

# Screening for HIV/AIDS: public health and motivations of quick test users in Northeast Portugal<sup>1</sup>

## A despistagem do VIH/sida: saúde pública e motivações dos utentes do teste rápido no Nordeste de Portugal

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<sup>1</sup> Research financed by HIV Portugal ([www.vihportugal.org/](http://www.vihportugal.org/)), under the coordination of Marta Maia, Network Center for Anthropological Research, investigating rapid tests in the HIV Counseling and Early Detection Center (CAD) in Bragança (Northeast Portugal) by the authors of this article.

### Abstract

The article examines the adherence of citizens to the quick test for HIV in the Counseling and Early Detection of HIV/AIDS Center (CAD), in the city of Bragança (Northeast Portugal). Specifically, it seeks to examine the role of a fast diagnosis in the fight against AIDS within the Portuguese public health system, to understand the circumstances underlying the demand for the service and to interpret the perceptions and practices of CAD users. In terms of methodology, it was a case study based on ethnographic inquiry, linking direct observation, informal conversations and interviews, which was associated with extensive documental and statistic research. The results obtained allow us to state that the quick test gave a very positive contribution to the fight against HIV/AIDS infection, facilitating citizen access to knowledge of their serological status almost instantly and improving their follow-up by health technicians. The so-called “dissipation of uncertainty”, following sexual risk behavior, is the main reason that leads users to perform a quick test. **Keywords:** Sexual Risk Behaviors; HIV/Aids; Information; Anonymity; Quick Test.

## Resumo

O artigo analisa a adesão dos cidadãos ao teste rápido de despistagem do VIH no Centro de Aconselhamento e Detecção Precoce do VIH/sida (CAD) da cidade de Bragança (Nordeste de Portugal). Em concreto, procura-se examinar o papel do diagnóstico rápido na luta contra a infeção pelo VIH/sida no quadro do sistema público de saúde português, compreender as circunstâncias subjacentes à procura do serviço e interpretar as percepções e práticas dos utentes do CAD objecto desta pesquisa. Em termos metodológicos, tratou-se de um estudo de caso assente em inquirição etnográfica, articulando observação direta, diálogos informais e entrevistas, a que se associou uma extensa pesquisa documental e estatística. Os resultados apurados permitem afirmar que o teste rápido proporcionou um contributo muito positivo para a luta contra a infeção pelo VIH/sida, facilitando o acesso dos cidadãos ao conhecimento praticamente imediato do seu estado serológico e melhorando o seguimento destes por parte dos técnicos de saúde. A chamada “dissipação da incerteza”, na sequência de uma situação de risco, é o principal motivo que leva os utentes a realizar o teste rápido. **Palavras-chave:** Comportamentos Sexuais de Risco; VIH/sida; Informação; Anonimato; Teste Rápido.

## Introduction

The HIV/AIDS quick test has significantly altered management of time, uncertainty and anxiety resulting from epidemiological risk, facilitating individual's access to diagnosis of their HIV status and, in consequence, access to early diagnosis and timely treatment. In Portugal, this type of testing began to be introduced in 1998 through an initiative of the National Commission for the Fight against AIDS (CNSIDA). At this time, there were only two centers of this type in the country, both in Lisbon. Aiming to ensure the spread of HIV testing, HIV Counseling and Early Detection Centers (CAD) gradually began to be established throughout Portuguese territory.

Assuming that early diagnosis and treatment are one of the greatest challenges in the strategy of HIV screening (and control), this article seeks to analyze the circumstances and underlying motivation for attending the CAD in Bragança for a quick test. More specifically, we aim to: (i) characterize CAD Bragança users; (ii) assess their knowledge, especially of HIV preventing and screening; (iii) perceive how knowledge and beliefs concerning the disease may condition perception of risk and the decision to get tested; (iv) understand the relationship between certain circumstances of expressing sexuality, emphasizing those related to having unprotected sex, as well as the more intimate subjective dimensions (fear, anxiety, imagination, dilemmas) underlying the decision to have a quick test done.

The reflections we develop here are the result of an investigation using a qualitative approach, the basic tool was a semi-structured interview, applied to participating CAD users, complemented by statistical data provided by the Bragança CAD. This research was conducted at the request of HIV Portugal. Such a request shows that the part of organized civil society engaged in the fight against HIV/AIDS recognizes the importance of studies by social scientists in exploring the disease and all aspects related to it, including those related to early diagnosis. In other words, socio-anthropological research on HIV infection is an essential and irrevocable feature of an in-depth reading of the disease, highlighting its social dimensions, and in the formulation of public policies in this area.

## HIV diagnosis: public health services, quick test and citizen involvement

A vast array of social dilemmas accompany infection with HIV/AIDS. From a social point of view, and according to Whiteside (2008), the way in which the disease spreads highlights fractures and inequalities characterizing our society. It is especially virulent amongst the poorest, from American Indian populations in Canada, to drug users in Dublin (or in any other European city) and entire nations, such as Malawi or Swaziland.

In public health terms, the disease brings public health care services, established in the welfare state<sup>2</sup> framework, under scrutiny in a way perhaps no other would. It provokes political discussion and citizen participation, especially in the field of prevention, uncovering and even accentuating countless ideological divides<sup>3</sup>. But, at the same time, it contributes forcibly to the political and social legitimacy of health care as a public good, especially considering that responses to infection are anchored in the States' public actions, in coordination with the World Health Organization (WHO). Faced with a disease with high economic costs, severely affecting sufferers living in poverty and more or less accentuated social marginalization, as in the case of drug addicts, it is only the public health care system which has appropriate conditions to guarantee that all citizens have access to treatment, without discrimination

or exclusion. And, on the other hand, to articulate social and prevention policies which can extend the fight against HIV/AIDS and make it more effective.

The quick test is one more example of public action concerning controlling infection, more effective the greater the voluntary adherence of citizens to the procedure. It provides individuals with an opportunity to discover their HIV status, although its reach is much broader, as it indisputably forms part of the field of prevention by reducing risk of contagion. It has been used in a wide variety of countries, both central and peripheral, with results in the above mentioned domain of prevention and raising citizens' awareness of HIV/AIDS infection, and thus having an exceptional effect on reduction (Lee et al., 2007; De Cook et al., 2006; Bayer et al., 2006; Njeru et al., 2011; Ferreira Júnior et al., 2005).

In an historical review of its establishment in Portugal, one of the greatest problems in the fight against HIV/AIDS infection in the late 1990s was under diagnosis. Due to the lack of a real strategy or means to track them, the number of infected individuals was clearly higher than the number of identified HIV cases, much higher than today's estimated number: around two infections for every diagnosed carrier. In order to decrease the gap between existing and identified infections, CADs were a key element in the strategy. They began to be established in 1998, with the creation of the anonymous Screening Center (CRA) in Lapa (Lisbon), followed by the CRA in Faro, in 2000, which provided, for the first

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<sup>2</sup> In this configuration, dominant in Europe, the State has a relevant role in financing and providing health care services, without distinction, at least in the legal sphere, between gender, age, class, disease, or any other "defining characteristic" of the citizens or their position in the social structure it is important to underline that the welfare state is the result of an unstable compromise between the owners of capital and the working classes, in which the latter are induced, or forced, to postpone the radical, socialist transformation of society, foregoing a part of surplus produced by the workers in the form of relative improvements in direct salaries and, above all, taxes to finance social investment and consumption redistributed via the state. This does not result, as Silva (2009) underlines, in compatibility between capital and labor, on the one hand, and capitalism and democracy on the other, despite the reasonable, albeit variable, success of European states in improving living conditions and protecting socially disadvantaged classes. In such a commitment, the State is both the mediator of conflicting interests of different social forces, and the manager of socio-economic structures and policies required by the relative autonomy and respective configuration of the state. These include those which structure and drive public health care systems, the fundamental characteristic of which is universal free or subsidized access not subject to the market. The backdrop of the debate regarding the relationship between civil society, welfare society and the welfare state reveals, in the case of Portugal, Mozzicafredo (1997) a democratic social vision of the regulating function of the State from a critical perspective, Santos (1993). See Hespanha and Carapinheiro (2002) on recent transformations in the welfare state, including those which are occurring in Portugal.

<sup>3</sup> For example, between the positions argued by the North American government during the Bush regime and by the Catholic Church and those argued by progressive activist sectors in the struggle against HIV/AIDS there is an enormous gap, which is especially evident in the field of prevention and reducing risk of contagion.

time in Portugal, free, anonymous and confidential testing, on a voluntary basis, very similar to the quick testing now conducted in the CADs.

Soon after, this institutional structure for HIV testing underwent changes. Following the 2001-2003 Strategic Plan of the National Commission for the Fight against AIDS (CNLCS), it was considered that testing should also include a counselling and prevention awareness raising aspect and, the configuration at the time being inappropriate for screening, the existing centers and those which were established later began to be known as CAD. Thus, between 2001 and 2003, the majority of CADs now existing in Portugal were established, with a territorial distribution which guaranteed relatively easy access to diagnosis for a significant part of the population<sup>4</sup>. The CADs, then, represented a significant simplification of the testing process, as well as an extraordinary closeness to potential users, safeguarding their rights throughout the process, with the emphasis on confidentiality. This simplification and closeness to the community was strengthened by the use of mobile units for quick testing for specific populations, or in contexts where it was deemed pertinent to intervene at the level of diagnosis.

As a result of the progressive expansion and flexibility of the service, the evolution in the number of quick tests conducted in Portugal was relevant. In 2009, 24,279 quick tests were performed in CADs. This number represents an extraordinary increase when compared with the 2,237 tests conducted in 2000, at a time when the CAD network was still being established and expanded. In the 2000 to 2006 period, although still increasing, the evolution was gradual. The really significant jump was in 2007, in which year around 75% more tests were performed than in the preceding year. This volume of diagnosis has remained relatively stable over the last few years, although there was a slight decrease in 2009

(Cnsida, 2010). Although it may be premature to say so, it is probable that in the immediate future the trend for stability in the annual number of tests will continue.

The widespread public service is, then, of critical importance in the overall strategy against HIV/AIDS infection and, among other things, allows early access to health care, higher survival rates and better quality of life for seropositive individuals, as well as a decrease in cases of transmission. But the quick test is more than this, it also serves as an instrument of contact and of raising citizens' awareness of the potential risk of HIV/AIDS infection and is, therefore, vital in creating a widespread prevention culture.

## The fieldwork

The field work took place in a space where the CAD and the Young People's Health Care Center (CAJ) operate. After several exploratory visits to get to know the facilities, and after prospective dialogues with members of the team in order to familiarize ourselves with the technical procedures and functioning, including division of tasks, the research team moved on to the next stage, that of interviewing the users. To do this, the days on which we would visit the facilities were agreed with the technical team. Confident that this was not "hostile" territory, with no particular difficulties or restrictions to access to the users in question<sup>5</sup>, the greatest difficulty lay in the unpredictable influx of users<sup>6</sup>. A total of 12 interviews were conducted in the center facilities, in the form of face to face interviews, with only the interviewer and interviewee present. We also conducted an interview with the psychologist, which was recorded, in which we attempted to discover and systematize aspects related to the CAD organization and way of functioning.

We gained access to the users through the CAD workers, being generally well received. In line with

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<sup>4</sup> The quick test can also be done in hospitals, health centers, "mobile units" and some non-governmental organizations.

<sup>5</sup> This is in contrast with other research fields in which we have worked over the last decade, such as that of prostitution (Ribeiro et al., 2008) or HIV/AIDS infected residents in the district of Bragança (Ribeiro et al., 2009), where there were proved to be significant, sometimes insurmountable difficulties gaining access to the social actors.

<sup>6</sup> It should be noted that there are many tests done outside the premises, especially in health centers and mobile CADs. This latter service is provided in a vehicle equipped for HIV testing. In addition to the service, every Tuesday the CAJ Miranda do Douro is used for ad hoc, although frequent, initiatives of quick tests and awareness raising sessions regarding HIV/AIDS and quick testing.

statistical data, the users interviewed were young adults, many students in secondary (the majority from the district of Bragança and residing there) and higher (some from outside of the district) education. The aim was to talk informally and in a relaxed way with the interviewer, who, ideally, followed Bourdieu's (1997) principles: mentally placing oneself in the place of the interviewee, without censure or qualifying their words or ideas. Despite the intimate nature of the questions asked, the majority related to sexual behavior, everyone spoke uninhibitedly of their experience, practices and expectations, and agreed to these being recorded<sup>7</sup>.

We also conducted a detailed bibliographic and documental search, seeking articles and data on infection and, specifically, quick testing. On the topic of infection, the main difficulty was in selecting from the very numerous texts based on the most varied theoretical perspectives and methodologies. Academic and other texts on quick testing were relatively scarce, signifying other types of pitfalls, which we naturally sought to avoid. In short, field research was conducted supported by a multitude of resources, following the principles defined by multiple designated methodologies<sup>8</sup>, combining ethnographic observation, statistical data and with emphasis on those collected by the CAD technical team, and the semi-scripted interviews with users<sup>9</sup>.

## The Bragança CAD

The Bragança CAD, inaugurated on the 11<sup>th</sup> April 2003, operates in the Loja Ponto Já, of the Portuguese Youth Institute (IPJ), in a street close to the Sé square, one of the busiest spaces in the city. The

service operates from Monday to Thursday between 09.00 and 18.00, and 09.00 to 12.00 on Fridays in the basement of the building housing the IPJ. The Young People's Health Care Center (CAJ) which offers advice, especially regarding young people's sexuality, is right next to the CAD. The two services completely occupy the basement, a reserved space through which no one who is not involved with the services passes. In this way, users' anonymity is further guarded, a thing which some of them highlighted as essential to their decision to get tested:

*I was 99% sure no one here would know me. In Vimioso (the user's hometown) it was always more complicated. There was always the need to look over your shoulder. I was in a café when I saw the number (of the CAD). I tried to copy it down in such a way that no one noticed (Male, 42).*

Although some individuals were aware of the CAD from the formal divulgation process, as in the case of publicity in regional media, the majority of quick test users had become aware of the service through friends or through the Young People's Sexuality Support Service (Bragança, 2010). In many contexts, such as that of the paradigmatic case of the school environment, divulgation of information through friends and acquaintances is very significant, taking over other processes of divulgation:

*I came with a classmate. I was going to university and my colleague said she was coming here, so I came to see it, to find out. [...] Many people, at least from the university... had already been here..., (Female, 20).*

In some contexts related to the practice of prostitution there is a deliberate attempt by many women

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7 This attitude attracted our attention due to the way in which intimacy is constructed and negotiated today. Widespread use of social networks such as Facebook and Orkut, the proliferation of Big Brother type programs and the use of YouTube to divulge homemade pornographic videos, challenges the very concept of intimacy, leading some authors (Sibilia, 2008) to characterize these changes as an expression of a new form of intimacy which they designate as extimacy. In their view, intimacy is so important in how we define ourselves as individuals that we feel compelled to demonstrate it to others.

8 Multiple methodologies are increasingly used in anthropological and sociological research in order to respond to the most diverse problems with which the researchers work. (Among others, v. Orlove, 2003; Burgess, 1997; Akilu, 1995).

9 The interview script used was made up of the following groups of questions: (i) personal characterization; (ii) sex life; (iii) use (of addictive substances); (iv) beliefs, knowledge and attitudes regarding HIV and infected individuals; (v) condoms (assessment and modes of use); (vi) testing (information, adherence and its place in prevention); and (vii) health (sexually transmitted infections, chronic illness, use of health care services). Interviews were recorded, then subject to content analysis, constructing typologies considering the responses given to the questions forming the above mentioned groups so as to identify the aspects which were most frequently repeated and valued by the interviewees, using Weber's comprehensive approach as a backdrop (Weber, 1993).

to pass on information about the CAD and encourage colleagues to get tested regularly using the quick test, as a strategy to safeguard collective health:

*When a new girl arrives we encourage her, we try to give advice and tell her where to have it (the quick test) done. Where she should go. When we do this, we're protecting ourselves. When someone new comes, you know... who is not from here in Bragança, who comes from somewhere, anywhere, else ... (Female, 47).*

The CAD technical team is formed of a psychologist, a nurse and a manager. The procedures, in terms of caring for those who use the service and have the test done, are in accordance with those governing all CADs, subdivided into four overall stages; counselling, pre-test, test and post-test counselling. In addition to the CAD, these three professionals also contribute to the CAJ, producing positive complementary effects in both services. For example, it is very common for a young person who goes to the CAJ for advice on questions of sexuality, or simply to request contraception, to also be advised on the important of HIV testing and then referred to be tested.

If we evaluate the functioning of the center from the point of view of the tests performed and results obtained in the first three years of operation (2003 to 2005), these were modest. This was recognized in the latest annual report (Bragança, 2010). On balance, it is recorded there that the most significant increase in production occurred from 2006 onwards, coinciding with when the current technical team began to operate there. Between 2005 and 2009, the annual total number of tests went from just 80 to 1,636, due especially to the work conducted in secondary schools and institutes of higher education, the authorities, civil society associations, police forces, fire brigade and the Izeda prison, located 30km from the city of Bragança, always working in close cooperation with health care centers.

Although it did benefit from the introduction of the quick test - spelling the end of unclaimed test results -, the extraordinary increase in the quantity

of tests performed in recent years is inseparable from the solicitude of the technical team, bearing in mind they have had to overcome lack of awareness, disinterest or even “reluctance” to make use of the service. Instead of waiting for the users to come to them, the team went out to workplaces and to places of education and leisure. This was a more pro-active attitude, clearly rooted in commitment to a public service, aiming to give meaning to their work, the team decisively opted to engage with the terrain, divulging the quick test in social contexts and to groups directly associated with risky behavior.

In terms of the geographical distribution of the tests performed, and notwithstanding the significant load conducted in CAD facilities, there is a reasonable district coverage through diagnoses performed in the various health care centers, even reaching the more peripheral districts, such as Freixo-de-Espada-à-Cinta and Vila Nova de Foz Côa. This work outside the CADs is of vital importance in ensuring the furthest reach of prevention strategies. In relation to the student community, the activities conducted at different times in the Instituto Politécnico in Bragança, including in Mirandela, in the Instituto Superior Jean Piaget, in Macedo de Cavaleiros, and in Miranda do Douro hubs of the Universidade de Trás-os-Montes e Alto Douro are noteworthy. As young people, especially students in higher education, commonly frequent bars and other nightlife establishments, the CAD technical team contacted more than a hundred bars and cafes in Bragança. Still within the ambit of activities carried out outside the CAD, and bearing in mind the well-known - sometimes exaggerated - scale of prostitution in Bragança (Ribeiro et al., 2008)<sup>10</sup>, the CAD team regularly travel to brothels to distribute safe sex materials and raise awareness.

## Quick test users

The majority of interviewees were young people, with 9 (of 12) being aged between 18 and 34, and with a slight predominance of females (7, compared with 5 males). In line with statistical data provided

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10 Currently, the CAD has more than 80 users working in the sex trade, who adhere closely to quick testing.

by the CAD (Bragança, 2010), the strong presence of young users can be understood by referring to a considerable number of factors, of which we highlight: (i) higher exposure and receptivity on the part of young people due to campaigns raising awareness of HIV/AIDS; (ii) the central location of CAD with regards the city schools and the Instituto Superior Politécnico de Bragança; (iii) the fact that it operates in a building which also offers a variety of other services aimed at young people (e.g., free internet access) which are, in some cases, directly related to young people's sexuality (e.g., CAJ); (iv) the added guarantee of anonymity, as the building is not itself associated with topics of sexuality or HIV/AIDS infection; and (v) awareness raising campaigns which the CAD team conducted together with the student community in the district.

Proceeding with the exploration of the statistical data provided by CAD, the search is regionalized, serving the place of residences which generally coincides with the district of Bragança. Almost a third of the 1,613 users reside in the main district, with Mirandela being the second location in which the most tests are carried out, and the municipalities of Vila Nova de Foz Côa and Vila Flor the fewest. It is notable that almost 10% of users are from outside the district, a fact which appears to be linked to the search for increased anonymity. Nor should it be forgotten that a considerable number of the users are students at the Instituto Politécnico de Bragança, and are not from the district.

When examining the situation according to profession (or activity), we found users from a wide variety of professions, such as biologist, teacher, sales assistant, dietician, nurse and prostitute, among others. The most frequent category was, however, that of student. This, in effect, is the group which has been widely exposed to campaigns raising awareness and prevention throughout their schooling (from elementary to further education), and thus have greater knowledge of HIV and are more concerned with their HIV status.

A relevant aspect concerns the 64 (7.3%) of female users who were sex workers. Many of them also kept in regular contact with the CAJ, where they were

provided with condoms and other products related with sexuality. The vast majority of them are Brazilian, as has been found in previous studies (Ribeiro et al., 2005, 2008), also in the context of Bragança and which conclude that, among other aspects, sex workers, in general, have fairly detailed knowledge of HIV and, as a rule, seek medical attention. In such cases, as can be seen in the excerpt below, the nature of their activity and the greater potential exposure to situations of risk are, subjectively, given as the main reason for having the test done:

*No, I had never had it done, neither here nor in Brazil, never. I had heard of it but I didn't know much about it and, as in Brazil we had a different way of earning a living, no, I never had it done. Then I came here and it attracted my attention (Female, 38).*

Regarding sexual orientation, the vast majority reported they were heterosexual, with a small number indicating their preferences were homo- or bisexual. There were 70 users (4.3%) who had never had sexual relations and 78 (4.8%) who had not been sexually active in recent months. As for the number of partners in the preceding six months, two thirds responded they had only had one, with 10.1% reporting two to four and only 1% more than five, data which do not entirely coincide with responses given to the question on total "number of partners": 26.7% reported between two and four and 16.7% reported five or more, of which 7.5% reported ten or more. These data reveal the importance of campaigns raising awareness of prevention and of safe sex, as we are faced with a population with multiple partners. Such sexual behavior needs to be understood as part of the situation of the "transformation of intimacy" in modern society (Giddens, 2001), characterized by greater contingency, transience and fluidity in relationship ties (Bauman, 2004), which, in many cases occur, break down and/or reoccur depending on the individuals' emotional and sexual needs.

### **HIV/AIDS infection and the quick test: perceptions and practices**

The length of the interviews varied considerably, between 20 and 90 minutes, and the details the interviewees gave provided relevant information on

the way in which users viewed HIV/AIDS and, in particular, the process of detecting infection. Although few could distinguish with precision the different stages of which the test is made up, they all knew that it was performed by means of a blood test from a finger prick, with the result being available within minutes. They all had reasonable knowledge of the disease as regards transmission, particularly those who are associated with high risk practices, such as sharing needles or unprotected vaginal or anal sex. However, if sharing needles is scarcely practiced, unprotected sex, especially with occasional partners, is relatively common (Bragança, 2010), showing that there is still a long way to go in the domain of raising awareness of, and adhering to, safe sexual practices.

The same is true concerning condom use in the context of more stable relationships, which is no less worrying. The strong emotional involvement generally accompanying longer lasting relationships tends to lead to partners trusting the other, not even admitting the possibility of the partner being HIV positive or posing any type of risk. Indeed, HIV/AIDS tends to be seen as a “disease affecting others”, those we do not know and who are distant from us (Parker, 1994; Guimarães, 1996; Knauth, 1998). Believing this, it is easy to consider safe sexual behavior, namely, using condoms in a relationship in which the partners is socially and emotionally closer, to be unnecessary. Furthermore, condoms tend to be symbolically understood as an obstacle in creating intimacy.

Regarding the motivation for going to the CAD to have the quick test done, that which stands out is, essentially, freedom from uncertainty, almost always marked by feelings of anguish concerning HIV status due to relatively recent risky sexual situations and/or behavior, such as not using a condom, or the condom splitting during sexual relations which are more or less occasional and with a partner who is not well known or considered untrustworthy.

The concern about the possibility of being infected and the subsequent need *to get tested* to put an

end to the worry of not knowing is especially acute when the situation of risk (e.g., condom splitting) occurs during sexual relations with a partner whose activity (prostitution) tends to be socially associated with danger and contamination (Douglas, 1991) and is therefore viewed as a possible focus of epidemiological contamination<sup>11</sup>:

*Condoms have split two or three times with partners who were not stable over the last six years. It was always with prostitutes. [...] Around three weeks ago, the condom split again. Now, in three or four months I'll be back here. I'm still very worried. If she hadn't been a prostitute, I wouldn't be so worried about HIV and the need to get tested. It's not the same, is it? Once, one of them said to me that she didn't go to the doctor. [...] Even though the condom didn't split, I was worried. Imagine if it had split, which has happened! (Male, 42).*

Thus, having the test done is viewed as a calming procedure, the result of which is confirmed later. For cases which are within the “window period”<sup>12</sup>; it is also viewed an “open door”; in the case of more stable relationships, for sexual practices in which the condom is perhaps not always used. For many other users, it means discovering their status due to having sexual relations which always result in a degree of uncertainty, even when using a condom or having unprotected sex with a partner in a regime of mutual exclusivity and of known HIV status.

All of the users had in common the positive impression the CAD and its team made on them, and the fact that they had heard of the institution through word of mouth:

*A colleague told me I could come here and it was free and... ok, I just came now... my colleague is also having it done now. He really wanted to come because he does engage in risky behavior. So, he said to me I had to have it done because he's really reluctant and I don't know what else, he had to have it done... and, here I am (male, 19).*

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<sup>11</sup> In such discourses not all those involved in the phenomenon are blamed equally: whereas women are cited as the main culprits in the spread of HIV and other sexually transmitted infections, customers receive less blame, despite the many studies that refer to them as largely responsible for risky sexual behavior (Kruhse-Mountburton, 1992; McKeganey and Barnard, 1996; Legardinier, 1997; Hart, 1998; Ribeiro et al., 2005).

<sup>12</sup> The so-called “window period” is the four to eight weeks during which the individual has still not developed HIV antibodies which enable it to be detected using a blood test.



There are also users whose motivation for having the test done is due to intravenous drug use, involving sharing needles, some of them encouraged to discover their HIV status by their doctors. There is also an important, relevant statistic, mentioned above, female users involved in the sex trade who therefore closely monitor their HIV status:

*A colleague told me about it and so I came to have the test done. I came last year and I return every three months to have it done. As I work in the nightlife scene, as well as earning a living I need to try and see my situation. I have to care for myself too, people... I don't live in a bubble, I know people, interact with people, so I need to know my status, you know? (Female, 47).*

There are recurring cases of users, especially women, who cannot manage to impose condom use until both partners know their HIV status. As one of the interviewees explains, making unprotected sex dependent on getting tested introduces distrust into the relationship, to such an extent that it could even provoke its breakdown. In a certain way, condoms continue to be seen as an element associated with partners marked by socially censured, namely prostitution, sexual relations with multiple partner and homosexuality<sup>13</sup>. This affects women, placed under suspicion due to dominant gender values, and leads to difficulty imposing protected sexual practices. Thus the urgent need to empower women's control of their sexuality, including choice of partners, and within the relationship itself. Even for women who work in the sex trade, condom use often requires a firm stance, as has been observed in other research (see, among others, Ribeiro et al., 2005, 2008):

*I've always worked in the nightlife scene. In Alentejo (south Portugal) they were more conscientious with the clients. And they didn't have a problem with that. Here no! I've had difficulties here. There are also the older people, it's more difficult to convince them to use a condom, it's not easy. They say "I'm going to die". So I say, "you're going to die, but I'm not looking to die, it's not like that!" Sometimes I say*

*to them, "and what about your family, don't you like your wife, your children, your grandchildren? I don't know. How can you live with your loved ones when you go out on the street and look for something to bring home..." (Female, 35).*

Although we did not find any cases of a woman being absolutely incapable of choosing her partner or the way in which she had relations with him, as occurs in many parts of the world, the moral restrictions imposed make it evident that, in Portugal too, women continue to be vulnerable to HIV, as suggested by Boler and Archer (2008), as they lack the power to protect themselves or to define when, how and with whom to have sexual relations. This rebalance of power in terms of gender is especially important if we consider that its lack has serious repercussions on women as, due to anatomy, they are more vulnerable to infection than men, in the context of heterosexual relationships. Thus, it is no surprise that, in Africa - where women's lack of power is not uncommonly linked to reduced educational capital - the majority of infections among young people affect females (Boler and Archer, 2008).

It also seems to be difficult to request a partner to get tested. This was understood, by many of the interviewees, as perhaps being perceived by the partner as distrust regarding their sexual history, as, in light of the dominant morality, promiscuity is not recommended. There are, however, numerous cases of the woman requesting her partner to get tested, as illustrated in the following statement: *I spoke to him about it (the test). I think that, in my opinion, if I come to have it done, it's good for him to come too, don't you think? There's no point in one person knowing their result if the other is oblivious, you know? (Female, 23).*

According to users' responses to a survey by the CAD technical team regarding the test, the majority had it done for screening, without any evident concrete motive. The second most common motive was having unprotected sex, with split or otherwise deficient condoms in third place. In short, for most users, their experience of situations of uncertainty

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<sup>13</sup> The first years of the infection's spread affected certain social groups particularly intensely, such as sex workers and intravenous drug users (IDU) and homosexual males, these being especially at risk as there is a greater risk of contagion from anal than from vaginal (Boler and Archer, 2008).

or risk appears to mean that infection with HIV/AIDS is no longer represented as a “disease affecting others, a distant problem” (Knauth et al. apud Valle, 2002, p. 192) and is subjectively recognized as a near and threatening reality. In this context, diagnosis is a “showdown” to definitively placate worry and uncertainty and gauge whether or not the infection remains a “disease affecting others”:

*You always have that doubt, you know? But you have to come, living with the doubt is worse* (Female, 47).

In some cases, partners recognize this verdict as an essential prerequisite to beginning a new sexual relationship.

## Final considerations

The fight against HIV/AIDS infection was profoundly and irrevocably changed by the introduction of the quick test. Almost immediate access to results enabled the organizations and technicians involved in the process to give the appropriate follow up in terms of counselling, especially in the case of negative results, and of rapid referral in the rare cases in which the diagnosis was positive. The advantages of the quick test depend, obviously, on the existence of a structure with the appropriate human resources and territorial distribution.

With reference to the Bragança CAD, Portugal has the minimum sufficient means to improve its performance in the difficult struggle against this infection. In the case of this CAD, the competent performance of all members of the team stands out, indefatigably working to raise users’ awareness, always available to seek them out, for example, through organizing screening activities in the most varied institutions and places in the district, with the emphasis on the schools.

It is therefore no surprise that the majority of users are students, from Portugal and with a sexual history of multiple partners. This does not mean that these users do not have elevated awareness of the risk of infection - something which was clearly demonstrated by the statements collected throughout the field work - as, without exception, they all knew methods of contagion and of protec-

tion. In contrast to what is generally thought, the younger users showed no particular aversion to using condoms, accepting them without noticeable discomfort - which does not mean, as stated above, that they always use them, above all in potentially risky sexual situations. Using this prophylactic means of preventing contagion is indispensable among sex workers, a fact which demonstrates that this professional group is not, as we have demonstrated in previous research cited here (Ribeiro et al., 2005, 2008), a field of contagion.

As has been analyzed in detail in the fifth point of this text, all users had reasonable knowledge of the how the quick test was conducted, although they were unaware of the stages. Still more relevant, they knew how the infection is transmitted, especially those associated with sharing needles - rare among the users interviewed - and unprotected sex, including vaginal penetration. In this area, there is still much work to be done, especially in combating the “false sense of security” produced by emotional proximity, leading partners to accept unprotected sex.

The principal reason for getting tested was related to “clearing up uncertainty”, normally due to relatively recent engagement in risky situations, sometimes resulting from not using condoms with an occasional or “untrustworthy” partner, sometimes because of the condom splitting or coming off. In some cases there was an imbalance of power between genders, with some women saying they did not feel capable of imposing condom use on their partner, as this could be understood as an expression of sexual promiscuity, morally frowned upon. This masculine domination also made many women feel incapable of persuading their partners to get tested, with this being seen as a censurable lack of trust.

To conclude, the quick test represents a very significant advance in the fight against HIV/AIDS infection and justifies the creation of the CADs. However, there is still much to be done, namely raising awareness of condom use as the rule in sexual relations, and in getting tested. It is obvious that users who get themselves tested in the CAD do not lack information on the forms of HIV/AIDS transmission, so what matters is to reach those who have never been tested.

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Received: 09/23/2012  
Reviewed: 07/22/2013  
Approved: 09/25/2013