infections and HIV Acquisition: Systematic Review and Meta-Analysis. PLoS ONE 5(2): egug, 1-11.

MARTIN HILBER, A., HULL, T. H., PRESTON-WHYTE, E., BAGNOL, B., WACHARASIN, C., SMIT, J. and WIDYANTORO, N. (2010b). A Cross Cultural Study of Vaginal Practices and Sexuality: Implications for Sexual Health. Social Science & Medicine, 70:392-400.

MARTIN HILBER, A., HULL, T., CHERSICH, M., BAGNOL, B., PROHMMO, A., SMIT, J., WIDYANTORO, N., UTOMO, I., FRANÇOIS, I., TUMWESIGYE, N. and TEMMERMAN, M., on behalf of the WHO GSVP study group. (Aceito, 2011). Prevalence of vaginal practices in Africa and Asia: findings of a multi-country household survey. Journal of Women's Health.

MCCLELLAND, R. S., LAVREYS, L., HASSAN, W. M., MANDALIYA, K., NDINYA-ACHOLA, J. O. and BAETEN, J. M. (2006a). Vaginal Washing and Increased Risk of HIV-1 Acquisition among African Women: a 10-Year Prospective Study. Aids, 20(2): 269-273.

MCCLELLAND, R. S., NDINYA-ACHOLA, J. O. and BAETEN, J. M. (2006b). Is Vaginal Washing Associated with Increased Risk of HIV-1 Acquisition? [8]. Aids, 20(9): 1348-1349.

MENON-SEN, K. (1998). Movingfrom Policyto Practice: A Mainstreaming Strategy for UNDP India. NewYork: UNDP. http://www.undp.org. in/Report/Gstrat/

Ministério da Saúde (2001). Plano Estratégico do Sector Saúde (PESS) 2001-2005. Maputo: MISAU.

Ministério da Saúde (2002). Report of the First Joint Mission to Evaluate the Performance of the Mozambique Health Sector in 2001, undertaken in July 2002. September. SINGLETON, G., ENEMARK, B., NIELSEN, O. F., OSORIO, M. C., DURÃO, J. and DJEDJE, M.

Ministério da Saúde (2004). Inquérito Demográfico de Saúde 2003-4. Maputo: MISAU.

MISAU/INS (2010). Inquérito Nacional de Prevalência, Riscos Comportamentais e Informação sobre HIV e SIDA (INSIDA) - Relatório Preliminar sobre dados de Prevalência. Maputo: MISAU/ INS.

MOORE, L. H.; SANDERS, T. and KAARE, B. (eds). (1999). Those who Play with Fire. Gender, Fertility and Transformation in East and Southern Africa. London: The Athlone Press.

MORAR N. S. and ABDOOL KARIM, S. (1998). Vaginal Insertion and Douching Practices Among Sex Workers at Truck Stops in Kwa- Zulu Natal, SAMJ, 88(4): 455-465.

MYER, L., DENNY, L., DE SOUZA, M., BARONE, M., WRIGHT, T. and KUHN, L. Intravaginal Practices, HIV and Other Sexually Transmitted Diseases among South African Women. Intravaginal Practices, HIV, and Other STDs, 31(3): 174-179.

MYER, L., KUHN, L., STEIN, Z. A., WRIGHT, T. C. JR. and DENNY, L. Intravaginal Practices, Bacterial Vaginosis and Women's Susceptibility to HIV Infection: Epidemiological Evidences and Biological Mechanisms. Lancet, 5: 786-94.

OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM and WHO (2008) Eliminating Female Genital Mutilation: An Inter-Agency Statement, Geneva: WHO.

OMBOLO, J. P. (1990). Sexe et Société en Afrique Noire. Paris: L'Harmattan.

ORGANIZAÇÃO DA MULHER MOÇAMBICANA (1983). Preparação da Conferência Extraordinária da Mulher. Relatório da Província de Tete. Tete: OMM.

ORUBULOYE, I. O., CALDWELL, P. and CALDWELL, J. C. (1995). A Note on Suspect Practices during the AIDS Epidemic: Vaginal Drying and Scarification in Southwest Nigéria, Health Transition Review, 5:161165.

PARIKH, A. S. (2005). From Auntie to Disco: The Bifurcation of Risk and Pleasure in Sex Education in Uganda. In: Sex in Development.

ADAMS V. and S. LEIGH PIGG. (eds.). London: Duke University Press. 125-158.

PARKER, G. R. and GAGNON, J. H. (eds.). (1995). Conceiving Sexuality. Approaches to Sex Research in a Post-Modern World. London: Routledge.

PRESTON-WHYTE E. M. (2003). Contexts of Vulnerability: Sex, Secrecy and HIV/AIDS. African Journal ofAIDS research, 2(2): 85-90.

RAIMUNDO, I., SAÚTE, A., SAIDE, A., MUCAMISA, C., BONIFÁCIO, M., MARUASSA, L., NDANGO, A. and MARIANO, E. (2003). Pesquisa Rápida Sócio-Cultural: Província da Zambézia. Maputo: Centro de Estudos de População (CEP) - Universidade Eduardo Mondlane (UEM) e United Nations Population Fund (UNFPA).

REED, B., FORD, K. and WIRAWAN, D. (2000). The Bali STD/AIDS Study: Association between Vaginal Hygiene Practices and STDS Among Sex Workers. Sexually Transmitted Infections, 77:46-52.

RUNGANGA, A., PITTS, M. and MCMASTER, J. (1992). The Use of Herbal and other Agents to Enhance Sexual Experience. Social Science Medicine, 35(8): 1037-1042.

SAHLINS, M. (1987). Ilhas de História. Rio de Janeiro: Jorge Zahar.

SCORGIE, F., BEKSINSKA, M., CHERSICH, M., KUNENE, B., MARTIN HILBER, A. and SMIT, J. (2010). "Cutting for love": genital incisions to enhance sexual desirability and commitment in KwaZulu-Natal, SouthAfrica. Reproductive Health Matters, 18(35): 64-73.

SCORGIE, F., KUNENE, B., SMIT, J. A., MANZINI, N., CHERSICH, M. F. and PRESTON-WHYTE, E. M. (2009). In search of sexual pleasure and fidelity: vaginal

practices in Kwazulu-Natal, South Africa. Culture, Health & Sexuality, 11(3): 267-83.

SMIT, J., MCFADYEN, L., ZUMA, K. and PRESTON-WHYTE, E. (2002). Vaginal Wetness: an Underestimated Problem Experienced by Progesterone Injectable Contraceptive Users in South Africa. Social Science and Medicine, 55(9): 1511-1522.

UNAIDS/WHO. (2003). Press Release on the AIDS Epidemic. Update of 2003 released on the 25 November at i4hoo GMT.

UTOMO, I. (2003). Vaginal Drying and Cleansing in Southeast Asia: Notes for Future Research. A presentation to the Asia Pacific Conference on Sexual and Reproductive Health.

VAN DE WIJGERT, J. H., CHIRENJE, Z. M., ILIFF, V. MBIZVO, M. T., MASON, P. R., GWANZURA, L., SHIBOSKI, S. and PADIAN, N. S. (2000a). Effect of Intravaginal Practices on the Vaginal and Cervical Mucosa of Zimbabwean Women. Journal of Acquired Immune Deficiency Syndrome, 24:62-67.

VAN DE WIJGERT, J. H., MASON, P., GWANZURA, L. and MBIZVO, M.T. (2000b). Intravaginal Practices, Vaginal Flora Disturbances, and Acquisition of Sexually Transmitted Diseases in Zimbabwean women. Journal of Infectious Diseases, 181: 587-594.

WHO. (2005). WHO Multi-country Study on Gender, Sexuality and Vaginal Practices.

WILLIAMS, O. A. (1993). More on Vaginal Inflammation in Africa. The New England Journal of Medicine, 328: 888-889.