Community Health Workers: Lives, Labor, and Hopes for an AIDS-free generation in Maputo, Mozambique

Celso A Inguane

A dissertation

submitted in partial fulfillment of the

requirements for the degree of

Doctor of Philosophy

University of Washington

2018

Reading Committee:

James Pfeiffer, Chair

Devon Peña

Matthew Sparke

Rachel Chapman

Program Authorized to Offer Degree

Anthropology

©Copyright 2018

Celso A Inguane

University of Washington

Abstract

Community Health Workers: Lives, Labor, and Hopes

for an AIDS-free generation in Maputo, Mozambique

Celso A Inguane

Chair of the Supervisory Committee:

James Pfeiffer

Department of Anthropology

Department of Global Health

In this dissertation, I describe how current efforts to meet the globally-defined ambitious HIV treatment goals to end AIDS by 2030 marginalize community health workers (activists and counselors) who have dedicated their lives, skills and experience to helping address HIV and AIDS. My focus fits within a broader research agenda that has been documenting the "social aspects of antiretroviral therapy scale-up" for the last decade and a half in the global south. It contributes to efforts to relativize the dominance of grand theory, and to value ordinary people's empirical and analytical contributions to social theory that Foucault (2003) articulated as political historicism, which resonates with calls for ethnography as a fruitful avenue for theory grounded on fieldwork experience and

data (Biehl 2013, Nader 2011). The dissertation is based on nearly 18 months of ethnographic research, between February 2016 and July 2017, mostly at a health facility in Maputo, Mozambique, using participant observation, ethnographic interviews and archival research. It was supplemented by nearly a month of exploratory research between August and September 2015, and a short weekly visit during dissertation writing in July 2018. For ethical reasons, I concealed the names of people who participated in the research and of the health facility and province where I conducted research.

Community health workers have for several years contributed with labor, experience and dedication that build and maintain enduring social ties that help ensure compliance to antiretroviral therapy and reproduce sociality. They also help bridge the gaps between the public-driven and the international non-governmental organization- driven patient tracking systems. This contribution is being marginalized by current efforts to meet the ambitious HIV treatment goals, under which experienced community health workers are being demoted, moved to other roles, reduce work hours, and train new staff that replaces them from their previous positions. Experienced community health workers perceive these changes as instantiating their marginalization, economic exploitation and disposability, in ways that have precedents in the scale up of universal antiretroviral therapy, about a decade ago (documented in Mozambique and in sub-Saharan Africa). This marginalization reveals a neglect for knowledge and skills represented as hierarchically inferior within the health sector (epistemic violence) and signal a growing risk of global HIV interventions contributing to neoliberal politics of social abandonment that produce undervalued and disposable labor, while undermining the institutional arrangements that have historically enabled the implementation of equity-oriented strategies through public health systems (political expression of structural violence).

DECLARATION

I declare that this dissertation is my own unaided work and has never been published elsewhere or submitted to fulfill the requirement of any other degree. It is submitted for the degree of Doctor of Philosophy in Sociocultural Anthropology at the University of Washington, Seattle.

Seattle, August 30, 2018

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APE	Polyvalent Elementary Health Worker (*Agente Polivalente Elementar*)
ART	Antiretroviral Therapy
ATS	Counseling and Testing for Health (*Aconselhamento e Testagem para a Saude*)
CCR	Consultation for Child at-risk consultation (*Consulta da Criança em Risco*
CDC	United States Centers for Disease Control and Prevention
e-PTS	electronic Patient Tracking System
FILA	Individual Antiretroviral Refill Form (*Ficha Individual de Levantamento de Antiretrovirais*)
Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
ILO	International Labor Organization
INE	National Institute of Statistics (*Instituto Nacional de Estatistica*)
MCH	Maternal and Child Health
MCHIP	Maternal and Child Health Integrated Program
MISAU	Ministry of Health (*Ministério da Saude*)
NGO	Nongovernmental Organization
NID	Patient Identification Number (*Número de Identificação do Doente*)
PCR	Polymerase Chain Reaction
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHC	Primary Healthcare
PMTCT	Prevention of Mother to Child Transmission
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
UATS	Counseling and Testing Unit - *Unidade de Aconselhamento e Testagem*
UNAIDS	The Joint United Nations Programme on HIV/AIDS
USAID	United States Development Agency for International Development
WHO	World Health Organization
WTO	World Trade Organization

GLOSSARY

APE: Is the community health worker category officially recognized by the Mozambican Ministry of Health. it is a category created as part of a national community health worker program in the late 1970s, to help implement the primary healthcare approach in Mozambique. The APE is trained to be polyvalent - provide health education, and preventive and minor curative services for various health conditions at the community level. From such a diverse portfolio derives the designation polyvalent elementary health worker/agent (*Agente Polivalente Elementar* – APE). Based on national guidelines, the APE should be selected by the community in which the APE lives, among reliable people, with basic education, and receives short training, usually six months, on a range of issues with a focus on public health, at a Ministry of Health training facility. The APE receives a kit with basic medical supplies from the health facility to which he/she reports, usually on a monthly basis. The APE is a volunteer, expected to dedicate a portion of his/her time to health activities (for which services the APE earns a monthly incentive or subsidy), and the APE should dedicate the other portion of her/his time to private income generating activities. The APE is part of the health management committee at the community level and represented at the health facility in which catchment area the APE works.

ATS: Counseling and Testing for Health, although the term invokes counseling on broad health issues and testing for various infections, it is more used for STI

screening, particularly HIV, done by a trained counselor or community health worker. It is done at the community level, known as ATSC or at the health facility level in specific rooms or buildings known as UATS (Counseling and Testing Units)

Capulana: A colorful, long cloth, usually 1.5-2.0-meter-long that women in Mozambique and sub-Saharan Africa wear for multiple purposes. They wear the cloth around their waist, and in Northern Mozambique they also wear on their heads. The *capulana* is worn in multiple occasions, including festive public and private events, memorials or every day. It can be used for clothing, to carry babies and toddlers on their backs, as bedding and for home decoration (table cloth and curtain) and public event decoration. It has recently been the object of Mozambican *haute couture* and ordinary people clothing, the latter facilitated by its affordability.

PMTCT: In this dissertation I use it to specifically mean the Prevention of Transmission of HIV from Mother to Child

STI: I use the term Sexually Transmitted Infection, instead of the other term, Sexually Transmitted Diseases – STD – still used in some literature.

NOTES ON TERMINOLOGY AND STYLE

Acronyms and abbreviations

I only included in the list of acronyms and abbreviations those I mentioned more than once in the text. For those I mentioned only once, when they are of common use, I provided wrote the long form of the term and provided the acronym or abbreviation in parenthesis.

l have tried to consistently use full names, instead of acronyms and abbreviations when describing or mentioning people. I do this inspired by the recommendations contained in the most recent UNAIDS Terminology Guidelines, 2015, (http://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf). For instance, I will write community health workers throughout the dissertation, instead of using the abbreviation CHW, and will use people living with HIV instead of the PLWH. An exception is APE, Mozambique's officially recognized community health worker, because they are best known for their acronym, and most people in Mozambique would probably not recognize the full name, as they do the abbreviation.

Translation

All translations are my own, and I have tried the best I could to provide idiomatic translations (those that make sense to the native English language speaker of American or British English) that also convey the context in which the word or

term I translate is originally used. For instance, I have translated Mozambique's officially recognized *Agente Polivalente Elementar* (APE) into polyvalent elementary health worker, because the literal translation 'polyvalent elementary agent, would not convey the sense that this is a community health worker.

I Have not translated into English names of people that are in other languages, nor do I write them in italics. I also did not translate into English names of places that are in other languages and that have no translation into English. But, I wrote them in italics.

I avoided translating several quotes from interviews and conversations with research participants. However, when I found that a translation into English would not convey the original meaning, I included the quote in the original language of the interview and provided the translation into English.

Footnotes and Endnotes

I avoided as best as I could the use of notes to minimize readers' distraction from the main narrative, Therefore, I provided more information in the main narrative than I would usually do if I used footnotes and endnotes. I used footnotes only when strictly needed, and to keep the narrative flow, without distracting the reader. Accordingly, I did not use any endnotes.

List of illustrations

Figure 1: HIV patient flow map in Mozambique	48
Figure 2: PEPFAR-implementing partners provincial assignment in Mozambique	50
Figure 3: Sketch of the health facility	55
Figure 4: The main archives (*ficheiro*)	57
Figure 5: Facility-based health workers included in the study sample	68
Figure 6: Community health worker's monthly household expenses, 2017	97
Figure 7: Monthly household expenses covered by community health worker's salary, 2017	98
Table 1: HIV/AIDS expenditures by source in Mozambique, 2016	41

ACKNOWLEDGEMENTS

I am morally and ethically indebted to my research partners, particularly experienced activists and counselors (*activistas e conselheiras*) for their generosity in sharing their knowledge, wisdom, experience and care for what they do. I am also indebted to people in HIV treatment, for their patience and for sharing with me their lives, challenges, and hopes. I hope to have conveyed here at least some of the quality of the work you do and the strength you have. I hope they will understand and forgive me for not mentioning their names, which I do to protect their privacy.

I am deeply grateful for the mentorship, care and support that James Pfeiffer (my PhD committee chair) and my committee members (Rachel Chapman, Devon Peña, Matthew Sparke, and Nora Kenworthy) gave me throughout the general exams, dissertation research and writing. I hope that this dissertation does not live too short of their expectations.

I received moral support from Ana Piedade Monteiro and Carla Braga (*Universidade* Eduardo Mondlane), Bernard Barrere (ICF Macro) and Peter Yong (CDC Mozambique), Isabel Sathane, Yvone Buttler, Marla Smith, Florindo Mudender, Gabriel O'Malley and Fernanda Freidtchart (I-TECH Mozambique and Seattle), and from Will McFarland, Heidi Frank, Henry F. Raymond, and Roberta

Horth (UCSF). I would not have started this graduation program without this support.

I found in HAI in Mozambique and Seattle, and at the Beira Center for Operations Research (CIOB) another extended family that I could rely on. Steve Gloyd, Sarah Gimbel, Kenneth Sherr, Marnie Chinn, Cathy Michel, Tracy Woodman, Andrea Chateaubriand, Mary Anne Mercer, Susan Thompson, Manish Kala, Ahoua Kone from HAI Mozambique and Seattle provide me or gave me access to financial and moral support without which I would not have started and completed this degree. Marnie Chinn, Andy Chinn and their children Sophie and Felix adopted me and my family into their family in ways that make an important difference.

Orvalho Augusto became the kind of a brother and an intellectual friend I did not expect to meet so easily at this point. Quinhas Fernandes and his family helped complete the sense that being a Mozambican is a special type of family bond. I would like to thank Caroline Soi, Consuelo Norris, Hugo Puerto, and Rassul Nalá for their generous friendship and support.

Staff, faculty and colleagues in the 2013 sociocultural anthropology cohort of the University of Washington provided generous support and inspiration. A special thanks to the staff, who are usually erased from this type of work - Catherine Ziegler, Diane Guerra, and John Cady.

I would have not completed this degree without the generous financial support I received from the Wenner-Gren Foundation for anthropological research, which funded most of my coursework, all of my dissertation research and write up, through the Wadsworth International Fellowship. Heartfelt gratitude to Judith Kreid, for her prompt responses and clear and helpful guidance.

My wife (Isa), has been my trusted partner, friend, and inspiration. I thank you for always being there for me, and for believing in me. And, our children Simphiwe, Chiquinho, Isis and Pericles, appreciate the fundamental lessons you tried to teach me about balancing of life, anthropology, and parenting. I only hope I have not made too many mistakes. To Isis, you asked me a question I am not sure I have responded adequately – is a PhD important? Why? Is it so hard? I will leave it at that.

CONTENTS

DECLARATION v
ABBREVIATIONS AND ACRONYMS vi
GLOSSARY vii
NOTES ON TERMINOLOGY AND STYLE ix
LIST OF ILLUSTRATIONS xi
ACKNOWLEDGEMENTS xii
PART 1: INTRODUCTION 1
Research problem 1
Global Structures of community health worker abandonment 13
Analytical Framework 31
Research Site 33
Dissertation outline 59
PART 2: METHODOLOGICAL APPROACH 61
Chapter 1: Producing ethnographic data 61
Chapter 2: Ethical experiments and predicaments 80
PART 3: LABORS, LIVES, AND A SHAPE OF THE FUTURE 88
Chapter 3: Local structures of community health worker vulnerability 89
Chapter 4: Labors of compliance and sociality 103
Chapter 5: Documentary multiplicity and politics of knowledge 125
Chapter 6: The Future, Change, and Life on the move 140
CONCLUSIONS 168
REFERENCES 173

PART 1: INTRODUCTION

Research problem

Through this dissertation, I contribute to efforts to documenting the "social aspects of antiretroviral therapy scale-up" (Hirsch, Parker, and Aggleton 2007) for the last decade and a half in the global south (Biehl 2007; Kenworthy, Thomas and Parker 2018; Nguyen 2007, 2010). I describe how, at a health facility in Maputo, Mozambique, efforts to meet the ambitious HIV treatment targets that were believed to lead to ending AIDS by 2030 (UNAIDS 2014) make more precarious and devalue the labor that experienced community health workers[1] ,who have for several years contributed to helping patients (18 years and older) continue in HIV treatment, continue their lives, and bridge the gaps and challenges created by a duplicated health information system (a paper-based public system, and an electronic-based system managed by an international NGO).

This examination, contributes to a growing anthropological literature that has been highlighting the voices of community health workers on contemporary moral economies of HIV care and treatment (Closser 2015; K. Maes et al. 2015; Kenneth Maes, Closser, and Kalofonos 2014; I. Kalofonos 2014a; Kenneth Maes and Kalofonos 2013; Colvin and Swartz 2015; Cooper 2015; Kenneth Maes 2017) (Closser 2015; Kalofonos 2014; Maes 2015), correcting the silence of most social science,

[1] I use the term community health workers to refer to activists and counselors involved in the response to HIV and AIDS in Mozambique and globally, who are often called volunteers, and sometimes peer educators, and labelled as lay health workers.

humanities, and public health literature, which has emphasized the perspectives of other health workers, particularly physicians and less often nurses, and of policy-makers, activists, and patients (Epstein 1996; Nguyen et al. 2007; Claros, de Pee, and Bloem 2014; Holtzman et al. 2015; Kelly et al. 2014; Konkle-Parker et al. 2012; Pecoraro et al. 2014; Stricker et al. 2014; L. S. Wilkinson 2013; Young et al. 2014; Iwu and Holzemer 2014; Tamara Kredo et al. 2014).

I argue that experienced community health workers at the health facility where I conducted dissertation research, build and maintain enduring social ties with patients in antiretroviral therapy, with their relatives and confidants, and with other health workers that help patients comply with antiretroviral therapy while carrying on with their lives. This community health worker labor of compliance and sociality blurs distinctions between those labors and affirms the resilience of the social[2]. I also contend that the current marginalization of community health workers as part of efforts to meet the ambitious HIV treatment goals, consistent with the global discourse on ending AIDS by 2030, enacts an extraction of their labor that is not unprecedented. It reveals a neglect for knowledge and skills represented as hierarchically inferior within biomedicine and public and global health. Ultimately, this marginalization expresses an increasing role of global HIV interventions in advancing a neoliberal politics of abandonment that produces more disposable

[2] Which have been variably described as the gift (Mauss 1950), economy of affection (Hyden 2006) or social networks (Mitchell 1969)

categories of human beings and that undermines the institutional conditions that can enable the implementation of equity strategies through health systems that tend to serve the most vulnerable people of the world.

I conclude by suggesting that current politics around the "end of AIDS" discourse seem to have been subverted into an anti-politics that raises fundamental political and ethical questions about the social justice rhetoric through which an important part of global health work has been justifying its influence over the last decade, particularly in countries most affected by HIV and AIDS, such as Mozambique.

Mozambique is far from reaching the ambitious HIV treatment targets (UNAIDS 2018), the last of which is that 90% of people on HIV treatment (ART) should achieve viral suppression by 2020 (UNAIDS 2014)[3]. The country has one of the highest HIV prevalence rates [4] (13.5%), among adults (15-49 years old) globally; but low proportion of knowledge about their HIV status (33.3%), low coverage of antiretroviral therapy (26.2%) and low viral suppression (31.9%) (INS, INE, and ICF 2018, 178, 206, 212) . Retention in antiretroviral therapy tends to decrease, down to 47% after three years on therapy (MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2018, 32), a consistent tendency throughout the years noted by

---

[3] Of 90% of people living with HIV knowing their status, 90% of them continuing on antiretroviral therapy for the treatment of HIV, and 90% of those on treatment achieving viral suppression by 2020 (UNAIDS 2014). Viral suppression means reducing the concentration of HIV into quantities that cannot cause AIDS to the person living with HIV, and the latter cannot infect people without HIV (UNAIDS 2014)

[4] HIV prevalence is the proportion of people living with HIV, and in this dissertation, I mostly use HIV prevalence in the adult population, conventionally, women and men 15-49 years of age.

Mozambique's national HIV program (MISAU 2015, 2015; MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2018; MISAU, Programa Nacional de Controlo de ITS-HIV/SID 2014; Ministério da Saúde, Direcção Nacional de Saúde Pública, and Programa Nacional de Controlo da Tuberculose 2015) scientific literature (Auld et al. 2011) and in sub-Saharan Africa (Rosen and Fox 2011)[5].

In reaction to low retention in antiretroviral therapy, global health research has focused on documenting the proportion, and the sociodemographic and clinical characteristics of people who are not retained (Rosen and Fox 2011; Tomori et al. 2014; Roura et al. 2009; Rowan et al. 2014; Boyles et al. 2011; Decroo et al. 2014; Hardon et al. 2007; Shepherd et al. 2013; Waldrop-Valverde et al. 2014; Govindasamy, Ford, and Kranzer 2012). This research has coupled with several HIV interventions approaches.

One category of interventions transfers responsibilities for the management of HIV (task-shifting) from higher level health workers to mid-level level ones, especially nurses and medical technicians, and from higher level to lower level health facilities - decentralization or "down referral" (Tamara Kredo et al. 2013; WHO, PEPFAR, and UNAIDS 2007). Another set of interventions transfers responsibilities for the

[5] In Mozambique, retention in antiretroviral therapy is measured through antiretroviral drug pickup within 60 days of the pharmacy appointment (MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2018), and is an important step into achieving viral suppression.

dispensation of drugs and monitoring of compliance to antiretroviral therapy, from health facilities and high and mid-level health workers to patient-support groups and community-based groups (Rasschaert et al. 2014; Decroo et al. 2013; Decroo, Telfer, Biot, Maïkéré, Dezembro, Cumba, das Dores, et al. 2011; Decroo, Koole, Remartinez, dos Santos, et al. 2014; Naslund et al. 2014; Kredo et al. 2013; Bemelmans et al. 2014). Transferring responsibilities to patients and community-support groups has been done under the assumption that patients and community members voluntarily associate based on their common therapeutic condition of being HIV-positive (Nicholas Rose and Novas 2005)[6].

The effectiveness of task-shifting and decentralization in ensuring retention has not been supported by quantitative systematic reviews (Tamara Kredo et al. 2013). It has also been challenged by ethnographic research that suggests that those interventions increase the workload of already underfunded primary health care facilities and overburdened mid-level health workers (Pfeiffer and Chapman 2015). Ethnographic research also suggests that these interventions lead to patients abandoning biomedical treatment (Olsen 2013; McKay 2012) and seeking other medical traditions, encouraged by mid-level health workers (Mattes 2011), often frustrated with the burden of managing extremely limited biomedical resources

[6] Rose and Novas (2004, 7) follow Paul Rabinow's theoretical proposition about biosociality, which he understands as based on groups "formed around genetic markers [who] will have medical specialists, laboratories, narratives, traditions, and a heavy panoply of pastoral keepers to help them experience, share, intervene, and "understand" their fate (Rabinow 1996, 102)".

(Rouse 2010). Patient evasion from biomedical compliance has been said to be also facilitated by the inability of the multiple data collection and monitoring and evaluation instruments, deployed by international NGOs, to track patients (McKay 2012). These ethnographic insights resonate with earlier reservations about task-shifting and decentralization (Philips, Zachariah, and Venis 2008a).

Ethnographic data has also challenged the voluntariness of patient and community support groups, by documenting subtle health worker coercion (Marsland 2012; Kalofonos 2010) of patients into participating in those groups. This ethnographic data helps raise reservations about theoretical propositions concerning the predominance of biological forms of sociality (Nikolas Rose and Novas 2004; Paul Rabinow 1996) on which the promotion of patient and community support groups are grounded. These propositions are part of a broader and current tendency within social theory, that discusses the demise of the social as part of the predominance of biological configurations of citizenship, sociality, and sovereignty (Lazar 2013; Long and Moore 2013; Nguyen 2010; Nguyen et al. 2007; Petryna 2013; P. Rabinow 2010).

This tendency reflects a habitus of cultural critique of western modernity as perverse, expressed through producing and perpetuating social precariousness (Marx 1977, 1973; "Durkheim (1893a), impoverishing sociality (Mauss 1950) subjectivity (Foucault 1988, 2003, 2009) and epistemology (Foucault 2003). Yet, this tendency has the potential to minimize and erase the agency of social actors and

institutions most exposed to structural violence, particularly those from geopolitical spaces regarded as outside what is commonly represented as the West. This erasure has happened, for instance, with the contribution of people living with HIV from the global south, to the social movement to provide universal antiretroviral therapy in the global south.

This social movement, which challenged particularly the South African government, the international pharmaceutical companies, and the World Trade Organization (WTO) (J. Comaroff 2007) was preceded by that of community-based organizations that provided home-based care to people living with HIV and AIDS, in the 1990s and early 2000s, in sub-Saharan Africa, when universal antiretroviral therapy was available to their fellow community members (Chimwaza and Watkins 2004; Kloos et al. 2003; Sepulveda et al. 2003; Uys 2003; I. Kalofonos 2014a; Colvin and Swartz 2015; Akintola 2011, 2008). The home-based care social movement was sustained mostly by women, who provided care voluntarily (Akintola 2008, 2011; Chimwaza and Watkins 2004; Uys 2003). Yet, the scale up of HIV testing and antiretroviral therapy led to their marginalization and fragmentation of their organizations. Marginalization occurred through shifting their roles from palliative care into recruitment for HIV testing and supporting initiation of antiretroviral therapy. It also occurred through narrowing the definition of care into technical and biomedical terms and incorporating home-based care into the national HIV and AIDS strategic plan (I. Kalofonos 2014a; Kenneth Maes, Closser, and Kalofonos 2014;

Bedell et al. 2015; Lefeuvre et al. 2014). The community-based organization was fragmented around disagreements about payment (I. Kalofonos 2014a, 14–20). That marginalization lead to the erasure of political agency and the contribution of the sub-Saharan African communities, and particularly the women who provided home-based care, from the global HIV treatment project.

Reviewing the home-based care social movement in this light, helps situate one of my central epistemological aims in this dissertation to highlight ethnographically the various expressions of agency of social actors, who given the extreme positions of vulnerability and structural violence become silenced in history. The global movement for universal antiretroviral therapy in the global south has erased the historical and epistemological agency of women who have provided home-based care and led the community-based response in the 1990s and 2000s. And now the global end of AIDS movement is performing similar erasures of experienced women community health workers who are serving patients in HIV care and treatment at health facilities and through community outreach work. Again, community health workers' roles are being redefined by other actors, following technical and biomedical protocols, and with disregard to the social consequences to both individual community health workers and to the people and social institutions (public health systems) through which community health workers have for so long been serving patients and building enduring social relationships with them.

Reading experienced community health workers' labor in this light - promoting compliance to the biomedical therapy and advice that can save lives, seems to be part of a broader politics of maintaining social life and community. This brings nuances to the theoretical proposition that medical anthropologists and medical sociologists advanced in the 1970s and 1980s (Crawford 1977, 1980; Illich 1976; Zola 1972; Frankenberg 1988; Singer 1987; Trostle 1988); that compliance to biomedicine plays simply the ideological role of promoting compliance to capitalism. Indeed, the decentralization to patient and community-support groups I have discussed seems to instantiate the shifting of the responsibility for the management of HIV care and treatment from the health system, the state, and global health institutions, to the level where individuals, families and the community are responsible. This looks like a current expression of a general politics of liberal social abandonment (Biehl 2007), or more concretely, spaces of neoliberal neglect, consistent with what has been described as "neoliberal rationality" (Lemke 2001). Yet, recognizing this should not come at the expense of meaningfully acknowledging the agency of those who carry the burden of task-shifting and decentralization everyday - people in antiretroviral therapy, community health workers and other community members, and mid-level and lower-level health workers.

This dissertation, empirically adds to the literature that has been documenting that community health workers involved in addressing HIV and AIDS perform

technically and emotionally challenging labor that involves employing the capacity to "build relationships with stigmatized people, reconcile family disputes, and confront death" (Kenneth Maes 2017). This labor has been said to positively contribute to care and treatment for people living with HIV (Bemelmans et al. 2016; Lefeuvre et al. 2014; Mwai et al. 2013) and to strengthening health systems (Lefeuvre et al. 2014). Yet, community health workers "recognition [...] remains marginal" (Lefeuvre et al. 2014) or neglected (Kenneth Maes, Closser, and Kalofonos 2014; I. Kalofonos 2014a). This literature suggests that community health workers' struggles for adequate recognition and compensation have been systematically undermined by local and global discursive and management politics that sustain a broader moral economy that devalues their labor by representing their altruistic motivations and desires for adequate financial remuneration as irreconcilable (Kenneth Maes and Kalofonos 2013; Kenneth Maes, Closser, and Kalofonos 2014; Akintola 2011; Closser 2015; Vander Meulen, Patterson, and Burchardt 2013; Olaniran et al. 2017; Kenneth Maes 2012).

In contrast to this valuable literature, however, these dissertation findings suggest a more nuanced interpretation of community health workers' highlighting of the economic value of their labor. It seems more like a critical commentary on changes that include their replacement by new, yet unexperienced and higher paid staff, rather than demands for monetary compensation. It is more like a commentary on their exclusion from state labor and social protection. To be concrete, the context I

studied was different from Pakistan (Closser 2015, 21–23), South Africa (Colvin and Swartz 2015, 34–35) and Ethiopia (K. Maes et al. 2015; Kenneth Maes and Kalofonos 2013; Kenneth Maes 2012; Kenneth Maes, Closser, and Kalofonos 2014), where community health workers were organized into social movements that demanded the state's recognition of their labor rights, including the payment of a minimum wage and other benefits that government employees have. Experienced community health workers I interacted with systematically expressed interest in becoming government employees mainly for the job security and long-term social protection such a position would offer them. They were quite aware that as government employees their income would be far below that of any international NGO employee (Mckay 2016; Mussa et al. 2013a). This reasoning extends to other categories of community health workers in Mozambique (Chilundo et al. 2015), whom, like those involved in the HIV response have for years contributed to sustaining the public health system.

To illustrate the reasoning, experienced community health workers have, over the years, developed a repertoire that helps compensate for the gaps and disconnections between often confusing patient management and health information systems in place at the health facility instead of passively resigning. An important feature of these duplicated systems is the paper-based health information system run by the local Ministry of Health which feeds the electronic-based patient tracking system run by the PEPFAR funded implementing partner and that primarily serves that

NGO and PEPFAR. These gaps and disconnects have been aptly described as "documentary disorders", and a challenge for retention in antiretroviral therapy in Mozambique (McKay 2012).

Experienced community health workers actively navigate through these "disorders" in ways that challenge representations of them as mere cultural brokers (Olaniran et al. 2017) or temporary assistants to mid-level and higher-level health workers (Perry, Zulliger, and Rogers 2014). Therefore, dispensing of their experience, knowledge, skills and commitment which in Mozambique they have contributed, in most cases, for at least a decade, manifests both a politics of abandonment, and configures a weakening of the capacity of the Mozambican health system to provide quality HIV services in public health facilities in ways the system might hardly recover from[7].

Such politics of abandonment contribute to turning community health workers into a disposable category of humanity. Contrary to what has been described in other contexts, with reference to other social categories (Davis 2003; Joao Biehl 2005; M. I. Ticktin 2011, 207–11) these dissertation findings suggest that community health workers are not disposed of, but kept under conditions of precarity (demotion or

[7] Recent ethnographies of HIV scale-up interventions in Mozambique (Pfeiffer and Chapman 2015) and elsewhere (Sangaramoorthy 2018), show that global (elite-driven) HIV treatment interventions and initiatives have these negative effects on people and health systems, of which the ending of AIDS initiative seems to be simple a contemporary example (Kenworthy, Thomas and Parker 2018).

underpayment) in the very global HIV interventions in which they work or float from one global HIV health intervention to another. This makes global health HIV interventions look more like connected zones of social abandonment from which community health workers can hardly escape. These zones of abandonment seem to have subverted the social equity considerations that have historically justified community health worker programs globally, as the following discussion suggests.

Global Structures of community health worker abandonment

Historical overview

Community health workers are currently employed globally, in low and middle income countries to expand access to health services, and in high income countries to address inequities in health outcomes, and have come back to the forefront of global discussions (Perry, Zulliger, and Rogers 2014; The Lancet Global Health 2017). They have a long history that dates back to their work in the 1920s in China, which was expanded to other countries in Asia, Latin America and Africa between 1960s-1970s (Perry, Zulliger, and Rogers 2014). They were internationally recognized as part of a people-centered approach to health in a 1975 publication of the World Health Organization (WHO) titled "Health by the People" that described experiences of eight countries in Africa, Asia, and Latin America (Newell 1975).

Based on the experiences of these eight and other countries of what is currently called the Global South, the approach was systematized as part of the Primary

Healthcare (PHC) movement, made popular through the International Conference on the theme, held in Alma Ata, in 1978 (WHO and UNICEF 2004). The movement's social justice orientation is evident in its statement (a) of health as a "fundamental human right" which should be regarded as the most important social goal to be achieved globally (section I), "by the year 2000" (section V), and (b) that health inequalities within and between countries were "politically, social and economically unacceptable" (section II).

PHC was regarded as "the key to attaining this target [health for all by the year 2000]" a social justice framework (section V). And PHC was defined as,

> [E]ssential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process (section VI).

Consistent with this global framework, in the 1970s and 1980s, countries in Global South organized their health systems within the framework of PHC and included community health worker programs. Yet, in the 1980s-1990s, PHC, along with community health programs collapsed or were weakened by a combination of

factors. Those included one the one hand, the overthrow of governments with socialist tendencies and the expansion of neoliberal policies that reduced social equity-oriented investments in health, education and other public goods and services, and on the other hand, the promotion of a selective and disease-oriented (or vertical) approaches to health and healthcare (Cueto 2004; Ooms et al. 2008).

In some countries, community health programs continued to work in the 1990s and 2000s, without the full logistical and financial support from states they had enjoyed in the previous decades (Perry, Zulliger, and Rogers 2014). In some cases, community health workers continued to work to help implement vertical interventions run by international NGO's, whose presence and influence had increased in the Global South (Ferguson and Gupta 2002). In tandem with community health workers who were created within the spirit of PHC, a new category emerged in sub-Saharan Africa, in the 1990s and early 2000s, as part of local community initiatives to provide home-based care to people living with HIV and AIDS, when antiretroviral therapy for the treatment of HIV was not available in sub-Saharan Africa (Chimwaza and Watkins 2004; Kloos et al. 2003; Sepulveda et al. 2003; Uys 2003).

Given the inability of public health systems to effectively address HIV and AIDS, community-based associations and other organizations provided counseling and home-based for several years, as volunteers, and with the advent of global health for

HIV in the early 2000's such community efforts were financially and logistically assisted by some international NGOs and donors (Colvin and Swartz 2015).

With the scale up of universal antiretroviral therapy in sub-Saharan Africa, the HIV response was taken over by local governments, which integrated the response within national HIV programs and coordination mechanisms, assisted by international NGOs and donors (Colvin and Swartz 2015; I. Kalofonos 2014a; Lambdin et al. 2013; Pfeiffer et al. 2010; Sherr et al. 2013). The HIV response shifted its focus from palliative care, into more technical and biomedical tones, home-based care community health workers were incorporated into the response, but their roles shifted into promoting HIV testing and uptake of and adherence to antiretroviral therapy, particularly to help alleviate the workload of mid-level health workers in the context of task-shifting (Mwai et al. 2013; Philips, Zachariah, and Venis 2008b; T. Kredo et al. 2014; WHO, PEPFAR, and UNAIDS 2007; Zachariah et al. 2009; Perry, Zulliger, and Rogers 2014).

Their community-based associations were marginalized from the HIV response (I. Kalofonos 2014b), not only because of the growing technical and biomedical tones of the response, but, also because those associations were fragmented over disagreements around payment for their work (I. Kalofonos 2014a, 14–20). In some cases, such as South Africa, community health workers were incorporated into the national health system as "key members of the ward-based primary healthcare

outreach teams" (Colvin and Swartz 2015, 34). Like in other contexts, community health workers' in South Africa used to work as volunteers, earning stipends far below the official minimum wage (Colvin and Swartz 2015, 33–34). But, the government eventually recognized and protected their labor rights, including payment at the level of government employees, as a result of a support from health sector labor unions, academics, NGOs and activist groups (Colvin and Swartz 2015, 33–34). In Pakistan, a community health worker labor movement also succeeded in improving their labor conditions, including payment at the level of government employees (Closser 2015).

This was not the case in other contexts, such as in Mozambique, where the status of community health workers has always been heavily influenced by expressions of morally and social justice driven rhetoric and human resources management formalist rhetoric and practices that have historically prevented their adequate material and monetary compensation. The morally driven and social justice rhetoric stems from the PHC principles of achieving health for all, including through community involvement as part of participatory democratic ideals and arrangements (WHO and UNICEF 2004). This rhetoric and associated practices have help represent community health workers as volunteers guided by altruistic motivations that vest their labor with such high a moral value that they cannot or should not be remunerable through material or financial resources (Closser 2015; Perry, Zulliger, and Rogers 2014). Working within western and biomedical

influences, human resources management rhetoric has represented community health workers as having limited educational qualifications and professional training (Olaniran et al. 2017), and defined as lay workers or paraprofessionals (given that biomedical training is used as a reference). Within this perspective, community health workers are treated like 'helpers' to better qualified health workers (Perry, Zulliger, and Rogers 2014), and their remuneration is viewed accordingly.

These representations have been advanced by institutions as diverse as international NGOs, local governments, and religious denominations alike (Closser 2015; Vander Meulen, Patterson, and Burchardt 2013), and have inspired most global health-oriented attempts to define community health workers (Lefeuvre et al. 2014; Olaniran et al. 2017; Perry, Zulliger, and Rogers 2014; Colvin and Swartz 2015). They have also inspired research that tries to understand community health workers' motivations to enter and continue in such a line of work, under such precarious labor conditions (Chilundo et al. 2015; Akintola 2011; Bedell et al. 2015; Greenspan et al. 2013; Kenneth Maes 2012; Mbilinyi, Daniel, and Lie 2011; Topp et al. 2015).

Defining community health workers

Several authors have acknowledged the multiplicity of terminology that reflects the diversity of the group, and translates into difficulties in reaching a unified definition for them (Lefeuvre et al. 2014; Olaniran et al. 2017; Perry, Zulliger, and Rogers 2014; Colvin and Swartz 2015). Despite recognizing such conceptual difficulties, some

definitions share an acceptance of the superiority of an ethnocentric (western) model of professional qualifications. This model is marked by western-defined notions of educational achievements and professional training that marginalize the importance of (often years or decades) work experience and other competencies.

Among them are competencies particularly oriented towards care labor, such as to "build relationships with stigmatized people, reconcile family disputes, and confront death" (Kenneth Maes 2017), in which the health system does not train them[8]. Such competencies, it has been argued, stem from socio-moral values they uphold, inspired by their parents (Kenneth Maes and Kalofonos 2013) and religious communities (Vander Meulen, Patterson, and Burchardt 2013; Kenneth Maes and Kalofonos 2013). But, they are crucially important for the provision of health services. This ethnocentric model, oblivious to the complex and rich contribution of non-western and non-biomedically defined qualifications and competencies, determines community health worker formally-accepted roles and tasks, which influence decisions about community health workers remuneration (Olaniran et al. 2017, 6).

[8] To illustrate the biomedical bias in definitions and classifications of health workers, the International Labor Organization's (2012) International Standard Classification of Occupations… classifies medical doctors in the first category of health professionals (category 22), and personal care workers are classified in the last subgroup (532) of the last group (53 – personal care workers). Community health workers would be classified as either "home-based personal care workers" or "personal care workers in health services not elsewhere classified" (ILO 2012, 26–28).

This model legitimates hierarchies in the way it differentiates community health workers from other health workers (mid-level or frontline health workers, regarded as hierarchically higher that community health workers, but ironically, also from lower-level health workers, such as hospital attendants, who often have the same or lower educational qualifications, but have some biomedical training). It also used to differentiate community health workers from other community-based health workers who do not have biomedical training. To illustrate the biomedical bias in definitions and classifications of health workers, the International Labor Organization's (ILO) International Standard Classification of Occupations, classifies medical doctors in the first category of health professionals (category 22), and personal care workers are classified in the last subgroup (532) of the last group (53 – personal care workers). Community health workers would be classified as either "home-based personal care workers" or "personal care workers in health services not elsewhere classified" (ILO 2012, 26–28).

Accordingly, community health workers are differentiated from mid-level health workers, also called 'frontline health workers' in other literature (cf. (Pfeiffer and Chapman 2015), whom after completing secondary education (grade 8-12), usually receive up to three years of professional training to perform specific biomedical tasks that are otherwise performed by health professionals with higher educational qualifications (Olaniran et al. 2017, 7). Based on the same model, community health workers are regarded as different from the so-called traditional birth attendants,

described as performing tasks usually associated with child delivery, because instead of learning those tasks at a biomedical institution, they have done so through apprenticeship training or by themselves (Olaniran et al. 2017, 7).

Such an ethnocentric and formalist model helps understand how income inequalities are structured in the health sectors, and guides efforts to establish categories of community health workers. The first two categories are broadly called "paraprofessionals", following ILO's definition (Olaniran et al. 2017, 6). The first category includes community health workers with some level of secondary education, followed by some formal training of longer duration in a recognized training institution (Olaniran et al. 2017, 6).. The second category includes community health workers with some level of secondary education, followed by informal pre-service training of short duration (Olaniran et al. 2017, 6).. The third category is the lowest in the hierarchy, called lay health workers, and includes those who usually have little or no educational qualifications, and receive no formal job-related training (Olaniran et al. 2017, 6). This broad classification model guides the legal and terminological status of community health worker monetary compensation. Accordingly, the first category of community health workers usually earns a salary, the second earns an allowance or incentive, while the third category works as unpaid volunteers or can earn an allowance (Olaniran et al. 2017, 6).

These formalist descriptions, however, hide other complexities, such as what counts as educational qualifications, and the importance of professional experience acquired through years of work that often benefits from on-the job training informally provided by other colleagues and through trial and error experiments. Yet, regardless of formalist representations, and community health workers level of educational qualifications and professional training, they usually perform diverse tasks, in vertical or polyvalent PHC activities in clinical (Perry, Zulliger, and Rogers 2014) or community settings (Akintola 2011; Kenneth Maes 2017; Mwai et al. 2013; Akintola 2008; Colvin and Swartz 2015; Cooper 2015). Their services have been regarded as equally or higher quality compared to health workers with biomedical training (Mwai et al. 2013). Therefore, this formalist literature's dismissal of community health workers as either paraprofessional or lay health workers, shows a difficulty in distancing itself from biomedical biases about professional qualifications. It also reveals a difficulty in challenging the narrow technocratic perspective that neglects the importance of knowledge and skills that are not acquired in Western-based educational institutions, even if they contribute to providing quality healthcare.

This is evident in attempts to recognize the value of community health worker's labor, which has come in two dominant perspectives. One is grounded in task-shifting rationales, that suggests that community health workers are accepted as a relatively temporary and substandard solution to address 'professional' health

worker shortage and lack of funding for public health systems, particularly in Sub-Saharan Africa (Perry, Zulliger, and Rogers 2014, 409–10). The underlying assumption is that if there were enough 'professional' health workers and if health systems were well-funded then community health workers wouldn't be needed. An apparently, yet, not radical attempt to correct this perspective is found in cultural competency prescriptions, and represents community health workers as cultural brokers:

> [I]ndividuals with an in-depth understanding of the community culture and language, have received standardized job-related training which is of shorter duration than health professionals, and their primary goal is to provide culturally appropriate health services to the community (Olaniran et al. 2017, 8).

A growing body of anthropological literature has challenged the assumed uniformity of community health workers' goals and has suggested that such uniformity is produced and contested through politics associated with the negotiation of conflicting moral economies around community health workers labor. I discuss this in the following section.

Moral economies of community health worker labor

Anthropologists have recently noted that current global interest in community health workers goes in tandem with the production of moral economies of heroism (Closser 2015), voluntariness (Vander Meulen, Patterson, and Burchardt 2013) and altruism (Kenneth Maes 2012) that prevent the recognition of community health

workers' labor as deserving of monetary compensation. They also document the resurgence of a "magic bullet" mentality within global health (Kenneth Maes 2015a) that reifies these health workers as a solution for much broader and complex health systems' and political problems (Colvin and Swartz 2015). One of these ideal types (agents of change) underlies disciplinary techniques through which governments expect community health workers to implement programs as governments tell them to (Kenneth Maes 2015a) which can be counterproductive since it builds community resentment towards both government programs and community health workers (Cooper 2015).

The morally-loaded experience that at least sub-Saharan Africa has had with HIV as a death sentence, has both inspired the development of moral economies based on altruistic values and accelerated the establishment of forms of transnational sovereignty in which global health is implicated (Crane 2013; Nguyen 2010; Biehl 2007), by exposing community health workers to experiences of extreme social abandonment structured through global health interventions to address HIV.

Community health workers providing HIV and AIDS care services in low and middle income countries (Lefeuvre et al. 2014) share the multiplicity of terminologies and financial compensation regimes that were documented for other community health workers globally (Perry, Zulliger, and Rogers 2014; Olaniran et al. 2017). Although they do technically and emotionally difficult work that involves employing the

capacity to "build relationships with stigmatized people, reconcile family disputes, and confront death" (Kenneth Maes 2017) beyond their formal job descriptions, and that has a positive impact on the care and treatment for people living with HIV (Bemelmans et al. 2016; Lefeuvre et al. 2014; Mwai et al. 2013) and strengthens health systems, their "recognition [...] remains marginal" (Lefeuvre et al. 2014) and neglected (Kenneth Maes, Closser, and Kalofonos 2014; I. Kalofonos 2014a).

Since the first years of the scale up of antiretroviral treatment in sub-Saharan Africa, community health workers who have contributed to addressing HIV and AIDS have had complex and various motivations for becoming involved in, and continuing to provide services for people living with HIV that challenge suggestions about an irreconcilable dichotomy between altruistic motivations and desires for material and financial remuneration (Kenneth Maes and Kalofonos 2013; Kenneth Maes, Closser, and Kalofonos 2014; Akintola 2011). Yet, organizations lack of understanding of volunteers' motivations, a mismatch between volunteers' motivations and organizational goals, and lack of funding led to volunteers main motivations not being addressed, and this was associated with volunteer attrition (Akintola 2011).

The complexity of motivations for community health workers' involvement and continued engagement in the provision of HIV and AIDS care was also documented years after the scale up of antiretroviral therapy in other sub-Saharan African contexts - Mozambique and Ethiopia (Kenneth Maes and Kalofonos 2013), along

with community health workers' understanding that there is no incompatibility between being driven by altruistic motives and receiving adequate remuneration for their work (Vander Meulen, Patterson, and Burchardt 2013; Kenneth Maes, Closser, and Kalofonos 2014; Kenneth Maes and Kalofonos 2013).

In those settings, anthropologists found that community health workers motivations to be involved in care for people living with HIV were associated with complex local histories and global forms of structural violence, including structural adjustment and poverty (Kenneth Maes and Kalofonos 2013), connected to socio-moral values they uphold, inspired by their parents (Kenneth Maes and Kalofonos 2013) and religious communities (Vander Meulen, Patterson, and Burchardt 2013; Kenneth Maes and Kalofonos 2013). In addition, there were individual reasons such as the need to engage in activities that help fight boredom that comes from routine, willingness to learn obtain new skills and knowledge, and peripheral benefits of training that included food (Vander, Patterson, and Burchardt 2013, 263), and the hope of employment. Those anthropologists also documented that community health workers reasons for continuing in their work included the strong relationships they built with people who benefit from their services, but also the search for greater compensation to escape poverty and provide support to their families and other community members. There was a sense of deservingness given the labor they contribute to addressing HIV and AIDS (Kenneth Maes and Kalofonos 2013).

However, Vander, Patterson, and Burchardt (2013) describe how the very socio-moral values that religious communities inspire in community health workers may both be accepted up to a point, yet be critically assessed by community health workers, when those values help perpetuate a moral economy (of voluntariness), which prevents community health workers' entitlement to adequate remuneration. This description fits well within what Mirian Ticktin described as an "antipolitics" (Ticktin 2011). To be concrete, religious leaders of the Anglican Diocese of Niassa Province, Northern Mozambique, in their attempt to address HIV and AIDS through home-based care, promote voluntariness as an important component of individual expression of religious faith and community activism, in ways that enable the participation of other religious congregations and communities. They foster team creativity in finding appropriate strategies that each team finds relevant for their team dynamics and community (Vander Meulen, Patterson, and Burchardt 2013, 253). This theologically framed assumption that communities have the capacity to contribute to management processes (Vander Meulen, Patterson, and Burchardt 2013, 257), resonates with ideas about active community participation in the management of public health services that have been institutionalized since 1976-1978, just several years after the independence of Mozambique.

Church leaders used a complex frame that mixed examples from religious organizational structures and practices, concerns with local and global sovereignty, and financial governance and accountability. Concretely, they framed community

health workers actions in terms of other volunteer roles within the church, such as catechists; they empowered volunteer teams with decision-making rights to counter a sense of the unequal and hierarchical position of donors who can impose their agendas and methods to recipients who have to follow donor directions. These relationships that develop when international NGOs and donors fund local civil society activities; and they insist on the importance of maintaining "financial transparency [and] keeping expenses as minimal as possible" (Vander Meulen, Patterson, and Burchardt 2013, 261). Contrary to international NGO practices, the church did not go to the communities to recruit people. Instead, it accepted those who "present themselves" to the care teams. Finally, church leaders tried to dispel misconceptions about volunteer work, by stressing that such was work without pay based on pure altruism, contrary to NGO language and practices that insisted on providing some sort of monetary payment, usually a subsidy or a stipend (Vander Meulen, Patterson, and Burchardt 2013, 262).

Yet, this church frame was challenged by terminology politics, the authors argue. Church leaders' use of the very term "volunteers", and "projects" was problematic. The authors argue that given international NGO and the Mozambican Ministry of Health discourse and practices of paying some form of monetary compensation (usually called an incentive or a subsidy) to so-called volunteers, members of the care teams expected to be paid, too (Vander Meulen, Patterson, and Burchardt 2013, 264). To add to this complication, in the spirit of autonomous planning when church

leaders asked care teams to develop activity plans, which they specifically called projects, members of care teams expected some monetary benefit too because following international NGO practices, members of the team understood projects to be funded activities (Vander Meulen, Patterson, and Burchardt 2013, 262).

The authors seem to endorse part of the church leaders' politics, through their assertion that donors brought to Mozambique the idea that voluntary work should be paid and created a relationship of dependency on Mozambican civil society regarded as "implement subcontractors, not as independent agents with an authentic voice" (Vander Meulen, Patterson, and Burchardt 2013, 260). That relationship, the authors argue, can decrease the quality of work since people will perceive that they are working for someone else, instead of working for themselves (Vander Meulen, Patterson, and Burchardt 2013, 260).

Yet, it is problematic that the authors do not question the double standard based on which church leaders insist that community health workers should contribute their labor without pay, while church leaders are paid by the church, for their theological, management and other work. This religious framing of community health work as activism and volunteerism, adds to other framings, such as those based on the need to maintain the moral superiority of care work of work labelled as too priceless to be financially compensated. More human resources management formalism and biomedical hierarchical perspectives also label community health workers as 'lay

workers', given their limited professional health training associated with limited 'educational' qualifications.

Rarely does one find thorough empirical accounts of the life experience that community health workers bring to their work (Closser 2015; Kenneth Maes 2012). Nor are there accounts of the quality and effort they contribute, the complexity and intellectually challenging aspects of their work (K. Maes et al. 2015), their radical questioning economic exploitation (Kenneth Maes 2012), and the level of exposure to abandonment from the very local and global health initiatives that community health workers help advance (I. Kalofonos 2014b). I add to these descriptions (ethnographic data), a serious consideration of community health workers interpretations of the global project to end AIDS within a generation as a project that accelerates their experiences of social abandonment (analytical perspective). This is consistent with what Foucault calls political historicism (Foucault 2003).

Analytical Framework

More broadly, the analytical framework that guides this dissertation is inspired by discussions about social abandonment, the global reconfiguration of social institutions that enable resilience of equity-oriented social strategies into neoliberal ones, and epistemic violence against people and institutions from the geopolitical spaces of the world that have been classically defined as outside the West. I try to be faithful to this framework by taking seriously community health workers descriptions and interpretations of their experiences as both a memory of a social and more specifically a labor struggle for the recognition of the multidimensional value of their labor (historical ethnographic data), and as a valid reading of current neoliberal practices of economic extraction and social abandonment advanced through global health interventions (analytical framework).

Doing this is possible within the epistemological standpoint of political historicism, which helps to counter the effects of epistemic violence that have for centuries been practiced against "subjugated knowledges", understood as

> the historical contents that have been buried or masked in functional coherences or formal systematizations [and, secondly] "a whole series of knowledges that have been disqualified as nonconceptual knowledges, as insufficiently elaborated knowledges" naïve knowledges, hierarchically inferior knowledges, knowledges that are below the required level of erudition and scientificity [...] knowledges from below [...] what people know (Foucault 2003, 7).

Ethnography has the potential to help rehabilitate “subjugated knowledges”, since it shares the epistemic stigma of “what people know” (Foucault 2003, 7). Concretely, in the division of scientific labor it is better accepted as the provider of empirical data to be transformed into theoretical propositions and frameworks by philosophy or expressions of social theory regarded as more prepared for the production of theory (Biehl 2013). Anthropologists have not, however, accepted this epistemological subordination as easily, and have proposed that ethnography itself should be looked at as both a strategy for the production of empirical data and of theory (Jean Comaroff and Comaroff 2003; Nader 2011; Biehl 2013).

Yet, such an epistemologically engaged ethnography should not neglect its ethical obligations of protecting the very strategies that have enabled research partners to continue living and working under precarity. I have tried to uphold that awareness through various means, in part by not disclosing the health facility and the specific geographic setting where I conducted fieldwork. I now turn to describe the geographic setting.

Research Site

Geographic context

Maputo City and Province are the southernmost and smallest of Mozambique's 11 provinces. Most of their population is of African descent, and speak Portuguese, *Xironga*, and *Xitchangana*. These provinces have the highest population density in the country (INE 2017), and the highest household income, compared to the national average (INE 2016). Their gender educational gender parity - the rate of rate of school aged women enrolled in primary and secondary school over men – is close to the national average (INS, INE, and ICF 2018), but, with slight differences. Maputo City has a slightly lower educational gender parity compared to the national average, while Maputo Province has a slightly higher rate (INS, INE, and ICF 2018, 212).

Maputo City and Province have the highest HIV prevalence in the general population, being second only to Gaza Province, also located in Southern Mozambique. Although viral suppression is comparatively higher in Maputo City (48.0%) than in Maputo Province (36.5%) (INS, INE, and ICF 2018, 212). [9], both provinces are still far from meeting the ambitious treatment target of 90% of people on antiretroviral therapy achieving viral suppression by 2020 (UNAIDS 2014).

[9] Confidence intervals are not provided in the national report. Therefore, we cannot reliable ascertain whether there are statistically significant differences between the provinces and comparing to the country.

Maputo City is the capital of the country, a province with a provincial government and a municipality with a corresponding executive and legislative body. Its continental part borders with the Indian Ocean on the East and South, and with Maputo Province on the North and West. The Indian Ocean separates the continental part of the city with two municipal districts (*Katembe*, across the bay to the South, and *Kanyaka* to the Southeast). With a population of 1,101,170 inhabitants in 2017, living in 300 km^2, Maputo City had the highest population density in the country (3,670.6 inhabitants/km^2) (INE 2017), which is 100 times higher than the country's, but its area is less than 1% of the country's (INE 2017).

Maputo City's population is mostly composed of Mozambicans of African descent, and most people speak Portuguese, *Xironga*, *Xichangana* and *Xindindinda* – which sounds like a dialect of *Xironga*, the language spoken by the natives of the City and of most of Maputo Province's. Maputo City households have the highest income per capita in the country and the city is the economic and political capital of the country, where the three branches of government and the main public institutions are located. The population is mostly of women (n=571,660, 51.9%), and the population lives in its seven municipality districts, mostly in the five continental districts (*Kampfumu, Nhlamankulu, KaMaxakeni, KaMavota*, and *Kamubukwana*), and the remainder one across the Maputo bay (*KaTembe*) and in *KaNyaka*.

Nearly all Maputo City households (94.6%) are at the highest wealth quintile, and this is almost five times the national average (INS, INE and ICF 2017, 26). This is consistent with their household income, which is the highest in the country (29,971 Mt), and five times higher than the national average of 5,902 Mt (INE 2016, 38). Maputo City has a slightly lower rate of school aged women enrolled in primary school (grade 1-7) over men (0.94), compared to the national average of 0.96, and an even lower rate (0.84) for those in secondary school (grade 8-12) compared to the national average of 0.96 (INS, INE, and ICF 2018, 33). In the general adult population in 2015, 38.7% knew they were HIV-positive, 32.3% were in HIV treatment, and 48.0% had achieved viral suppression (INS, INE and ICF 2017, 206, 209, 212).

Maputo province, with a population of 2,507,098 in 2017, living on 25,058 km², had the second highest population density (96.2 inhabitants/km²). Its capital is the city of Matola, which is also a municipality and the capital of the district with the same name and has the second highest income per capital in the country. Most of the population of the province is composed of women (863,415, 53.0%). Matola is the most populated district in the province (n=863,415, 34.4%), and the remainder of the population lives in the other seven districts (Boane, Magude, Manhiça, Marracuene, Matutuine, Moamba, and Namaacha). Seven out of 10 (68.9%) Maputo province households are at the highest wealth quintile, which is 3.5 times the national average (INS, INE and ICF 2017, 26). Not inconsistent with this, Maputo

Province households have the second highest income in the country (14,597 Mt), which is 2.5 times higher than the national income per household (INE 2016, 38).

Maputo Province has a slightly higher rate of school aged women enrolled in primary school (grade 1-7) over men (1.03), compared to the national average of 0.96, and a similar rate (1.01) for those in secondary school (grade 8-12) compared to the national average of 0.96 (INS, INE and ICF 2017, 33). In the general adult population in 2015, 42.2% knew they were HIV-positive, 36.8% were in HIV treatment, and 36.5% had achieved viral suppression (INS, INE and ICF 2017, 206, 209, 212).

HIV, along with the introduction of structural adjustment programs, and a war that started a year after Mozambique's independence (June 25, 1975) and lasted 16 years (1976-1992), produced profound transformations in Mozambique, including in its health system. In what follows I provide an overview of the health system and the transformations it experienced, as a context for a description of dynamics that I witnessed at the health facility where I conducted fieldwork.

The Mozambican Health System

After independence in 1975, a national health system was established in Mozambique, organized in four levels of healthcare attention (primary, secondary, tertiary, and quaternary) with corresponding levels of health system management (rural or urban areas, city or district, province, and regional) (MISAU 2002). The first guidelines for the Mozambican health service, issued in 1977-1978, recognized the provision of PHC at both health centers and health posts (MISAU, n.d.), but the health bill of 2002 extinguished health posts , although some continue to operate.

As part of the establishment of a national health system, private clinics and other health-related property were nationalized on July 24, 1975 (MISAU, n.d.). In November 1977 (almost a year before the Alma Ata conference), the Bill on Socialization of Medicine was approved, which provided the legal grounds for the implementation of PHC, provided for free in-patient admissions, clinical exams and preventive drugs and symbolic user fees for outpatient services (MISAU, n.d.).

Starting in 2002, legally, the PHC level is composed of health centers, which can be urban (type A, B, and C) or rural (type I or II), so categorized based on the technical complexity of their infrastructure, management and equipment, on the qualifications and training of its personnel, and on the number of people the health center caters to in its catchment area. Urban health facility type A and rural type I

are the most complex and resourced in urban and rural areas, respectively (MISAU 2002).

Consistent with the PHC approach, health centers provide preventive services that try to address the social determinants of health, therapeutic and curative services, and referrals. Their specific services include health education, vaccination, maternal and child health and family planning, sanitation promotion and surveillance, water and food quality assurance, prevention of endemic illnesses, clinical diagnosis and disease treatment, first aid and urgent treatment for the most common trauma events, collection and analysis of statistical, epidemiological and demographic data and report writing, logistical and technical support and supervision for health and sanitation at periphery of the health facility catchment areas, resource management, and referral of complicated cases to higher levels in the health system (MISAU 2002). The national guidelines anticipated that only type A urban health facilities would have a physician, in addition to other personnel, and the total number of personnel was estimated at 26-36. Because there were and still are few physicians compared to the country's population, the guidelines anticipated that physician would be in charge of two type A urban health centers (MISAU 2002).

To ensure the coverage of PHC for the whole population, a community health worker program was established in 1976 (Chilundo et al. 2015; MISAU, n.d.). As part of the PHC approach the polyvalent elementary agent (APE), the only community

health worker recognized by the Mozambican health authorities to date was created. They were members of rural communities, who had completed primary education, were at least 18 years old, and trusted by the community that selected them under the orientation of local administrative authorities and the management of the health center in which catchment area the APE community was situated. They worked under the guidance of management of the health center, of which they were extensions of sorts.

They were trained in basic health knowledge and skills for six months at a training center. The first training was conducted in September 1976. They dedicated part of their time to their health activities and another part in agricultural activities at their community of origin, from which activities they obtained their income. They conduct internships at the health facility to which they report and attend regular refresher trainings. Their responsibilities are to provide PHC at their village, including sanitation and health and nutritional education, addressing communicable diseases, antenatal and postnatal maternal and child healthcare, recognizing the most common illnesses and providing basic therapeutic care. They provide first aid for the most common occurrences at their village and collect basic sociodemographic and statistical data. Because the APE is the link between the health facility and the community and represents an extension of the national health system at the community, the health facility provides medical equipment, medication and supplies (kit) and supervises the APE's work,

In the first years following independence (1975-1978) the health budget as a percentage of the national budget improved (4.6-10.1%), the national vaccination campaign of 1976 was internationally celebrated as the most successful in Africa (MISAU, n.d.), health indicators improved and 30 years after the Alma Ata conference the country was still singled out as one of the best examples of the implementation of PHC in Africa ("Primary Health Care Comes Full Circle" 2008).

Yet, the uncanny symbiosis of 16 years of post-independence war (1976-1992), the implementation of structural adjustment programs since 1987, and global efforts to address HIV and AIDS mainly through international NGOs since the 1990s have contributed to weakening the national health system, its PHC orientation, and the ability of the Mozambican government to autonomously decide about local health policy and priorities (Pfeiffer and Chapman 2010, 2015; Pfeiffer et al. 2017; Gimbel et al. 2018; Biehl 2011). One of the implications has been admitting the inclusion of the for-profit private sector as part of the health system of Mozambique. The national health system is now composed of the public, the private (for profit and non-profit), and the community sector (in which community health workers are included as a conventional component, different from the so-called traditional component) (MISAU, DNSP 2017). The public sector covers only 60 percent of the Mozambican population (MISAU, DNSP 2017).

The global response to HIV and AIDS in Mozambique has been funded mainly by the Global Fund to fight AIDS, tuberculosis and Malaria, and by the United States President's Emergency Plan for AIDS Relief (PEPFAR). The latest report on HIV/AIDS expenditures for 2016, in Mozambique, is estimated at over $3000 million[10] (UNAIDS 2018, 50), most covered by international sources, particularly PEPFAR, which covers nearly two thirds (64.9%) of the total expenses (table 1).

Table 1: HIV/AIDS expenditures by source in Mozambique, 2016

	Domestic	International			Total	
	Public	PEPFAR	Global Fund	Other international	International	All sources
Amount (US$)	8,501,812.0	206,158,981.0	84,130,028.0	18,854,333.0	309,143,342.0	317,645,154.0
Percent (%)	2.7	64.9	26.5	5.9	97.3	100.0

Source: UNAIDS data (2018)

The Global Fund budget is used to cover priorities defined by the Mozambican health authorities, including strengthening the local health system. The funds are directly allocated to the Mozambican Ministry of Health (Pfeiffer et al. 2017, 210) and the local civil society, along with some international and national NGOs tasked with implementing community-based activities that are part of the HIV response

[10] Based on my calculations, adding all sources, total expenses were US$317,645,150.0, which is nearly US$12 million less than the US$329,521,479 total that the UNAIDS report presents. (this must have been either an arithmetic error or the UNAIDS entered the data from the sources in which they obtained them. However, I could not check because UNAIDS did not provide their primary source).

(UNAIDS 2018, 50). The funds allocated to the Ministry of Health are executed using Mozambique's rules and regulations.

PEPFAR funds are used for acquisition of antiretrovirals, to fund HIV surveillance activities, such as population surveys (including the AIDS indicator survey, the demographic and health survey and integrated behavioral and biological surveys in key populations), and health facility-based surveys (such as the antenatal surveillance survey on HIV and syphilis). Part of the funds are allocated to international NGOs, (particularly those with affiliations to American research and university institutions), known as implementing partners (Pfeiffer et al. 2017, 213), who second technical assistants to the National HIV program and participate in the technical working groups. PEPFAR funds and the NGOs it funds are completely "outside the scope of government-led health sector financial planning" (Pfeiffer et al. 2017, 210).

These NGOs are part of various technical groups in Mozambique's National HIV program, within the Ministry of Health, and command immense influence, derived from the size of the PEPFAR budget and the extremely limited accountability they have towards the Ministry of Health, which is facilitated by PEPFAR funding flow and reporting mechanisms that do not go through the Ministry. The Ministry does not even know clearly how much PEPFAR allocates to each implementing partner, and how much those partners allocate to activities in the sector. One of the few

mechanisms the Ministry has for (indirect) monitoring and holding those partners accountable is through monitoring the progress of indicators of the HIV response.

At the national level through those working groups, these NGOs influence the design of (and often draft) national HIV guidelines, protocols and instruments that are usually legitimated as national documents through various practices, the most public of which are validation meetings. But they also exert their influence at the provincial, district and local level, where they implement or fund the implementation of activities and provide financial and logistical support, including allocating part of their funds to local directorates of health through sub-agreements.

Implementing partners are broadly categorized into two groups. Those who provide technical and logistical support and implement activities at the health facility (clinical partners), and those who manage and implement activities at the community-level, including outsourcing some activities to Mozambican community-based organizations (community partners). Both clinical and community partners can be funded by either through the Centers for Disease Control and Prevention (CDC) or the United States Development Agency for International Development (USAID).

There is a perception within some sectors of the Mozambican Ministry of Health, that although the Global Fund is extremely rigorous, its funding mechanisms and

budget execution rules and practices do not undermine Mozambique's public sector practices, as a Ministry of Health official explained to me during an interview on August 18, 2015, in Maputo. The official noted that, for instance, even though

> The global fund does the procurement of drugs. It uses does so following [Mozambican] state mechanisms to deliver the drugs and transfer the funds. In other words, the fund uses the rules and procedures of the Mozambican public sector, such as the decree 15/2015 on the procurement of goods and services and the electronic fund transfer system (e-sistafe).

Echoing a general sentiment that PEPFAR funding and budget implementation mechanisms undermine the Mozambican public sector, the Ministry of Health official challenged me to decide which funding mechanism is more adequate and is better.

> A funding mechanism such as the Global Fund, which funds the public sector directly, using local public sector rules and regulations. Or a funding mechanism like PEPFAR, which does not fund the Mozambican state directly, nor does it follow Mozambican state rules and regulations (interview with Mozambican Ministry of Health official, August 18, 2018, Maputo).

Implementing partners support activities that aim at preventing infection with HIV or lead to people living with HIV entering the HIV cascade. The cascade starts from HIV counseling and testing and ends with continuing in antiretroviral therapy for the treatment of HIV (retention) or being lost from the cascade (abandon treatment, death, or for other reasons). Counseling and testing are done at the community level and at the health facility and can be initiated by the provider or by the user (MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2015b). Community-based counseling and testing is provided by activists and counselors recruited and

(logistically and financially) supported by community-based groups or my NGOs, including PEPFAR-funded (community) implementing partners.

People whose test result is HIV-positive receive a referral for linkage to HIV care or treatment at health facilities, usually of their choice. At health facilities, counseling and testing initiated by the user are provided at offices known as counseling and testing units (*Unidade de Aconselhamento e Testagem* – UATS) and counseling and testing initiated by the provider is offered at various health facility sectors, including wards, tuberculosis section, antenatal care (ANC), at-risk child consultations, emergency services, etc. After testing and result disclosure, those with a negative test result are counselled on how to maintain their negative status, while those whose results are positive receive post-positive result disclosure counseling and are linked to care or treatment.

The flow of people with an HIV-positive result is described in the national guidelines for antiretroviral therapy (MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2014) implemented with slight variations across health facilities (Inguane et al. 2016). These were in in place in most facilities until I completed fieldwork in July 2017, when the test and treat strategy to meet the ambitious HIV treatment goals started to be implemented in selected health facilities of 29 out of the 161 districts of Mozambique (MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2018).

Pregnant women, people with a concurrent tuberculosis infection and children under the age of five open their chart, have their clinical consultation and can start antiretroviral therapy the same day at the health facility sector where their HIV test was done. Other patients have a different flow, which includes their being sent to the HIV reception to open a patient file, from which they are sent to a laboratory for CD4 count and to their first clinical consultation in which it will be determined if they are eligible to start antiretroviral therapy or not. If they are not eligible they will continue in pre-antiretroviral therapy care.

If they are eligible they will be sent for a psychosocial assessment and adherence counseling by an experienced activist or counselor to determine if they are ready to start antiretroviral therapy. If they ready they will be sent back to a second clinical consultation usually within that week to receive a prescription for antiretroviral drugs that they should collect at the health facility pharmacy. After about 15 days of starting antiretroviral therapy they return for another clinical consultation, adherence counseling and antiretroviral drugs refill, and return for the same activities 15 days afterwards. Thereafter they return every month to refill their antiretroviral drugs prescription. If their clinical condition improves and they adhere to the therapy (show no sign of clinical complications or increase in the concentration of HIV, usually measured through their CD4 count, but in some instances through a viral load test) they can start refilling their antiretroviral drug prescriptions every two and, in few cases, every three months. Nine months after

they start antiretroviral therapy they can receive a referral to a patient support group or a community-support group.

For the first year in antiretroviral therapy the patient comes for clinical consultations and adherence counseling every three months. Thereafter, the patient comes for a clinical consultation every six months, for antiretroviral drug refills every three months, and for adherence counseling only when needed – when clinical complications arise, the concentration of the virus is detected or if patients miss drug refill appointments for over 60 days. This is a complex flow, that varies across health facilities, but, invariably patients are lost along the cascade (figure 1), particularly from HIV-positive result disclosure to opening the chart, from there to first laboratory tests and their first clinical consultation, from there to their second clinical consultation and between antiretroviral drug refills (Inguane et al. 2016; MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2018).

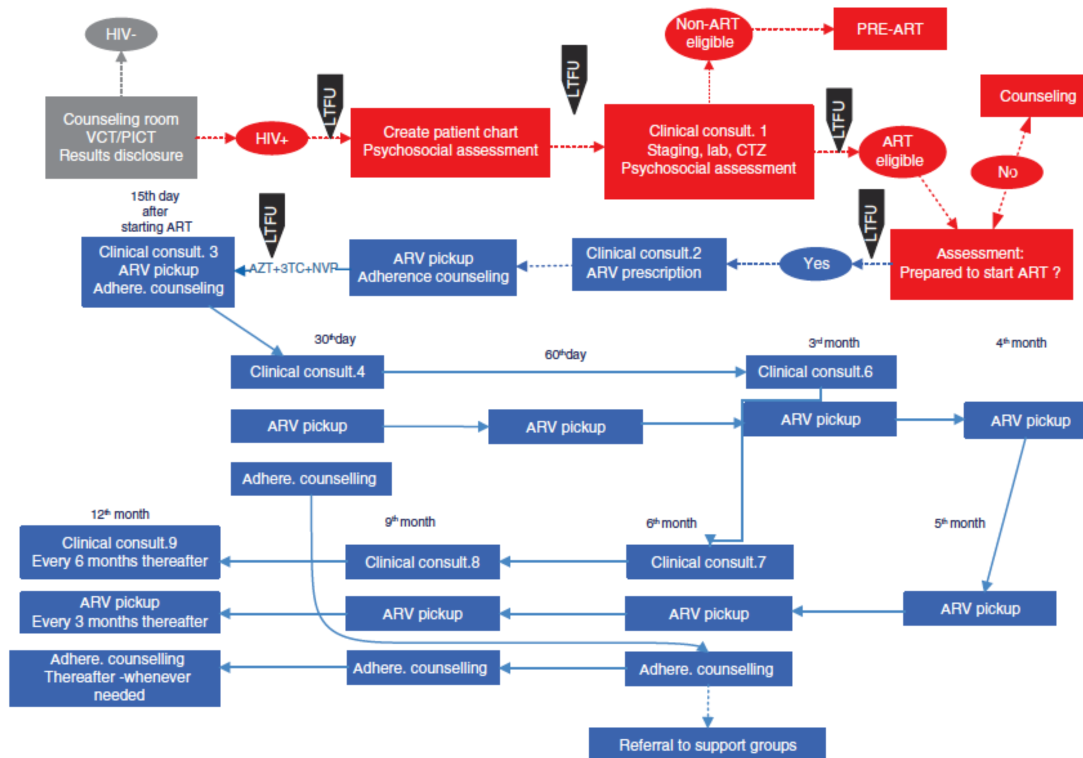


Figure 1: HIV patient flow map in Mozambique, from Inguane et al. 2016

As a result, retention in antiretroviral therapy in Mozambique continues far below the globally expected 90%. Public health facility data shows that in 2017, 70% of people who start antiretroviral therapy continue after the first year (retention), and retrospective analysis shows that this proportion drops to 54% after two years in treatment and to 47% after three years (MISAU 2018). This decreasing tendency that has been consistent throughout the years in Mozambique (Auld et al. 2011, MISAU 2015, 2016, 2017). Community health workers involved in addressing HIV and AIDS have been playing a crucial role in providing counseling and testing at the community and health facility level (user initiated), helping patients navigate the complex patient flow at the facility, providing adherence counseling, and tracking

patients who are lost from the system and helping them reintegrate into the care cascade.

Each clinical partner is assigned one or more of the 11 provinces of Mozambique (figure 2), at which health facilities they provide technical and logistical support, including community health workers, and clinical and nonclinical personnel. Clinical partners also provide funds to provincial and district directorates of health to cover HIV and AIDS related activities through sub-agreements. The assignment of provinces to implementing partners suggests a balkanization of the country through the health sector in ways that resonate with what the Portuguese colonial administration did when Mozambique was a Portuguese colony. It assigned most parts Mozambican territory to state-like plantation companies and as labor reserves to the mining industry of South Africa (Newitt 1995; Covane 1996).

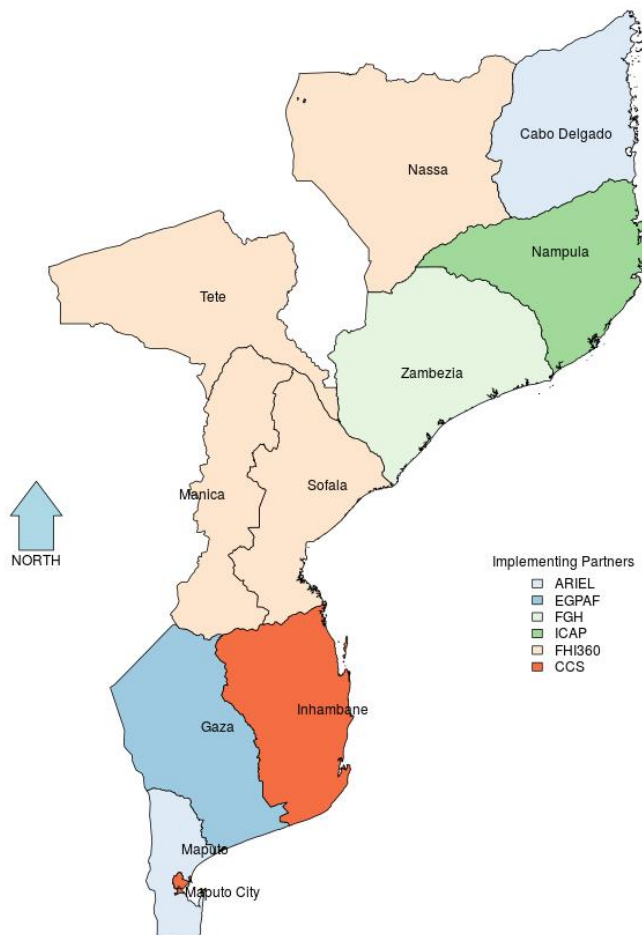


Figure 2: PEPFAR-implementing partners provincial assignment in Mozambique

These companies had sovereign power, including issuing their own currency, imposing tax, and having their own police apparatus. In exchange for the allocation of Mozambican territory, those companies paid a sum to the Portuguese colonial authorizes. Mozambique migrant labor to the South African mining industry brought financial advantages to the Portuguese colonial government as well. South

African companies built a railway that connects part of South Africa (formerly known as Transvaal) to Maputo in Mozambique, through which South African cargo was transported, and South African companies paid fees to the Portuguese colonial government.

In addition, Mozambicans working in the South African mining industry earned part of their monthly salary in South Africa and another part was sent to Portuguese colonial government bank accounts in Mozambique, which invested the funds and gained interest fees, until the Mozambican miners returned to the country and could access their money. The colonial government could earn interest fees over several months, since miners on their first contract usually remained in South Africa for at least 18 months, and in the following years usually stayed a few more months each time, before they would return to the country.

Added to the influence of PEPFAR funded international NGOs on national HIV policy, program and interventions, it instantiates transnational forms of sovereignty that have been amply documented, which are expressed, among other ways, through the influence over the management of HIV services at primary health facilities that provide those services, such as the one where I conducted fieldwork. These forms of sovereignty are resented by sectors of Mozambican public institutions involved in the national response to HIV, and, in addition to funding restrictions from the Ministry of Health, contribute to the Ministry not formally 'recognizing' activists

and counselors as community health workers. Those sectors regard these community health workers as a creation and an issue that belongs to international NGOs as I was told in an interview in 2016 (interview with a Ministry of Health official, March 28, 2016, Maputo). The official reiterated this view during a telephone conversation in which I tried to schedule another interview on the matter during a field trip in July 2018.

Indeed, some activists and counselors' positions were created by international NGOs and supported by them. Yet, part of them came from the home-based care provided by community-based organizations and associations in the 1990s through the early 2000s, when antiretroviral therapy was not universally available yet, as I discussed in the introduction of this dissertation, even when they sign contracts with the Mozambican state. Regardless, it seems open to careful debate whether these experienced community health workers should solely be an international NGO and donor issue alone, given the public interest work they perform, including in public health facilities managed by the government through the Ministry of Health. in addition, a great portion of the national budget and even a greater portion of the health budget is funded by international donors (Pfeiffer et al. 2017, 214). Such funding has also supported, and still supports, the activities of the only category of community health workers that the Mozambican health sector recognizes (APEs). And, since 1989, when the national APE program was closed, most APEs who

continued their activities were taken over by international NGOs (MISAU, DNSP 2010, 2017).

The health facility

The health facility in which I conducted fieldwork is a type C urban health center (MISAU, DPC 2014) that used to be a private clinic in the colonial era, until it was nationalized and turned into a public health center after independence (SDSMAS/DSCM 2014) in July 1975. During the 16 years' war (1976-1992) part of the health facility was destroyed and abandoned. Eventually, it was taken over by the Mozambican military, until it was renovated and expanded to offer TB treatment, adult triage and a waiting area through funding of an international NGO in 2000 (SDSMAS/DSCM 2014).

In 2008, the health facility was further expanded, through funding from an international NGO that started the HIV services, and added two prefabricated containers where the HIV reception, counseling and testing room, ANC and family planning room work, in addition to the building of a water reservoir and restroom (SDSMAS/DSCM 2014). As of March 2014, in theory, the health facility served a population of 114, 896 in its catchment area(SDSMAS/DSCM 2014), which is 4.5 times higher than the 25,000 maximum population estimated in the national guidelines (MISAU 2002). In reality, the health facility served people from other

districts in the same province, and in some cases from other provinces, particularly people doing HIV care and treatment.

As a type C urban health facility, this one should have only a minimum of four health workers, namely, a medical assistant – *agente de medicina* -, an MCH nurse, a general nurse and a hospital attendant (MISAU 2002). But a 2014 list of health facilities mentioned 21 health workers, without mentioning their professional categories, but clearly excluded physicians or any personnel with higher education, and excluded so called volunteer personnel – APEs, TBA and activists(MISAU, DPC 2014).

The MISAU inventory is far away from the 45 mentioned in the description of the health facility catchment area (MISAU 2002), and from the 43 that I documented during my fieldwork, including 3 physicians, MCH and general nurses, medical assistants, laboratory and pharmacy technicians, a clinical psychologist and a psychiatric technician, and activists and counselors, in addition to administrative personnel. Such personnel composition, the above-mentioned infrastructure and the population in the health facility catchment area was consistent with a type A urban health center, which the legal guidelines estimated to have 26-36 health workers, and a population of 40,000-100,000 inhabitants (MISAU 2002).

By the time I completed fieldwork there were about 65 personnel, including 6 new counselors, an archivist and a laboratory assistant hired by the implementing

partner to help meet the 90-90-90, a team of four technical assistants hired by the implementing partner, and about 10 community outreach workers hired for implementing partner research. All this people shared the small space of this health center that up to this day looks like a two-bedroom apartment (figure 3).

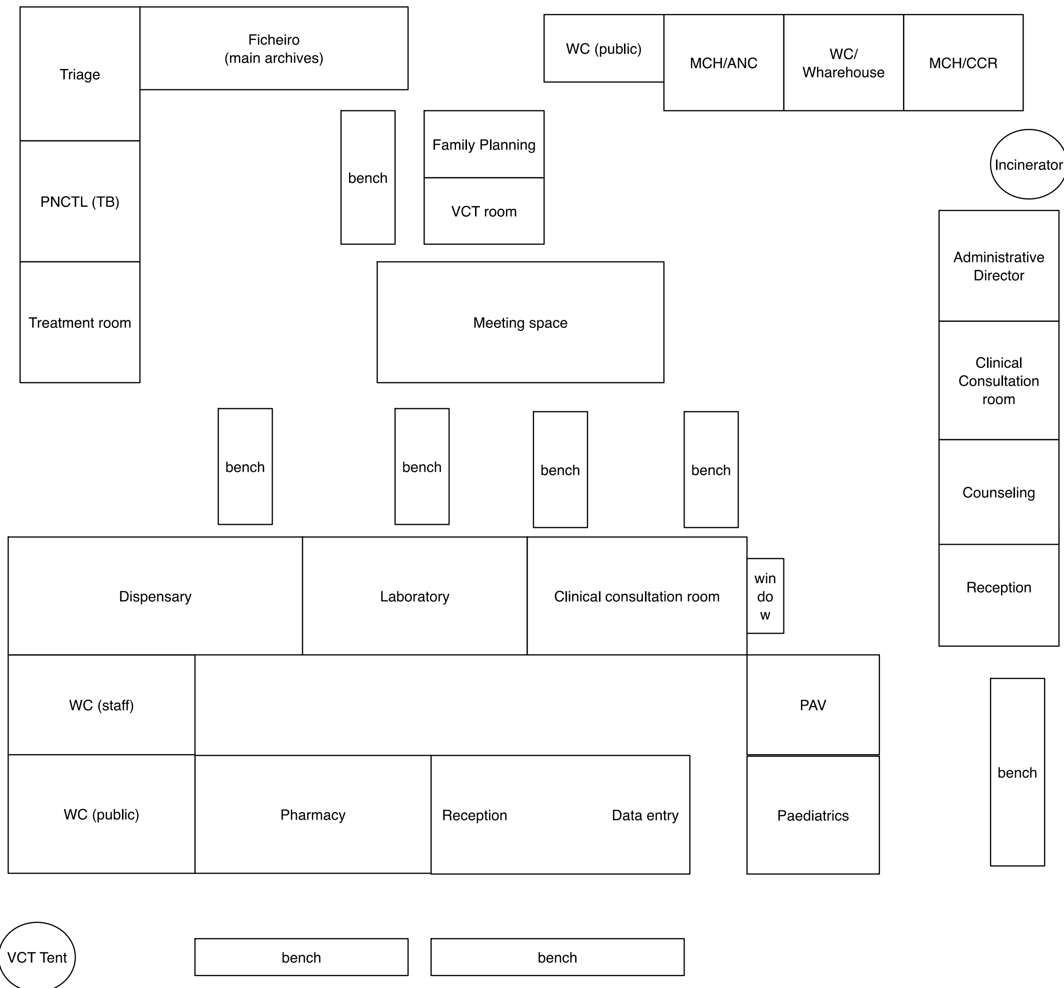


Figure 3: a sketch of the health facility

It is a small health facility for the patient volume it has, which is between 200-400, depending on the flow of the day. The health facility is crowded by both patients

and health workers, and in most rooms, health workers are crammed. Therefore, there is not much privacy in the HIV counseling tent, the main consultation room, the data entry section if you need to re-issue your patient card or need to discuss any other matter about yourself, or in the tuberculosis section if you are seen outside the consultation room. But, there is privacy in the new HIV counseling and testing room, in the maternal and child health rooms.

When it rains parts of the health facility are severely affected, particularly the main reception and the main archives. Water leaks from the roof, and at the reception it enters the electricity switch board, so the data entry computers are switched off, and people fear for electrocution or explosions. All attempts to solve the problem had been unsuccessful until I completed fieldwork. The only major change done was to replace the switchboard and electric wires, when closing the roof where the rain was leaking from would be the solution.

In the main archives, when it rains the water leaks through the zinc roof, and through the ceiling, and soaks the several hundreds of patient files stored in cardboard boxes on top of filing cabinets inside of which there is no space. In one of these occasions when it rained, the contractor came and replaced the ceiling, only for water to leak again and do the same damage when it rained again. This was the situation I left when I completed fieldwork in July 2017.

When I returned for a daylong visit in July 2018, the storage issue was worse, with far more patient files (2017-2018) stored in open cardboard boxes on the floor and on top of the filing cabinets, and several labels had been removed from the filing cabinets (figure 4). When I was doing fieldwork, only some 2017 patient files were stored outside the filing cabinets, on top, and none on the floor. When I noted the current states of the archives with the counselor who used to run the main archives, we exchanged the following ironies over WhatsApp:

> Me: Wow, the archives look really great.
> Counselor: Indeed, pretty, doc☺☺☺☺
> Me: A real reason to be proud of☺
> Counselor: Yes, something to be really proud of. Thank God.

Figure 4: The main archives (*ficheiro*)

When we talked face-to-face in a relatively more serious tone, she mentioned that the main archives were so disorganized since she had left them that around 30 patients in HIV care and treatment were asked to come another day for their clinical or laboratory visits or counseling sessions because the new cadre of health personnel working at the archives could not find the patients' individual files. The former head

of the main archives felt sorry for the patients who had to return another day, and who knows when that day would really come when their file was found – I thought to myself. But, she said that in a way she was happy that she had been moved from the archives to her current position, because the archives where a dangerous place to work from, due to exposure to respiratory illnesses, including tuberculosis, for which there was no protection and no hazards subsidy.

I remembered my own attempts to help organize the archives. Some were partially successful, such as organizing and labelling the filing cabinets, obtaining a lock and a fan. But, others failed, such as obtaining funding to buy more filing cabinets and an air conditioner. Part of the attempts at improving the archives found local opposition from some implementing partner technical assistants, who argued that they would use less rudimentary organizational methods and dedicate personnel, none of which ever materialized. And that did not surprise the counselor in charge of the main archives but made me stop out of frustration for several months, until, in a fit of anger I decided to carry on with my work using my own resources. I explained to anyone who wanted to tell me otherwise that 'I was a Mozambican citizen with rights and duties to contribute to a well-organized health facility'.

My tribulations with the organization of the main archives, and the regressing to unprecedented levels of disorganization that I witnessed when I visited the facility in July 2018, suggest that one of the main products of the HIV response and

associated power dynamics at the health facility is futility. The persistence of such production, discourages people to try and address important problems, and leads to general sentiment that fits within what has been called a "politics of resignation" (Benson and Kirsch 2010).

Dissertation outline

The dissertation has three parts (introduction, methodological approach, and a substantive presentation of findings), and a conclusion.

In the first parts (introduction) I frame the dissertation by stating the research problem, providing an overview of global health and anthropological discussions about community health workers, outlining the epistemological influence and analytical framework, and describing the research site, the health system and the health facility in which I conducted fieldwork.

In the second part, I outline the methodological approach I used, particularly the process through which I produced ethnographic data (chapter 1) and discuss some ethical experiments I made and the associated predicaments I found (chapter 2).

In the third part, I describe the local politics that structure community health workers experiences of vulnerability and social abandonment (chapter 3), and I describe the multidimensional contribution of community health workers to the

global and local response to HIV and AIDS, with particular emphasis on the effort to ensure that people continue in antiretroviral therapy (chapters 4-5). My description focuses on histories and experiences of three community health workers, and a hospital attendant, and are punctuated by descriptions about the experiences of other health workers and people in antiretroviral therapy whenever those descriptions are necessary to illustrate or strengthen the argument of the chapter or section. I end this part by describing the context in which the current experience of community health worker marginalization takes place (chapter 6), specifically efforts to meet the globally-defined ambitious HIV treatment targets believed to lead to the end of AIDS by 2030. I describe how those efforts, accelerate strategies of social abandonment expressed in the marginalization of experienced community health workers and other health workers, and expressed in the weakening of the local health system.

In the conclusion, I state my main contention and discuss some implications for theoretical debates within social theory and anthropology, and for ethical discussions around social justice that animate both medical anthropology and global health.

PART 2: METHODOLOGICAL APPROACH

Chapter 1: Producing ethnographic data

In this chapter, I reflect on how I produced ethnographic data through different stages - from study design, to fieldwork through data analysis and write up - and on how I took methodological decisions influenced by my engagement with people and with non-human actors. In writing from this perspective, I raise reservations about assumptions of methodological control, of a researcher able to collect data construed as passively lying in wait to be acted upon by researchers assumed to be the only active subjects of the ethnographic encounter. Such assumptions are based on anthropocentric epistemological notions that assume the primacy of human actors over other (non-human) actors, including what we call data.

This research initially aimed to document motivations, and life experiences of people who continue in antiretroviral therapy, and strategies and resources different social actors mobilize to ensure that adults (18 years and older) continue in antiretroviral therapy in Maputo, Mozambique. Yet, the fieldwork dynamics I describe below, and the changes I observed associated with the implementation of efforts to meet the ambitious HIV treatment goals, guided me to decide on presenting and discuss findings on the contribution of community health workers to ensuring that adults continue in antiretroviral therapy.

The dissertation, then, is the result of nearly 18 months of ethnographic research that I conducted between February 2016 and July 2017, about 14 of which at a health facility in Maputo, Southern Mozambique. It was supplemented by nearly a month of exploratory research between August and September 2015, and a short weekly visit during dissertation writing in July 2018. For ethical reasons, I concealed the names of people who participated in the research and of the health facility and province where I conducted research.

Whenever I arrived early enough (6h30-7h00 am) at the facility, I observed health education talks, coordinated by an experienced health worker, and delivered by health workers, including herself. I also attend all HIV sector-related meetings and most non-administrative staff meetings. I worked at various sectors of the health facility, where HIV-related services where provided (main archives, HIV reception, pharmacy, reception and data entry room, and occasionally at the library). At each sector, I learned and executed tasks that were related to my research interests, and others that were unrelated, in an effort to combine my research interests with helping alleviate the workload of health workers.

I ran errands for the health facility, such as transporting medicines from other health facilities when there were stockouts. My errands included contacting or going to the Ministry of Health or the Provincial Directorate of Health to help resolve issues that I could. I conducted small projects for the benefit of the health facility,

the implementation of which lasted between one and four months, at the request of the health facility management or at my own initiative. One project consisted in an analysis of patient flow, linkages to care and data quality to help health facility management decide how to improve on those areas. In another project, I helped the community health worker responsible for the main archives. On a third one I helped laboratory personnel reconcile lists of HIV viral load samples collected and results received from the referral laboratory.

My work at the different sectors, the errands I ran and the projects I became involved in facilitated my understanding of the archives containing data relevant for my research, and helped me build relationships of trust, and in some case of friendship with several health workers. This facilitated my archival research, provided me easier access to interviews and meetings and other social events, and helped me circulate through different sectors when I needed.

I conducted what James Spradley (1980) calls ethnographic interviews, which he means interviews that extend from the relatively informal aspects of ordinary conversation to the more formal characteristics of semi-structured interviews. I conducted individual interviews with seven patients in antiretroviral therapy, and with 41 health workers, including eight experienced community health workers, seven new and unexperienced ones, and conducted a group interview with 4 experienced activists and counselors. I interviewed six Ministry of Health officials,

at the provincial and national level, and six representatives of international NGO's including the implementing partner of the health facility where I conducted fieldwork. I conducted multiple interview sessions with patient in antiretroviral therapy at their homes and in public spaces, particularly a park nearby the health facility or in restaurants. I also conducted multiple interviews with health workers at the health facility, in public places, and in their homes. In the following section I provide details about how I produced the ethnographic data presented in the dissertation.

Producing ethnographic data through sampling

One important instance through which I, in collaboration with my research partners (human and non-human actors) produced the ethnographic data I present and discuss in this dissertation was the sampling process, including the selection of the health facility, people to interact with, sections of the health facility at which to work, and events to observe, to document and to report about.

The selection of the health facility in which I conducted fieldwork resulted from negotiating my initial research plan with the local directorate of health. The authorities selected a health facility that had included some of the criteria I had anticipated in my research plan and added criteria I had not anticipated. I had anticipated selecting a health facility in which efforts to ensure that people continue in antiretroviral therapy were being implemented since January 2015,

with technical and/or financial assistance from an international NGO. The health authorities added that I should go to a health facility that was understudied, and the health official who facilitated my access to the health facility added a warning that I should not take much time from the only physician who was working at the facility at the time. In doing this, inadvertently the official was influencing my sampling, by trying to select who I should interact with and for how long. Yet, I also understood the official's management concern in protecting the time of the only physician at a small urban health facility that sees about 400 users a day a sizeable portion of whom see the physician.

My selection of people to interview was more eventful and unpredictable. I had initially planned to interview people who had started antiretroviral therapy between June 1, 2012 and January 1, 2015, who had refilled their antiretroviral prescriptions at least once a year and were still in treatment at the time I was conducting fieldwork. I chose the start date of June 2012 because around that time at most health facilities in Mozambique a new HIV data collection and monitoring protocol had been implemented (Inguane et al. 2016). My definition of being in treatment is more generous than the 60 day one used by the Mozambican Ministry of Health (MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2014), and 30-60-90, and sometimes 180 day definitions used in the biomedical and public health literature (Brennan, Browne, and Horgan 2013; Decroo, Koole, Remartinez, Dos Santos, et al. 2014; Audet, Salato, and Vermund 2017; L. Wilkinson 2013;

Decroo, Telfer, Biot, Maïkéré, Dezembro, Cumba, Das Dores, et al. 2011). It was meant to capture different experiences and dynamics of being in treatment, including being late and being lost-to-follow-up and returning, or continuing in treatment while not documented as such in the medical files. I had learned about these dynamics during my pilot research.

I had planned to spend the first six months of fieldwork navigating the medical archives (counseling, clinical care and drug refill registries) of a sample of 126 people in treatment, out of which I would select a subsample of 16 people that I would interview over the following 12 or more months of fieldwork when they came to the health facility to refill their antiretroviral prescriptions. After those six months, I had planned to extend my ethnographic research to sites and people outside the health facility, and therefore, fulfil the requirements of studying up (Nader 1972). I had also planned to spend those first six months learning about the organization of the health facility and of the HIV section of the chronic illnesses program by participating in HIV care and treatment-related activities, by building rapport and interviewing healthcare workers who were better acquainted with people in treatment, with the health facility and with HIV treatment.

However, against my initial expectations, it took me almost 12 months to obtain a reliable sample of people in treatment, because I had challenges finding all medical files I needed, which were scattered around the health facility. Some data

were missing, inconsistent, or unreadable, and it took me time to resolve those data quality issues. Some data were in the paper medical files that in theory should feed the electronic-based patient tracking systems (e-PTS) run by the implementing partner. Yet, some data were in one and not on the other system. So, against my initial plan of treating the paper-based patient medical records, I decided to combine those with e-PTS. To add to the complexity, some data were not available in either biomedical archive, but, so to speak, could be found in the minds of experienced hospital attendants and community health workers who interacted more regularly with people in treatment.

I had not determined in advance the number of health workers that I would interview at the health facility, but, intended to include all who worked directly with medical archives, and treatment for people on HIV treatment at the different sections of the facility, regardless of their position in the facility hierarchy and their employer. My final sample of health workers had 41 people, including health facility managers, physicians, implementing partner technical assistants and data collectors, nurses, pharmacy and laboratory technicians, activists and counselors, from the main archives (locally called *ficheiros*), the tuberculosis section, psychosocial support, the HIV reception, the general reception (locally called *secretaria*), clinical consultation rooms, pharmacy, and drug dispensary (figure 5).

HIV Reception	Receptionist (Hospital-attendant)	1				
Archive (*ficheiro*)	Counselor (sector supervisor)	New cadre counselor	2			
Drug dispensary	Data entry clerk	Activist	2			
Other activists and counselors	Community-based counselors/activists (2)	HIV counseling and testing counselor	3			
Psychosocial support	Clinical psychologist(sector	New cadre counselors (2)	3			
Reception (data entry)	Data entry supervisors (2)	Data entry clercs	5			
Reception (*secretaria*)	Health facility manager	Assistant health facility manager	Receptionist (hospital attendant)	3		
Clinical consultation room	Clinical director	Clinical director (replacement)	Physician	3		
Laboratory	Laboratory technician (sector supervisor)	Laboratory technician	Laboratory assistant (new cadre)	3		
TB section	Facility head nurse	Community-based activist	facility-based Counselor	Clinical technician	4	
Implementing partner TA's	Team leader	Clinical care	Psychosocial assistance	Monitoing &Evaluation	4	
Pharmacy	Pharmacist (sector supervisor)	Pharmacy technicians (2)	Hospital attendant	Counselor	New cadre counselor	6

Figure 5: Facility-based health workers included in the study sample

Most of what I learned from implementing partner technical assistants was through observations during health facility meetings and task-force activities, informal conversations or through data request interactions, because they wouldn't consent for interviews without their supervisors' authorizations. The authorization never came. The implementing partner granted me an interview only when I was preparing to complete fieldwork (July 2017), and after a long bureaucratic process, which puts in an interesting light some conversations and deeply held assumptions that circulate among international NGOs and other international institutions about what they regard as unreasonable and challenging data access and obstructing bureaucratic practices in the Mozambican public service.

I only managed to take the offer of an interview when I returned for a short visit to Mozambique in July 2018. In addition to granting me the interview, the interviewee was concerned about the possibility of my sharing the interview findings with other

implementing partners described as competitors, and no document was shared with me, except for a two-page description of approaches to retention. Documents that described community health worker's terms of references, their salaries or stipends and the basis for that, the reasons why they were being replaced by a new cadre of counselors and other people since 2016 were not shared. Rather than my criticizing the implementing partner, my point, for now is about how international organizations might not be as impermeable to challenging data access and obstructive bureaucratic practices, and for good reason.

While I had informative interviews with Ministry of Health officials, including those in the National HIV and STI control program, and received important documents from them, I could not obtain information about community health workers engaged in the HIV and AIDS response (so-called peer educators, activists, volunteers, and lay counselors). I was told that those community health workers were created by "the partners"; if I needed to learn more about them I should ask "the partners"; and the ministry did not recognize those community health workers. Again, while this response closed important doors for me, I understand why the ministry would have such a position; and I will explain those reasons during this dissertation.

Therefore, to learn about community health workers engaged in the HIV and AIDS response, I relied on alternative sources that granted me access to some documents;

but, I mostly relied on ethnographic interviews and observations at the health facility. I spent several months in the main archives (*ficheiro*), the general reception, and the pharmacy, and a few months at the HIV reception and at the laboratory. I observed health education talks in the health facility patio (usually around 6h30-7h00 am), and I attended monthly HIV care and treatment adherence committee meetings, and other health facility staff meetings and some task-force activities. I interacted regularly with health workers through a mix of conversations, semi-structured interviews, and participant observation.

At the main archives, I interacted with the head of the archives (Angelina) and her assistant (Felicia), where I helped organize and retrieve files, reviewed biomedical files for my study sample, ate lunch with them most of the days I was at the health facility, amid excellent conversation and gossip. I feel relatively confident that I could be a competent assistant archive supervisor if I were asked to do that job. I also worked at the HIV reception where the supervisor (Lolita), for quite some time the only person who staffed that sector, taught me how to open patient files and enter patient information in the PRE-ART and ART logbooks. She trained me to be an assistant of sorts, but, I do not think my eyes could last for long if I continued looking at the small font letters of those logbooks, or that my heart wouldn't fail me given the emotionally demanding character of the work she does.

I also interacted with healthcare workers at the tuberculosis section, especially the community health worker responsible for the community activities. This community health worker is still categorized as an activist and earns the lowest stipend/subsidy for community health workers. She has not made it to counselor only because she doesn't have 'formal' educational qualifications, although she speaks excellent English and isiZulu, and fills out forms and prepares reports. At the tuberculosis section I also interacted with a counselor who was Angelina's friend and I sometimes interacted with the clinical technician and the chief health facility nurse who was simultaneously in charge of the section. I did not work at this section, except for a small project that I developed to try and understand linkages to care involved HIV-positive people who had done their HIV test in the tuberculosis section and elsewhere at the health facility.

I spent several months on and off at the general reception trying to understand how the e-PTS works, looking for medical files I could not find elsewhere at the facility or verifying data I had found elsewhere. I interviewed the health facility manager and the assistant manager, and I had long conversations with the data entry clerks - who helped me so much making sense and obtaining the data I needed for my research. A now retired senior, smart, fun and sweet lady taught me how to distribute cards, collect user fees and make appropriate change. I would occasionally do other reception chores when I was bored or frustrated with other research tasks or when there was no one else to do those chores and facility users needed service.

I would often have breakfast at the reception, and (rarely) have lunch there. When I was too distracted to notice, I would read my newspaper in the beginning of the day, after observing the daily health promotion talk and greeting everyone. I also spent time chatting and exchanging jokes with the implementing partner Monitoring & Evaluation technical assistant.

I had several conversations with the health facility clinical director about my work, and I reported to her on the small health facility projects I worked on. I also had brief conversations with the other physician who worked part-time (the therapeutic failure focal point). I never secured an interview with the clinical technician who replaced the previous clinical director. We would often have conversations, though and managed this interesting relationship in which she never gave me informed consent for the interview nor did she refuse to – for lack of a better term. I call this relationship a dialectics of pending. I had several conversations with the head of psychosocial support and with counselors. Only incidentally, when I was working at the pharmacy did I learn that there was another archive housed at this section of the health facility. Although the head of psychosocial support never gave me a formal interview, we built a friendship, and she offered me her office to conduct (several) interviews with health workers, which I did after working hours.

I worked a few months at the laboratory, particularly with the head of the laboratory, a laboratory technician and the laboratory assistant who was part of the new cohort

hired to ensure that the ambitious HIV treatment goals are met. Most of the time I spent at the laboratory I was working on a small health facility project related to HIV viral load data quality, which I will describe elsewhere, not in this dissertation. I spent the last four months of my fieldwork at the pharmacy, navigating the complex and tiring documentary multiplicity associated with dispensing antiretroviral drugs. I think that I spent some of the most instructive and hilarious moments of fieldwork in this section. An experienced activist taught me how the pharmacy archives are organized and complex, a counselor from the new cohort taught me the pains (and sometimes pleasures) of retrieving patient antiretroviral refill forms (FILA, from the Portuguese language *Ficha Individual de Levantamento de ARVs*). I enjoyed the fine Portuguese of a new 'activist' and learned about the organization and disconnects between the electronic and the paper-based medicine management records through interviews with the implementation partner hired pharmacy data entry clerk.

I had several interactions with the counselor responsible for HIV Counseling and Testing and for managing health education talks. I ran a simple descriptive analysis on the main themes, regularity and health workers involved in health education talks for her that she took seriously. Through that analysis, I also learned about other health workers that I should interview, but whose relevance for my research had not been obvious before this analysis.

Finally, I had some interesting interactions, especially conversations with the supervisor of the implementing partner team at the health facility. But, I did not manage to secure any interviews with her, nor with her colleagues, who told me that they needed authorization from their supervisors to give me an interview (as I described earlier in this section). I only interacted socially with healthcare workers from the triage section, pediatrics, and family planning and PMTCT, since their work was not part of my research interests. On a few occasions, when I asked, PMTCT health workers would do a few favors that I asked for people on treatment I was interviewing.

In the beginning of my dissertation research I interviewed people at the Ministry of Health's National Directorate of Public Health and at the National HIV and STI Control Program, which was initially at the National Directorate for Medical Assistance, and sometime in the beginning of 2016 moved to the National Directorate of Public Health. Later, amid the hospital-based ethnography, I interviewed Provincial Directorate of Health officials when I had to follow up on threads that were directly associated with my work at the health facility. On one occasion, I wanted to understand more about the job descriptions of activists and counselors, and the logistical and technical support agreements between the implementing partner and the provincial health authorities. On another occasion, I wanted to have a better sense of the protocol the health facility needs to follow when a CD4 count machine (PIMA) stops functioning.

I simply followed the issues, questions and documents directly related to my hospital-based ethnography, wherever they led. In addition, the dynamics related to ensuring that people continue in treatment at the health facility seemed complex and interesting enough to keep me focused at the health facility. This decision, I think, helps me describe in as much depth as possible, how global health interventions work in local settings such as health facilities. By making this methodological decision, I am aware that I am missing out on other important issues, such as the production and negotiation of national and global policy outside the health facility, with city or district, provincial, national and international actors. Yet, at the time, I thought, and still do think that I would be artificially fragmenting my research focus by trying to study up when the problem, the threads, the archives and people, and what I was experiencing and learning at the facility seemed to be complex and interesting enough for me to understand.

It is in this other sense, of doing a hospital-based ethnography (Livingston 2012), that pays ethnographically consequential attention to research partners contributions and to locality (Marsland 2012), that I have produced the ethnographic data I am sharing here. However, I have no 'small or isolated community' illusions that by my focusing at the health facility I was able to capture the totality of what was happening with efforts to ensure that patients continue in treatment, better than someone studying up would do. There was an important

degree of selection and serendipity, as I described above and will also do in the next section.

Producing ethnographic data through documentation

I produced and documented data that I decided to focus on, through a combination of qualitative and quantitative strategies and methods, some of which I had anticipated. Fieldwork circumstances inspired me to add other production and documentation strategies. Yet, because this dissertation focuses on community health workers, I will only describe the methods I used to learn from them and about them.

I had planned to use individual ethnographic interviews with all research partners. Yet, the more I talked with experienced community health workers following my semi-structured interview guide, the more I realized that I needed to use some variation of the life history interview approach (Werbner 2004) to have a better sense of these healthcare workers' motivations to enter into this activity and to continue in it and their trajectory. So, I adapted the interview guide to include what now looks like brief professional histories.

I had planned to document interviews through audio recordings and field notes using a notebook. However, I only recorded one interview, because there were several instances in which recording interviews and having very personal

conversations was impractical or seemed unethical. Most of my interactions with research participants were through conversations, some in public spaces, others at the health facility, and yet other ones at participant's home or restaurants or in my car while I gave participants a ride. Under these circumstances using audio-recorders would be awkward. In addition, given the persistence of HIV-related stigma, I did not think it would be ethical to record conversations I had with healthcare workers when those conversations involved mentioning the names of people in treatment, which inevitable was often done, even after I had asked research partners not to mention people's names. No research participant had problems with my documenting our interactions in my notebooks.

I had intended to take notes of meetings and other observations by writing immediately in my notebooks or immediately thereafter, depending on what was practical. And, I did that for the first few observations, until I came to the obvious conclusion that taking notes immediately interrupted by observations of events and interfered with my participation activities (and introduced a type of selection I could avoid). So, I decided to focus on observing and memorizing as best I could and write my notes in my notebook or directly in my laptop immediately after my observations and participation.

Yet, I also realized that several people spent most of the meeting time writing (or doing heavens knows what) on their phones. I am not sure if they did this out of

boredom or of dependence on social media, particularly WhatsApp and Facebook. Therefore, whenever I mostly had to listen instead of also talk in those meetings, I would type my field notes on the spot in my phone and transfer them to my laptop and expand them later in the day. This documentation technique proved non-intrusive and extremely efficient, and in this age of conformity to multi-tasking and other expressions of neoliberal subjectivity and sociality, I imagined that people who attended those meetings with me did not care whether I was taking notes or if I was distracted with my email, texting, WhatsApp or other forms of social media. They never asked, never frowned on me, nor have I heard any negative comments about my meeting habits. I think that I became addicted to writing so much on my phone, an occupational hazard that only my wife realized, frowns upon, and makes negative comments about.

Finally, an important part of my production of ethnographic data derived from my involvement in what I call small health facility projects that did not seem to be directly related to my research topic. I originally did them for the benefit of the health facility and they were small enough in scope that I could complete them within a month and with my own resources. I became involved in those projects out of impulse to help solve some challenges that I witnessed at the health facility or that health facility staff identified. I worked on three specific projects to (a) better organize the medical files in the main archives (b) understand how to improve the

flow of people in HIV care and treatment, and (c) verify whether the health facility had received viral load testing results from samples sent to the national laboratory.

As part of my efforts to make those projects useful for the health facility, I produced short reports that I shared with healthcare workers and the facility clinical director. Although I had initially regarded these projects as completely disconnected from my dissertation research, inadvertently they helped me understand the health facility organization, dynamics, and relationships in ways that illuminate important portions of my research questions and interests. They also suggested to me the centrality of the work community health workers and hospital attendants do, which influenced my decision to focus this dissertation on them (analytical serendipity). But, what did work at the health facility look like?

Chapter 2: Ethical experiments and predicaments

In doing participant observations, I tried to always be aware of the impact of my presence, by adopting an ethically conscious approach that included trying to engage in work that was useful for the health facility and healthcare workers. I learned activities by doing them, by observing what healthcare workers did and how, and by engaging in conversations with them. I also learned by documenting my field experience through field notes that I extended at the end of the day's work, whenever I could. I also tried to make ethically-oriented decisions around my dissertation title, the management of my identity and institutional affiliation, and my work conduct. Yet, I did, and still have deep feelings of failure and futility of some of my efforts at upholding ethical principles.

Infusing ethics into participant observation

In the first place, I tried to engage in activities that the healthcare workers found useful or that I thought were useful for the health facility, in the sense of alleviating their workload, solving problems they wouldn't easily solve or did not have the time and sometimes the specialized knowledge (such as the small health facility research projects I conducted), resources (such as my car, cellphone airtime or personal connections), or the emotional energy to deal with, because they had tried several times and did not work (such as having CD4 count machines fixed or replaced timely, or calling the Ministry of Health to inquire about CD4 flows or national HIV archives guidelines). I would usually ask the head of the sector in which I would like

to work to assign me an activity they thought I could help with. Or, if I had an idea of what I could help with I would run the idea through the head of the sector. In doing that, I expected to be giving to the health facility at least something in return for their kindness and patience in accepting me in their (extremely busy) work place. This is how I see my work as being ethical. I hope it was.

Secondly, I tried to learn by doing those tasks and becoming proficient in what people do, in that sense, I would try to understand the healthcare workers point of view phenomenologically – be in their shoes - how they feel by doing those tasks. In learning to do tasks, I benefited from the patience and pedagogic skills of the healthcare workers who accepted be as their apprentice. Yet, I should admit that, I was not fully in the healthcare workers' shoes. I had more freedom of stopping doing tasks when I wanted to or felt bored or tired, or, as often happened, when I felt hungry. In those cases, I would sneak out and go and have a snack, usually at the archives. Healthcare workers did not have such a freedom – I must be fair with them, and not be presumptuous about how I immersed myself in the healthcare workers' work lives.

Thirdly, while I performed the tasks I was given or which I proposed I did, I observed what healthcare workers around me did, when, how, with whom, for what, etc. I combined my observations with questions to clarify when I was confused about something, when I had no clue or when I simply was curious about anything that

was happening at that moment or had happened before. Healthcare workers were usually very generous with me and responded to my questions.

Sometimes, I would keep my questions for later in the day, when the days' work was completed. Until today, I have mixed feelings about how ethical of me it was to keep healthcare workers in these ethnographic interviews, minutes after their workday, without my compensating for their time. But, there is no other formula I could come up to compensate them. I only hope that my trying to help with their work might have mitigated for (what I often felt to be) the nuisance of my presence and interviews.

To show my appreciation for healthcare workers' generosity with their time and knowledge, I would often offer them a ride to their homes. This worked very well, I think, because I had a car, and often by the end of the day those healthcare workers who relied on public transportation needed a ride to avoid waiting for hours at the bus-stop to hop into crowded public transportation. My ride, however, would usually be another opportunity to continue the ethnographic interview. I usually gave a ride to more than one healthcare workers, at which times I avoided conducting my ethnographic interviews.

Finally, I learned through reflecting on each day's events and on my experiences, particularly through notetaking. I tried to take my notes at the end of the day at the

health facility or when I was back home at night. I tried as much as possible to always write my field notes at the health facility, because I had to drive to get my wife and children from school, and when I we got home, I was either too tired to write, or to ashamed to take time off from family to write. My wife understood that I needed to write, and often encouraged me to write whenever I was not too tired. But, my children wanted to be with me, and I did not think it was fair for me to pay attention to field notes, instead of them when I was home. Such are the joys and predicaments of anthropology, marital partnership, and parenting.

I always tried to write rough field notes of some sort everyday – on the phone or in my notebooks. When I had quality time I would extend the notes and write some reflections and interpretations. However, I was often too tired to extend my notes every day, in which case I would try to extend notes over the weekend. There were times when I had to take three days off or a complete week off to catch up on field notes I needed to extend. And, whenever I could, every month, I would write progress reports to check to what extent my findings were still relevant to my research questions or aims and what analytical implications I could draw. This is what Miles, Huberman, and Saldaña (2013) call interim reports. Sometimes, I would simply get too bored with my fieldwork or feel that I was not making sense of what I was doing, at which point I would take several days off reading the literature and trying to write longer reports.

Ethical failures, futilities, and predicaments

With the dissertation title 'Community Health Workers: Lives, Labor, and Hopes for an AIDS-free generation in Maputo, Mozambique', I firstly intend to highlight the key themes I discuss in this dissertation, particularly the important labor community health workers contribute to keeping the hope of an AIDS-free generation, for which they have, for almost a decade, articulated through their dedication to people living with HIV. For me, it is an ethical imperative to adequately recognize and value these health workers' labor. Within that ethical vain, I also intend to be as vague as I can be about the health facility in which I conducted fieldwork. I do this out of concern with the welfare of the healthcare workers and implementing partner employees with whom I worked at that site, and the welfare of people in treatment I met through my work at that facility.

People lose jobs because researchers describe their work in ways those who have power to hire or fire them can construe as performance assessments. People in treatment that I interviewed wanted to keep their HIV status private, some refused to consent to participate in the study, some had not revealed their status to their spouses, and still others took other measures to conceal their HIV status, an indication of the persistence of stigma associated with HIV. I am aware, however, of the certain degree of futility of my expectations, especially for someone doing ethnographic research that includes such a visible strategy as participant observation. People saw me there, some knew what my research was about, and I

do not know what exactly they can do with that information. I just tried to do the best my conscious and training in anthropology and research ethics allowed me to do. I hope this was really the best for my research partners.

I also tried my best to keep the purpose of my research a secret, only sharing with a few healthcare workers I worked directly with. So, at times, I was happy to know that people where not sure what I was doing there, nor did they know what my institutional affiliations were. I learned that some people thought that I worked for the implementing partner, others thought I that worked for the Ministry of Health, and, at least one person thought that I worked for the State Intelligence Service[11].

The two first identities facilitated my access to information, but also suggested that I was a physician working for the Ministry of Health, which I am not. I learned about the first identity by accident. I remember one day a counselor who had what looked like malaria or flu symptoms (to my biomedically lay eyes) coming to me looking for some clinical advice, because she thought I was a physician, only to be disappointed when I told her I was an anthropologist, an occupation that she had no clue about.

In addition to managing the complexity of personal identity, which, was partially of my interest, there were times when I was reminded of how impractical it was to

[11] Mozambique's National Inteligence Services are better known locally by their Portuguese Language abbreviation SISE, for *Serviço de Inteligência e Segurança do Estado*.

follow some research ethics principles. I remember in the first few days, when I was bored with work at the archive, and one of the health workers suggested that I went and set at a counseling or a consultation session with a patient living with HIV to observe it. They thought that this was consistent with the ethnographic approach I had explained to them that I was going to follow – learn by observing, by participating, by talking to people, and by studying medical and other records. When I told them that I could only observe a session of one of the persons I selected to participate in the study, and only with that person's consent, the healthcare workers did not understand. Actually, they gave me a look that made me feel stupid. They had grasped my quick explanation of how ethnographic research in the participation observation mode operated, but, could not understand by research ethics-related explanation for not observing some events.

And, I remember doing other things that I think were utterly stupid and embarrassing. For instance, there were times I felt completely useless and bored. So, I would volunteer to do tasks that no one else liked to, such as entering patient data in logbooks. So, I would sit in the HIV reception, and without planning, I would overhear complete conversations between the receptionist and people who had recently tested positive, but, had not allowed me to be in those meetings. And, sometimes, the receptionist would ask me a question or ask me to do something. In those occasions, she would call me by my name and title (Dr. Celso) this, and that. I do not remember how I managed to keep my face down on the logbooks or only

to look at her and not at the person for whom the chart was being opened. I basically did not want that person to feel that I also knew their condition. I just felt stupid, embarrassed and unethical.

There were also times I spent at the general reception, where the e-PTS and data entry people sit. So, some people in HIV care or treatment who had lost their patient cards would come to the reception window, and in front of everyone (healthcare workers and other health facility users) would volunteer their name so that their medical data could be retrieved from the computer to re-issue a card for them. The data entry clerk had no choice but asking as many questions as needed to verify their identity and ensure they were not issuing duplicate cards, as usually happened. There was no privacy at all, I thought to myself.

To make matters worse, anyone who knew how the health facility works would know that if you asked for your information to the data entry clerks it is because you were HIV-positive. So, the very location of the data entry people disclosed people's HIV status. Yet, the health facility was small (the size of a three-bedroom house), and there seemed to be no effort at moving the data entry room to a more private place. I was there, inadvertently learning about people's status without their consent. Yet, everyone else around me did not seem to worry about that or had naturalized that. I just could not believe my predicament.

PART 3: LABORS, LIVES, AND A SHAPE OF THE FUTURE

In this part of the dissertation, I describe how the job description formalized in both the work agreements and reiterated through everyday practices at the health facility place community health workers under conditions of vulnerability that seem chronic and aggravated by their gender, and which they share with a hospital attendant who has had supervision responsibilities in the HIV services – a condition that seems to highlight the particular exceptionalism of HIV (chapter 3). In chapter 4, I describe three dimensions of the labor that experienced community health workers and the hospital attendant contribute to the HIV response at the health facility – promoting patient compliance with antiretroviral therapy, producing and reproducing sociality, and bridging the gaps between the public health information system and the electronic-based health information system managed by the implementing partner. I conclude with a description of the changes at the health facility and to the work conditions and lives of experienced community health workers and the hospital attendant, as part of efforts to meet the ambitious HIV treatment targets.

I rely on the multiple ethnographic interviews that I had with experienced community health workers and the hospital attendant, on my observations of their work and reflections on my participation in health facility activities, and on archival documents I had access to. I punctuate those descriptions with discussions of global health and anthropological literature and policy documents, whenever relevant.

Chapter 3: Local structures of community health worker vulnerability

Introduction

In this chapter, I describe the different categories of community health workers and their formal job description as anticipated in their work agreements. I also describe how much they are compensated monthly, and what portion of their monthly household expenses that payment covers. As comparison reference, I also provide the same description about an experienced hospital attendant, who, like experienced community health workers, has worked in the HIV sector for several years, and has educational qualifications close or even lower than those of some experienced community health workers.

Of job descriptions and vulnerability

All community health workers and hospital attendants are women, typically with no more than the first level of secondary education (grade 10) and are at the lowest professional category at the health facility and at the Mozambican public service, where they earn the lowest monthly income. Although the monthly payment of some community health workers is called a salary (counselors) and of the others is called a subsidy (activists), and they sign a contract with the government represented by the district directorate of health, all community health workers experience perceptions of extreme job insecurity.

The health attendant has a permanent contract as a public-sector employee, which she and other health workers at the facility perceive as ensuring job security. Only the hospital attendant is contractually expected to do cleaning and other custodial work at the health facility. As a counter-part, her monthly payment includes an occupational hazards' subsidy (*subsídio de risco*). Yet, although activists and counselors' written job descriptions do not include the need to do cleaning and other custodial work, other health workers, expect and some demand that they perform these tasks. Cleaning becomes a defining feature of activists and counselors' job description and occupational identity as lower level health workers.

During a group interview I had with activists and lay counselors (January 27, 2017), they mentioned their discomfort with cleaning, because they thought it was risky, and they understood that task to be hospital attendants', who earn an occupational hazard subsidy to cover such work. I asked them whether they had raised that issue with the health facility management or the implementing partner. They responded with an ironic question: "who do you think is interested in listening to such complaints?" And, in the way of an explanation, they added that: "If you talk about it, they tell you that no one called you. You volunteered to do this work".

To this, a counselor added that, she was the only one who volunteered to do this work. The other ones did not. Yet, another activist added that, ironically, the new counselors, hired to meet the ambitious HIV treatment targets were not expected

to clean the health facility, and they do not do so: “Only these new counselors do not do any cleaning” (Interview with experienced community health worker, January 27, 2017, Maputo).

In addition, community health workers’ monthly payment distinguishes them from other health workers at the heath facility. The hospital attendant is the lowest category of health worker in the hierarchy of Mozambique’s National Health Service (Technical assistant 98 A-E), and earns a monthly salary between $79-121 (4,715 Mt-7,261 Mt), as set forth by the Ministry of Economy and Finance authorization of May 31, 2017 (Moçambique, Ministério da Economia e Financas 2017). They also receive additional government benefits, such as an occupational risk subsidy and a retirement package.

Activists and lay counselors earn a monthly stipend, locally called a subsidy, which varies depending on their professional category and whether they conduct community-outreach activities or not. Their monthly payment is covered by PEPAFAR funds through a sub-agreement between the implementing partner and the district directorate of health. Their most recent contracts (signed between January and June 2014) legally treat activists and counselors as Mozambican state employees with “all the rights and obligations that Mozambican state employees have”. Yet, since these are annual agreements, that are automatically renewed, unless one of the parties has justifiable reason to terminate, it fuels activists and

counselors' perceptions that they are not actually state employees, with the level of job security that other state employees have, including hospital attendants, whose contracts are permanent.

To be concrete, at the health facility where I conducted fieldwork, the lowest level of community health workers usually includes the so-called activists and peer educators, who have lower educational qualifications (less than grade 8 in most cases), no supervising responsibilities at the work place, and conduct outreach work. They earn about $28 (1,100 Mt) a month, including a monthly allowance of about $10 (600 Mt) for transportation for community outreach activities. Activities in the community include, direct observed therapy for tuberculosis, HIV counseling and testing, and tracking of patients who are late or lost-to follow up from their antiretroviral therapy drug refills (Group interview with activists and experienced counselors, January 27, 2017, Maputo). Their monthly payment is covered by PEPAFAR funds through a sub-agreement between the implementing partner and the district directorate of health. Their most recent contracts (signed between January and June 2014) legally treat activists and counselors as Mozambican state employees with "all the rights and obligations that Mozambican state employees have".

The highest level includes counselors, who have usually completed the first level of secondary education (grade 10), although there are cases in which they have not

completed that level but have completed grade 8. They are usually fluent in Portuguese language, usually with more years of work experience (around 10 years or more). They have supervision responsibilities at the work place that include overseeing a health facility sector (particularly the main archive and the HIV reception) and, in some cases, supervising other colleagues, and do not conduct community outreach work. Counselors are employed by the district directorate of health for one year, renewable, and earn a monthly "subsidy" of nearly $58 (3,500 Mt), using PEPAFAR funds under a similar arrangement as activists.

The designation of activists and counselors' monthly payment as a "subsidy" is another source of their perceptions of job insecurity. Mozambican labor law only provides for a "salary", not for subsidies or stipends as the main form of monthly payment. These can be added to the salary (Moçambique, Governo 2007). This terminology might, however reflect local and global representations of community health workers' as volunteers (Kenneth Maes 2015b; Akintola 2011; Greenspan et al. 2013; Kenneth Maes 2012; Olaniran et al. 2017; Topp et al. 2015), and the Mozambican Ministry of Health oscillating between tolerating experienced community health workers as a creation of international NGOs that are currently needed to help address HIV and AIDS (Vander Meulen, Patterson, and Burchardt 2013) and not recognizing them as community health workers.

The CDC and USAID, through their implementing partners have made attempts to harmonize the categories and salary schedule across all community health workers involved in the response to HIV in Mozambique. Although documentation of these attempts and the official position of Ministry of Health is not publicly available, the position is widely known among those involved in the Mozambique's national HIV program. One attempt was made between 2006-2008 and is documented in a proposal to clarify the role of the so-called "polyvalent voluntary counseling and testing counselor" (n.a. 2006) as part of efforts to support the scale up of antiretroviral therapy in the country through the provision of quality HIV services. This proposal was not approved. The most recent proposal was presented in December 2016, and proposed a new terminology (health educator), and like the previous figure, this community health worker would work at the health facility and conduct community outreach activities. Only this time, their role would be in the whole cascade of HIV, from testing to linkages to services and retention and adherence to biomedical care and treatment (n.a. 2016). This proposal was not approved either. During my field visit in July 2018, I learned that CDC and USAID were leading yet another attempt at harmonizing community health worker categories and their salary schedule (yet, I did not have access to the document).

Lack of an official decision on the harmonization of categories and salary schedules leaves the decision on the issue at the responsibility of implementing partners, with the possibility of what Biehl and Petryna, with reference how global health

interventions are implemented globally, call "open source anarchy" (João Biehl and Petryna 2014, 382–83).

During an interview on July 2, 2018, an implementing partner representative told me that since sometime around 2016 (which the representative did not remember), activists and counselors started work agreements with a human resources management company to which the implementing partner had outsourced human resources management responsibilities. The representative added that all counselors were paid the same salary, which the representative did not specify. However, activists and counselors retorted that they were working under the contracts they had signed with the District Directorate of Health in 2014. Some ironically mentioned that what matters about the contract is that their stipends/subsides reflect on their bank account every month, and it doesn't matter much whether they are employed by the implementing partner or by the government.

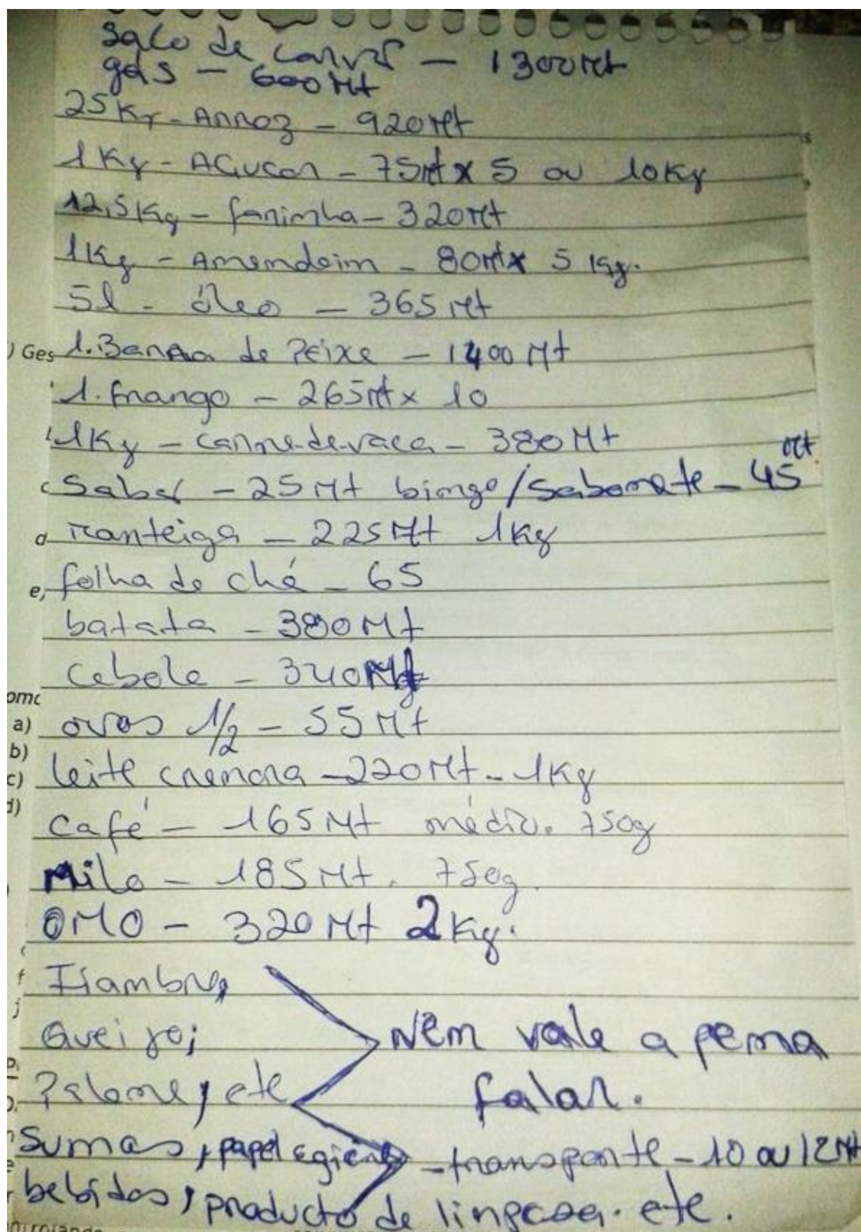
The only contract between the human resources management company and a counselor that I had access to was for a counselor who accepted a higher paid counselor position, doubling her salary from about $58 to $117. This was a permanent contract signed on January 11, 2016, which, however was terminated 1.5 years later, due to "the implementation partner's work force reorganization and structuring, resulting from lack of economic and financial resources from the implementing

partner's partner" (as stated in the termination letter signed on August 30, 2017). Termination based on this cause was anticipated in the work agreement and is legal under Mozambique labor law (Moçambique, Governo 2007).

Regardless of how much community health workers and hospital attendants earn, what their monthly payments are called, and regardless of their perceived or real job security, what expenses can their monthly payments cover?

Covering basic monthly expenses

Most community health workers and hospital attendants have larger household sizes than the average of five people in urban areas of Mozambique (INS, INE, and ICF 2018). In addition to their children, their households usually include their mothers and other relatives, particularly younger siblings, nephews and nieces. Most of these health workers do not have a male partner; therefore, they are responsible for the monthly expenses of their households. Their basic monthly expenses include food and grocery food, and transportation, which would be around $200. This estimate is based on a household monthly budget that one of the counselors shared with me (figure 6). The sheet is a mix of what she usually tries to cover and includes a 'wish list' component that she aptly noted that she "doesn't bother to think about it" or thinks its "useless to talk about" (*nem vale a pena falar*).



Saco de carvão — 1300Mt
gás — 600Mt
25Kg - Arroz - 920Mt
1Kg - Açucar - 75Mt x 5 ou 10Kg
12,5Kg - farinha - 320Mt
1Kg - Amendoim - 80Mt x 5 Kg.
5l - óleo - 365Mt
1.Banda de Peixe - 1400Mt
1.frango - 265Mt x 10
1Kg - carne de vaca - 380Mt
Sabão - 25Mt bingo/Sabonete - 45Mt
manteiga - 225Mt 1Kg
folha de chá - 65
batata - 380Mt
Cebola - 340Mt
ovos 1/2 - 55Mt
leite cremora - 220Mt - 1Kg
café - 165Mt médio. 750g
Milo - 185Mt. 750g.
OMO - 320Mt 2Kg.
Fiambre, Queijo; Salame, etc — nem vale a pena falar.
Sumos, papel higiénico - transporte - 10 ou 12Mt
bebidas, producto de limpeza. etc.

Figure 6: Community health worker's household monthly expenses, 2017-2018

Yet, none of the activists or counselors, including the higher paid counselors, earns a monthly pay check that can cover even the least basic expenses of their households. In fact, the highest paid community health worker/hospital attendant, including the counselor who works in the highest paid position can only cover up

to 58% of those basic expenses. The hospital attendant's salary covers nearly 51%; a counselor's subsidy covers 28%; and an activist's subsidy covers 14% (figure 7).

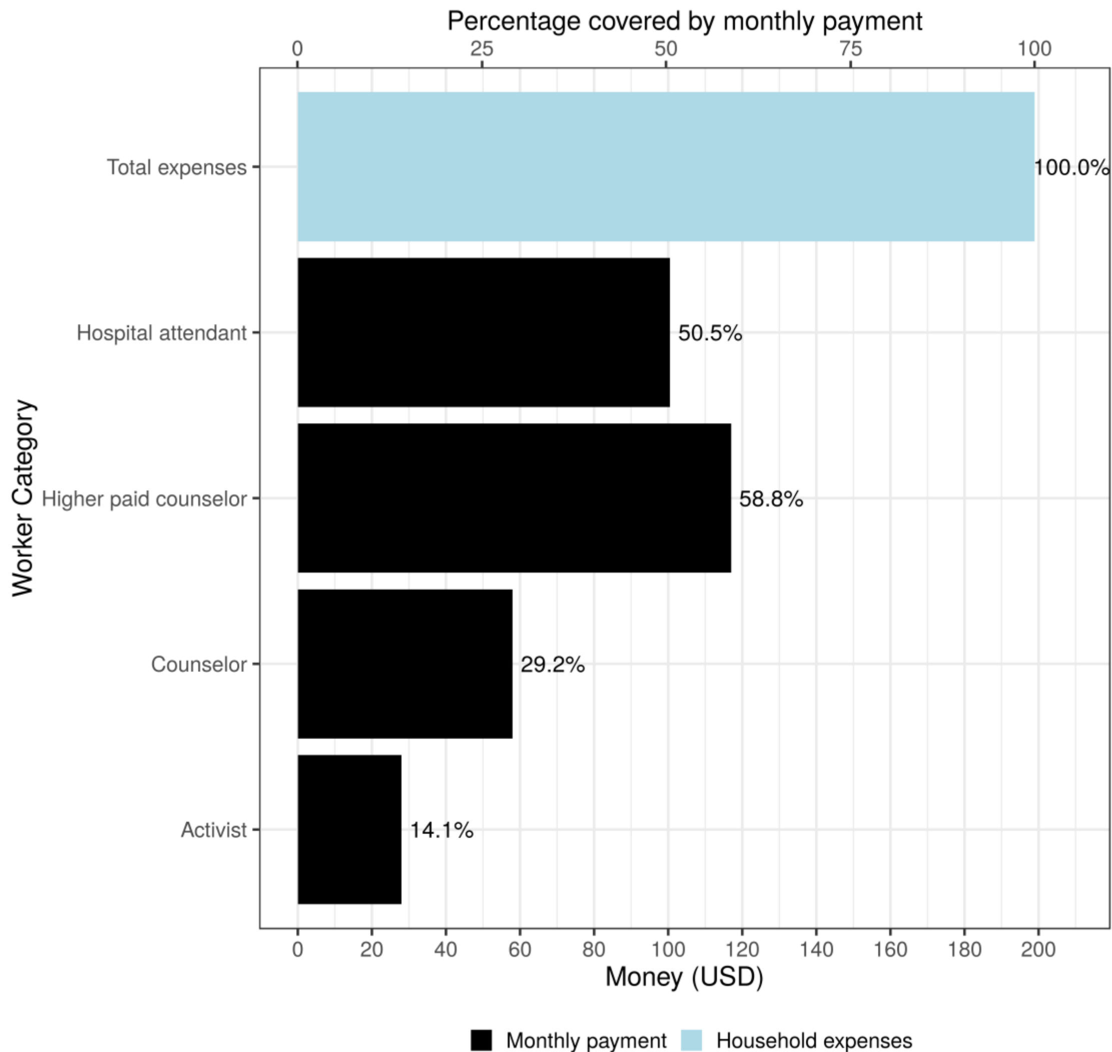


Figure 7: Monthly household expenses covered by community health workers' payment, 2017

That the monthly pay of the hospital attendant should not cover even her basic household expenses can be attributed to broader macroeconomic dynamics associated with the implementation of structural adjustment policies since the late

1980s in Mozambique, that have contributed, among other consequences, to the eroding the real value of public sector employee salaries (Pfeiffer and Chapman 2010).

Therefore, to compensate for the income gap, some community health workers run small business in their homes, have vegetable farms, some buy products across the border in South Africa or in other provinces in Mozambique and bring them to sell in Maputo. These efforts can in interpreted as them subsidizing the very global health interventions that would be expected to provide them with a livable income. Such subsidizing is not unprecedented in the recent history of Mozambique, after the introduction of structural adjustment programs, in the late 1980s, nor in the colonial period when the Portuguese colonial government relied either on low paid or free labor of Mozambicans. In that regard, these community health workers, as Mozambicans who share common historical experiences or memories have been trained for their current labor experience within global health interventions - some people insist that I say global HIV interventions.

Discussion

The formal job description, stated in work agreements, positions experienced community health workers and the hospital attendant who has worked for several years in the HIV sector at the lowest level of the occupational hierarchy at the health facility. Such a position defines both the terminology and amount of their monthly

payment and reflects the persistence of an ethnocentric (western and biomedically-centered) model of professional qualifications that dominates in the health sector. This model is marked by western-defined notions of educational achievements and professional training that marginalize the importance of (often years or decades of) work experience and other competencies, particularly those that are important for the provision of care.

This combination of factors structures the occupational vulnerability of the experienced community health workers and of the hospital attendant. Such vulnerability extends beyond their workplace (the health facility) and is made visible by the inability of their monthly payment to cover even the basic monthly household expenses. That the health workers are women, and their job descriptions include the provision of custodial and care labor, which are socially and professionally stigmatized and deemed unworthy of adequate monetary compensation, seems to aggravate their vulnerability, as scholars working within feminist analytical frameworks have noted (Akintola 2008, Closser 2015, Maes 2012). This scholarship is echoed by a recent ILO report (*Care work and care jobs for the future of decent work*), which acknowledges how care work, globally, is marked by gender inequality and income inequality - mostly performed by women, and is undervalued, underpaid and often not paid (ILO 2018).

The report's view of the future is divided between a concerned and an optimistic tone. One the one hand, it shows concern that that those who provide care work might abandon it, given the precarious conditions in which they perform. Yet, on the other hand, the report has an optimistic tone, evident in the assertion that it is possible to create a policy environment that can ensure good quality care work based on gender quality. Yet, it recognizes that such an environment is context dependent. The challenges in officially accepting experienced community health workers who provide HIV services as part of Mozambique's community health worker traditions, which partially prevent efforts to harmonize both their categorization and remuneration, highlight how the Mozambican context might is not conducive to the optimistic view put forward by the ILO report.

Mozambican authorities understanding of community health workers as part of international agendas that undermine the PHC principles on which the national health system is grounded, reflects an interpretation focused on how implementing partners operate in the national health system, including how they use community health workers. Such interpretation expresses sovereign concerns about how the national health system should deliver services to the Mozambican population, and how certain partners, in practice, exclude the local official voice from those decisions. Yet, this official interpretation comes at the risk of erasing the historical links that experienced community health workers have with the community-based efforts that provided home-based care to people living with HIV and AIDS before

antiretroviral therapy was available. Such erasure leads to the very government that champions social justice and has been trying to meet that goal through the health system (using the PHC approach), ironically using that system to leave part of its citizens to the vulnerability of precarious labor conditions in the hands of institutions represented as pursuing international interests.

While this reluctance remains, experienced community health workers are left to compensate for the income gap. Some community health workers run small businesses in their homes, have vegetable farms, and some buy products across the border in South Africa or in other provinces in Mozambique and bring them to sell in Maputo. These efforts can in interpreted as them subsidizing the very global health interventions that would be expected to provide them with a livable income. Such subsidizing is not unprecedented in the recent history of Mozambique, after the introduction of structural adjustment programs, in the late 1980s, nor in the colonial period when the Portuguese colonial government relied either on low paid or free labor of Mozambicans. In that regard, these community health workers, as Mozambicans who share common historical experiences or memories have been trained for their current labor experience within global health interventions.

Chapter 4: Labors of compliance and sociality

Introduction

No single history, experience, or labor contribution can be reduced to comparable similarities or differences. Attempting such comparisons would impoverish their phenomenological complexity and would instantiate the very epistemic violence that I have been trying to challenge in this dissertation. Therefore, I will resort to a common ethnographic gesture of introducing the reader to some community health workers and a hospital attendant with whom I interacted during my fieldwork. I am well aware that I run the risk of amputating important aspects of their histories, experiences and contributions I had access to. Yet, I can only hope the reader will have an idea of how they have contributed and continue to contribute to improving the lives of people in antiretroviral treatment and, indirectly, of those who depend on and love these people, through to addressing HIV and AIDS in their workplace. I also hope and thank in advance that community health workers and the hospital attendant will correct me wherever I make gross omissions, mindful as I am of the barrier the language in which I am writing is for most of them.

A trajectory of a community health worker

I will start by introducing you to the counselor who was responsible for the main archives where the medical files of people undergoing chronic care and treatment were housed. I have replaced the counselor's real name with an alias (Angelina). Chronic health issues included diabetes, hypertension and HIV. More than 90

percent of those people were in HIV care and treatment, though. I met her on the first day of my dissertation fieldwork at the health facility, along with other health workers the clinical director, who at the time was also the health facility manager, introduced me to. After the round, the clinical director asked me where I would like to start working from, and I told her I wanted to start from the *ficheiro*. I chose that place because it housed the medical files I needed to select my subsample of people in treatment (it was strategic) and it was run by an experienced and charismatic lady, who had worked at the facility since the HIV services had started 10 years ago, in 2008. In addition, Angelina sounded smart, serious, and someone who knew exactly what she was doing.

In the end, I maintain that opinion about her, because, in addition to teaching me the routine (and frankly boring) tasks of retrieving patient files and putting them back in the right place and order, she taught me very much about the facility, the HIV services, the archives, and how to accept that were things I could not fix or organize at the health facility. I am not sure I have learned the latter lesson well, though. But, I am sure we became very good friends - one of the running gossips at the health facility was that we were having an affair, and we still chat regularly through WhatsApp.

Before Angelina worked at this facility (she and another activist were at the foundation of the HIV services at the facility in 2008), she was an activist at the Red

Cross, providing first aid and home-based care for people living with HIV. Her first aid training was provided by the Red Cross and received weekly training on HIV counseling and testing and home-based care from the *Sant'Egidio* Community – the latter training continued every week for the first few years of her work at the health facility. Like other trainings that came with the expansion of international NGOs in Mozambique, she received meals and a monetary incentive for her participation. Like other activists and counselors, and as their terms of reference and the attempts at harmonizing the profile of community health workers reveal, Angelina's work is polyvalent, covering not only all areas of HIV and AIDS services she is professionally allowed to, but, also other conditions, such as diabetes, hypertension and tuberculosis. For the sake of the scope of this dissertation, I will only highlight the work she does that seems directly relevant to efforts to ensure that adult patients continue in antiretroviral treatment, the first of which is around HIV counseling and testing.

Counseling and the production of compliance and sociality

Counseling for acceptance of a positive test result and for adherence to HIV care and particularly adherence to antiretroviral treatment is one of the most important labors that community health workers contribute to local and global efforts to address HIV. It goes beyond routinely following protocols described in the HIV counseling and testing and in the treatment guidelines (MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2014, 2015b), and beyond simply

reproducing compliance to biomedical care and treatment to build new configurations of citizenship (Nguyen et al. 2007). Interest to ensure compliance was there, in ways that challenge suggestions to the contrary (Rouse 2010), but importantly, as part of efforts to build enduring social ties (sociality) that could help patients navigate care and treatment and carry on with their lives outside the dynamics of biomedical care and treatment. I became aware of this multidimensionality and complexity of counseling earlier in my fieldwork, as the following description should illustrate.

One afternoon, a month into my fieldwork, while I was having lunch with Angelina and her assistant at the archive, a lady came over, started talking to Angelina, and handed her a patient card. Angelina told her that she did not need to wait, because Angelina would bring the medication to her late in the day. I was not sure whether that lady gave Angelina only one or more than one card. Except for greeting the lady, all the time they were chatting, I was trying my best to keep my head down, focusing on my meal, because, for ethical reasons, I felt ashamed of the possibility of my overhearing something I should not.

When the lady left, Angelina told me how she had befriended her. She told me that the lady is the spouse of someone who is HIV-positive - a friend of a physician who used to work at the health facility. When the woman's husband came to the health facility several years ago, Angelina remembers him being very thin, and

when he received the HIV-positive diagnosis he went on denial and said he would go home and drink mouse poison (locally called *ratex*) and die, because he did not know how on earth he would bring himself to tell his spouse he was HIV-positive. His friend, a physician who was working at the health facility at the time, tried to calm him down, and to counsel him, unsuccessfully.

Then the physician asked for Angelina's help. Angelina asked the physician to leave the counselling room, so she would stay with the patient alone. She told me that she had never seen a man cry that much as he asked difficult questions such as "will I be ok?" Will I recover from this?" meaning from being so thin. She did not give me the details, except for telling me that she eventually succeeded in talking him out of suicide, and he started taking his medication. After two months on antiretroviral therapy, he started to feel well but was still worried about how he could tell his wife. Angelina asked him to bring his wife to the health facility, and she would test them both for HIV, without telling her that her husband had been tested. So, he did, and when his wife's result came and was positive, she also started crying profusely, as her husband had done. Angelina told me that she gave counseling to the lady, and the lady also started treatment.

Treatment is going well for the couple, Angelina told me, and the couple told Angelina that they were happy, and at work people had been commenting about the fact that he was getting fat and becoming handsome, which for most people in

Mozambique, usually, gaining weight is perceived as a sign of good health, wealth, and happiness. Angelina told him, that's exactly what she wanted to hear. This reminded me of how Angelina often told me that she likes it when the treatment works, and people feel good, and carry on with their lives.

Angelina added that the woman's husband came to talk to her one day and told her that the couple was thinking about having a baby. Angelina replied that this would not be a problem. On her advice, the lady came to the Antenatal Care (ANC) to be attended, but the nurse at ANC did not attend to her well. So, the woman went out of the health facility, crying, and went to a bus station or a park nearby. Apparently, she called her husband, because he called Angelina and told her what was going on.

Angelina went after the lady to tell her that she should not leave the health facility crying like that because that would raise suspicions. Eventually, the lady stopped crying and returned to the facility, where Angelina went and talked to a nurse to attend to her, and the nurse refused. Angelina talked to another nurse, who attended to the lady. This relationship between Angelina and the couple has been enduring for years. Because Angelina helps the couple at the health facility, the couple also helps her. The lady works at a government institution, and whenever Angelina needs to obtain any documents at that institution the lady helps her, just like Angelina helps the couple when they come to the health facility.

This theme of a moral economy based on non-market exchange of goods and services, that Marcel Mauss has called "the gift"(Mauss 1950) and others have called the economy of affection (Hyden 2006) or social network (Mitchell 1969), is recurrent in several conversations I had with Angelina, and with people in treatment I interacted with. These people mentioned not only the assistance they obtain from community health workers, but also from mid-level health workers at the laboratory and at the pharmacy, people that patients described as family.

Such is the case of a lady whom at the time I interviewed had been in treatment for 10 years, including five at this health facility. She told me that she has a strategy to ensure she does not take too long at the health facility. She tries to make friends with healthcare workers wherever she goes for care or treatment, because they might help her when she needs. For instance, if she has to be somewhere, she talks to a healthcare worker, and they help her without asking for anything in return. In this particular health facility, before her cousin started to work an activist (Zélia) used to help her at MCH, and they became friends to the extent that whenever she came, Zélia helped through the process without asking for anything, just out of friendship, according to the patient (Interview with patient in treatment, January 15, 2018 and February 20, 2017, Maputo).

The relationships that community health workers build with people in treatment often have to be sustained over several years, and other health workers at the

health facility become involved in them and exert influence even when they are no longer working at that facility. This bears witness to the strong historicity of these relationships and gives an idea of the effort that community health workers need to dedicate to maintaining these relationships. Angelina told me another instance, in which the physician whose friend wanted to commit suicide when he was being traveling to his home town, he brought another friend who was doing treatment at the health facility and asked Angelina to take care of his friend as if she were taking care of the physician, as follows:

> When you see him, you see me. He is my friend; a friend who has become more than a friend to me. He is a brother to me.

On another occasion, I asked Angelina some variation of one of the questions I had in my interview guide - what she does to help people continue in treatment, and who else at the health facility helps those same people (Individual interview with experienced counselor, January 19, 2017, Maputo). She told me that there are people who live in the same neighborhood as she does, who do not have time to always come and pick up the medicines at the facility, either because they are too busy or because they are afraid that by asking so regularly to go to the health facility, other people might suspect that they are doing HIV treatment. So, those people ask her to refill their medications for them, which she does. They come to her house later in the day and pick up their medicines from her. Some of these people thank her with gifts, as is the case of a woman that she helps in this way who came to the health facility when she was absent and left a *capulana* for her

and gave another *capulana* to two other Angelina's colleagues who help the lady when Angelina is absent from work.

The *capulana* is a colorful piece of cloth originally from Asia, which has been adopted as part of Mozambican women's identity across the country, particularly in Southern and Northern Mozambique. Women can wear it as a shirt, make a dress-like piece, and when offered as a gift, at least in Southern Mozambique it is regarded as a token of special appreciation or a symbol of a valued relationship. It is significant that the lady had brought a *capulana* for Angelina, but, even more significant that she had brought it for Angelina's two other colleagues, who are part of the same social network.

While we were talking, a colleague from the health facility came and asked her whether she knew someone at the National Institute of Vehicle and Driver Licensing (*Instituto Nacional de Viação – INAV*) who could help her brother in law get his driver's license. The brother had been issued a temporary license in Maputo, which had eventually expired, and it was taking forever for him to get the permanent license while he was in Nampula, Northern Mozambique, about 2,000 km and 2-3-day drive away from Maputo. Angelina asked her whether she wanted to be seen by a man or a woman. The woman joked that she preferred to be seen by a man, because women menstruate, which makes them moody, in which occasions they can provide bad service. Then she changed her mind and said that

she would prefer to be seen by a woman because men can be a pain too.

Angelina told her not to worry, that she would write her a note so that she would be seen by a woman at licensing office. When we resumed out conversation, in the way of an explanation, Angelina mentioned to me that the woman she knows at the licensing office is doing treatment at the health facility and is someone she helps ad who helps her when she needs assistance at the licensing office. Thanks to Angelina's relationship with the licensing office lady, her colleagues would be seen at the licensing office without waiting long on a queue and without worrying whether their documents were taking long to be issued because the licensing officer staff wanted a bribe. She explained to me that "this is how you make family."

But, there is another group of people who come to the health facility and look her help. There are more than 10, she keeps a list of them, and they come on the 6th, 15th, 16th, and 18th, I think. She has to call them a day before the pick-up date or the clinical consultation day to remind them to come. Some do not pick up the phone. So, she leaves a message to the effect that "please do not forget that tomorrow is your day...", taking all the care to keep confidentiality about the real purpose of the message, lest the message fall in the hands of someone who does not know what the patient needs to come and do at the health facility. Some patients do not respond and do not even show up. She says that is their problem,

because she has done her part. Another group includes people who do not want to be seen going to the clinical consultation or waiting in lines. So, they ask Angelina to advocate for them so that her colleagues can see them without their having to stand in the line but go straight to the doctor or the clinician.

There are yet other people who moved somewhere very far from the health facility yet did not want to transfer to a nearest health facility. One example is a couple who live in Gaza Province, more than 300 km away from Maputo and only come to the health facility every three months. So, Angelina asked her colleagues at the health facility to authorize the couple to pick up medicines every three months, instead of every two months. Which they did. All this 'sociality work' is part of the job description she enacts and has to maintain every day, which she thinks is fundamental to keeping people in treatment and to building her 'family' relationships. What has priority cannot be clear, and one is not easily distinguished from the other type of work.

Angelina has a rigid rule however. If she realizes that people whom she picks up medicines for are not going to their clinical consultations or to get exams done at the laboratory, she threatens to stop helping them, and she actually does, she told me. She says if she continued picking up medicines for people who do not come to their clinical or laboratory appointments, where they can be checked whether they are clinically well or not (in her words, "whether the medicines are working or

not"), she would be committing a sin, because she would not be helping them in the long run.

The relationships Angelina builds with patients, in certain cases, end up turning her into a confidant, a shoulder to cry on, often caught in the middle of marital conflicts. In one instance, she confirmed the story a man in treatment had told me about how his wife of nine years had abandoned him for reasons he did not know, and he did not know her whereabouts (Interview with patient in treatment, January 16, 2017, Maputo). The lady, however, had come to bid farewell to Angelina, explained that she was leaving her husband because his children from a previous relationship were giving her a hard time. She had met another man who would marry her, and she would live in Maputo.

Angelina also carries with her the burden of knowing people who do not comply with HIV treatment, and this pains her. She said that she knows people who come and pick up medicines every month and confess to her that they flush the medicines down the toilet. One of these cases, which makes her curious is a woman whose CD4 count remains high, however, oscillating roughly between 800 and 1,000 cells and looks healthy. Reflecting about this lady, Angelina joked about "how black people can be complicated – they do not take the medicines, yet their CD4 count is high".

Angelina told me the story of a woman whose husband she says she unfortunately lost (she means he died while he was in treatment). But she is alive and in treatment at the health facility. Angelina says that she became friends with the couple because the woman used to jokingly call her rival, meaning that they were competing for the same man (the woman's husband). Recently, because the woman was moving to somewhere far from the health facility, and was transferring her file there, she brought a relative and asked Angelina to take care of her relative as well as she did her husband.

Angelina told me that she succeeds in building friendship and trust in people on treatment because she does not judge them. And she starts to build these non-judgmental relationships of trust from the time she does HIV pre-test counseling. During that counseling, she finds people she knows, some of whom are her neighbors. She tells them they do not need to worry about this relationship, and do not have to greet her at the facility if they do not feel comfortable doing that. She adds to them that she will never mention in the neighborhood that these people are in treatment.

Angelina mentioned that she does not treat people well only because that helps build social ties (a will to care based on a politics of sociality), but also because some people continue in treatment at the health facility where she works because they feel well treated and want to be well treated (will for care). One of the

examples she mentioned is the couple who moved to Gaza Province, yet continue to pick up their medicines at her health facility, instead of moving their file to a facility closer to where they live now. She told me that she once suggested they get a transfer, but they refused. They said they would rather continue here, because Angelina would take care of them and of their "situation". This couple always insists that she visits them and stays over, when Angelina goes to Gaza on personal business, because Angelina has become part of their family. Angelina told me that whenever she can, when she goes on personal business to Gaza, she stays with them for a few days to please them. One day, she says, I should go there with her to visit them and hear the story from themselves. Unfortunately, until the end of my fieldwork I did not find the time for that visit, and I doubt that such a visit would make me comfortable, giving the ethical protocol of my research.

Angelina mentioned however, that she doesn't have to deal only with patients who do not comply with treatment, but with some clinicians who do not treat patients with respect. (And I think I know who she was talking about). She told me that those clinicians decide that they can only see 20 patients a day, for reasons she does not understand. To add to the problem, those clinicians do not treat patients well nor with respect. She uses me as a surrogate of the clinicians, to explain a point she would make to them about the importance of respect for patients. She says 'you may be someone important in your work place, but patients also are important in theirs. So, they want to be treated with respect. And, lack of respect

makes many people abandon treatment or move to another health facility. Yet, lack of respect is not directed only at patients. In one case, a colleague from this facility who was doing treatment here moved to continue with treatment elsewhere because she did not feel she was being well treated at this facility.

Angelina's efforts at building social ties were not only directed to patients, as part of a strategy to maintain them in treatment. She made similar efforts to maintain good relationships (keep peace with her colleagues). In one of those occasions when a clinician did not want to attend to one of Angelina's acquaintances, because the clinician had completed her daily quota or for other reasons, Angelina went and asked for help from a nurse, who attended to the patient.

Yet, Angelina also breaks down, and is also famous at the health facility for sometimes being in such a bad mood that she hides herself at the *ficheiro* or elsewhere at the facility, lest she be rude and scare people away. This is something she told me the first day we met. However, nobody seems to take her seriously, because, as she told me that, when she is in one of those days, people ask her whether she is pretending to be rude to scare them away. She says that she is not pretending. She is really trying to scare them away. They tell her that she cannot scare them even if she tries hard … she laughs about it as she tells me.

Since the beginning of her work at the health facility, Angelina's work has been multidimensional and demanding in ways that even her job description as a polyvalent counselor did not anticipate. During her initial work focused on counseling she mastered the skills of pre-HIV-test counseling and post-test counseling for both a life with HIV and initiation and adherence to the therapy that she believes can save and improve the quality of patients' lives. And in doing that she developed social ties with patients in treatment that have now gone beyond the confined interests of ensuring compliance to biomedical treatment. These ties have become a fabric that also sustains social relationships that she has and cares about keeping them. These patients have become parts of a big family, of social networks to which other colleagues at the health facility are invited and the researcher himself is invited.

Keeping these relationships calls for considerate and careful efforts and openness to performing various tasks, including marriage counseling, navigating clinical consultations and laboratory appointments, facilitating the dispensing of medicines, and even being patient enough to endure 'brave patients' who think they get away with not taking their medications, and training patients on how to keep secrecy of their condition to protect themselves from the stigma associated with HIV.

All this work forces Angelina to sharpen her memory to be able to remember each and every person who needs her help, including those who need reminders to come to their appointments, some of which do not come. To these, she has to show firmness, in what she regards as the patients' own interest in contributing to their health and lives in ways that challenge observations and interpretations from other sub-Saharan contexts that mid and lower-level health workers would help patients evade compliance to antiretroviral treatment (Rouse 2010). She shows a willingness to care for the patients, one that is recognized in her and in other health workers at the facility through gifts vested with an important symbolism such as the *capulana*. Yet, she often breaks down – breaks that other people around her do not easily allow. And, humor is invited to the rescue of both Angelina, her colleagues and, in some occasions of myself. Whether humor and laughter are enough to ease the burden of the demands community health workers bear is unclear to me. What becomes clear is that, community health workers contribute to ensuring that people continue in antiretroviral therapy in yet other important ways that I describe below, and that merit more careful analytical attention.

The hidden archive

One day, at the main archives, I was going through the process of trying to find the individual files of patients for my sample, and I was feeling frustrated because I couldn't find them, and I asked for Angelina's help. I gave her three or more patient

ID's (*Número de Identificação do Doente* - NID), I do not remember the exact number. She immediately remembered their names and told me that the files were not at the archives that day - they were elsewhere at the health facility. We went through the process of my giving her NID's so that she could help me find patient files of a few more patients. After some more tries, she got impatient, and asked me to tell her the patient's names, because she remembers people by their names faster than she does NID's sometimes. So, I tell her people's names, and she tells me their NID, and whether their patients files are in the main archives or elsewhere at the health facility. She also tells me whether those patients are late or lost to follow-up as as defined by the national guidelines (*abandon,* she says) or if based on their experience they are really lost to follow up (abandono-abandono, she says).

Now, I am a little impressed and decide to challenge her and give her a relatively longer list, of maybe over 20 patient names, and she goes on telling me their NID's, their retention status, etc., while for others she promises to find their files. After this, I decide to stop what had also become a game of sorts for me and I ask her if she knows the names and NID of everyone whose files are or at a certain point were stored at the archives. She says, 'of course not!' But, that she knows most people who started care or treatment between 2008 and 2012 and can recognize their names, their NID or connect one identifier to the other. She tells me that she cannot recognize with this level of certainty people who started care and treatment after 2012, because that year the HIV forms and registries were changed (cf. Inguane et al.

2016). Yet, she tries to keep up, because here, things are always changing, particularly when leadership changes. And one needs to keep up.

Now, I remember that whenever I went to the data entry room and requested patient data using a NID, the data entry clerks always asked for patients' names, because they said they could remember people's names quicker, and in some instances different people would share a NID (a nuisance they hated). When I worked at the pharmacy, I realized that the same principle was used there – names, not NID. Yet, I am really impressed at how she can remember so many people. But, I am not entirely surprised, because she has been at this facility since when the facility started offering HIV care and treatment in 2008, and has worked all over the HIV cascade, including counseling and testing, opening patient files, coordinating patients' clinical appointments, and she has overseen the archives for several years now. In addition, she is an extremely popular person, well-liked by several colleagues and patients, and has built enduring social relationships that I have described in the previous section.

To make the significance of her knowledge evident, I need to provide a little more context. When I started fieldwork, on February 1, 2018, there were a little over 12,000 people in HIV care and treatment at the health facility, and about ¾ of them (8,000 people) had started care or treatment by 2012. I cannot conceive that she remembers information about 8,000, yet, it looks like she can connect information about several

of them. Yet, this is not the first time I met someone with this type of memory. Readers who have used the Mozambican Historical Archives (*Arquivo Histórico de Moçambique* - AHM), in Maputo City will remember that Antonio Soupa has this type of amazing and extremely helpful memory. You ask him about a document in archival sources on the history of Mozambique, and he will tell you with ease whether the source exists at the archives and if it does where. He is a human catalogue of the archive that facilitated the lives of many of young students in the social sciences and the humanities like I was several years ago. So, I was both impressed and shocked back them. Yet, in hindsight, comparing with Antonio Soupa, I do not find such a working knowledge impossible, although I have no idea of how far such a memory can go.

So, when I recovered from the shock I asked Angelina if she was the only one with this knowledge at the health facility. She tells me she is not. She thinks the head of the reception (a hospital attendant) has the same knowledge, because she opens patient files for every patient in HIV care and/or treatment, except for women and children who are seen in the maternal and child health section (for PMTCT) and everyone who starts by doing tuberculosis treatment, because they start antiretroviral treatment in the respective health facility sections. Yet, eventually their information has to be entered into the logbooks at the reception, and when they are discharged from those sections, they have to go through the HIV reception to go to their clinical, laboratory and pharmacy appointments. So, I decided on the

spot that, after I felt confident that I had learned all the basics at the *ficheiro*, I would go and work at the reception – if the head of the reception accepted me, that is.

Discussion

Angelina was among the few health workers who, along with an international NGO, started the HIV services, in 2008, at the health facility. She brought to her work at the facility her experience as a first aid activist, and like other community health workers and health workers engaged in the response to HIV, she performs work that goes beyond what is anticipated in the national guidelines on counseling and testing and on HIV treatment.

A central part of her work is counseling, both for testing and adherence to biomedical advice and antiretroviral therapy, but also on other aspects of patients and their relatives and confidants' lives in ways that lead to building enduring social ties that help patients comply with biomedical advice, and carry on with their lives, and ensures the reproduction of sociality. In these webs of sociality, other health workers are involved, patients became members of larger social networks, and share goods and services in ways that, as Angelina says, they become a family.

Angelina's work to ensure compliance to biomedical advice, to antiretroviral therapy, and her strict rules for patients to respect the cycles and flows of HIV care and treatment outlined in the national guidelines, show that, contrary to what has

been documented in other sub-Saharan African contexts, she is not part of those health workers who promote evasion from compliance. She adds to this engaged labor of sociality and compliance an interest and strict professional ethic of providing the best service she can, guided by the assumption that patients, like anyone else, like to be treated with respect. As part of her efforts to provide the best service she can, she resorts to her history as one of the founders of the HIV services, her responsibilities as head of the main archive and her knowledge of the dynamics and organization of the health facility to build a personal archive of sorts, that she uses to compensate for the disconnections between the paper-based health information system managed by the public health system and the electronic-based system managed by the implementing partner.

Angelina connects these systems and helps patients navigate their otherwise confusing duplication. In doing this, she suggests that, rather than suffering the "documentary disorders" that this duplication of information systems would lead to, and rather than being frustrated by the limitation of each system, she exercises her agency on an everyday basis. She builds ties with people and with the systems in place at the facility, she contributes to maintaining people in treatment, alive, and to maintaining the functioning of the services that patients rely on.

Chapter 5: Documentary multiplicity and politics of knowledge

Introduction

In this chapter, I discuss how epistemic labor is connected with labors of compliance and sociality, by examining the professional trajectories and labor that two health workers classified as lower level – a community health worker with a multifaceted professional trajectory, work style and critical attitude (Amélia), and the hospital attendant responsible for the HIV reception (Lolita). I look at how two professional trajectories dedicated to the National Health Service relate in how they use their experience, knowledge, age and the respect they command from colleagues and patients alike. I end with a reflection about how the anthropological literature should pay more attention at contributions these health workers make to preserving the plurality of medical archival sources (oral, written, and digital), can also lead to appreciating their contribution of the HIV treatment project, while reproducing the social.

Into the HIV reception

The opportunity to work at the reception came during an HIV adherence committee meeting at the facility. The committee was a meeting in which everyone at the health facility who worked on HIV-related issues met regularly, usually every Friday afternoon, for an hour, to discuss clinical and management issues associated with HIV. I was invited to those meetings, because people who worked in the HIV sector knew that my research was HIV-related. In one of those meetings, the discussion

was on how to improve HIV-related indicators, a discussion that soon moved to identifying problems in the patient flow. One of the sectors that was identified as a bottleneck in the flow of patients and of medical documents was the reception, because the head of the reception (Lolita) was overworked.

The chair of the meeting explained to us the complexity of the work that Lolita does, as follows. She has to open patient charts, for which she has to interview patients who had recently been diagnosed HIV-positive and collect some demographic data from them (including they name, age, sex, place of residence, marital status, and whether they had children or not). Lolita also had to fill in a CD4 test request form, and usually at the end of each day she would enter everyone's data on the relevant logbook. Whenever people came to a counseling session, to a consultation, laboratory or pharmacy appointment, she had to update that information in the logbook. Patients who were not going to start HIV treatment – would be on HIV care only – were entered in the pre-ART logbook, while those who started ART were entered in both the pre-ART and the ART logbook. She had to enter people in the correct pre-ART and ART logbook. There were two pre-ART logbooks (I, and II), and the same number of ART logbooks. I later learned, through observation at the reception, that she also did some type of counseling after HIV-positive result disclosure. So, when I learned that she was having challenges, because she had an immense work overload, I volunteered to help her, if she wanted my help. She said she was glad to have me on board.

Therefore, what follows is a description of the work Lolita did as the head of the reception, the way I learned it through observing what was happening around me. I tried to pay as much attention as possible, asked as many questions as possible, whenever they came to my mind, or questions I had in my interview guide. Yet, she was usually so busy that often she did not have time to address questions that required long elaborations. Or, we were simply interrupted by patients and other health facility users. So, at the end of the day, I would give her a ride back home, along with other colleagues, and when we were alone, I would ask her the pressing questions that we could not address. As soon as I got home, I would record as much as I remembered in fieldnotes. I did not succeed in obtaining more than one longer interview outside the health facility, when I could immediately record what she was sharing with me. She had an extremely busy social life, too, that made it difficult to schedule longer interviews. Yet, she was generous enough to meet with me one Saturday, at her home.

Instead of providing yet another illustration of an existing repository of medical information of people in treatment, in my first description of Lolita's work, I will describe how she mobilizes her repository to connect with other archives in the health facility and tries to overcome archival or documentary multiplicity and disconnections, instead of passively suffering through or being discouraged by these challenges. I also show how her work complements Angelina's hidden archival capabilities, intellectual demanding work that is not anticipated in their work

agreements, nor in commonly held perceptions about the complexity of these health workers responsibilities, who are regarded as either temporary and relatively unskilled helpers or cultural brokers.

Negotiating documentary multiplicity

I remember one day I was at the reception helping Lolita enter patient information in the logbooks – that is what I usually did. I never ventured into interviewing patients or opening patient charts. She received some medical records of a patient and was expected to open a new file for him. But, when she saw the name she said she recognized him. She looked at him and she connected the name to the face. So, she asked him whether he was sure that he had not started treatment at this facility and had dropped out. She said no, he had never been to the facility before. She did not believe him and told him that she was almost 100 percent positive that he had been in treatment at this facility before, because she is the only person who opens patient files. So, it would be in his advantage if he told her the truth, she said. He insisted that he was a new patient. So, she told him that, although she wasn't sure she could quickly find his patient file (paper records at the archives) there were computers at the health facility and she could go and confirm her suspicions. She said "we have computers here at the center. I will go and check if you have ever done treatment here". Since, he did not back up after this warning, she went to the reception, and after a few minutes came back with a print out of the patient file. Needless to say, the patient was embarrassed beyond belief.

She went on to give him a long lecture about how useless it was to lie to healthcare workers about their treatment status, especially these days when there are computers at health facilities. In this instance she was showing how in her work she needs and does connect her knowledge of patients and their files, with her use of the electronic records from the implementation partner run patient tracking system (e-PTS). She was not the only one from the public servants here using the e-PTS. The health facility clinical management and other healthcare workers, including subaltern people would often rely on this system if needed – when they could not find patients' paper files, when they wanted to check whether NID had been duplicated, or when they wanted a quick report, such as the number of people in treatment. And, the implementing partner-hired data entry people usually help quickly. I have never seen them refusing information to other health workers, nor have they even refused to give information to me.

So, back to the lecture, she asked him "you my son-in-law, why you guys from Quelimane (the capital city of Zambézia province) like to lie?" To which his embarrassment paralyzed any reply. She then explained to me that she made the comments because the partner of one of her daughters is from Quelimane, and he also tells a lot of lies. Then, she went on through the process of re-issuing him a patient file and sending him to a counselor for counseling sessions (locally called *escolinha*). *Escolhinha* in Portuguese, is roughly equivalent to day care or pre-school, and health workers here use the term to mean that this is where patients are

educated on how to live with HIV also known as positive life (MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2015a). Only after he had gone through counseling sessions, and the counselor had determined that he was ready to be compliant would he be reinstated into treatment. At this point, Lolita, ever the extremely attentive critical subject, noted that although he would be reinstated, there was nowhere in the ART logbooks to document that important event.

I was extremely impressed at how she used both her knowledge at the e-PTS, in ways that bridge the divide between the paper-based system used by the national health system and the electronic-based implementing partner/PEPFAR system. She had to connect the two systems herself, because there are no protocols that ensure that once a patient arrives at the health facility, the patient can be identified using the electronic system. The electronic system works mainly to enter the data from the paper-based system, to track patients who default to their appointments, and to report to PEPFAR. The work of checking whether the patient has a record at the health facility, for cases like Lolita's 'in-law' is left to health workers such as Lolita, whose memory is good, yet, relying on her memory to identify these patients is risky. Checking for that depends on the initiative of healthcare workers, particularly subaltern ones, on how fresh or tired or moody they are. By doing that, subaltern health workers, such as Lolita help mitigate the documentary disorders (McKay 2012) that the disconnections between these systems can and often create.

Lolita can make this connection because she uses her knowledge of the paper-based, the electronic based, and of the seemingly invisible repository she has in her mind. The same kind of repository that Angelina has is part of how oral history works and is an important part of the (epistemic or knowledge) labor that community health workers and hospital attendants contribute to addressing HIV and AIDS, which has not been adequately discussed in anthropological and global health literature.

This discussion is important at this time, when global health initiatives and interventions seem to be investing more on digital systems and records for medical data, and less on paper-based ones(Changizi and Kaveh 2017; Lafort et al. 2018; Ma et al. 2016; Christopoulos et al. 2014; Nhavoto, Grönlund, and Chaquilla 2015; Public Health Professionals n.d.). This investment seems to contribute to building a new hierarchy among medical sources, through which the digital is regarded as more reliable than the paper-based. This hierarchy replaces the older hierarchy between written and oral sources historical sources (Zeitlyn 2012) and calls for a serious reflection about why such an investment on the digital does not go all the way and do the work that Lolita's memory did. While such an investment is not done, Lolita and other subaltern health workers do the work the best way they can, mobilizing all their skills and capabilities, including their mnemonic repository. If community health workers' and hospital attendants' monthly salary/stipends are partially defined by their lower level of education in relation to other health workers, which imply fewer intellectual abilities developed, how do we deal with this important

intellectual work? Ignoring this repository and intellectual work brings not only a broader politics of epistemic violence, but also a politics of alienation of labor of an important cadre that contributes to global efforts to address HIV and AIDS.

Critical subjectivity and politics of knowledge

Amélia is a widow, who takes care of seven children, and lives on her activist subsidy that compensates for her work at the maternal and child health section of the HIV program, and for conducting community-outreach work in the health facility catchment area and neighborhood. She also works as a community midwife (*matrona*) in a USAID-funded Maternal and Child Health Integrated Program (MCHIP). She is also part of the health facility management committee, a body that is composed of the management of the health facility and select members of the community to represent the community, as part the participatory democracy practices that were developed in the first few years of the Mozambican PHC approach, consistent with the Alma Ata declaration (WHO and UNICEF 2004; MISAU, n.d.). Before she started her current position, she also worked as an activist on a mental health project that was operating from a site near the Infulene Psychiatric Hospital, in Matola, Maputo Province, helping people with mental health issues (Interview with experienced counselor, on February 28, 2017, Maputo). In 2008. she was trained to provide the Integrated Attention to Childhood Illnesses and was trained on HIV counseling and home-based care by MONASO, a Mozambican NGO.

Sometime between 2011 and 2012, Amélia was invited to come and help with cleaning the health facility in afternoons, because she oversaw the portfolio of environmental health (including cleaning) at the management committee. She worked at this position until 2013, when she was asked to start working the whole day at the pediatrics section of the facility. In 2014 she started doing counseling and testing, a time that coincides with activists and counselors signing work agreements with the local health directorate, which I mentioned in the beginning of this part of the dissertation.

She had several trainings, including as a community health worker responsible for health promotion (giving health education talks), advising people about where to obtain first aid, and walking people to the health facility. She does not remember when she had this training. She remembers, however, that she was trained as a "lay counselor" in HIV and malaria testing, HIV counseling and testing, and age-specific test result disclosure. She thinks that her work has changed since 2016, when a cadre of counselors was hired, and the activists and counselors were asked to train them, and activists work hours were reduced from full-day to half a day, including at the health facility and doing community outreach work.

At the health facility, Amélia works at the pediatric section. She organizes the patient queue, checks who did the HIV test, and updates the test. By updating she means that sometimes some people will come with the wrong test results, and

because the new counselors do not know what they are doing they cannot tell right from wrong (test results). So, she studies the patient file and other records, and sees whether there are indications of errors, and tests the patient if she finds errors. She also does malaria testing, because, as she explained to me, for a lot time the pediatrics section used to do HIV tests only, and it was difficult to meet the targets. So, she decided to start doing both HIV and malaria tests. In addition to doing more tests this means that children and moms do not have to go and wait in the queue at the lab and can go home earlier than they did when this system was not in place.

During one of the interviews I had with her she displayed excellent knowledge of the nuances of HIV testing in children. She explained to me that a child of a positive mother who is below nine months old should not be tested using a rapid diagnostic test because she will be positive or have an indeterminate result even if she is not positive, because she will have her mother's antibodies. This child needs to be tested using a Polymerase Chain Reaction (PCR) assay, she said. If a child is being followed up at the Consultation for Child at-risk (*Consulta da Criança em Risco* – CCR), the child shouldn't be tested at the pediatrics section, she should be tested at CCR.

After normal working hours at the health facility, she also does community-based work that is unrelated to her work as an HIV community health worker. She is a

birth attendant at the community, for which she received training from Medicus Mundi in 2001, with which she worked until Pathfinder replaced it and now she workers for MCHIP. She says this is voluntary work, without any formal pay nor other money incentives. For compensation she occasionally goes to trainings, and MCHIP sometimes gives them prizes.

Like Angelina and Lolita, an important part of Amélia's work involves counseling for compliance with biomedical care and treatment for HIV, which starts from the first opportunity she has to address the topic. But importantly, her work is permeated by concerns about providing good and caring service. She explained to me a little about what she does in counseling. In pre-ART counseling, the person needs to understand well and accept that they are positive, and the counselor needs to ensure that the person is ready to start. The person needs to understand that once they start taking the medicine there is no break [f*olga*]. They also talk about condom use, the need to keep clinical consultation appointments, lab appointments, avoid smoking and so on. Then the counselor writes in the APPS what counseling content she has addressed.

After this the counselor schedules follow-up counseling visits (*aconselhamento de seguimento*). In this counseling, the counselor discusses the time to take the medicine, counseling, and the need to bring a confidant - which can be a friend, a neighbor or a relative. In this session the counselor needs to recap what she talked

about the previous day to ensure that the user understood the previous step, otherwise you will go on without good foundations. She said that there are cases when people do not remember anything they talked about in the previous session. They will say something like "I know. I know what we have talked about". After these seasons, the following ones are adherence counseling, which starts after one has initiated the therapy.

Discussion

This chapter highlights the epistemic labor that two health workers classified as lower level without clinical training contribute to providing HIV services at the health facility. The chapter highlights two different professional trajectories. One, of a hospital attendant responsible for the HIV reception, whose career has been built as a public servant in the national health system of Mozambique, and who uses her experience, knowledge, age and the respect she commands to contribute in unique ways to the provision of services. The other contribution comes from a community health worker, classified as an activist, but who sees herself and is seen as a counselor. Her selection process and trajectory fit very well within community involvement in health practices that are part of Mozambique's PHC traditions. She was selected by her religious congregation to be part of the health facility management committee, of which she is still a member, and she works as a community birth attendant.

Lolita, the hospital attendant who has worked in the HIV reception for several years is one of the few health workers at the facility who interacts with most of patients on HIV care or treatment, and who manages the medical records of all those patients. Although she does not open the charts of women and children in PMTCT and of patients who start antiretroviral therapy at the tuberculosis sector, she enters the data of all patients in the pre-ART and ART logbooks. This is what is in her formal job description as the only staff of the HIV reception. To ensure that she does her work effectively, amidst the duplication of information systems, and the confusion and limitations of the paper-based registries that she works with, she resorts to her work experience and knowledge of the organization and dynamics of the health facility, and her relationships with other health workers, and her authority associated with her age and experience in the national health system, to navigate those spaces and dynamics and build an archival knowledge and system that helps her do her work effectively.

These unique skills, which she was not taught in any training or by anyone particularly are recognized as unique and command the respect of other health workers, particularly Angelina, who sees in Lolita the only other health worker who could do the work Angelina does as effectively, and the only one qualified to run the HIV reception. Yet, this attention to detail and critical mindset towards the registries and the health information system, and the authority she commands is not taken as easily by a few health workers and implementing partner employees.

Yet, she uses it effectively to build relationships of trust with patients, making her an important part of the counseling for compliance. But, she also helps minimize the risks of duplication in the registries and helps people continue in treatment.

In doing this, with Angelina, Lolita is an example of how oral history works is an important part of the (epistemic or knowledge) labor that community health workers and other health workers regarded as lower level (who were not contemplated in discussions about task-shifting) contribute to addressing HIV and AIDS. This contribution has not been adequately discussed in anthropological and global health literature. Such a discussion is particularly called for at this time, when global health initiatives and interventions seem to be investing more on digital systems and records for medical data (m-health). This investment that seems to contribute to building a new hierarchy among historical sources, in which the digital is regarded as more reliable and better than paper-based and replaces the older hierarchy between written and oral sources.

That such an investment in the digital does not go all the way and do the work that Lolita's and Angelina's memory does is a crucial shortcoming, and it runs the risk of erasing another important dimension of these health worker's agency. They pursue professional excellence, despite all odds, as part of a broader politics of care that I found among other community and (so-called) lower-level health workers. This attitude seems to be part of what I consider an ethos that is found in other categories

of health professionals, particularly the so-called 'traditional healers', in Southern Mozambique. Prominent among those, as documented by the ethnographic literature is the *nyamussoro*, an interesting character whose work is guided by a deep knowledge of local history and healing practices, dedication to preserving social harmony (Honwana 1996; Granjo 2009) , and insatiable curiosity about other forms of medical knowledge, including biomedicine (Granjo 2009). From this perspective, their promotion of compliance to biomedicine is not inconsistent with the reproduction of sociality in ways that do not necessarily conform with capitalist-inspired moral economies.

Chapter 6: The Future, Change, and Life on the move

Introduction

In 2016, Mozambique piloted the implementation of protocols to meet the internationally-defined ambitious treatment targets (MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2016) of testing 90% of people living with HIV, maintaining in antiretroviral treatment 90% of those diagnosed, and achieving viral suppression in 90% of people in treatment by 2020, then believed to lead to the end of AIDS by 2030 (UNAIDS 2014). Despite this global optimistic narrative, current HIV statistics in Mozambique (INS, INE, and ICF 2018; MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2018), and the local Ministry of Health approach to meeting the targets (MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2016, 2018) have suggested the unreasonableness of those global expectations, which echoed reservations from anthropologists (Aggleton and Parker 2015), that only now do global health influential institutions and scientists start to recognize (Bekker et al. 2018).

In this chapter I describe how the implementation of efforts to meet the ambitious treatment targets has driven changes at the health facility where I was conducting fieldwork that have the potential for lasting negative impacts in people's lives and in the health system that should serve them.

Current HIV statistics in Mozambique suggest the limited reasonableness of the ambitious treatment targets. To be concrete, two years away from the international deadline to meet those targets (2020), Mozambique still has one of the 10 highest HIV prevalence rates worldwide, low HIV testing uptake and retention in antiretroviral treatment (MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2016), and about half (45%) of the health facilities that piloted the Test and Treat protocol were ready. Laboratory capacity to handle viral load was the most challenging aspect of readiness (MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2016) . In addition, the quality of HIV data produced by the national health information system (Inguane et al. 2016; MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2016 2015) , and by international NGOs is so low that the Mozambican Ministry of Health uses them with manifest reservations (MISAU, Programa Nacional de Controlo de ITS-HIV/SID 2014; MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2018).

The way the local Ministry of Health is implementing the global recommendations also suggests that it had reservations about the reasonableness of the ambitious treatment targets. The protocols were planned to be implemented in phases, the first of which, starting in August 2016, would cover health facilities of 12 out of the 150 country districts – the 11 provincial capitals and an additional district (MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2016) - including where I was conducting my dissertation research. The approach, locally known *testar e iniciar*

(test and treat) (MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2016) is consistent with the guidelines set forth by the World Health Organization (WHO) in 2015, that for the first time, recommended the initiation of antiretroviral therapy for anyone who is HIV-positive, regardless of their virologic (CD4 count) or clinical conditions (World Health Organization, Department of HIV/AIDS, and World Health Organization 2015). Yet, the approach seems also to signal Mozambique's reservations towards international pressure to implement the recommendations without an assessment of the feasibility of the implementation (interview with MOH official, February 2, 2016, Maputo).

The country's caution is suggested by the conservative implementation plan, which included a pilot, with three phases, a baseline health facility readiness assessment a month before implementation start, and readiness assessments every six months. The pilot was conducted between August 2016 and December 2017 and included health facilities only in 29 out of the country's 161 districts (INE 2017; MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2016). Results from the pilot were expected to inform the development of a nation-wide implementation plan, based on which the approach would be scaled-up to the remaining districts (MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2016)

The readiness assessment focused on key areas of the HIV cascade of services, namely, appropriate space for counseling and testing and a counseling and testing

management system; space for psychosocial support and counseling and strategies to improve retention in care and treatment; laboratory capabilities to handle viral load testing; pharmacy capabilities for the storage and dispensation of antiretroviral drugs, and monitoring adherence to the therapy; and enough qualified human resources to help implement the approach (MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2016, 2018).

The readiness assessment confirmed MOH reservations. At baseline, the mean readiness in all districts in their first evaluation was low, and improved into levels regarded only as acceptable, by the second and third evaluation – 'good' readiness was never achieved (MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2016, 2018).. These results suggest reservations about the optimistic global narrative about the end of AIDS that has been advanced by global health institutions at least since around 2010 (Kenworthy, Thomann, and Parker 2018b; Kenworthy and Parker 2014; UNAIDS 2014; World Health Organization and Department of HIV/AIDS 2015; Sangaramoorthy 2018), and that only recently those global institutions are admitting reservations (Bekker et al. 2018; Sands 2018).

That the end of AIDS discourse and associated politics would be pushed on Mozambique is not surprising, since such discourse is part of a global movement that has gained momentum following the international financial crisis of 2008, grounded on "biomedical triumphalism" (Kenworthy, Thomann, and Parker 2018a,

921) that justifies international donors, organizations and governments' retreat from long-term assistance to addressing HIV and AIDS globally (Kenworthy, Thomann, and Parker 2018a, 2018b; Sangaramoorthy 2018). This retreat happened in tandem with the co-opting and marginalization of the international AIDS activist social movement (Aggleton and Parker 2015, 1) and social science and humanities perspectives from the global HIV and AIDS response (Kenworthy, Thomann, and Parker 2018a, 921).

In doing this, the ending AIDS discourse and associated politics succeeded in biomedicalizing (Kenworthy, Thomann, and Parker 2018b, 967) and domesticating the response to HIV and AIDS into a technocratic issue (Aggleton and Parker 2015, 1) that could be best addressed through biomedical and technical solutions. Such a move shifts attention away from "the unending possibility of suffering, poverty, and illness" (Sangaramoorthy 2018, 985) among people living with HIV globally, and away from "impacts on civil society, health systems, and the real futures of the epidemic" (Kenworthy, Thomann and Parker 2018, 962).
(Kenworthy, Thomann, and Parker 2018b, 962).

Enacting change

Around the end of the first quarter of 2016, I started noticing a few changes at the health facility where I was conducting dissertation research, particularly staffing and efforts to improve patient flow. Some of these changes become apparent during an adherence committee meeting held on March 2 at the health facility. All health workers involved in the HIV services, the health facility managers, and implementing partners representatives seconded to the health facility and provincial representatives of the partner who had not seen at the facility before were attended the meeting. During the meeting, the implementing partner representatives introduced a team of 10 counselors from a local NGO who would be working in project to test people and enter their data in a cellphone, and through the index case they would try and find other cases that were connected to the index, try and test them and follow them through the HIV care and testing cascade at the health facility. The representative explained that the project is called *infomóvel*. Although this was not revealed at the meeting, I later learned that this was a study conducted by the implementing partner, in which people would be followed for six months.

At the same meeting the representative of the implementing partner informed that some changes would be implemented at the health facility, including that the patient card needed to be completed well (with full identity information, including a full physical address), and that active tracking would be replaced by consented

tracking. The apparent difference between these two patient tracking strategies were that the later would be done only after obtaining patient consent. A new counselor supervisor and a case manager were introduced, and one of the latter's tasks was explained as ensuring that every new patient would have their files opened and their clinical consultation on the day they tested positive, and that data of priority patients would be entered on the e-PTS that same day. The implementing partner representative added that all patients who would get a referral from the community to the health facility should be seen that very day, and that the health facility needs to be prepared to address that need.

Health workers did not receive those changes well and asked several questions. One raised the question of what would happen with the other patients who would have been on the line before the "priority" patients sent from the community arrived. Other people raised other reservations, such as the lack of space at the health facility. The implementing partner representative retorted that "unfortunately, we need to work within the resources that we have", and all health facilities in the district, with a few exceptions were like that one, with little space. Health workers raised several other reservations, all touching on the theme of lack of adequate planning and resources to implement the proposed changes. Those reservations met the same response – recognition that the resource limitation was a problem, yet health workers needed to find creative ways to implement those changes with the resources they had. Several health workers left the meeting with

frustration expressed in their faces and in comments. When I went back to the main archives to have lunch with the counselors I usually had meals with, these counselors showed irritation because new counselors had been hired, without the experienced ones (them) having been notified in advance.

In the following months, I witnessed several other changes. For the first time since I was here, there was at least one new implementing partner hire at each of the health facility sectors that was part of the HIV services: the main archives, the HIV reception, family planning and at risk child consultation, pediatrics, pharmacy and laboratory, the voluntary counseling and testing, and at one of the two clinical consultation rooms. In addition, between 7:30-9 am every day the 10 new counselors/activists were crammed at the main archives, after which time they went for their activities at the community. They would leave their belongings at the archive, and when they were back they would hold debriefing meetings. The archive became a place where the confidentiality and restricted access mandated by the National Archiving Guidelines for HIV Care and Treatment (MISAU, Programa Nacional de Controlo de ITS-HIV/SID 2013, 12, 16) could not be guaranteed.

Life on the move

Then other changes started to happen at the health facility that the experienced activists and counselors started to resent. The first change that made an impression on me was about a year after the meeting on March 2, 2016. In fact, on February 9, 2017, a year after I had started fieldwork, I was shocked to learn that Lolita, the head of the HIV reception had been moved from the specific reception to the general reception where she would be doing very routine and simple work that anyone without any experience can do. Take myself for instance, after one or two days of standing at the reception I felt capable of doing that work. The work consisted of selling appointment cards, making change and directing health facility users to the right place at the health facility, stamping physician notes, and, in the case of hospital attendants and community health workers, also clean up the reception at the end of the day.

The head of the reception had a vast experience with work at the HIV reception, was extremely competent, liked her job and was well-liked by health facility users More importantly, the only person who colleagues at the health facility through that had skills close to her, the head of the archives (Angelina), used to say that Lolita was the only person in that health facility who could run that reception by herself. So, I did not understand the rationale for moving her from the HIV reception to the general reception. And, no one explained to me or had cared to explain to the head of the reception or to me why she had been moved.

I tried to talk to Lolita when I learned the she had been moved. However, she was not there that day, because she had a clinical consultation in another health facility. So, there was no one at the HIV reception, which Lolita loved and found amazing. On Feb 10, Angelina was back and took over the HIV reception. In her new position she worked with as much energy as she had done at the HIV reception. She started organizing her small desk right away, asking the head of the general reception about the multiple papers she found at her desk, so that she could recycle some, and ensure that the useful ones could be used.

Although no one could tell me why this decision was taken, everyone I talked to, except the facility management, thinks this is a foolish decision, for various reasons. The workload at the HIV reception is extremely high; many users already know and are used to Lolita; and to make matters worse Lolita is often called to go and help Angelina at the HIV reception. Angelina thinks work is so much work, that she cannot cope, and people will start complaining soon. I mean, Angelina told me that she needs to work at the reception, opening files, entering data in the logbooks, sending people to the different sector, such as clinical consultation, counseling, etc., and is also expected to do some work at the archive, particularly looking for patient files. So, she said, just because she did not come to work one day, there was a complete mess at the reception.

Moving the head of the HIV reception from the sector she had run and worked hard at for so long, and for which both colleagues and health facility users recognized suggested to me the importance of rethinking analysis of brain drain, particularly brain drain within health systems. Both global health and anthropological descriptions and analytics of internal brain-drain have been elitist, in the sense that they have focused on healthcare workers at the top of the hierarchy, particularly physicians, managers and other healthcare workers with high education qualifications and management positions within health systems. They have not described the loss of healthcare workers lower in the hierarchy, such as hospital attendants, activists and so-called lay counselors as brain drain, since the work of such subaltern healthcare workers has not been conceptualized as involving intellectual work. It is often assumed as menial or intellectually low-intensity work.

Another move that surprised me, but that was celebrated by the person moved, was Angelina's, first from the main archives to the HIV reception, and then from a tent where she provides HIV counseling and testing, until the last time I went to the health facility for a short visit (July 2018). Angelina was moved to the HIV reception in early June 2017, before Angelina's move, the HIV reception was staffed by a new counselor hired by the implementing partner, a counselor who had little experience at the sector, and who regularly asked for Lolita's help.

Angelina's moved to her original position of simple counselor, with no supervision responsibilities seemed like a demotion to me. So, I asked her whether she felt better in her new position in comparison with her previous position as head of the archives. She said she did feel much better, because the archive is a dangerous place for people's health. "Aleluia, I couldn't wait to move away from the main archive. That place is not good... Too much paper... " But, she ironically notes that she traded one danger with another: "I have another source of suffocation. But, I moved away from one source of suffocation".

She notes that her work in the new position at the HIV reception is so much more that she will not do all of it. And she told her new boss that if she cannot do somethings she will have to ask for help. She says that, however, she doesn't complain about work. She does what she can. People who complain such as Lolita end up with problems, like Lolita did, who was moved from a relatively prestigious position as head of the HIV reception to distributing line cards at the general reception.

And she joked about something she told me several times, that she is going to have a disciplinary process opened against her, because her work at the reception is too much. Yet, the former head the HIV reception told me that Angelina knows very well how to do the job at the reception. This makes me suspect that Angelina might

be trying to protect her time and energy through a cautious form of everyday resistance (Scott 1985).

Asforssa continues to work as an activist, doing community outreach work in the morning during some days and organizing the line at the health facility during other days. Although she was demoted from her supervisory role, she is still asked to prepare reports, which does, and with a hint of sarcasm often asks why they ask her to write reports if they cannot promote her to counselor because they say that she is uneducated. Other activists and counselors also note this resistance in promoting her with irony, and remind me that, along with Angelina, she is the only community health worker left at the health facility who was part of the team that started the HIV services. She is as qualified as anyone else to be a counselor.

Célia, who taught me how to organize and look for individual antiretroviral refill forms (FILA), was also demoted from working every day at the pharmacy to working only half a day during somedays at the community and other half days at the facility. She was replaced by a young man from the new cadre of implementation partner hires who completed grade 12 yet does not have any experience and has more ambitious plans that remaining in this line of work.

Amélia, who used to be responsible for the pediatrics section has not been demoted, just like Cindy who works at the family planning section. They both work some half

days doing community outreach work and other half days at the health facility. Amélia is often asked to prepare reports and to train the new cadre of counselors, because the latter do not have experience in their line of work. Amélia says that she does it for the patients that need to receive good quality service, but, she is aware that soon she might be disposed of, when the new cadre of counselors have acquired the skills and knowledge to be independent from the experienced ones.

The change in the other three older activists/peer educators was in their schedule. They now only work in the mornings at the health facility or doing community outreach work. They had no positions of responsibilities, so they were not demoted.

When I visited the health facility in June 2018, I learned that Rosalina had been demoted from her previous positions as supervisor for voluntary counseling and testing, and for health education talks into psychosocial support counselor. She was moved from the renovated and comfortable counseling and testing unit room into sharing a space in a new tent with Angelina, where both do counseling and testing. Sharing the tent defeats the principle of ensuring privacy during HIV counseling and testing that is mandated in national guidelines on HIV counseling and testing and the guidelines on psychosocial support (MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2015a, 2015c), and reiterated during staff meetings at the health facility. Health workers are left to deal with the ethical dilemma associated with providing counseling and testing under such conditions.

Criticizing change

Other activists and counselor are not as silent as Lolita or as dismissive of the new changes as Angelina. They are incisive in their critique of the events that have been happening at the health facility. One of them is Amélia, the counselor who also works as a midwife at her community. I had a long interview with her on her on February 28, 2017. Her narrative about changes at the health facility is often punctuated by critical reflections that highlight perceptions of the decrease in the recognition of her and other subaltern health workers contribution, since the mid-2016, when a new cadre of counselors was hired to help meet the ambitious treatment targets at the health facility.

She started by noting that the difference between activists and the new counselors is that counselors need to have 10th grade, be below the age of 40, and, with an intentional ironic tone, she adds that counselors have better pay. She notes that this difference came as a surprise, because it suggested a career path that seemed to lead to activists eventually becoming counselors. She noted that she and her colleagues where raising in the ranks, from cleaners to activists, and from activists to counselors. But, now they were going down again.

At times, she would express feeling of being used and demoted: "I was a counselor. But, here, since they are using us." At this point and several other similar moments, I felt so bad for interviewing her about such a painful and ongoing

experience, and there were times when she stopped talking and I thought she was going to start crying. But, she would compose herself, and explain to be how her work is part of a wider politics of knowledge and care, because through her knowledge she wants to help people, she wants to give better care, as she says:

> I am working because I want to acquire knowledge. I have been helping many people because I have knowledge (interview with experienced community health worker, February 28, 2017, Maputo).

The importance she attributes to knowledge becomes evident when she described feelings of happiness with her other community health work, as a community midwife. She said that she is happy because in the community midwifery project, the project manager's concern is with skills, not with age and education:

> In that project age doesn't matter, nor whether you studied or not. There, people who cannot even write their names know how to deliver babies.

This is a modest critical subjectivity, who appreciates the recognition one global health project gives to her and other community health workers' skills and knowledge, regardless of their (western-defined) educational qualifications. She calls to attention the importance of translating knowledge into service that is useful to other people and challenges the fetishism of educational qualifications in which practical value is not visible, in a professional environment where it is needed. Ever the critical subject, when I asked her about the requirements to be a counselor, she responded by joking that age did not matter, because each person has their own age and one day everyone will be old. She added that you cannot be

sure that people's school certificates are authentic these days, and that, regardless, she had several certificates but were not understood to add up to professional qualifications: “There are many certificates. But, they have no school grades”

She connected the current disregard for qualification with (the health facility widespread perceptions of corruption that other health workers at the facility hold in the hiring of the new cadre of counselors, archivist, laboratory assistants, and other people who are expected to help meet the ambitious treatment targets, as follows:

> These people who were put in the offices/rooms paid for their positions. [One of them once complained] I cannot pay for a position and come and sweep the floor (interview with experienced community health worker, February 28, 2017, Maputo).

Yet, she notes that the new counselors do not have the professional skills to do their job yet. She told me of an episode when a new counselor could not tell a negative from a positive test result: they misinterpreted the cross sign for a negative result. And, the experienced activists and counselors are called to correct the mistakes of the new cadre, which the new cadre makes, because they do not know what to do. As she saw once in a queue. Thanks to her training and work experience, she has learned to identify all the tricks women who go to HIV consultations have, and she has learned ways of diplomatically dealing with those tricks.:

> I know all these women. I know their tricks and lies. Once a woman shows me a second issue of a patient card and tells me that she is treatment naïve

> (*noviça)*, I know that is not treatment naïve (interview with experienced community health worker, February 28, 2017, Maputo).

She says that in all Mozambican maternity wards, public ones she means, all women are tested positive before they give birth, and are told their result before they leave the ward. The baby is also given the antiretroviral syrup at the health faculty, and the test result and whether the woman and the baby have started ART or not or are in ART is written in the form/or card? At ANC the test is done again, if it has not been done again. So, she knows that if a woman comes with a card full for corrections, or comes with a second issue card, that's because something is fishy, and she has ways to confirm the result:

> There is no lady who gives birth at a health facility and does not know her HIV status or the status of her child. If the test if positive, she will give nevirapine syrup to her child, and that will be recorded in the child's card. If ART is written in the child's card, and she says that she doesn't know whether the child is positive or not. She is lying (interview with experienced community health worker, February 28, 2017, Maputo).

She told me all this to restate the point that the new cadre of counselors was easily fooled by these ladies, who pretended they did not know their HIV status nor their babies', so that they could do the HIV test again and start HIV treatment afresh. The new counselor could not tell whether the woman was lying or not because they did not know how to read the forms. She also told me how she can check what is in mom's cards, swiftly. She makes small talk with the moms and asks them to see the card to check the child's weight. Innocently, moms give the cards.

She says that she is also called to prepare a report when that is no longer part of her terms of reference. Yet, she eventually does the job of interpreting the test results and producing reports for the new counselors, for which she is not paid. She does this out of compassion for the health facility users who need quality service (compassion as part of a politics of care), because she was trained as an activist at her parish and was told that she needed to use her knowledge to help fellow human beings: "I was training in the parish and they told me that my training was to help people" (interview with experienced community health worker, February 28, 2017, Maputo). She also continues to do her work out of compassion for the new counselors, because she understands that the person who hired the new counselor should be held accountable, not the new hired.

The motivation to do work, even if it is outside the scope of one's terms of reference, and even if the person who should do that work is paid a higher income, was explained as part of a broader politics of care, that contributes to the reproduction of a moral economy that allows for the continued extraction of the economic labor of experienced activists and counselors, under the guise of morally/religiously sanctioned altruism.

On the other hand, narratives about corruption that Amélia shared, are part of a broader interpretation about changes that occurred since the mid-2016 at the health facility, and such interpretations circulate through different sectors of the

health facility. In one case, when I was discussing the problems with lab registry with the head of the lab, she said she was sick and tired of the new phlebotomist, because he was hired to the position, but he does not have a driver's license and he does not know how to do his job. He collects samples without following protocol (he doesn't use gloves, is careless, and so forth). She also mentioned that she realized that he was not eating well enough and told him that this is what happens when people buy a position, for which you have to pay with a big portion of your salary every month. She said that she did a blood test to him and confirmed that he had anemia, which proved her theory.

On another occasion, Angelina told me how the new archivist's salary had raised within a few months of working at the facility, although she doesn't know how to do her job, because her father is the godson of someone important in the hiring process. She explained that such connections were the reason why the new archivist was so arrogant and disrespectful of other people at the facility. Whenever someone tries to teach her something, she doesn't let the person finish what they are saying. She says she already knows: "I know, I know" (*"já sei, já sei")*. I was dumbfounded at this, because I had heard Angelina call out to another counselor using the phrase *"já sei, já sei"*, and I had thought this was the other counselor's nickname. I had no idea that I was a critical discourse on the politics of knowledge, and of the hiring processes associated with the implementation of the ambitious treatment targets was circulating under my very nose.

Living abandonment

Amélia, Angelina, Lolita and other experienced counselors and activists have been demoted from their supervising or prestigious roles. Angelina and Lolita continue at the health facility. Other counselors and activists' work time has been reduced to 7h30-12h00, some days at the health facility and other days doing community outreach work, an attitude that makes them feel marginalized. Zélia, who took on the challenge of the new contract which would allow her to double her salary, and it did for a year and a half, after which period she lost her job, could not go back to her previous position at the health facility, nor a similar position in another project elsewhere. I learned about her job loss through a WhatsApp message she sent me on August 31, 2018, in which we had the following exchange:

> Zélia: Good afternoon, doc, my work on the project is over. I am home
>
> Me: good afternoon. I am sorry. Did they explain you the reasons? Will anyone replace you in your sector?
>
> Zélia: Yes. I have no acquaintances [someone who can protect her through nepotism or other forms of favoritism]. That's why they fired me. But, I will not give up. I will knock on doors until God opens them for me.
>
> Me: You have a lot of knowledge and you are professional. Yes, you will have more opportunities, probably better ones. Do you know Laurinda [this is an alias a former data collector at the facility, who became a friend of mine, and who found a better job at another international NGO]. She is a good person and works at a good NGO. She might know of vacancies you can fill. And, also prepare your CV and send to me. I am very far, but if I

hear about any job openings I can tell you about. I will only be back in December, and I would like to hear more of this story then. Do not give up.

Zélia: Ok, doc. Thank you so much for the encouragement. So, I am in bed now, I cannot even eat.

Me: Do not waste your energy on that. Go out and fight. I am waiting for your CV. When can I call you, so we can talk about this?

Zélia: Saturday[12].

We talked that following Saturday and continued with daily communication for the next two weeks (until September 13, 2017). That communication included her contract, and the termination letter. I learned that the opportunity she had taken had allowed her to double her counselor salary from about $58 to $117, and that her contract, signed on January 2016[13] was 'permanent'. But, that it had been terminated because of "the implementation partner's work force reorganization and structuring, resulting from lack of economic and financial resources from the implementing partner's partner[14]. Termination based on this cause was anticipated in the work agreement and is legal under Mozambican labor law[15]. So, it was legal. Well, I am not a lawyer, I do not have legal or paralegal training, but, I am fairly

[12] WhatsApp chat with an experienced community health worker, August 31, 2017 (Seattle and Maputo).
[13] Work agreement between counselor and human management consultancy company, January 11, 2016, Maputo.
[14] Work agreement (between counselor and human resources management company) termination letter, August 30, 2017, Maputo.
[15] Mozambique, Labor law, law 23/2007, August 1, Republic Bulletin, Official Publication of the Republic of Mozambique, Series I, Number 31, Maputo, article 130, line a.

conversant with Mozambique's public sector legislation. So, after reading the contract, with a pained heart I could not muster more that the following words of resignation:

> Hi. I read the documents. I did not see anything illegal in them. I am sorry that you have lost your job. The termination letter even said great things about you and can help you find another job. Did you talk to Laurinda?[16]

Only after nine months of intensive job searching did she find a job. But, as an activist in another global HIV project to address, for which she had the knowledge, experience, and educational qualifications (she completed grade 12). She communicated this to me as follows:

> Zélia: Goodnight, doc. I am working at [I will not mention the project's name for ethical purposes]. I am an activist. I work with orphaned children and widows who are in antiretroviral therapy.
> Me: And, do you have a contract?
> Zélia: No.
> Me: Ok[17].

I researched the project she is working for, and it exists, it "is a five-year project, funded through USAID and supported by PEPFAR"[18]. I called her to try and understand why she did not have a contract and whether she was earning better than in her previous position. She told me that she earns $28 a month, far below

[16] WhatsApp chat with an experienced community health worker, September 6, 2017 (Seattle and Maputo).
[17] WhatsApp chat with experienced counselor, May 10, 2018.
[18] This quote comes from the website of the project. I am in an ethical aporia as to whether I should disclose the name of the project or not. Yet, because I would like to protect to protect my research partner (the community health worker), I decide, for now, not to disclose.

her qualifications, skills and work experience. I asked her why she would settle for such a low paying position and she said that her daughter had been accepted at the university, her husband had a disability that did not allow him to work, and she needed the 'subsidy' to help her daughter at least pay for transportation and photocopies to the university.

While other counselors understood Zélia's desire to improve her income, they said that she made a mistake in taking such a high stakes position. Actually, two of the best qualified counselors received, and resisted to several invitations from the implementing partner to take on the new position, and they also resisted encouragements from part of the new managers of the health facility. When I asked them why, one told me that it was not worth the trouble, and the other said that she wanted to continue to enjoy her weekends in peace. Now, they continue at the health facility, living the precarious life of their unlivable stipend/subsidy and a return to a position of simple counselors, while Zélia experiences another extreme of precariousness, she moved into another zone of global health abandonment, reigned by the same moral economy that does not allow her to earn a decent monetary remuneration.

But, how long will it take until the new counselors, with high education, unclear commitment to the lives and health of patients in treatment, no experience with the provision of HIV services can come up to the level of professional skills and

personal commitment that allowed the experienced counselors and activists to build professional and personal ties that have for several years contributed for retention in HIV care and treatment at the facility where I conducted fieldwork? How can we explain Zélia's experience of losing her higher paying job, for which she had all the necessary qualifications, only have to settle for a lower paying position for which she was more than professionally and academically qualified, on an extremely well-funded project?

To be sure, the other activists and counselors seem to be exposed to a risk of losing their job that can be concretized any time, and for reasons that would be legal and the Mozambican labor law, as became evident in a recent WhatsApp exchange I had with Angelina:

> Angelina: Good morning doc. How are things going over there with my nephew and niece?
> Me: Good morning Angelina. I am doing well. How about you? How about my nephews and niece?
> Angelina: Everything is ok doc.
> Me: Very good.
>
> Angelina: How is the program going?
> Me: It's moving along. I am writing up – bit my bit.
>
> Angelina: Huuuu. That's great doc. Courage. Do not give up.
> Me: Thank you so much. And how is work going? How about your classes?

> Angelina: Work is ok. Doc, they just wanted to fire us allegedly because they do not salary to pay us anymore. School is going well. I am about the receive my assignment results.

> Me: Thank you. My God – fire you? All of you? Or fire all counselors, including the new ones?
> Angelina: No. Rosalina and I only. They said that was because of old age. Kkkkkkkk.
>
> Me: With the increase in wages [nationally] did you also receive an increase. Indeed, the country must be tired of experienced people – for you to be regarded as old people. Or you lied to me about your age, when you are 50 years old or even older than that?☺ ☺☺☺☺☺☺
>
> Angelina: They will start paying us in May, the 260 Mt wage increase. Somebody helps me. It's a lie doc. I cannot lie. I will be 38 this year. I haven't even finished 25 kg of table salt. ☺ ☺☺☺☺☺☺
> They do not want to tell us the truth. It's just blackmail[19].

Discussion

The Mozambican Ministry of Health gave away to international pressure and implemented steps to meet the ambitious treatment targets. But, it used a conservative implementation approach in line with its reservations about the reasonableness of those targets.

[19] WhatsApp chat with experienced counselor, April 30, 2018.

The ambitious treatment targets created the opportunity for the pursuit of research goals based on a logic of social exclusion, by centering on a new cohort instead of improving services for people already in treatment. This reproduces a broader global dynamic, through which health systems in the global south, particularly in sub-Saharan Africa have become experimental spaces of sorts, that enable the production and extraction of a growing resource – data (Gimbel et al. 2018; Crane 2013).

It also created the opportunity for staffing changes that were not coupled with improvements in the health facility infrastructure, thus putting more pressure on an already small health facility and disrupting work routines and protocols that had been negotiated through collaborative management processes. Staffing changes also negatively impacted experienced health workers, particularly community health workers and hospital attendants, who were moved from supervising roles and from positions, and their interactions with patients they had built social relations with were reduced.

Staffing changes induced a new temporality and uncertainty, through which new hires will have to go through a process of trial and error in their new positions until the acquire the work experience that experienced community health workers and hospital attendants did over several years. How long will this experiment take,

and what impact this will have in the quality of services to patients, including on their continuing on treatment is a question worth considering with seriousness.

Staffing changes made under a biomedicalized approach to care and treatment, in the context of a technocratic effort to end AIDS without considering sociality, can break social networks of care that community health workers have built over years with people living in treatment.

CONCLUSIONS

In this dissertation, I present findings based on nearly 18 months of ethnographic research that I conducted between February 2016 and July 2017, mostly at a health facility in Maputo, Mozambique, using participant observation, ethnographic interviews and archival research. During that research I built personal relationships that allowed me to maintain communication beyond the duration of fieldwork particularly through electronic media (WhatsApp, and occasionally through email). This allowed me to keep informed about developments at the facility. This continuous engagement challenges positivist illusions about control over the tenure of fieldwork.

As a professional practice, deeply embedded in social and other relationships, fieldwork was infused with a multisitedness in which physical and virtual sites connect, and to which the contribution of research partners, through the production of ethnographic data, and their interpretation is work ever in progress. Such a recognition counters the dominant epistemological habitus within social theory that tends to regard the researcher as the sovereign subject of the process of knowledge production. This habitus is reflected in ethnographic writings, which from their very title and descriptions represent ethnographic volumes as single hero narratives. That habitus erases very important knowledge on which ethnographic research is grounded, which Foucault called “subjugated knowledges.

This dissertation tries to honor those knowledges by following anthropological proposals of "listening to the voices of community health workers" (Kenneth Maes, Closser, and Kalofonos 2014) in ways that can help understand their labor conditions (Maes, Closser, and Kalofonos 2014; Maes and Kalofonos 2013; Maes et al. 2015; Kenneth Maes 2015a, 2015b), as a way to reposition them as legitimate historical actors vested with both political (Comaroff 2007) and epistemic agency (João Biehl 2013; João Biehl and Petryna 2014; Foucault 2003).

Specifically, the dissertation makes an analytical contribution to an empirically rich, anthropological literature that has documented the scale up of antiretroviral therapy in sub-Saharan Africa. The dissertation notes that, this literature has not adequately theorized how such scale up has led to the erasure of historical connections between experienced community health workers, such as the ones I interacted with during my fieldwork, and the community-based social movement that provided home-based care for people living with HIV and AIDS before antiretroviral therapy in the 1990s and early 2000's (Chimwaza and Watkins 2004; Kloos et al. 2003; Sepulveda et al. 2003; Uys 2003; I. Kalofonos 2014a; Colvin and Swartz 2015). This disconnection fueled representations that certain local government sectors have of HIV community health workers as a creation or instruments of international NGOs or donors to undermine the principles of community involvement in health, that, partially sustain primary health care (Chilundo et al. 2015; Give et al. 2015; Perry, Zulliger, and Rogers 2014), which is the

backbone of many public health systems in the global south (Mussa et al. 2013b; Prince and Otieno 2014).

Based on these perceptions, HIV and other community health workers are still kept at the margins of the public service to which they would like to fully belong (Chilundo et al. 2015). This marginalization is aggravated by local government concerns over financial sustainability of employing such a large workforce. This particular view point resonates well with international health development ideas that Swider and Watkin (2009) (cited in Maes 2015b) aptly articulate as the:

> sustainability doctrine" – the steadfast idea that health-development projects are sustainable only when local organizations can take over the project and sustain it with local initiative and labor when donors withdraw their resources. In this approach to sustainability, creating jobs and paying local labor with international donor funds is considered a bad idea, because these expenditures cannot be sustained – when international funding is removed – by local organizations and governments that are strapped for cash and constrained by International Monetary Fund-influenced wage caps (Pfeiffer and Chapman 2010). In this framework, global donors, policymakers, and programmers must choose between job creation and sustainability; in choosing the latter, they must then rely on – and attempt to coax – local people's willingness to donate their labor (Kenneth Maes 2015b, 100).

Missing from anthropological discussion is a clear articulation of how the "sustainability doctrine" relates symbiotically with the principles of voluntariness that underlie community involvement in health - in which PHC is partially grounded – to justify the economic exploitation of already impoverished

communities and their members, several of which find a place in the global economy as community health workers.

This symbiosis seems like a subversion of the broader social justice goals that the global PHC social movement articulated in the late 1970s (WHO and UNICEF 2004) to which anthropologists still need to meaningfully follow up, as important, yet, insufficient step being proposals for future research on social inequalities (Maes 2012, 62) and policy-making and voluntarism (Maes 2015b) in our time.

Instead, I contend that the current marginalization of community health workers as part of efforts to meet the ambitious HIV treatment goals, consistent with the global discourse on ending AIDS by 2030, enacts an extraction of their labor that is not unprecedented. It reveals a neglect for knowledge and skills represented as hierarchically inferior within biomedicine and public and global health. Ultimately, this marginalization expresses an increasing role of global HIV interventions in advancing a neoliberal politics of abandonment that produces more disposable categories of human beings and that undermines the institutional conditions that can enable the implementation of equity strategies through health systems that tend to serve the most vulnerable people of the world.

In doing this, current politics around the "end of AIDS" discourse seem to have been subverted into an anti-politics that raises fundamental political and ethical

questions about the social justice rhetoric through which an important part of global health work has been justifying its influence over the last decade, particularly in countries most affected by HIV and AIDS, such as Mozambique. This raises reservations about the success of health systems strengthening efforts that rely on HIV interventions, if those interventions do not take into consideration people who have, for several years, articulated the hope for an AIDS free-generation through their care labor (experienced community health workers and other people). Reservations are also warranted about the positive impact of these interventions, if they are not implemented within the framework and traditions based on which the Mozambican health system and other health systems in the global south have been structured for decades to serve the most vulnerable people (primary healthcare).

REFERENCES

Aggleton, Peter, and Richard Parker. 2015. "Moving Beyond Biomedicalization in the HIV Response: Implications for Community Involvement and Community Leadership Among Men Who Have Sex with Men and Transgender People." *American Journal of Public Health* 105 (8): 1552–58. https://doi.org/10.2105/AJPH.2015.302614.

Akintola, Olagoke. 2008. "Unpaid HIV/AIDS Care in Southern Africa: Forms, Context, and Implications." *Feminist Economics* 14 (4): 117–147. https://doi.org/10.1080/13545700802263004.

———. 2011. "What Motivates People to Volunteer? The Case of Volunteer AIDS Caregivers in Faith-Based Organizations in KwaZulu-Natal, South Africa." *Health Policy and Planning* 26 (1): 53–62. https://doi.org/10.1093/heapol/czq019.

Audet, Carolyn, Jose Salato, and Sten Vermund. 2017. "Adapting an Adherence Support Workers Intervention: Engaging Traditional Healers as Adherence Partners for Persons Enrolled in HIV Care and Treatment in Rural Mozambique." *Implementation Science* 12 (January). https://doi.org/10.1186/s13012-017-0582-z.

Auld, Andrew F., Francisco Mbofana, Ray W. Shiraishi, Mauro Sanchez, Charity Alfredo, Lisa J. Nelson, and Tedd Ellerbrock. 2011. "Four-Year Treatment Outcomes of Adult Patients Enrolled in Mozambique's Rapidly Expanding Antiretroviral Therapy Program." Edited by Rupert Kaul. *PLoS ONE* 6 (4): e18453. https://doi.org/10.1371/journal.pone.0018453.

Bedell, Precious, John L. Wilson, Ann Marie White, and Diane S. Morse. 2015. "'Our Commonality Is Our Past:' A Qualitative Analysis of Re-Entry Community Health Workers' Meaningful Experiences." *Health & Justice* 3: 19. https://doi.org/10.1186/s40352-015-0031-5.

Bekker, Linda-Gail, George Alleyne, Stefan Baral, Javier Cepeda, Demetre Daskalakis, David Dowdy, Mark Dybul, et al. 2018. "Advancing Global Health and Strengthening the HIV Response in the Era of the Sustainable Development Goals: The International AIDS Society—Lancet Commission." *The Lancet* 392 (10144): 312–58. https://doi.org/10.1016/S0140-6736(18)31070-5.

Bemelmans, Marielle, Saar Baert, Eric Goemaere, Lynne Wilkinson, Martin Vandendyck, Gilles van Cutsem, Carlota Silva, et al. 2014. "Community-Supported Models of Care for People on HIV Treatment in Sub-Saharan Africa." *Tropical Medicine & International Health* 19 (8): 968–77. https://doi.org/10.1111/tmi.12332.

Bemelmans, Marielle, Saar Baert, Eyerusalem Negussie, Helen Bygrave, Marc Biot, Christine Jamet, Tom Ellman, Amanda Banda, Thomas van den Akker, and Nathan Ford. 2016. "Sustaining the Future of HIV Counselling to Reach 90-90-90: A Regional Country Analysis." *Journal of the International AIDS Society* 19 (1). https://doi.org/10.7448/IAS.19.1.20751.

Benson, Peter, and Stuart Kirsch. 2010. "Capitalism and the Politics of Resignation." *Current Anthropology* 51 (4): 459–486. https://doi.org/10.1086/653091.

Biehl, Joao. 2005. *VITA: Life in a Zone of Social Abandonment*. Berkeley: University of California Press.

Biehl, João. 2007. *Will to Live: AIDS Therapies and the Politics of Survival*. Princeton and Oxford: Princeton University Press.

———. 2011. "Antropologia No Campo Da Saúde Global." *Horizontes Antropológicos* 17 (35): 227–256.

———. 2013. "Ethnography in the Way of Theory." *Cultural Anthropology* 28 (4): 573–97. https://doi.org/10.1111/cuan.12028.

Biehl, João, and Adriana Petryna. 2014. "Peopling Global Health." *Saúde e Sociedade* 23 (2): 376–389. https://doi.org/10.1590/S0104-12902014000200003.

Boyles, Tom H., Lynne S. Wilkinson, Rory Leisegang, and Gary Maartens. 2011. "Factors Influencing Retention in Care after Starting Antiretroviral Therapy in a Rural South African Programme." Edited by Robert J. Wilkinson. *PLoS ONE* 6 (5): e19201. https://doi.org/10.1371/journal.pone.0019201.

Brennan, Aline, John P. Browne, and Mary Horgan. 2013. "A Systematic Review of Health Service Interventions to Improve Linkage with or Retention in HIV Care." *AIDS Care*, December, 1–9. https://doi.org/10.1080/09540121.2013.869536.

Changizi, Maryam, and Mohammad H. Kaveh. 2017. "Effectiveness of the MHealth Technology in Improvement of Healthy Behaviors in an Elderly Population—a Systematic Review." *MHealth* 3 (November). https://doi.org/10.21037/mhealth.2017.08.06.

Chilundo, Baltazar GM, Julie L. Cliff, Alda RE Mariano, Daniela C. Rodríguez, and Asha George. 2015. "Relaunch of the Official Community Health Worker Programme in Mozambique: Is There a Sustainable Basis for ICCM Policy?" *Health Policy and Planning* 30 (suppl_2): ii54–64. https://doi.org/10.1093/heapol/czv014.

Chimwaza, A. F., and S. C. Watkins. 2004. "Giving Care to People with Symptoms of AIDS in Rural Sub-Saharan Africa." *AIDS Care* 16 (7): 795–807. https://doi.org/10.1080/09540120412331290211.

Christopoulos, Katerina A, Elise D Riley, Jacqueline Tulsky, Adam W Carrico, Judith T Moskowitz, Leslie Wilson, Lara S Coffin, Veesta Falahati, Jordan Akerley, and Joan F Hilton. 2014. "A Text Messaging Intervention to Improve Retention in Care and Virologic Suppression in a U.S. Urban Safety-Net HIV Clinic: Study Protocol for the Connect4Care (C4C) Randomized Controlled Trial." *BMC Infectious Diseases* 14 (1). https://doi.org/10.1186/s12879-014-0718-6.

Claros, Joan M., Saskia de Pee, and Martin W. Bloem. 2014. "Adherence to HIV and TB Care and Treatment, the Role of Food Security and Nutrition." *AIDS and Behavior* 18 (S5): 459–64. https://doi.org/10.1007/s10461-014-0870-4.

Closser, Svea. 2015. “Pakistan’s Lady Health Worker Labor Movement and the Moral Economy of Heroism.” *Annals of Anthropological Practice* 39 (1): 16–28. https://doi.org/10.1111/napa.12061.

Colvin, Christopher J., and Alison Swartz. 2015. “Extension Agents or Agents of Change?” *Annals of Anthropological Practice* 39 (1): 29–41. https://doi.org/10.1111/napa.12062.

Comaroff, J. 2007. “Beyond Bare Life: AIDS, (Bio)Politics, and the Neoliberal Order.” *Public Culture* 19 (1): 197–219. https://doi.org/10.1215/08992363-2006-030.

Comaroff, Jean, and John Comaroff. 2003. “Ethnography on an Awkward Scale: Postcolonial Anthropology and the Violence of Abstraction.” *Ethnography* 4 (2): 147–179. https://doi.org/10.1177/14661381030042001.

Cooper, Amy. 2015. “What Does Health Activism Mean in Venezuela’s Barrio Adentro Program? Understanding Community Health Work in Political and Cultural Context.” *Annals of Anthropological Practice* 39 (1): 58–72. https://doi.org/10.1111/napa.12063.

Covane, L. A. 1996. “Migrant Labour and Agriculture in Southern Mozambique with Special Reference to the Lower Limpopo Valley 1920-1992 (BL).” ProQuest Dissertations Publishing.

Crane, Johanna Tayloe. 2013. *Scrambling for Africa: AIDS, Expertise, and the Rise of American Global Health Science*. Expertise (Ithaca, N.Y.). Ithaca: Cornell University Press.

Crawford, Robert. 1977. “You Are Dangerous to Your Health: The Ideology and Politics of Victim Blaming.” *International Journal of Health Services* 7 (4): 663–680. https://doi.org/10.2190/YU77-T7B1-EN9X-G0PN.

———. 1980. “Healthism and the Medicalization of Everyday Life.” *International Journal of Health Services* 10 (3): 365–88.

Cueto, Marcos. 2004. “The Origins of Primary Health Care and Selective Primary Health Care.(Author Abstract).” *The American Journal of Public Health* 94 (11): 1864–74. https://doi.org/10.2105/AJPH.94.11.1864.

Davis, Mike. 2003. “Planet of Slums.” *New Left Review*. http://oat.tao.ca/~jerome/Work_and_Industry/Nov8/Davis_slums.pdf.

Decroo, T., F. Rasschaert, B. Telfer, D. Remartinez, M. Laga, and N. Ford. 2013. “Community-Based Antiretroviral Therapy Programs Can Overcome Barriers to Retention of Patients and Decongest Health Services in Sub-Saharan Africa: A Systematic Review.” *International Health* 5 (3): 169–79. https://doi.org/10.1093/inthealth/iht016.

Decroo, Tom, Olivier Koole, Daniel Remartinez, Natacha Dos Santos, Sergio Dezembro, Mariano Jofrisse, Freya Rasschaert, Marc Biot, and Marie Laga. 2014. “Four-year Retention and Risk Factors for Attrition among Members of Community ART Groups in Tete, Mozambique.” *Tropical Medicine & International Health* 19 (5): 514–521. https://doi.org/10.1111/tmi.12278.

Decroo, Tom, Barbara Telfer, Marc Biot, Jacob Maïkéré, Sergio Dezembro, Luisa Isabel Cumba, Carla Das Dores, Kathryn Chu, and Nathan Ford. 2011.

"Distribution of Antiretroviral Treatment through Self-Forming Groups of Patients in Tete Province, Mozambique." *Journal of Acquired Immune Deficiency Syndromes (1999)* 56 (2): e39-44. https://doi.org/10.1097/QAI.0b013e3182055138.

"Durkheim (1893a) Divison of Labor (C.2 Mechanical Solidarity).Pdf." n.d.

Epstein, Steven. 1996. *Impure Science: AIDS, Activism, and the Politics of Knowledge*. Medicine and Society ; 7. Berkeley: University of California Press.

Fassin, Didier. 2012. *Humanitarian Reason: A Moral History of the Present Times*. Berkeley: University of California Press. http://dx.doi.org/10.1525/california/9780520271166.001.0001.

Ferguson, James. 1990. *The Anti-Politics Machine: "Development", Depoliticization and Bureaucratic Power in Lesotho*. Cambridge: Cambridge University Press.

Ferguson, James, and Akhil Gupta. 2002. "Spatializing States: Toward an Ethnography of Neoliberal Governmentality." *American Ethnologist* 29 (4): 981–1002. https://doi.org/10.1525/ae.2002.29.4.981.

Foucault, Michel. 1988. *The History of Sexuality*. 1st Vintage Books ed. New York: Vintage Books.

———. 2003. *Society Must Be Defended : Lectures at the Collège de France, 1975-76*. Edited by Mauro Bertani, Alessandro Fontana, and François Ewald. Translated by David Macey. New York: Picador.

———. 2009. *Security, Territory, Population: Lectures at the Collège de France*. Basingstoke: Palgrave Macmillan.

Frankenberg, Ronald. 1988. "Gramsci, Culture, and Medical Anthropology: Kundry and Parsifal? Or Rat's Tail to Sea Serpent?" *Medical Anthropology Quarterly* 2 (4): 324–337.

Frenk, Julio. 2010. "The Global Health System: Strengthening National Health Systems as the Next Step for Global Progress." *PLoS Medicine* 7 (1): e1000089. https://doi.org/10.1371/journal.pmed.1000089.

Gimbel, Sarah, Baltazar Chilundo, Nora Kenworthy, Celso Inguane, David Citrin, Rachel Chapman, Kenneth Sherr, and James Pfeiffer. 2018. "Donor Data Vacuuming: Audit Culture and the Use of Data in Global Heath Partnerships." *Medicine Anthropology Theory | An Open-Access Journal in the Anthropology of Health, Illness, and Medicine* 5 (2): 99. https://doi.org/10.17157/mat.5.2.537.

Give, Celso Soares, Mohsin Sidat, Hermen Ormel, Sozinho Ndima, Rosalind McCollum, and Miriam Taegtmeyer. 2015. "Exploring Competing Experiences and Expectations of the Revitalized Community Health Worker Programme in Mozambique: An Equity Analysis." *Human Resources for Health* 13 (September): 54. https://doi.org/10.1186/s12960-015-0044-0.

Govindasamy, Darshini, Nathan Ford, and Katharina Kranzer. 2012. "Risk Factors, Barriers and Facilitators for Linkage to Antiretroviral Therapy Care: A Systematic Review." *AIDS* 26 (16): 2059–67. https://doi.org/10.1097/QAD.0b013e3283578b9b.

Granjo, Paulo. 2009. "Saúde e Doença Em Moçambique" 18 (4): 567–581. https://doi.org/10.1590/S0104-12902009000400002.

Greenspan, Jesse A., Shannon A. McMahon, Joy J. Chebet, Maurus Mpunga, David P. Urassa, and Peter J. Winch. 2013. "Sources of Community Health Worker Motivation: A Qualitative Study in Morogoro Region, Tanzania." *Human Resources for Health* 11 (October): 52. https://doi.org/10.1186/1478-4491-11-52.

Hardon, A. P., D. Akurut, C. Comoro, C. Ekezie, H. F. Irunde, T. Gerrits, J. Kglatwane, et al. 2007. "Hunger, Waiting Time and Transport Costs: Time to Confront Challenges to ART Adherence in Africa." *AIDS Care* 19 (5): 658–65. https://doi.org/10.1080/09540120701244943.

Harvey, David. 2007. "Neoliberalism as Creative Destruction." *The Annals of the American Academy of Political and Social Science* 610 (1): 21–44. https://doi.org/10.1177/0002716206296780.

Hirsch, Jennifer S., Richard G. Parker, and Peter Aggleton. 2007. "Social Aspects of Antiretroviral Therapy Scale-up: Introduction and Overview." *AIDS* 21: S1–S4.

Holtzman, Carol W., Judy A. Shea, Karen Glanz, Lisa M. Jacobs, Robert Gross, Janet Hines, Karam Mounzer, Rafik Samuel, Joshua P. Metlay, and Baligh R. Yehia. 2015. "Mapping Patient-Identified Barriers and Facilitators to Retention in HIV Care and Antiretroviral Therapy Adherence to Andersen's Behavioral Model." *AIDS Care* 27 (7): 817–28. https://doi.org/10.1080/09540121.2015.1009362.

Honwana, Alcinda. 1996. "Spiritual Agency and Self-Renewal in Southern Mozambique." London: University of London.

Hyden, Goran. 2006. "The Economy of Affection." In *African Politics in Comparative Perspective*, 72–93. Cambridge, New York: Cambridge University Press.

Illich, Ivan. 1976. *Medical Nemesis: The Expropriation of Health*. New York: Pantheon Books.

ILO. 2012. "International Standard Classification of Occupations: Structure, Group Definitions and Correspondence Tables." ILO. https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_172572.pdf.

———. 2018. *Care Work and Care Jobs for the Future of Decent Work*. Geneva: International Labour Office. https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_633135.pdf.

INE. 2016. "Relatório Final do Inquérito ao Orçamento Familiar- IOF 2014/15, Quadros Básicos."

———. 2017. "Vamos Todos Contar Moçambique: REsultados Prelominares, Censo 2017 e Definitivos de 2007 e 1997."

Inguane, Celso Azarias, Stephen Gloyd, João Luis Manuel, Charlene Brown, Vincent Wong, Orvalho Augusto, Wisal Mustafa Hassan, et al. 2016. "Assessment of Linkages from HIV Testing to Enrolment and Retention in

HIV Care in Central Mozambique." *Journal of the International AIDS Society* 19 (S4): n/a–n/a. https://doi.org/10.7448/IAS.19.5.20846.

INS, INE, and ICF. 2018. "Inquérito de Indicadores de Imunização, Malária e HIV/SIDA Em Moçambique (IMASIDA) 2015." 2018. https://dhsprogram.com/publications/publication-AIS12-AIS-Final-Reports.cfm.

Iwu, Emilia Ngozi, and William L. Holzemer. 2014. "Task Shifting of HIV Management from Doctors to Nurses in Africa: Clinical Outcomes and Evidence on Nurse Self-Efficacy and Job Satisfaction." *AIDS Care* 26 (1): 42–52. https://doi.org/10.1080/09540121.2013.793278.

Kalofonos, Ippolytos. 2014a. "'All They Do Is Pray': Community Labour and the Narrowing of 'Care' during Mozambique's HIV Scale-Up." *Global Public Health* 9 (1–2): 7–24. https://doi.org/10.1080/17441692.2014.881527.

———. 2014b. "'All They Do Is Pray': Community Labour and the Narrowing of 'Care' during Mozambique's HIV Scale-Up." *Global Public Health* 9 (1–2): 7–24. https://doi.org/10.1080/17441692.2014.881527.

Kalofonos, Ippolytos Andreas. 2010. "'All I Eat Is ARVs':: The Paradox of AIDS Treatment Interventions in Central Mozambique." *Medical Anthropology Quarterly* 24 (3): 363–80. https://doi.org/10.1111/j.1548-1387.2010.01109.x.

Kay, Adrian, and Owain David Williams. 2009. *Global Health Governance: Crisis, Institutions, and Political Economy*. International Political Economy Series (Palgrave Macmillan (Firm)). Basingstoke: Palgrave Macmillan.

Kelly, J. Daniel, Christine Hartman, James Graham, Michael A. Kallen, and Thomas P. Giordano. 2014. "Social Support as a Predictor of Early Diagnosis, Linkage, Retention, and Adherence to HIV Care: Results From The Steps Study." *Journal of the Association of Nurses in AIDS Care* 25 (5): 405–13. https://doi.org/10.1016/j.jana.2013.12.002.

Kenworthy, Nora J., and Richard Parker. 2014. "HIV Scale-up and the Politics of Global Health." *Global Public Health* 9 (1–2): 1–6. https://doi.org/10.1080/17441692.2014.880727.

Kenworthy, Nora, Matthew Thomann, and Richard Parker. 2018a. "Critical Perspectives on the 'End of AIDS.'" *Global Public Health* 13 (8): 957–59. https://doi.org/10.1080/17441692.2018.1464589.

———. 2018b. "From a Global Crisis to the 'End of AIDS': New Epidemics of Signification." *Global Public Health* 13 (8): 960–71. https://doi.org/10.1080/17441692.2017.1365373.

Kloos, Helmut, Tadesse Wuhib, Damen Haile Mariam, and Bernt Lindtjorn. 2003. "Community Based Organizations in HIV/AIDS Prevention, Patient. Care and Control in Ethiopia." *Ethiopian Journal of Health Development* 17 (4). https://doi.org/10.4314/ejhd.v17i4.9819.

Konkle-Parker, Deborah J., Judith A. Erlen, Patricia M. Dubbert, and Warran May. 2012. "Pilot Testing of an HIV Medication Adherence Intervention in a Public Clinic in the Deep South: Pilot Testing of an HIV Medication."

Journal of the American Academy of Nurse Practitioners 24 (8): 488–98. https://doi.org/10.1111/j.1745-7599.2012.00712.x.

Kredo, Tamara, Folasade B Adeniyi, Moses Bateganya, and Elizabeth D Pienaar. 2014. “Task Shifting from Doctors to Non-Doctors for Initiation and Maintenance of Antiretroviral Therapy.” In *Cochrane Database of Systematic Reviews*, edited by The Cochrane Collaboration. Chichester, UK: John Wiley & Sons, Ltd. http://doi.wiley.com/10.1002/14651858.CD007331.pub3.

Kredo, Tamara, Nathan Ford, Folasade B Adeniyi, and Paul Garner. 2013. “Decentralising HIV Treatment in Lower- and Middle-Income Countries.” In *Cochrane Database of Systematic Reviews*, edited by The Cochrane Collaboration. Chichester, UK: John Wiley & Sons, Ltd. http://doi.wiley.com/10.1002/14651858.CD009987.pub2.

Lafort, Yves, Aleny Couto, Ute Sunderbrink, Roxanne Hoek, Estifanos Shargie, Jinkou Zhao, Kirsi Viisainen, and Bertha Simwaka. 2018. “Validity of Reported Retention in Antiretroviral Therapy after Roll-out to Peripheral Facilities in Mozambique: Results of a Retrospective National Cohort Analysis.” *PLOS ONE* 13 (6): e0198916. https://doi.org/10.1371/journal.pone.0198916.

Lambdin, Barrot H., Mark A. Micek, Kenneth Sherr, Sarah Gimbel, Marina Karagianis, Joseph Lara, Stephen S. Gloyd, and James Pfeiffer. 2013. “Integration of HIV Care and Treatment in Primary Health Care Centers and Patient Retention in Central Mozambique: A Retrospective Cohort Study.” *JAIDS Journal of Acquired Immune Deficiency Syndromes* 62 (5): e146–e152.

Lazar, Sian. 2013. *The Anthropology of Citizenship: A Reader*. First edition. Wiley Blackwell Anthologies in Social and Cultural Anthropology. Hoboken, NJ: Wiley-Blackwell.

Lefeuvre, Delphine, Mamadou Dieng, Farid Lamara, Gilles Raguin, and Christophe Michon. 2014. “[Community health workers in HIV/AIDS care].” *Sante Publique (Vandoeuvre-Les-Nancy, France)* 26 (6): 879–88.

Lemke, Thomas. 2001. “‘The Birth of Bio-Politics’: Michel Foucault’s Lecture at the Collège de France on Neo-Liberal Governmentality.” *Economy and Society* 30 (2): 190–207. https://doi.org/10.1080/03085140120042271.

Livingston, Julie. 2012. *Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic*. Duke University Press.

Long, Nicholas J., and Henrietta L. Moore. 2013. *Sociality: New Directions*. Wyse Series in Social Anthropology ; v. 1. New York: Berghahn Books. http://public.eblib.com/choice/publicfullrecord.aspx?p=1094723.

Ma, Qingyan, Lai Sze Tso, Zachary C. Rich, Brian J. Hall, Rachel Beanland, Haochu Li, Mellanye Lackey, et al. 2016. “Barriers and Facilitators of Interventions for Improving Antiretroviral Therapy Adherence: A Systematic Review of Global Qualitative Evidence.” *Journal of the International AIDS Society* 19 (1): 21166. https://doi.org/10.7448/IAS.19.1.21166.

Maes, K., S. Closser, E. Vorel, and Y. Tesfaye. 2015. "Using Community Health Workers: Discipline and Hierarchy in Ethiopia's Women's Development Army Ethiopia's Women's Development Army." *Annals of Anthropological Practice* 39 (1): 42–57. https://doi.org/10.1111/napa.12064.

Maes, Kenneth. 2012. "Volunteerism or Labor Exploitation? Harnessing the Volunteer Spirit to Sustain AIDS Treatment Programs in Urban Ethiopia." *Human Organization* 71 (1): 54–64.

———. 2015a. "Community Health Workers and Social Change:" *Annals of Anthropological Practice* 39 (1): 1–15. https://doi.org/10.1111/napa.12060.

———. 2015b. "'Volunteers Are Not Paid Because They Are Priceless': Community Health Worker Capacities and Values in an AIDS Treatment Intervention in Urban Ethiopia." *Medical Anthropology Quarterly* 29 (1): 97–115. https://doi.org/10.1111/maq.12136.

———. 2017. *The Lives of Community Health Workers: Local Labor and Global Health in Urban Ethiopia*. Anthropology and Global Public Health. New York, New York ; London, [England]: Routledge. http://lib.myilibrary.com?id=974140.

Maes, Kenneth, Svea Closser, and Ippolytos Kalofonos. 2014. "Listening to Community Health Workers: How Ethnographic Research Can Inform Positive Relationships among Community Health Workers, Health Institutions, and Communities." *American Journal of Public Health* 104 (5): e5-9. https://doi.org/10.2105/AJPH.2014.301907.

Maes, Kenneth, and Ippolytos Kalofonos. 2013. "Becoming and Remaining Community Health Workers: Perspectives from Ethiopia and Mozambique." *Social Science & Medicine (1982)* 87 (June): 52–59. https://doi.org/10.1016/j.socscimed.2013.03.026.

Marsland, Rebecca. 2012. "(Bio)Sociality and HIV in Tanzania: Finding a Living to Support a Life." *Medical Anthropology Quarterly* 26 (4): 470–485. https://doi.org/10.1111/maq.12002.

Marx, Karl. 1973. *Grundrisse. Foundations of the Critique of Political Economy.* [1st American ed.]. The Marx Library. New York: Random House.

———. 1977. *Capital: A Critique of Political Economy*. Vintage books ed. New York: Vintage Books.

Mattes, Dominik. 2011. "'We Are Just Supposed to Be Quiet': The Production of Adherence to Antiretroviral Treatment in Urban Tanzania." *Medical Anthropology* 30 (2): 158–82. https://doi.org/10.1080/01459740.2011.552454.

Mauss, Marcel. 1950. *The Gift : The Form and Reason for Exchange in Archaic Societies*. Translated by H.D. Halls. New York: W.W. Norton.

Mbembe, Achille. 2017. *Critique of Black Reason*. John Hope Franklin Center Book. Durham: Duke University Press.

Mbilinyi, Deogratius, Marguerite Daniel, and Gro Th Lie. 2011. "Health Worker Motivation in the Context of HIV Care and Treatment Challenges in Mbeya Region, Tanzania: A Qualitative Study." *BMC Health Services Research* 11 (January): 266. https://doi.org/10.1186/1472-6963-11-266.

McKay, Ramah. 2012. “Documentary Disorders: Managing Medical Multiplicity in Maputo, Mozambique.” *American Ethnologist* 39 (3): 545–61. https://doi.org/10.1111/j.1548-1425.2012.01380.x.

Mckay, Ramah. 2016. “The View from the Middle: Lively Relations of Care, Class, and Medical Labour in Maputo.” *Critical African Studies* 8 (3): 278–290. https://doi.org/10.1080/21681392.2016.1233504.

Ministério da Saúde, Direcção Nacional de Saúde Pública, and Programa Nacional de Controlo da Tuberculose. 2015. “Relatórios das Actividades Desenvolvidas durante o ano 2014.” Maputo City: MISAU.

MISAU. 2002. *Diploma Ministeria no. 127/2002:, de 31 de Julho, Caracterizacao tecnica, enunciado de funcoes, criterios e mecanismos para a classificacao das instituicoes do SNS de nivel primario*.

———. 2007. “Estrategia de envolvimento comunitario aprovada 2004 rev 2007-em revisão.doc.” MISAU.

———. 2011. “Relatório de Retenção TARV: Analise de Retenção aos 12 Meses dos Pacientes que Iniciaram TARV em Junho de 2009.” Cidade de Maputo: MISAU.

———. 2015. “Relatório Anual. Relatório Anual das Actividades Referentes ao HIV/SIDA.” MISAU, Maputo, Mozambique.

———. n.d. *Cuidados de Saude Primarios em Moçambique*. Maputo.

MISAU, and DNAM. 2014. “Guia de Tratamento Antiretroviral e Infecções Oportunistas no Adulto, Criança, Adolescente e Grávida, 2013.” MISAU.

MISAU, DNSP. 2010. “Programa de Revitalizacao dos Agentes Polivalentes Elementares.” MISAU.

———. 2017. “Estrategia Do Programa Nacional Dos Agentes Polivalentes Elementares (APEs), 2018-2024.” MISAU.

MISAU, DPC. 2014. “Rede sanitaria: todas entidades definidas no Sistema. Periodo de 1/2014 a 5/2014.” MISAU.

MISAU, Programa Nacional de Controlo de ITS-HIV/SID. 2013. “Guiao do Arquivo para os Cuidados e Tratamento de HIV.” MISAU.

———. 2014. “Relatório de Actividades Desenvolvidas durante o Ano de 2013.” Maputo City: MISAU.

MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA. 2014. “Guia de Tratamento Antiretroviral e Infeccoes Oportunistas no Adulto, Adolescente, Gravida e Crianca, 2014.” MISAU.

———. 2015a. “Directriz Nacional de Apoio Psicossocial e Prevenção Posi va (APSS & PP), 2015.” MISAU.

———. 2015b. “Directriz Nacional para Implementação do Aconselhamento e Testagem em Saúde.” MISAU.

———. 2015c. “Directriz Nacional para Implementação do Aconselhamento e Testagem em Saúde. Moçambique: MISAU/DNAM - 2015.” MISAU.

———. 2016. “Guiao de Implementacao Da Abordagem Do Testar e Iniciar.”

———. 2018. “Relatório Anual 2017: Relatório Anual das Actividades Relacionadas ao HIV/SIDA.” Maputo City.

MISAU, Programa Nacional de Controlo de ITS-HIV/SIDA 2016. 2015. "Relatório AQD-HIV 2014 Relatório da Ronda Piloto Nacional da Avaliação da Qualidade de Dados." Cidade de Maputo: MISAU.

Mitchell, J Clyde, ed. 1969. *Social Networks in Urban Situations: Analyses of Personal Relationships in Central African Towns*. Manchester: Manchester University Press.

Mitchell, Katharyne, and Matthew Sparke. 2016. "The New Washington Consensus: Millennial Philanthropy and the Making of Global Market Subjects." *Antipode* 48 (3): 724–749. https://doi.org/10.1111/anti.12203.

Moçambique, Governo. 2007. *Lei no. 23/2007: Aprova a Lei do Trabalho e revoga a Lei n.º 8/98, de 20 de Julho*.

Moçambique, Ministério da Economia e Financas. 2017. *Despacho: Tabela Salarial a Aplicar Aos Funcionarips e Agentes Do Estado, Baseado No Artigo No.. 5 Do Decreto No. 15/2017, de 18 de Maio*.

Mussa, Abdul H, James Pfeiffer, Stephen S Gloyd, and Kenneth Sherr. 2013a. "Vertical Funding, Non-Governmental Organizations, and Health System Strengthening: Perspectives of Public Sector Health Workers in Mozambique." *Human Resources for Health* 11 (1). https://doi.org/10.1186/1478-4491-11-26.

———. 2013b. "Vertical Funding, Non-Governmental Organizations, and Health System Strengthening: Perspectives of Public Sector Health Workers in Mozambique." *Human Resources for Health* 11 (1). https://doi.org/10.1186/1478-4491-11-26.

Mwai, Grace W., Gitau Mburu, Kwasi Torpey, Peter Frost, Nathan Ford, and Janet Seeley. 2013. "Role and Outcomes of Community Health Workers in HIV Care in Sub-Saharan Africa: A Systematic Review." *Journal of the International AIDS Society* 16 (1): 18586. https://doi.org/10.7448/IAS.16.1.18586.

n.a. 2006. "Proposta: O papel do conselheiro polivalente no ambito do ATS, 12 de Zembro de 2006."

———. 2016. "Estrategia de revitalizacao e expansao da abordagem de educadores de saude, 5 de Dezembro de 2016."

Nader, Laura. 1972. "Up the Anthropologist: Perspectives Gained from Studying Up." http://eric.ed.gov/?id=ED065375.

———. 2011. "Ethnography as Theory *." *HAU: Journal of Ethnographic Theory* 1 (1): 211–219. https://doi.org/10.14318/hau1.1.008.

Naslund, John A., Jodie Dionne-Odom, Cléonas Junior Destiné, Kristen M. Jogerst, Redouin Renold Sénécharles, Michelande Jean Louis, Jasmin Desir, et al. 2014. "Adapting and Implementing a Community Program to Improve Retention in Care among Patients with HIV in Southern Haiti: 'Group of 6.'" *AIDS Research and Treatment* 2014: 1–9. https://doi.org/10.1155/2014/137545.

Newell, Kenneth W., ed. 1975. *Health by the People*. Geneva : [Albany, N.Y: World Health Organization ; obtainable from Q Corp.].

Newitt, M. D. D. 1995. *A History of Mozambique*. London: Hurst & Co.

Nguyen, Vinh-Kim. 2010. *The Republic of Therapy: Triage and Sovereignty in West Africa's Time of AIDS*. Body, Commodity, Text. Durham [N.C.]: Duke University Press. http://public.eblib.com/choice/publicfullrecord.aspx?p=1172317.

Nguyen, Vinh-Kim, Cyriaque Yapo Ako, Pascal Niamba, Aliou Sylla, and Issoufou Tiendrébéogo. 2007. "Adherence as Therapeutic Citizenship: Impact of the History of Access to Antiretroviral Drugs on Adherence to Treatment." *AIDS (London, England)* 21 Suppl 5 (Suppl 5): S31-5. https://doi.org/10.1097/01.aids.0000298100.48990.58.

Nhavoto, José António, Åke Grönlund, and Walter Ponce Chaquilla. 2015. "SMSaúde: Design, Development, and Implementation of a Remote/Mobile Patient Management System to Improve Retention in Care for HIV/AIDS and Tuberculosis Patients." *JMIR MHealth and UHealth* 3 (1): e26. https://doi.org/10.2196/mhealth.3854.

Olaniran, Abimbola, Helen Smith, Regine Unkels, Sarah Bar-Zeev, and Nynke van den Broek. 2017. "Who Is a Community Health Worker? – A Systematic Review of Definitions." *Global Health Action* 10 (1): 1272223. https://doi.org/10.1080/16549716.2017.1272223.

Olsen, Bent. 2013. "Structures of Stigma: Diagonal AIDS Care and Treatment Abandonment in Mozambique." Roskilde: Roskilde Universitet, Institut for Samfund og Globalisering.

Ooms, Gorik, Wim Van Damme, Brook K Baker, Paul Zeitz, and Ted Schrecker. 2008. "The 'diagonal' Approach to Global Fund Financing: A Cure for the Broader Malaise of Health Systems?" *Globalization and Health* 4 (1): 6. https://doi.org/10.1186/1744-8603-4-6.

Pecoraro, Anna, Matthew J. Mimiaga, Conall O'Cleirigh, Steven A. Safren, Elena Blokhina, Elena Verbitskaya, Evgeny Krupitsky, Sergii Dvoriak, and George Woody. 2014. "Lost-to-Care and Engaged-in-Care HIV Patients in Leningrad Oblast, Russian Federation: Barriers and Facilitators to Medical Visit Retention." *AIDS Care* 26 (10): 1249–57. https://doi.org/10.1080/09540121.2014.897910.

Perry, Henry B., Rose Zulliger, and Michael M. Rogers. 2014. "Community Health Workers in Low-, Middle-, and High-Income Countries: An Overview of Their History, Recent Evolution, and Current Effectiveness." *Annual Review of Public Health* 35 (1): 399–421. https://doi.org/10.1146/annurev-publhealth-032013-182354.

Petryna, Adriana. 2013. *Life Exposed: Biological Citizens after Chernobyl*. New ed. / with a new introduction by the author. Princeton, N.J. ; Woodstock: Princeton University Press. http://public.eblib.com/choice/publicfullrecord.aspx?p=1053774.

Pfeiffer, James, and Rachel Chapman. 2010. "Anthropological Perspectives on Structural Adjustment and Public Health." *Annual Review of Anthropology* 39 (1): 149–65. https://doi.org/10.1146/annurev.anthro.012809.105101.

———. 2015. "An Anthropology of Aid in Africa." *The Lancet* 385 (9983): 2144–2145.

Pfeiffer, James, Sarah Gimbel, Baltazar Chilundo, Stephen Gloyd, Rachel Chapman, and Kenneth Sherr. 2017. "Austerity and the 'Sector-Wide Approach' to Health: The Mozambique Experience." *Social Science & Medicine* 187: 208–216. https://doi.org/10.1016/j.socscimed.2017.05.008.

Pfeiffer, James, Pablo Montoya, Alberto J. Baptista, Marina Karagianis, Marilia de Morais Pugas, Mark Micek, Wendy Johnson, et al. 2010. "Integration of HIV/AIDS Services into African Primary Health Care: Lessons Learned for Health System Strengthening in Mozambique-a Case Study." *Journal of the International AIDS Society* 13 (1): 3.

Philips, Mit, Rony Zachariah, and Sarah Venis. 2008a. "Task Shifting for Antiretroviral Treatment Delivery in Sub-Saharan Africa: Not a Panacea." *The Lancet* 371 (9613): 682–684.

———. 2008b. "Task Shifting for Antiretroviral Treatment Delivery in Sub-Saharan Africa: Not a Panacea." *The Lancet* 371 (9613): 682–684. https://doi.org/10.1016/S0140-6736(08)60307-4.

"Primary Health Care Comes Full Circle." 2008. *Bulletin of the World Health Organization* 86 (10): 747–48. https://doi.org/10.2471/BLT.08.041008.

Prince, Ruth J., and Phelgona Otieno. 2014. "In the Shadowlands of Global Health: Observations from Health Workers in Kenya." *Global Public Health* 9 (8): 927–45. https://doi.org/10.1080/17441692.2014.941897.

Public Health Professionals. n.d. "Improving TB Treatment and Retention in Mozambique - Mobile Health Without Borders | NovoEd." https://novoed.com/mhealth/reports/52079.

Rabinow, P. 2010. "Artificiality and Enlightment: From Sociobiology to Biosociality." *Politix* 23 (90): 21–+. https://doi.org/10.3917/pox.090.0021.

Rabinow, Paul. 1996. "Artificiality and Enlightenment: From Sociobiology to Biosociality." In *Essays on the Anthropology of Reason*, 91–111. Princeton: Princeton University Press.

Rasschaert, Freya, Barbara Telfer, Faustino Lessitala, Tom Decroo, Daniel Remartinez, Marc Biot, Baltazar Candrinho, Francisco Mbofana, and Wim Van Damme. 2014. "A Qualitative Assessment of a Community Antiretroviral Therapy Group Model in Tete, Mozambique." Edited by Paula Braitstein. *PLoS ONE* 9 (3): e91544. https://doi.org/10.1371/journal.pone.0091544.

Rose, Nicholas, and Carlos Novas. 2005. "Biological Citizenship." In *Global Assemblages : Technology, Politics, and Ethics as Anthropological Problems*, edited by Aihwa Ong and Stephen Collier, 494. Malden: Blackwell Publishing Ltd.

Rose, Nikolas, and Carlos Novas. 2004. *Biological Citizenship*. Blackwell Publishing. http://planetarities.web.unc.edu/files/2015/04/RoseandNovasBiologicalCitizenship2002.pdf.

Rosen, Sydney, and Matthew P. Fox. 2011. "Retention in HIV Care between Testing and Treatment in Sub-Saharan Africa: A Systematic Review." Edited by John

Bartlett. *PLoS Medicine* 8 (7): e1001056. https://doi.org/10.1371/journal.pmed.1001056.
Roura, Maria, Joanna Busza, Alison Wringe, Doris Mbata, Mark Urassa, and Basia Zaba. 2009. "Barriers to Sustaining Antiretroviral Treatment in Kisesa, Tanzania: A Follow-up Study to Understand Attrition from the Antiretroviral Program." *AIDS Patient Care and STDs* 23 (3): 203–210.
Rouse, Carolyn. 2010. "Patient and Practitioner Noncompliance: Rationing, Therapeutic Uncertainty, and the Missing Conversation." *Anthropology & Medicine* 17 (2): 187–200. https://doi.org/10.1080/13648470.2010.493602.
Rowan, Sarah E., William J. Burman, Steven C. Johnson, Elizabeth Connick, Daniel Reirden, Elaine Daniloff, and Edward M. Gardner. 2014. "Engagement-in-Care During the First 5 Years After HIV Diagnosis: Data from a Cohort of Newly HIV-Diagnosed Individuals in a Large US City." *AIDS Patient Care and STDs* 28 (9): 475–82. https://doi.org/10.1089/apc.2013.0340.
Sands, Peter. 2018. "HIV: From Exceptionalism to Endgame." *The Lancet* 392 (10144): 261–62. https://doi.org/10.1016/S0140-6736(18)31434-X.
Sangaramoorthy, Thurka. 2018. "Chronicity, Crisis, and the 'End of AIDS.'" *Global Public Health* 13 (8): 982–96. https://doi.org/10.1080/17441692.2018.1423701.
Scott, James. 1985. *Weapons of the Weak Everyday Forms of Peasant Resistance*. New Haven: Yale University Press.
SDSMAS/DSCM. 2014. "Reconhecimento da Areas de Saude do Centro de Saude (hea;th faco;oty name concealed for ethical reasons)." SDSMAS/DSCM.
Sepulveda, Cecilia, Vincent Habiyambere, Jacinto Amandua, Margaret Borok, Ekie Kikule, Barbara Mudanga, Twalib Ngoma, and Bogale Solomon. 2003. "Quality Care at the End of Life in Africa." *BMJ* 327 (7408): 209–13. https://doi.org/10.1136/bmj.327.7408.209.
Shepherd, B. E., M. Blevins, L. M. E. Vaz, T. D. Moon, A. M. Kipp, E. Jose, F. G. Ferreira, and S. H. Vermund. 2013. "Impact of Definitions of Loss to Follow-up on Estimates of Retention, Disease Progression, and Mortality: Application to an HIV Program in Mozambique." *American Journal of Epidemiology* 178 (5): 819–28. https://doi.org/10.1093/aje/kwt030.
Sherr, Kenneth, Fatima Cuembelo, Cathy Michel, Sarah Gimbel, Mark Micek, Marina Kariaganis, Alusio Pio, João L. Manuel, James Pfeiffer, and Stephen Gloyd. 2013. "Strengthening Integrated Primary Health Care in Sofala, Mozambique." *BMC Health Services Research* 13 (Suppl 2): S4.
Singer, Merril. 1987. "Cure, Care, and Control: An Ectopic Encounter with Biomedical Obstetrics." In *Encounters with Biomedicine: Case Studies in Medical Anthropology*, 249–65. New York, London, Paris, Montreux, Tokyo, Melbourne: Gordon and Breach Science Publishers.
Storeng, Katerini T., and Arima Mishra. 2014. "Politics and Practices of Global Health: Critical Ethnographies of Health Systems." *Global Public Health* 9 (8): 858–64. https://doi.org/10.1080/17441692.2014.941901.
Stricker, Sebastian M., Kathleen A. Fox, Rachel Baggaley, Eyerusalem Negussie, Saskia de Pee, Nils Grede, and Martin W. Bloem. 2014. "Retention in Care

and Adherence to ART Are Critical Elements of HIV Care Interventions." *AIDS and Behavior* 18 (S5): 465–75. https://doi.org/10.1007/s10461-013-0598-6.

Swidler, Ann, and Susan Cotts Watkins. 2009. "'Teach a Man to Fish': The Sustainability Doctrine and Its Social Consequences." World Development 37 (7): 1182–96. https://doi.org/10.1016/j.worlddev.2008.11.002.

The Lancet Global Health. 2017. "Community Health Workers: Emerging from the Shadows?" *The Lancet Global Health* 5 (5): e467. https://doi.org/10.1016/S2214-109X(17)30152-3.

Ticktin, Miriam. 2014. "Transnational Humanitarianism." *Annual Review of Anthropology* 43 (1): 273–89. https://doi.org/10.1146/annurev-anthro-102313-030403.

Ticktin, Miriam Iris. 2011. *Casualties of Care: Immigration and the Politics of Humanitarianism in France*. Berkeley: University of California Press.

Tomori, Cecilia, Caitlin E. Kennedy, Heena Brahmbhatt, Jennifer A. Wagman, Jessie K. Mbwambo, Samuel Likindikoki, and Deanna L. Kerrigan. 2014. "Barriers and Facilitators of Retention in HIV Care and Treatment Services in Iringa, Tanzania: The Importance of Socioeconomic and Sociocultural Factors." *AIDS Care* 26 (7): 907–13. https://doi.org/10.1080/09540121.2013.861574.

Topp, Stephanie M., Jessica E. Price, Tina Nanyangwe-Moyo, Drosin M. Mulenga, Mardieh L. Dennis, and Mathew M. Ngunga. 2015. "Motivations for Entering and Remaining in Volunteer Service: Findings from a Mixed-Method Survey among HIV Caregivers in Zambia." *Human Resources for Health* 13 (September): 72. https://doi.org/10.1186/s12960-015-0062-y.

Trostle, James. 1988. "Medical Compliance as an Ideology" 27 (12): 1299–1308.

UNAIDS. 2014. "Ambitious Treatment Targets: Writing the Final Chapter of the AIDS Epidemic." UNAIDS, Geneva, Switzerland. http://www.unaids.org/en/resources/documents/2014/90-90-90.

http://www.unaids.org/en/resources/documents/2014/90-90-90.

UNAIDS, El. 2018. "UNAIDS Data 2018," 376.

Uys, Leana R. 2003. "Aspects of the Care of People with HIV/AIDS in South Africa." *Public Health Nursing* 20 (4): 271–280. https://doi.org/10.1046/j.1525-1446.2003.20404.x.

Vander Meulen, Rebecca J., Amy S. Patterson, and Marian Burchardt. 2013. "HIV/AIDS Activism, Framing and Identity Formation in Mozambique's Equipas de Vida." *Canadian Journal of African Studies/ La Revue Canadienne Des Études Africaines* 47 (2): 249–272. https://doi.org/10.1080/00083968.2013.829955.

Waldrop-Valverde, Drenna, Ying Guo, Raymond L. Ownby, Allan Rodriguez, and Deborah L. Jones. 2014. "Risk and Protective Factors for Retention in HIV Care." *AIDS and Behavior* 18 (8): 1483–91. https://doi.org/10.1007/s10461-013-0633-7.

Werbner, Richard. 2004. *Reasonable Radicals and Citizenship in Botswana: The Public Anthropology of Kalanga Elites*. Indiana University Press. +are%22+&ots=ljaixNhCze&sig=MVhmLw8EVo6r3c_hOpfhu-HYFrA.

WHO, PEPFAR, and UNAIDS. 2007. "Task Shifting: Rational Redistribution of Tasks among Health Workforce Teams: Global Recommendations and Guidelines." http://apps.who.int/iris/handle/10665/43821.

WHO, and UNICEF. 2004. "Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978." *Development* 47 (2): 159–61. https://doi.org/10.1057/palgrave.development.1100047.

Wilkinson, Ls. 2013. "ART Adherence Clubs: A Long-Term Retention Strategy for Clinically Stable Patients Receiving Antiretroviral Therapy." *Southern African Journal Of Hiv Medicine* 14 (2): 48–50. https://doi.org/10.7196/SAJHIVMED.924.

Wilkinson, Lynne Susan. 2013. "ART Adherence Clubs: A Long-Term Retention Strategy for Clinically Stable Patients Receiving Antiretroviral Therapy." *Southern African Journal of HIV Medicine* 14 (2): 48. https://doi.org/10.7196/sajhivmed.924.

World Health Organization, and Department of HIV/AIDS. 2015. *Consolidated Strategic Information Guidelines for HIV in the Health Sector: HIV Strategic Information for Impact.* http://www.ncbi.nlm.nih.gov/books/NBK299486/.

World Health Organization, Department of HIV/AIDS, and World Health Organization. 2015. *Guideline on When to Start Antiretroviral Therapy and on Pre-Exposure Prophylaxis for HIV.* http://apps.who.int/iris/bitstream/10665/186275/1/9789241509565_eng.pdf.

Young, Sera, Amanda C. Wheeler, Sandra I. McCoy, and Sheri D. Weiser. 2014. "A Review of the Role of Food Insecurity in Adherence to Care and Treatment Among Adult and Pediatric Populations Living with HIV and AIDS." *AIDS and Behavior* 18 (S5): 505–15. https://doi.org/10.1007/s10461-013-0547-4.

Zachariah, R., N. Ford, M. Philips, S.Lynch, M. Massaquoi, V. Janssens, and A.D. Harries. 2009. "Task Shifting in HIV/AIDS: Opportunities, Challenges and Proposed Actions for Sub-Saharan Africa." *Transactions of the Royal Society of Tropical Medicine and Hygiene* 103 (6): 549–58. https://doi.org/10.1016/j.trstmh.2008.09.019.

Zeitlyn, David. 2012. "Anthropology in and of the Archives: Possible Futures and Contingent Pasts. Archives as Anthropological Surrogates*." *Annual Review of Anthropology* 41 (1): 461–80. https://doi.org/10.1146/annurev-anthro-092611-145721.

Zola, Irving. 1972. "Medicine as an Institution of Social Control" 20 (4): 487–504.