

The politics of adherence to antiretroviral therapy: between ancestral conflicts and drug resistance

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Abstract

This article investigates the implementation of antiretroviral therapy (ART) in Maputo, Mozambique. Firstly, the author examines the enrolment procedures of medical professionals in health centres, which are intended to “produce” adherent patients. Secondly, through the exemplary case study of Joana, a young patient and her family, the author explores the zone of social abandonment (Biehl 2007) where vulnerable subjects become trapped, leaving little hope for adherence to therapy or other survival strategies. The author argues that the shortage of infrastructure, as well as other social forces, clash with the emergence of so-called ‘therapeutic citizenships’ analyzed from other anthropological studies since the introduction of ART (Nguyen 2010). Caught between the shortcomings of the health system and a violent family context, Joana’s body became a battleground for ancestral conflicts and a stark illustration of medical failure.

Keywords: HIV/AIDS, adherence, ancestral conflicts, health facilities, Mozambique

Research setting

The design and development of Mozambique’s primary health care system began following independence from Portugal in 1975, with the new socialist government, which scaled up basic services to the country’s largely rural and impoverished population. President Samora Machel (a former nurse) and his independence party known as the Mozambique Liberation Front (FRELIMO) made the creation of a national health system a top priority¹. After the successful initial rollout of the system, however, a civil war broke out between FRELIMO and RENAMO (Mozambique National Resistance), lasting from 1977 until 1992².

From the late 1980s a structural adjustment program was imposed on the country, leading to the privatisation of public services and industries, budget cuts in the fields of health and education and the scaling down of other social safety nets (for

¹ Pfeiffer 2019.

² Cliff and Noormahomed 1988.

instance food transfers, school feeding programs)³. At the same time, a large proportion of health sector aid was redirected towards NGOs. By the early 1990s nearly 100 agencies had mushroomed to support the health sector and, by 2000, there were hundreds of health projects managed by NGOs across the country, with only superficial linkages to the national health system⁴.

The Mozambican health system still has one of the lowest health-worker-to-population ratios in the world, with only three doctors and twenty-one nurses per 100,000 people. Furthermore, AIDS remains a major cause of death in the country and the second leading cause of disability⁵.

Data from 2018 estimates that 2,200,000 people were living with HIV in Mozambique, of which 140,000 are children. The HIV incidence rose from 11.5% in 2009 to 13.2% in 2015 in the age group 15 to 49 years⁶.

My interest in HIV/AIDS studies began during the psychology training with foreign patients at the Frantz Fanon Centre in Turin. The first case I had during my training was a Nigerian woman victim of trafficking and affected by HIV. It was one of the first instances in which I realised what are the challenges in the psychological context when dealing with patients with different interpretations of care and illness. These challenges brought me closer to anthropology and, later on, as part of the master degree in psychology, I carried out research on the juvenile perception of HIV/AIDS in the city of Namaacha, Mozambique. Subsequently, I continued working in Mozambique for an Italian NGO. Not too convinced about working in the field of humanitarian aid, in 2016 I started the PhD in anthropology and between 2017 and 2018 I conducted 15 months of ethnographic fieldwork in Maputo, the capital of Mozambique.

With my PhD research project, I aim to investigate how politics of care and adherence affected young people living with HIV⁷. This article analyses how the lack of infrastructures, as well as economic and social forces, clashes with the emergence of so-called ‘therapeutic citizenships’, especially in the case of extremely vulnerable subjects. The gender issue further problematises the already difficult situation of teenagers living with HIV, and Joana’s story⁸ is exemplary in presenting how teenagers often end up trapped in zones of social abandonment⁹. As I will show, caught between the shortcomings of the health system and a violent family context,

³ Pfeiffer 2003; Cliff 1991; Fauvet 2000; Hanlon 1996.

⁴ Hanlon 1996; Pfeiffer 2019.

⁵ MISAU 2015.

⁶ PEPFAR 2018.

⁷ The research project received funding from FCT (Science and Technology Foundation of Portugal) doctoral program at the Institute of Social Sciences of the University of Lisbon (ref. SFRH/BD/115356/2016) and received the approval of the Bioethical Committee of the Ministry of Health in Mozambique (ref. 1999/ CNBS/17).

⁸ All the names in the article are pseudonyms.

⁹ Biehl 2007.

Joana's body became a battleground of ancestral conflicts and a stark illustration of medical failures¹⁰.

During fieldwork, I came across new and different categories of representation of health and illness and with my intrinsic ethnocentrism. As the Kleinmans critically examine, ethnocentrism is the main dilemma of medical anthropology, rather the inability to think of and value other people's lives in any other way than in our categories¹¹.

As an anthropology scholar, I was aware of my own ambiguous relation with this attitude. As Sjaak van der Geest pointed out, while I can feel the moral and political danger of ethnocentrism, which I thus try to criticise and fight, at the same time, I acknowledge that ethnocentrism was part of my culture and that no culture could survive without at least some degree of it¹². My own cultural practice, in this context as a biomedical-oriented approach, filtered my way of representation and discourse.

This did not imply, however, an inability in understanding local cultural practices. While firmly convinced that taking antiretroviral drugs was the only way to control the virus, over time I learned to understand and analyse other therapeutic pathways implemented by family and patients and recognise the need for the coexistence of all of them.

Theoretical and methodological framework

As Castro, Farmer and Kleinman point out, I will adopt a biological approach to adherence that relies on a dynamic analysis of the clinical and social course of the disease and the continuous interaction of biological and social processes over time¹³. Adherence differs in time and space and must be framed with respect to multifaceted causes within its larger social, economic and political contexts. Furthermore, as I will analyze in the paragraph about ancestral conflicts, in Mozambique the "social cause" is profoundly linked with the "spiritual cause" and the presence of ancestors in the everyday life of people and families.

The use of a biosocial framework grounded in the lived experiences of people diagnosed with HIV is essential for understanding adherence, how it changes over

¹⁰ Data from UNAIDS (2018) reported that women are disproportionately affected by HIV in Mozambique: of the 2 000 000 adults living with HIV, 1 200 000 (60%) were women. New HIV infections among young women aged 15–24 years were slightly less than double those among young men: 39 000 new infections among young women, compared to 20 000 among young men. (<https://www.unaids.org/en/regionscountries/countries/mozambique>)

¹¹ Kleinman & Kleinman 1991.

¹² Sjaak van der Geest 2002.

¹³ Castro and Farmer 2005; Farmer 1990; Kleinman et al. 1995.

time, and what are the reasons for non-adherence. Often, and particularly in resource-poor settings, the analysis of the patient's life trajectories and social contexts allows to observe these reasons as lying outside personal responsibility¹⁴.

Besides participant observation in two health centres in Maputo (*Clinica 1* and *Centro de Saúde*), interviews with health workers, psychologists, traditional healers, NGO workers, I followed the life of ten teenagers (between thirteen and nineteen years old) living with HIV, who manifested difficulties in complying with ART.

My expertise as a psychologist facilitated the collection of their stories, which was assisted by the implementation of a support group for teenagers with adherence difficulties in a daily centre led by a Catholic congregation¹⁵. The group was made by four female and six males, all coming from a poor socio-economic environment and living in *cidade de caniço* [the city of reed]. Eight of them were parentless and lived with either grandparents or older siblings. Two were fatherless, but considering the precarious situation in the maternal house, they lived with their grandmothers. Among them, six had already begun the second line of antiretroviral treatment¹⁶ and four have died due to AIDS-related complications during 2018/2019.

The creation of a support group aimed to build trust and intimacy with the participants so that they would feel confident in sharing their experiences. The group was characterised by great flexibility in regards to both schedule and space: members could arrive when they chose to, for instance after school, attending was not mandatory with the opportunity to choose different activities. The possibility of choosing without strict rules proved to be powerful in the creation of a safe space.

In this context, becoming an active participant in my research occurred naturally. Following Ruth Behar observations, anthropologists have to embrace their own emotional involvement in the fieldwork. Behar brilliantly debunked the false and conventional idea that science credibility implies a detached and neutral observer¹⁷. Although this aspect is not explored in this article, my emotions in the field became an important aspect in the analysis and interpretation of the ethnographic data as they had an essential role in building my fieldwork relations, in shaping knowledge on them, as well as in designing research approach¹⁸.

Furthermore, psychological well-being of the participants of the support group was always a priority in the collection of ethnographical data. As George Devereux observes, the double role psychologist/anthropologist is a useful tool to investigate

¹⁴ Castro 2005.

¹⁵ The centre offered various micro-credit activities, school, psychological and food support for vulnerable families with members affected with HIV.

¹⁶ When the virus becomes resistant to a particular ART drug, the patient passes from first-line treatment – which consists of one or two pills a day – to a second-line treatment – which involves more than 5 pills a day and implies a much more significant collateral effect (<http://www.aidsmap.com/Viral-load/page/1327496/>).

¹⁷ Behar 1996

¹⁸ Stodulka 2015.

the cognitive processes of incorporation and the profiles of structural violence - in this case concerning the context of HIV/AIDS¹⁹. However, the ethnographic and clinical positioning has led to some dilemmas concerning the tension and the integration between these two dimensions.

The experience of working with them and be a testimony of their lives made me aware of the privileged position I held, as a foreigner. As Simona Taliani, Paul Farmer and Nancy Sheper-Huges remind us, while working within extremely vulnerable contexts, is impossible not to feel this privilege²⁰. During the meeting with the participants, anguish and guilt were persistent in me. The proximity with their daily violence, their illness and occasionally even their deaths made me feel sometimes unable to emotionally control similar experiences.

Joana was one of the first members of the support group. I met Joana for the first time in March 2017 at the day centre. Due to severe malnutrition, her weight at the time was 31 kilos and she was unable to walk. She was born in a little village near Chibuto, in Gaza Province, southern Mozambique. Her mother had been a cleaner in a rural hospital and had died six years earlier, murdered by her stepfather, who died a few years later in jail. Her alleged biological father had been hit by a truck and killed when Joana was a baby. Joana contracted HIV through vertical transmission and started ART when she was ten years old. She lived for a while in Gaza with an aunt and then moved to Maputo to live with her grandmother in a house near the airport. At the time I met her, she was living with her uncle's wife and their daughter. Her uncle Pedro had died earlier that year in February from an AIDS-related illness. He had not been taking his treatment and had blamed Joana for his illness. Joana lived behind the garage of uncle João. João was considered by the whole family a person to fear, and a rich man too. Rumours in the family suggested that he had killed his brother with the help of witchcraft and that this was the reason for his wealth. He tried to expel Joana from the house several times, accusing her to be a sorcerer and the cause of many problems.

Politics of care and adherence

«Joana is not taking treatment. The other day
when I was at the hospital,
I found a lot of pills in her pocket.
This means that is now a body without drugs».
(Clelia, Joana's grandmother, January 2018)

Health care in Mozambique is shaped by a range of interventions constituted through diverse actors, aims, and temporalities. Care, in this framework, encapsulates all the

¹⁹ Devereux 1967.

²⁰ Taliani 2006; Farmer 2001; Sheper-Huges 1992.

material, social, epistemological, and medical work that accompanies HAART (Highly Active Antiretroviral Treatment) pharmaceuticals, affecting the everyday life of the young people I met during fieldwork.

Amid the diversity of caregiving actors in Mozambique, one can say that the various health workers, and also to an extent my own work, all pointed towards a common objective. Still, this approach to care is a matter of practice: adherence practice is produced differently in different places and modalities (hospitals, public health centres, NGO health centres, daily centres). The multiplicity and difference of care practices in the Mozambican health sector show how diverse and deeply unequal are the ways in which different actors and institutions come to be invested in the objects, actors, and practices of medical care²¹.

Obviously, the present work is by no means the first to stress the importance of care. However, as Anne-Marie Mol pointed out, there are two logics in health care, the 'logic of care' and the 'logic of choice'. The 'patient choice' and 'good care' may sometimes complement each other, but more often they clash²².

In public health centres, patients have little decision-making capacity for what concerns adherence to ART. To provide the possibility of free choice is surely a valuable ideal, but it remains an abstract one, which only applies to situations in which people are sufficiently equipped to actually make their own decision. According to the logic of choice, an actor is someone who makes decisions. In order to make decisions, the person has to consider the relevant arguments and weigh up the advantages and disadvantages of the available options²³. This component practically did not exist in the care policies within the health centre where I conducted research.

When patients like Carlos, another member of the support group, refused to take ART in the late stages of AIDS, I remember feeling particularly distressed by this choice. On the one hand, I thought and looked for possible strategies to improve their adherence but, on the other hand, I wondered if, after all, for him, this was his only way of acting his agency and consequently a choice that had to be accepted.

However, I believe that in contexts where structural violence is persistent we have to be cautious and highlight when people cannot choose in an autonomous way. The course of their illness had been dictated by a series of external factors which, following the work of authors such as Farmer and Bhiel, do not allow subjects to act and actually 'choose'²⁴. Furthermore, structural barriers are still persistent in the

²¹ McKay 2018.

²² Mol 2008.

²³ Mol 2008.

²⁴ Farmer 2001; Bihel 2007.

implementation of the exams that control the HIV trends (CD4 counts and Viral Load test)²⁵.

The implementation of viral load as a monitoring tool still faces considerable challenges in Mozambique, with national coverage reported by PEPFAR's (President's Emergency Plan for AIDS Relief - US) implementing partners at 33%. The whole process requires improvement, as clinicians rarely make requests on time, the referral system is weak, the equipment maintenance is poor and the technical assistance is scarce – this leads to frequent breakdowns, resulting in long waiting lists and turnaround times – and, finally, there is no reliable system to ensure that test results reach patients' files²⁶.

Medical consensus states that to achieve an undetectable viral load and to prevent the development of drug resistance, a person on ART needs to take at least 95% of the prescribed doses on time²⁷. In this paragraph, I do not question the veracity of this medical statement. Rather, I focus on how the politics of ART implementation in Mozambique are both complicated and contradictory.

The inability to obtain and take medications after the initiation of therapy is often labelled as “non-compliance” or “non-adherence”, and it is usually categorised by the health workers according to patient-related characteristics, often ignoring the social, medical and economic causes²⁸.

One of the main concerns for HIV positive teenagers who contract the virus through vertical transmission, like Joana, is the disclosure of their status to improve adherence. According to the guidelines of the Ministry of Health, the disclosure of the HIV diagnosis should ideally be conducted by a family member with the support of a health centre's medical staff and should take place between the ages of 9 and 11 years old, when the person can understand the disease, even if he or she is asymptomatic²⁹. Health technicians have the task of accompanying family members in this process, which becomes even more complex if started during adolescence³⁰.

Often young patients were orphans and lived in families led by grandparents or older family members. During my observations in the *Centro de Saúde*, I noticed that this complicated the disclosure process within the family, which therefore was often performed by a health worker, sometimes with a long delay.

Theoretically, as part of the disclosure process, a patient is required to attend at least three meetings with health centre workers. During my observations in *Centro*

²⁵ CD4 count is like a snapshot of how well the immune system is functioning. As an HIV infection progresses, the number of CD4 cells declines. Viral load is the term used to describe the prevalence of HIV in the blood (<https://www.aidsmap.com/about-hiv/basics/cd4-and-viral-load>).

²⁶ PEPFAR 2018.

²⁷ Paterson et al. 2000.

²⁸ Castro and Singer 2004.

²⁹ MISAU 2015.

³⁰ MISAU 2015.

de Saúde, I was able to participate in different moments of the disclosure. The following extract is drawn from one of these instances and involved a counsellor³¹ talking to an HIV positive teenager:

«You have a small bug inside your body. This small bug is attacking the body's soldiers that protect your body from disease, called CD4 cells. When you take this medication, the small bugs go to sleep and stop attacking the good soldiers. If they awake again in case of treatment interruption, they would feel well-rested and therefore attack with even more fervour. Therefore, is very important that you take the drugs every day exactly at the same hour»³².

This rigidity of rules has also been encountered by Domenik Mattes in the Tanzanian context, where technicians have often stressed “self-responsibility”, in the sense that adherence to the treatment regime is normally established through a rigid control system that favours patient disempowerment, with mechanisms of reward and punishment aimed at their full subjugation to the medical authorities³³. As I observed a nurse in the *Centro de Saúde* explaining to a patient:

«You have to take the pills twice a day. One in the morning, when you wake up at 6 am, and one in the evening at 6 pm. Cannot be 6:30, cannot be 6:15, has to be exactly 6:00! You know what happened if you are not taking the treatment right? The virus will increase and, in the end, there will be nothing to do for you. So it's up to you, do you want to live?»³⁴.

This extract highlights an interesting point: the stress on self-responsibility to keep adherence is formulated as if was being given a choice to the patient. Yet, the process of making patients ‘good adherents’ unfolds by communicating and imposing precise notions of responsibility on them. In other words, the process does not entail enabling patients to make well-informed decisions based on a biomedical understanding of the body and the therapeutic process: it is more explicitly about establishing rules and fixing routines³⁵.

In the *Centro de Saúde* the health workers treat the act of taking drugs as a moment disconnected from other contexts and life trajectories, and solely based on individual responsibility (e.g. they linked it with everyday activities such as watching

³¹ A counsellor is an HIV positive person who works at the health centre and gives support to HIV positive patients.

³² Counsellor of Centro de Saúde, fieldnotes, April 2017.

³³ Mattes 2011.

³⁴ Counsellor of Centro de Saúde, fieldnotes, April 2017.

³⁵ Hardon et al. 2009; Mattes 2011.

a *telenovela* or brushing teeth). They were much less interested in explaining how the drugs work and what the possible side effects may be³⁶.

In addition to treatment adherence, personal responsibility is a common way of framing discourses about the alleged role of women as responsible for the propagation of the virus. As in the *Centro de Saúde*, Farmer observes an evident exaggeration of the notion of personal agency, often through highlighting certain psychological or cultural attributes. Women are commonly blamed for having promiscuous attitude and multiple sexual partners, and thereby accused to be the vector of the disease³⁷. For instance, in the *Centro de Saúde* much more agency was given to women than to men in the use of condoms. However, as shown by Mozambican scholars³⁸, while in the Mozambican context gender dynamics overall play a hindering role vis-à-vis women, the axis of class plays an important role as well. This is evident in the case of working-class young women, for whom the interlocking categories of gender and class operate simultaneously. As a consequence, this group tends to be more resigned to, and accommodating towards, gender power asymmetries, generally being less assertive and more dependent on their partners for material needs, something which weakens women's bargaining power concerning safe sexual behaviour and renders them more vulnerable.

Ancestral conflicts

«You have two options when bewitched.
Either you pray a lot for it to go away, or, at the same
time as you receive it, you send it back»³⁹

Joana appeared for the first time at the daily centre in November 2015, along with her grandmother Clelia, who was very worried about her health condition. Clelia explained that Joana was too thin and had a persistent cough. As Emilia, the day centre's social assistant said:

«When Joana's grandmother came to ask for help, she told me that Joana's problem was not HIV, but she had a spiritual problem. And she refuses to give her (biomedical) treatment. I decided to do a home visit and she showed me a dozen jars of hers full of ART»⁴⁰.

³⁶ Mattes 2011.

³⁷ Farmer 2001.

³⁸ Machel 2001; Manuel 2005.

³⁹ Emilia, social assistant of the day centre, March 2017.

⁴⁰ Emilia, social assistant of the day centre, March 2017.

When I first meet Joana, she was just reappearing at the day centre after a year's absence, and she started her narrative:

«I spent the last year in Gaza (a region in the South of Mozambique), my father's family kidnapped me. One day some alleged relatives of my dead father demanded to take me to Gaza. I did not know who my father was ... I was curious. My mother died 6 years ago. My stepfather killed her. He died too, in jail. After all of this happened, I began living with my grandmother from my mother's side and my uncles. We moved to Maputo. Before we lived in Chibuto (Gaza Province). In Maputo, I started living alone with my grandmother. It was better.

Some people came here last year. They said they were my father's family. They said they have to take me to Gaza because if not, I would have gotten sicker and sicker and I would have died. They said I had a problem with my father's spirits. My grandmother did not want me to go, but then she let me go: "Take her and bring her back when she is better" she said. But I was sick, I had HIV and tuberculosis. They brought me to Gaza, they told me that I was going to do a ceremony, and I needed to stay there for the whole ceremony. If not, I would die. When I was there, I asked to go back home, but they refused.

There we did the ceremony. First, they brought me to my dead father's room. But whether he was my real father, I do not know. They told me that I had to sleep alone there. But there were 'things' inside the room... this *vovò* (grandmother) was a *Nyanga* (traditional healer). I slept there for three days, then we went to another healer. He told her to buy a goat and a chicken. They cooked it and served the food on the floor where I was sleeping, they gave me something to drink and then they went to another room. They started eating too. After a while, I noticed that I was always sick, that I was not getting better, and I asked this *vovò*, "*Vovò*, I'm not getting any better, can you bring me to the hospital?" They refused. They obliged me to put water on my father's grave... They hit me, this *vovò* and her daughter. They hit me because I was not able to bring water and flour in the house, I was too weak. This *vovò* told me that my father had been her son. He died when I was one year old, he was hit by a truck. They had told my mother that I had to stay there because it is a tradition to stay in the father's family, but my mother had taken me away»⁴¹.

Ancestors interventions were a constant presence in Joana's life. In southern Mozambique, ancestors are described as "being alive", suggesting their power of intervention in the "real" world and the affairs of living humans. The ancestors represent the dominant supernatural agency that, under the traditional system, is believed to control and condition human existence. The "visible" constitutes or

⁴¹ Joana, fieldnotes, April 2017.

represents a manifestation of the “invisible” and vice versa⁴². It is through dialogue between the living and the dead that the balance of the spiritual forces responsible for prosperity, protection (especially against acts of witchcraft), health, fertility, social prestige, production and so on is guaranteed⁴³.

As Paulo Granjo claims, there are two fundamental starting points for the system of interpretation of misfortune, health and disease predominant among the Mozambican population. On the one hand, “fate” does not exist, coincidence is not casual, and undesirable events are not limited to “natural” causes. On the other hand, the dichotomy between body and mind does not apply to this system, which does not recognise the dichotomy between individual health and social context as well⁴⁴.

In other words, Granjo continues, within this system uncertainty is “domesticated”, and even if the effect can be tangible, for instance with a disease biomedically measurable, it is assumed that the reason must be searched in the social and spiritual sphere such as the “bad” behaviour of the victim, the conflict among the living beings, or a lack of harmony with the dead – all of which are considered an integral part of society and the relationships established therein, as we have seen above. If the person manifests the symptoms of a disease, this presupposes the existence of a mental or spiritual imbalance that is affecting the patient. In turn, this imbalance presupposes the existence of social causes⁴⁵. According to this holistic perspective, to treat the disease it is necessary to restore social balance, including harmony with the ancestral spirits. If this does not take place, the health problems will continue, because their root cause has not been solved⁴⁶.

After the mother’s death, according to the predominant patriarchal structure of the Gaza province, Joana should have remained with her father’s family. The ritual conducted in Gaza by Joana’s father’s family was aimed at restoring the balance that had been broken in the past by Joana’s absence. This was a family ceremony called *mhamba*, in which, as Luis Passador describes, the whole family should participate. *Mhamba* is always mediated by a traditional healer, a *Nyanga*. It is the most important family ceremony for the relationship between the living and the ancestors and should occur at regular intervals. The non-fulfilment of the ceremony and non-participation of a family member can lead to punishments by the spirits of the ancestors against their descendants⁴⁷. Joana’s family discourse and representation of her illness and misfortune were consistent with this model.

⁴² Mahumane 2015.

⁴³ Feliciano 1998; Honwana 2002.

⁴⁴ Granjo 2009.

⁴⁵ Ibid.

⁴⁶ Granjo 2009.

⁴⁷ Passador 2011.

Due to the severity of Joana's clinical condition, the social workers at the daily centre decided to seek for a medical opinion at *Clinica 1*, a health centre specialized in resistant cases of HIV/TB and run by an international NGO.

Together with the counsellor Lara, we decided to meet Clelia, Joana's grandmother, to understand her aetiological perspective on Joana's health problems: Clelia argued that if she believes that the cause is witchcraft, we should listen to her and suggest an intervention also on the spiritual side. If we give legitimacy to the spiritual part, this is going to help her in compliance with the treatment.

The meeting took place in one of *Clinica 1*'s room. Lara was taking care of the dialogue that was mainly in *changana* (the local language). In an extract of the conversation, Clelia explained to us:

«You get HIV if you had sexual relations without condoms with someone that is infected (by HIV). During the nineties, this happened a lot because no one knew what it was. I got HIV like this. I take my pills and I'm fine. That's because I got it through sex. Joana never had sexual intercourse with anyone and her mother didn't die of AIDS but she was murdered. So Joana's status doesn't depend on HIV. Therefore, before going to Gaza, Joana's health was always bad and she was not getting better. We decided to go to the family *nyanga*, before the Gaza period. After a query with the ancestral spirits, he claimed that the cause of her illness was because Joana had to be a *nyanga* too. The spirit of her great-grandmother from the father's side was bothering her. If she doesn't want to be a *Nyanga*, we can do another ritual to calm down the spirits, but this will cost 7000 meticaï (more than 100 euros), and we can't afford it»⁴⁸.

Clelia gave two different explanations for the same illness. In her case, treatment was effective because she had contracted the illness by having sexual intercourses without condoms. In the case of her granddaughter, however, she believed that the treatment was not working because the "real" cause of her illness was due to conflicts with ancestral spirits. Thus, as I have pointed out before, the "risk" in this case was material (e.g. being seropositive), but the cause was attributed to a social reason (Joana's neglected "call" to be a *nyanga*)⁴⁹.

In the above story, we may see that Joana, her grandmother, her father's family and the social workers, had all a different aetiology to explain what was happening. In Clelia's interpretation of illness, these symptoms would not disappear unless Joana followed her path to become a *nyanga*. Since being a *nyanga* is a matter of lineage, this made sense as the mother of Joana's dead father was also a *nyanga*. Local explanations of healing offer the advantage of transforming a medical problem

⁴⁸ Clelia, fieldnotes, May 2017.

⁴⁹ Granjo, 2009.

into a socially manageable issue. Indeed, this interpretation offers meaningful explanations of the disease by locating it within kin relations, community problems and local history, and thereby also fuelling hope for a cure. This explains much of the ontological force of healing traditions which belongs, as Brigitte Bagnol indicates, to the cosmology of local explication⁵⁰.

During my fieldwork in Mozambique, I had the opportunity to interview traditional healers in the southern region⁵¹. As other authors observed, HIV/AIDS patients are often diagnosed with a “calling disease” – i.e. sickness due to the unanswered call to become a healer⁵². As Dr Pinto, one of the traditional healers I spoke with, argued:

«Becoming a healer practitioner is not a personal choice. The spirits of your ancestors are calling you and you have to follow your path. When you have the “call” to be a healer, you start to be really sick. Sometimes it looks like HIV, sometimes it looks like you are getting crazy (*maluco*). It is normally a very prolonged disease. You have to go to a traditional healer to do the divination process, and if he tells you that you are having the “call” you have to stay with him to learn to be a healer. The symptoms will disappear only following the suggestions of the healer»⁵³.

During my fieldwork experiences in Mozambique, when searching for an explication, patients with HIV/AIDS often give multiple concurrent or sequential interpretations of their illness. Diagnosis is often associated with the transgression of taboos, the actions of bad spirits and long-lasting diseases that cannot be cured. In particular, for women, the accusation of witchcraft is a common practice⁵⁴.

The literature on medical pluralism has shown how patients, families and health workers have for a long time moved between diverse systems, epistemologies and practices of care in a search for therapeutic efficacy⁵⁵. As McKay points out, this literature has shown how health is not limited to physical wellbeing but encompasses financial, domestic, relational, spiritual and bodily experiences. These accounts make clear that the health of individuals is inseparable from the relations in which these

⁵⁰ Bagnol 2017.

⁵¹ This was realized thanks to the collaboration in the project “INTEGRA: Between biomedicine and local therapies. Crossed looks on Mental Health in Mozambique” in partnership with the University of Turin, University Eduardo Mondlane of Maputo, and ICS – University of Lisbon.

⁵² Bagnol 2017; Wreford 2008.

⁵³ Dr Pinto, interview, June 2018.

⁵⁴ Bagnol 2017; Passador 2011; Ashforth 2002; Rödlach 2006.

⁵⁵ Feiermann and Janzen 1992; Granjo 2009; Janzen, Leslie and Arkininstall 1982; Langwick 2008; Meneses 2004.

individuals are embedded. It is important to consider this heterogeneity in representations of health and illness⁵⁶.

During the whole conversation with Clelia and Lara I was sitting next to Joana in silence when I realised that she was crying. Following Farmer, we clearly see how the fact of her being poor and a woman had robbed of her voice long before HIV appeared to complicate her life⁵⁷. This is also evident in the accusations moved against her. As the weak link in the family – young, poor, ill and woman – all the family “evils” were projected onto her.

Joana was considered and condemned by her whole family to be the cause of her own – and her family’s – misfortune, since she was not taking up the ‘call’ to become a traditional healer. She was accused of causing the death of her uncle, occurred in a car accident that her paternal grandmother was involved in. Obviously, she was also accused of her own illness. However, Joana’s explanation for her illness status was different, and afterwards, as we were having a snack in the garden of the *Clinica 1*, I asked her why she had been crying during the meeting:

«I was crying because my grandmother was saying a lot of things that are not true. When my grandmother speaks, I can’t say anything. If I do, when we are home she will beat me. She told me to stay quiet before entering the room. She believes in traditional doctors and the fact that I am sick from spirits, and that’s why she let me go to Gaza! But I know it’s not like that! I realised that I got HIV through my mother. They explained it to me at *Clinica 1*. My grandmother does not believe in it. She is very kind to you when she is here, she says she understands, but then when she is at home she completely changes her attitude and begins to accuse me that I am the ruin of the family»⁵⁸.

After the meeting with Clelia at *Clinica 1*, I discussed some aspects of Joana’s case with Lara. Suddenly becoming more cautious when thinking about an intervention using traditional medicine, I sensed fear in Lara’s words as she spoke about medical legitimacy, considering better only to take care of the biomedical part. She demonstrates how in Mozambique the dialogue between health workers and traditional healers is problematic. I believe that biomedical discourse, rather than deconstructing “traditional” conceptions of disease, may even provide elements to ratify them when manipulated by the logic of “traditional” models, even though they work with different assumptions and aetiologies⁵⁹. Rather than “respecting” the spiritual aspect, I agree with Mariano that it would be useful to create a common sense of spaces, things, thoughts and ideas between patients, biomedical health

⁵⁶ McKay 2018.

⁵⁷ Farmer 2001.

⁵⁸ Joana, fieldnotes, May 2017.

⁵⁹ Passador 2011.

workers and traditional healers, which would allow patients to say the “unsayable” and to restore the balance needed⁶⁰.

Health facilities

Diagnostics in uncertainty: Third floor, bed 43, tuberculosis ward

Due to the worsening of her condition, in May 2017 Joana was hospitalised. As suggested by van der Geest and Finkler, biomedical institutions are reinterpreted by the local culture in which they are located, and this is significant both theoretically and practically⁶¹. This was also the case of the structure where Joana was hospitalised. As the authors argue, life in the hospital should not be regarded as being in contrast to life outside the hospital – the “real” world – but as rather being shaped by it. This was evident in the way in which everyday societal hierarchies, inequalities and conflicts were reproduced within the hospital.

My first visit in a hospital was at Machava hospital, known as the place where people in the final stages of tuberculosis (TB) are hospitalised. Joana had already been sent several times to the tuberculosis ward to recover. Life here was not easy. Usually, parents and visitors would bring the patients meals, considering that the hospital food was neither healthy nor tasty. However, goods entering inside the hospital were often noticed by other patients and workers, and as Joana pointed out, people often stole things. Furthermore, Joana was the youngest in her room, and hierarchically she was not in a position to complain. Joana’s rooms consisted of 10 beds with a large window on one side that opened onto a common terrace.

Foucault’s “gaze-thinking” can be useful to analyse the ward, considering his understanding of the gaze as a technology of power by which the object (the body) becomes visible and thus knowable to the observer. Foucault argues that the medical gaze has to do with a particular kind of seeing, which is not the “gaze of any observer” but that of a doctor endowed with the power of decision making and intervention⁶². However, this was quite absent in the TB ward and here the patients were not being under the constant surveillance of the medical gaze. In fact, we may say that the TB ward presented instances of “gaps in the gaze”, where patients became invisible to the medical observer⁶³.

As in the ethnography described by Gibson in South African hospitals, despite the apparent surveillance in the ward, there were instances of patients who appeared to had been “forgotten” or “lost” in transit while in foyers, in waiting rooms, and

⁶⁰ Mariano 2018.

⁶¹ van der Geest and Finkler 2004.

⁶² Foucault, 1973, p. 89.

⁶³ Gibson 2004.

between wards⁶⁴. In fact, also in my case surveillance was quite absent: I was able to get in and out of the ward without being questioned. Either I was feeling a total absence in the medical eye that involved action and thus a material practice that was directed at bodies⁶⁵.

The lack of economic resources sometimes led to unequal and poor treatment in the hospital, which particularly affected disadvantaged families. There was thus a continuous shifting of patients, services and staff in an attempt to provide redress and equal health services for all. Access to beds was difficult and patients such as Joana were commonly discharged before time.

When I visited Joana at Machava, her body was marked by a severe rash, common in patients in the later stages of AIDS. Doctors explain that Joana was not suffering from TB but from pneumonia. Her CD4 count was low which meant that the virus was starting to become resistant to the treatment. Meanwhile, ‘the gaps in the gaze’ were so evident that when we were leaving the hospital, no one noticed that she still had the cannula from the drip in her left hand, and we had to go back into the yard to take it out. I was baffled by the situation. How can an HIV positive immunosuppressed patient with pneumonia be sent to recover on a TB ward, where she risked being infected again? Dr. Carla, part of the *Clinica 1* team, tried to explain the situation:

«Joana is a peculiar case. She had TB so many times in her life that now she has what is called ‘sequelae of tuberculosis’. It is not a hopeful prognosis for her, because she is living with just one lung. She will always be like this: she will be fine for short periods and then have long relapse phases. When doctors do an X-ray, the result is so bad that they immediately think it is TB. It will be good for her to have an old X-ray or exam that reports that it is not TB, but this is difficult because patients are not allowed to have their exams... if she could always have a paper with the last diagnosis, she would avoid being so often in the Machava TB ward. Otherwise one day she will get TB again!»⁶⁶.

Bureaucratic difficulties, negligent health care workers, inconsistent record-keeping and imperfect diagnostic techniques all generate what is referred to as a «technology of invisibilities»⁶⁷. This technology transforms patients like Joana and their caretakers into largely absent, discarded “waste” thrown at the margins. As Biehl warned, people become “absent things” through the very processes that involve them as patients⁶⁸.

⁶⁴ Gibson 2004.

⁶⁵ Foucault 1973.

⁶⁶ Dr. Carla, fieldnotes, September 2017.

⁶⁷ Biehl 2007, p. 202.

⁶⁸ Biehl 2007.

In November 2017, the situation for Joana in her family was becoming unsustainable, as no one was taking care of her. Doctors of *Clinica 1* decided to accommodate her for four months in *Casa 1*. This structure, for people in disadvantage socio-economical situation led by the Sisters of Calcutta, was one of the very few social safety nets present in Maputo.

Similar to Blake's research in a paediatric oncology ward in South Africa, the young people in my research maintained a distinction between "real" and "temporary"⁶⁹. Joana never felt that *Casa 1* was the "real world" and she always expressed the wish to go back home and to attend the activities in the daily centre. Indeed, the rules of *Casa 1* were so strict that Joana didn't manage to stay there for a long time.

During the Christmas holidays, Joana had left *Casa 1* to be hospitalised for one week due to respiratory issues. When she was released from the hospital, the nurse called her grandmother, who came to pick her up and took her home for a couple of nights. According to the policy of *Casa 1*, however, this was against the rules: if you have a family that can provide food for you, this means you can live there and cannot stay in *Casa 1*. As a result, she was no longer able to re-enter *Casa 1*. The brutality of lack of resources in Maputo's health and social security network created scales of vulnerability in which the few social services that did exist adopt policies that could appear quite cruel and discriminatory, with the result of leaving young people in situations of extreme precariousness with no possibility of choice, as was the case of Joana and many others.

Joana received a new diagnosis at the end of January 2018, after a period of sufferance that saw her moving back and forth between hospitals:

«She has pulmonary hypertension. She is living just with one lung and this means that she will always have respiratory distress. To circulate more blood, her pulmonary artery works harder. This creates an increase in resistance and hypertension. This flow increase causes the swelling in her body. She must start taking diuretics so that this will not happen again. She has been my patient in the past and I have been asking for pulmonary advice, but it takes too long»⁷⁰.

These difficulties in the transmission of clinical information or «health bureaucracies»⁷¹, as we observe in Joana's story, are unfortunately a common situation in Mozambique, as Alfredo, the psychosocial coordinator of *Clinica 1*, illustrated during an interview:

⁶⁹ Blake 2009.

⁷⁰ Joana's doctor at Machava hospital, fieldnotes, January 2018.

⁷¹ Kleinman, 1980, p. 26.

«Each hospital has a different clinical process. I am talking about the hospitalisation regime. When you are discharged, they give you a discharge guide with a little summary of the diagnosis, which should then be presented to your health facility. With this guide in a health centre, they open a new process or update an old one. The patient should keep a copy of the clinical history given in the hospital. On the other side, if the hospitalisation reference arrives from the health centre, the health centre will transfer a transfer guide to the hospital, in which the whole clinical condition is explained. However, if you leave your house and go directly to the hospital, you will no longer have this guide. There is no electronic system at the national level, so the hospital will always open a new process with new information, and they would never know what happened before. It would be useful to take always the health card, but no great information is written on it. If you are taking ART, for example, the hospital does not know what kind of regime they have to prescribe you. So, for example, Joana stayed without medications for two weeks»⁷².

The impossibility of giving clinical records to patient deserves two levels of attention. On the one hand, their availability would permit to not reopen new record every time. On the other hand, having these files could give responsibility to the patients to know more about their health condition and make decisions.

Amid the overflow of papers, doctors and health workers, as well as other staff, struggled to balance too many patients with too little information on each patient they attended. It sometimes seemed remarkable that patients' clinical files could be found at all; although they usually were, patients were nevertheless exhorted not to rely on what was recorded in the treatment plan but to take responsibility for remembering when blood tests and other exams needed to be done⁷³.

Missing

Researcher: «*Vovò*, where is Joana? »

Clelia: «Joana ran away, she ran away tonight, she opened the door and ran».

Researcher: «How is that possible? »

Clelia: «I am teasing you! (Laughing) She is at Machava hospital. She was really bad when she came back home from the hospital. Her legs were swollen and she asked me to do a massage, but it did not work, so we went back to Mavalane. They took an XR and blood test and transferred her to Machava»⁷⁴.

⁷² Ernesto, interview, February 2018.

⁷³ McKay 2012.

⁷⁴ Conversation with Clelia, fieldnotes, January 2018.

After a few weeks where Joana had not shown up at *Clinica 1* to get her ARV, a doctor contacted me to ask if I could manage to do a home visit to find out what had happened. Due to the memory of the abduction of the previous year and the concern for her precarious health situation, I decided to go immediately, dropping my previous commitments. Yet, due to the physical and psychological atmosphere of violence prevalent in Joana's family, home visits to her house were always difficult for me. Veiled accusations about Joana's health status were commonly made to me and the medical staff of *Clinica 1*, and the presence in the back office of the 'dangerous' uncle always made me feel uncomfortable. Upon this visit, Joana's grandmother claimed:

«Joana is at the hospital. She stayed at home two days after the Central hospital, but then she was getting sicker, she could not breathe. (...) I know she is not getting ART, nobody knows that she is in the hospital. She is in the hospital because she had a cough. I left her at Mavalane, but when I went back there the day after they told me she was at Machava. You see that I'm not able to walk, I can't get there, but I think she is there»⁷⁵.

Things were confused, and after a few phone calls to hospitals, we discovered that she was still at Mavalane. Joana had gotten lost in transit from one hospital to another, receiving no treatment and taking no past clinical records with her, another example of "the invisible patient" routine⁷⁶. The working conditions at Mavalane hospital reflected the profound resource deficiencies in the health care system in general. The buildings were deteriorating (parts of the electrical and sewage systems were permanently out of order, for instance) and the equipment was faulty or lacking, making it impossible to carry out even basic hospital procedures. An extract from my diary shows the feelings that I had during one of my visits:

«I arrive at the entrance to the adult general practice unit. On the side of the main door, there is a cat with the bite of a dog that brought him back still half alive. Why is no one taking care of it?

When I enter Mozambican hospitals, I have the feeling that I need to be in apnoea. It is an apnoea for many reasons, not just because of the strong smell that surrounds the hospital. I need this apnoea to have an emotional numbness and avoid tears, anger and fear of death. When you are so near people who are dying, you can feel it. I try to avoid it, however without great results.

I begin to walk along a dark hall. The silence is broken by the chatter of the nurses, who recreate a state of normality in my mind. In a threatening tone, they tell me that

⁷⁵ Clelia, fieldnotes, January 2018.

⁷⁶ Gibson 2004.

it is not visiting time but, probably thanks to my ‘whiteness’, they let me pass. The day is one of the hottest since the beginning of the year, which didn’t help my apnoea desire. Patients are bedridden and covered only with a synthetic blanket suitable for the winter season. People’s physical nudity reminds me of another kind of nudity, dictated by deprivation of dignity and social respect, what Agamben calls bare life. This time Joana does not run to hug me as usual. She is sitting in the bedroom and she doesn’t even look at me. I sit at her side and hug her. She is so full of bubbles on her body. I am not sure that I want to look around... the room has 8 beds, all full of women, they are all naked. The smell inside the room is heavy and peculiar, I’ll never forget it. “I’m feeling better, sis”, Joana said. Bubbles are all over her body, her hands are constantly shaking, wounds all around her mouth, candidiasis. I was sure it would be the last time I would meet her, and somehow I was relieved for the end of her sufferance»⁷⁷.

Due to her high viral load, doctors from Mavalane explained that Joana had been shifted to second-line treatment for HIV. Meanwhile, Joana was telling me about her journey from a hospital to another and the fact that she was not taking the ART for two weeks because her grandmother never brings it to the hospital. This was another crucial reason for her non-adherence, which has already been mentioned before: if you arrive at the hospital without your ARV, someone from your family will have to bring it to you. The hospital itself will not provide the drugs because there are no electronic files to confirm what you are taking them. Joana’s case here exemplifies another aspect of the poor operation of the health system.

The day after I returned to Mavalane, ready to hear bad news. Joana was in the same position, seated and playing with the needle of the IV: «They are discharging me from the hospital, sis». How is that possible? I thought. She is not even able to walk. We eat together some boiled egg and I bring her home.

Final reflections: “Where should I go now?”

One day, while we were sitting on her bed in Machava hospital drinking a juice, Joana began to talk, with the lucidity and clarity that had always distinguished her:

«I am quite worried about where to go to live when I will get out from here. I am sure that I cannot go back home. When I came back from Gaza, they were not happy at all. My grandmother said, “why you did not stay there?”. My uncle does not want me at home. He said that I did something wrong and they expelled me from *Casa 1*. He said that I cannot live anymore in the house, also my grandma now says that... My uncle

⁷⁷ Field diary, January 2018.

refused to come to pick me up at the hospital. He has money, he rents houses in Zimpeto neighbourhood. When my grandma was hit by the car, the owner of the car gave money to my uncle, he never gave it to my grandma. No one speaks with him, because we are all scared... When I was really ill, he told me: “If you are sick and die, then I have to pay for your funeral. You know that I had to pay for your mother’s coffin! I’ll not pay for yours too!”. I cannot go back to *Casa 1* either, it is not a nice place. They bring you to the hospital, then they leave you there and they never come to visit you. Then, if you come back home, they do not want you anymore»⁷⁸.

While Joana was struggling to find a solution to stay inside the circuits that would legitimate her therapeutic citizenship, she died in Machava hospital in May 2018. In the months before she passed away, she had a vivid and troubling vision of the situation of abandonment that she was in; even the hospitals did not want to have a patient that was sure to die – in particular from AIDS-related issue – and thus continued to let her stay “in transit”. It appeared as if everyone around her was giving up. Nonetheless, she was not prepared to do the same, and kept looking for alternative solutions until the end.

Looking at Joana’s story and following the reflections of Farmer, I think that as anthropologists we must be careful to recognise the difference between what is dictated by structural violence from an alleged cultural difference⁷⁹. Having said that, however, I agree with Simona Taliani who warns us about the danger in seeing this dichotomy. While it is important to understand the differences between ‘social causes’ (violence and misery), ‘biological causes’ (the parasite, the virus) and ‘cultural causes’ (the alterity of beliefs and habits), these are not to be assumed as separated and in contract with each other, since this may prevent understanding the intersection between factors that are simultaneously at stake in stories of illness and death⁸⁰.

Writing stories like Joana’s roots ethnographic research in the critical medical anthropological paradigm, to create a more visible whole to those parts of the analysis that are often invisible to the (medical) society.

The context of violence present inside the family, accusation of witchcraft together with the shortage in medical care and social safety net did not let her have the chance (to chose) to survive.

The choice of using a single ethnographic case study, through the voice of the most involved people, allows for the understanding of the dynamics that often do not emerge from the quantitative analyses proposed by the global health actors. To better direct its interventions, global health research should increase a multi-disciplinary approach and the dialogue with fields such as anthropology and social science in

⁷⁸ Joana, fieldnotes, February 2018.

⁷⁹ Farmer 2001.

⁸⁰ Taliani 2006.

general. As ethnographers, we have to be engaged and critical about global health interventions, shining a light on the ambiguity of interventions and the tensions between theory and practice⁸¹.

After getting to know Joana's story, the narrative of individual responsibility for non-compliance with HIV treatment loses its force and meaning. The logic behind it, which states that some patients seem to be irrational and resistant to the medicalisation of their everyday life through the ART regime, becomes irrelevant when we consider the deep history of this behaviour in respect to the cultural, social and medical factors that affect the everyday life capacity for complying with the ART regime, as well as the general struggle to survive. We have to look behind and beyond self-responsibility and consider that in some contexts there are external factors marked by structural violence which do not allow people to "act their agency"⁸². In analysing treatment outcomes among teenagers, it is important to understand the broader family dynamics that influence the possibility of adherence. Indeed, the context of family violence and accusations in which Joana was living was a frame where the gaps in the health system, the failure in the dialogue between traditional medicine and biomedicine, and the absence of social safety nets all exercised their brutality.

Bibliography

Abney, Kate

At the Foot of Table Mountain: Paediatric Tuberculosis Patient Experiences in a Centralised Treatment Facility in Cape Town, South Africa, Thesis presented for the degree of doctor in philosophy. Social Anthropology School of African & Gender Studies, Anthropology and Linguistics. University of Cape Town. 2014

Ashforth, Adam

"An Epidemic of Witchcraft? Implications of AIDS for the Post-Apartheid State", *African Studies* 2002, 61 (1): 1-21

Bagnol, Brigitte

"The aetiology of diseases in central Mozambique: with a special focus on HIV/AIDS", *African studies* 2017, 76 (2): 205- 20

⁸¹ Biehl 2016.

⁸² Farmer 2001.

Behar, Ruth

The Vulnerable Observer: Anthropology That Breaks Your Heart, Boston: Beacon Press, 1996.

Biehl, João

Will to Live: AIDS Therapies and the Politics of Survival, Princeton, NJ: Princeton University Press, 2007

“Theorizing global health Medicine”. *Anthropology Theory* 2016, 3, no. 2: 127-142.

Blake, Rosemary

“Please keep these doors closed”, unpublished Honours thesis, University of Cape Town, Department of Social Anthropology, 2009

Castro, Arachu

“Adherence to antiretroviral therapy: merging the clinical and social course of AIDS”. *PloS Medicine* 2005, 2(12): e338. Chesney, MA.

Castro Arachu., Farmer Paul

“Understanding and addressing AIDS-related stigma: From anthropological theory to clinical practice in Haiti”. *Am J Public Health* 2005, 95: 53–59.

Castro Arachu, Singer Merrill, eds.

Unhealthy health policy: A critical anthropological examination, Walnut Creek (California): Altamira Press, 2004

Cliff, Julie

“Donor dependence or donor control? The case of Mozambique.” *Community Development Journal* 1993, 28 (3): 237–244.

Cliff, Julie, and Abdul Razak, Noormahomed

“Health as a target: South Africa’s destabilization of Mozambique.” *Social Science and Medicine* 198827 (7): 717–722.

Conrad, Peter

“Medicalization and social control”, *Annual Review of Sociology* 1992. 18:209–232.

Crawford, Robert

“Healthism and the medicalization of everyday life” *Journal of Health Services* 1980, 10(3):365–388.

Devereux, George

From Anxiety to Method in the Behavioral Sciences, The Hague, Paris. Mouton & Co. 1967.

Farmer, Paul

“Sending sickness: Sorcery, politics, and changing concepts of AIDS in rural Haiti” *Medical Anthropology Quarterly* 1990. 4: 6–27

Farmer, Paul

Infections and inequalities: The modern plagues. Berkeley: University of California Press, 2001

Fauvet, Paul

“Mozambique: Growth with poverty, a difficult transition from prolonged war to peace and development” *Africa Recovery*, 2000, 14(3), 12–19.

Feierman, Steven and John M., Janzen eds

The Social Basis of Health and Healing in Africa. Edited by. Berkeley: University of California Press, 1992

Feliciano, José Fialho

Antropologia económica dos thonga do Sul de Moçambique, Maputo, Arquivo Histórico de Moçambique 1998

Foucault, Michel

Discipline and Punish. London: Penguin. 1973.

“Technologies of the self. In *Technologies of the Self. A Seminar with Michel Foucault*” L. Martin et al., eds. 1988, Pp. 16–49. London: Tavistock.

Kalofonos, Ippolytos Andreas

“All I Eat Is ARVs”: The Paradox of AIDS Treatment Interventions in Central Mozambique”, *Medical Anthropology Quarterly*, 2010 Vol.24, Issue 3, pp. 363–380

van der Geest, Sjaak and Finkler, Kaja

“Hospital ethnography: introduction”. *Soc Sci Med*. Nov; 2004, 59(10):1995-2001.

Gibson, Diana

“The gaps in the gaze in South African hospitals”, *Social Science & Medicine*, 2004 (59) p. 2013–2024

Granjo, Paulo

“Saúde e Doença em Moçambique” *Saúde Soc.* São Paulo 2009., v.18, n.4, p.567-581

Hanlon, James

Peace without profit: How the IMF blocks rebuilding in Mozambique, Portsmouth, NH: Heinemann, 1996

Hardon, Anita et al.

“Engaging in biomedical hypes and hopes: Health activism and access to ART in Africa”. Paper presented at the workshop *The authority of science: On the relation between governance and biomedicine in Africa*, Max Planck Institute for Social Anthropology, Halle, Germany, 2009, June 15–17.

Honwana, Alcinda

Espíritos vivos, tradições modernas: possessão de espíritos e reintegração social pós-guerra no sul de Moçambique. Maputo, Promédia. 2002.

Illich, Ivan

Medical Nemesis. New York: Pantheon 1976.

John M. Janzen, Charles Leslie, William Arkininstall

The Quest for Therapy in Lower Zaire, University of California Press 1982

Junod, Henri

Usos e costumes dos Bantu, tomos I e II, Maputo: Arquivo Histórico de Moçambique, Série Documentos nº 3. 1996.

Kleinman, Arthur; Wang, Wen-Zhi, Li, Shi-Chuo, et al.

“The social course of epilepsy: Chronic illness as social experience in interior China”, *Soc Sci Med* 1995, 40: 1319–1330.

Kleinman, Arthur

Patients and healers in the context of culture. An exploration of the borderland between anthropology, medicine, and psychiatry. Berkeley, CA: University of California Press. 1980

Kleinman, Arthur. & Kleinman Joan

“Suffering and its professional transformation. Towards an ethnography of interpersonal experience” *Cult Med Psychiatry*, 1991;15(3):275-301. doi:10.1007/BF00046540

Langwick, Stacey

Articulate(d) “Bodies: Traditional Medicine in a Tanzanian Hospital”, *American Ethnologist* 2008 35(3):428–439

Mahumane, Jonas

“*Marido Espiritual*” *Possessão e Violência Simbólica no Sul de Moçambique*, Tese especialmente elaborada para obtenção do grau de Doutor em Antropologia, ICS Universidade de Lisboa, 2015.

Manuel, Sandra

“Obstacles to condom use among secondary school students in Maputo City, Mozambique”, in *Culture, Health and Sexuality*, 7 (3), 2005: 293-302.

Mariano, Esmeralda

“The “Unsayings” of Reproductive Affliction in Mozambique Witchcraft and Local Reproductive Knowledge”, *The Oriental Anthropologist*, Vol. 16, No. 2, pp. 303-320, 2016.

Machel, Josina Zyiaia

“Unsafe sexual behaviour among schoolgirls in Mozambique: a matter of gender and class”. In *Reprod Health Matters*. 2001;9(17):82-90. doi:10.1016/s0968-8080(01)90011-4

Mattes, Dominik

“We Are Just Supposed to Be Quiet”: The Production of Adherence to Antiretroviral Treatment in Urban Tanzania”, *Medical Anthropology: Cross-Cultural Studies in Health and Illness*, 2011 30:2, 158-182

McKay, Ramah

Medicine in the Meantime: The Work of Care in Mozambique. Durham: Duke University Press. 2018.

Meneses, Maria Paula G.

“Quando não ha problemas, estamos de boa saúde, sem azar nem nada”: Para uma concepção emancipatória de saúde e das medicinas”, In *Moçambique e a reinvenção da emancipação social*, Boaventura de Sousa Santos and Teresa Cruz e Silva, eds. 2004 Pp. 77-110. Maputo: Centro de Formação Jurídica e Judiciária

MISAU

Plano estratégico do sector da saúde [Health sector strategic plan]. Maputo: MISAU, 2015

Mol, Annemarie

Logic of Care: Health and the Problem of Patient Choice, London: Routledge, 2008.

Nguyen, Vinh-Kim

The Republic of Therapy: Triage and Sovereignty in West Africa's Time of AIDS. Durham, NC: Duke University Press, 2010.

Passador, Luis Henrique

Guerrear, casar, pacificar, curar: o universo “tradição” e a experiência com o HIV/Aids no distrito de Homóine, Sul de Moçambique. Campinas. Tese de doutorado apresentada ao instituto de filosofia e ciências humanas da unicamp, 2011

PEPFAR

Mozambique Country Operational Plan 2018, Strategic Direction Summary, 2018

Pfeiffer, James

“Austerity in Africa”, *Focaal*, 2019 (83), 51-61

“International NGOs and primary health care in Mozambique: The need for a new model of collaboration.” *Social Science and Medicine* 2003 56 (4):725–738.

Paterson David L. et al.

“Adherence to protease inhibitor therapy and outcomes in patients with HIV infection” *Ann Intern Med* 2000 133: 21–30.

Rodlach, Alexander

Witches, Westerners, and HIV: AIDS and Cultures of Blame in Africa. Walnut Creek, California: Left Coast Press. 2006.

Nancy Scheper- Hughes

Death Without Weeping: The Violence of Everyday Life in Brazil., Berkley: University of California Press, 1992.

Sjaak van der Geest

Introduction: Ethnocentrism and medical anthropology Ethnocentrism, in ed. by Sjaak van der Geest & Ria Reis, *Reflections in medical anthropology* Amsterdam: Aksant 2002: 1-23.

Stodulka, Thomas

‘Emotion Work, Ethnography, and Survival Strategies on the Streets of Yogyakarta’,

Medical Anthropology, 34(1): 84-97, 2015

<https://doi.org/10.1080/01459740.2014.916706>

Wreford, Joanne

Myths, Masks and Stark Realities: Traditional African Healers, HIV/AIDS Narratives and Patterns of HIV/AIDS Avoidance, Centre for Social Science Research Working

Paper 209. 2008.

Taliani, Simona

Il bambino e il suo doppio. Malattia, stregoneria e antropologia dell'infanzia in Camerun, FrancoAngeli, Milano 2006.