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**JOURNEYS TO HEALTH: MIDDLE-CLASS
MOZAMBICAN WOMEN ASSESS HEALTHCARE
SERVICE DELIVERY IN MOZAMBIQUE AND SOUTH
AFRICA**

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CHCMAR003

A minor dissertation submitted in partial fulfilment of the requirements for the award of
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This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: _____ Date: 29 March 2011

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ABSTRACT

My thesis explores how Mozambican middle-class women perceive official local healthcare services in both their public and private dimensions, within their country, and why they sometimes travel abroad to South Africa in search of healthcare across a range of gynaecological services, ranging from basic procedures to more complex requirements. I trace the stories of fifteen women to convey their experiences and opinions of the Mozambican health system. I show the women negotiating their way through barriers and limitations within this system, in ways that point out its inadequacies and inefficiency. I investigate how searching for “quality” healthcare, often abroad, is intertwined with middle-class women’s crafting of identities that aspire to a certain demonstration of “modernity” in which social status is claimed. Such aspirations lead women to fall in with the commoditisation of healthcare and to seek technological advancements in biomedicine often unavailable to them locally. Their negotiations within the health systems in Mozambique and South Africa lead to a distancing between themselves as middle-class women, and their poorer fellow citizens, who are often unable to access even basic services. In this way a section of the Mozambican population is able to claim to a degree a meaningful identity as global citizens, whereas the majority of the population must suffer the more constraining outcomes of globalization. The Mozambican healthcare system is, thus, left unchallenged by middle-class women as they are able to do find other alternatives.

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I thank my family for their support, especially my parents, not only for keeping me grounded, but also for giving me the opportunities without which I would not have been able to start or to finish this work.

I dedicate this piece of work to my participants and all the other women out there, who are constantly finding ways to negotiate healthcare.

University of Cape Town

LIST OF ACRONYMS

AMETRAMO	Association of Mozambican Traditional Healers <i>(Associação dos Médicos Tradicionais de Moçambique)</i>
FRELIMO	Mozambican Liberation Front <i>(Frente de Liberação de Moçambique)</i>
HCM	Maputo Central Hospital <i>(Hospital Central de Maputo)</i>
ICOR	Heart Institute <i>(Instituto do Coração)</i>
INE	National Statistics Institute <i>(Instituto Nacional de Estatística)</i>
MISAU	Ministry of Health <i>(Ministério de Saúde)</i>
MZN	Mozambican Metical
NGO	Non-governmental organisation
NHS	National Health Service
NRT	New Reproductive Technologies
OMM	Mozambican Women's Organisation <i>(Organização da Mulher Moçambicana)</i>
PCOS	Polycystic Ovarian Syndrome
RENAMO	Mozambican National Resistance <i>(Resistência Nacional Moçambicana)</i>
UCT	University of Cape Town
USD	United States Dollar
WHO	World Health Organisation
ZAR	South African Rand

Chapter One: Introduction

1.1. Negotiating through the borders and boundaries of healthcare

After completing my undergraduate studies at the University of Cape Town (UCT), and upon my return to Maputo, my hometown, I became aware of how much my family, friends and neighbours, were dependent on South Africa. At least once a month my family travelled to South Africa to shop for food, clothing and other goods. Sometimes we would book a check-up with a general practitioner in Nelspruit or Johannesburg. These journeys to South Africa began in 1996 after we had returned from living in Wales.

As the conditions of travel between Mozambique and South Africa improved, more parents began to send their children to South African boarding schools. I myself attended a South African run school in Maputo with the purpose of making my later transition to a South African university easier. Dynamics such as these concerning travel from Mozambique to South Africa led to my interest in gathering women's perceptions of healthcare services in both countries.

During May and June 2010 I conducted ethnographic research in Maputo, exploring how middle-class¹ women perceived healthcare services there. I was interested in the relationship Mozambicans had with healthcare services "at home" and in South Africa. I wanted to know what public services were locally available in Mozambique and what factors influenced people's decisions either to use them or to find other alternatives within private clinics or abroad. More specifically, I wanted to know how women experienced gynaecological and obstetrical services in Maputo and what they perceived to be the barriers in accessing these. I knew women went to South Africa not only to give birth but also for other healthcare related issues.

¹ For the purposes of this research, I attempted to work with women who considered themselves middle-class, in that they were educated at the best institutions, had access to pursuing higher levels of education, and could afford privileges not readily available to the majority of the population. Most women defined their middle-class status based on their family background and upbringing.

My work also aimed to explore whether middle-class Mozambican women's pursuit of healthcare represented more than a fulfilment of objective healthcare needs. Did going to South Africa, for example, play a part in women's performance and configuration of middle-class identities? Part of the construction of such identities seemed to involve women looking for ways to ensure that their needs were met in the "best" possible way. Women were searching for alternatives because there were serious problems in the local healthcare system. Women with means often felt compelled to make choices that led them to seek healthcare in South Africa. This was evident from the fact that some women agreed that if improvements were made to the local healthcare system they would not have to go abroad as these journeys were often considered tedious, time-consuming and costly.

Women's local reality in Maputo was interplayed between the barriers they found to accessing "quality" health, and the borders they crossed so that they would be able to do so. In this sense, barriers were not only institution-based, but were socially constructed, and overcoming them was a process with imaginative reach.

Little has been written regarding middle-class women and healthcare in Mozambique, particularly regarding their perceptions of healthcare service delivery in their own country, and the reasons for their seeking such services abroad. My research contributes not only to the body of literature on healthcare in Southern Africa, but also considers issues regarding the commoditisation of healthcare, a growing concern in the field of Anthropology (see Appadurai 1996, Pellegrino 1999, Rylko-Bauer & Farmer 2002). The blurred boundaries between patients and clients, especially with increased privatisation of healthcare in countries like Mozambique and South Africa, was demonstrated by women's constant movement between public and private healthcare services in both countries.

Having set the broad parameters of my research, I will present a background to the research by describing the country and city in which I undertook research, as well as touching on the historical connections between Mozambique and South Africa. I then proceed to contextualise healthcare services in Mozambique historically in order to provide a background to issues of service delivery women may face in Maputo today.

This section of the chapter is followed by a review of a small body of literature on relevant global healthcare issues, including the issue of healthcare inequalities, women's health and service delivery. I conclude the introduction with a brief chapter outline.

1.2. *Mozambique, Maputo and South Africa*

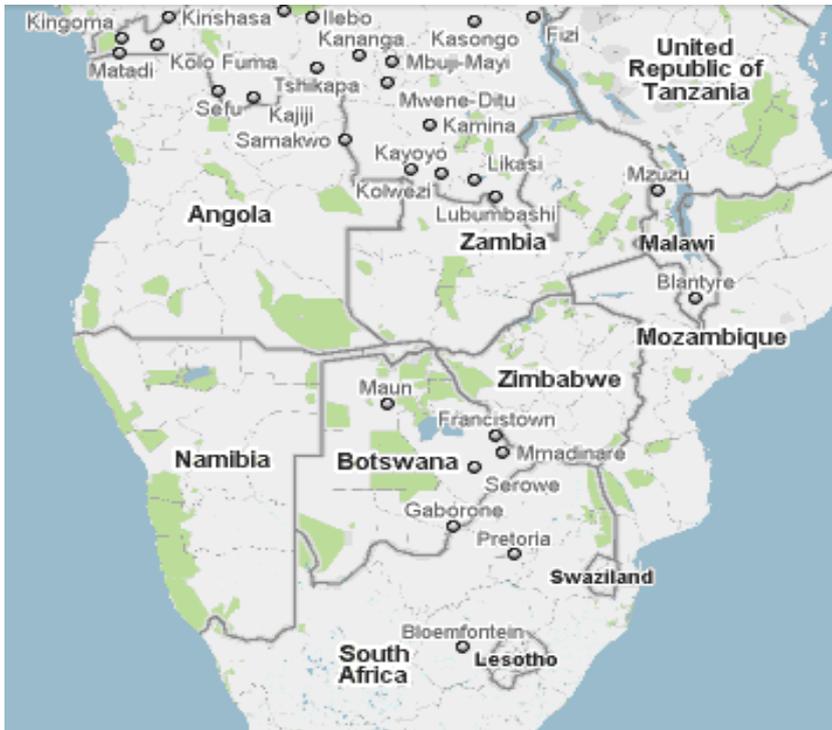


Figure 1: Map of Southern Africa showing Mozambique and its bordering countries (Source: Google maps)

Mozambique lies in the south-east region of the African continent and borders South Africa and Swaziland (southwestern borders), Zimbabwe (western border), Malawi (northwestern border) and Tanzania (northern border) (see Figure 1). It is bordered to the east by the Indian Ocean and is divided into eleven provinces, namely, Niassa, Cabo Delgado, Nampula, Zambézia, Tete, Manica, Sofala, Inhambane, Gaza, Maputo Province and Maputo City (Figure 2). It has an estimated overall population of 21,802,866 (www.ine.gov.mz, 21.08.2010). The official language is Portuguese, but there are more than twenty other languages including *Xichanga*, *Cicopi*, *Cishona*, *Kiswahili*, *Guitonga* and *Macua* (General Information about Mozambique 2010, www.portaldogoverno.gov.mz, 21.08.2010).

Maputo City, Mozambique's capital² lies in the farthest southern region of the country and has a population of 1,120,360, of which 577,282 are women and girls (INE Census Data 2009). It is separated into seven districts and 73 *barrios* or neighbourhoods (CMM 2009).

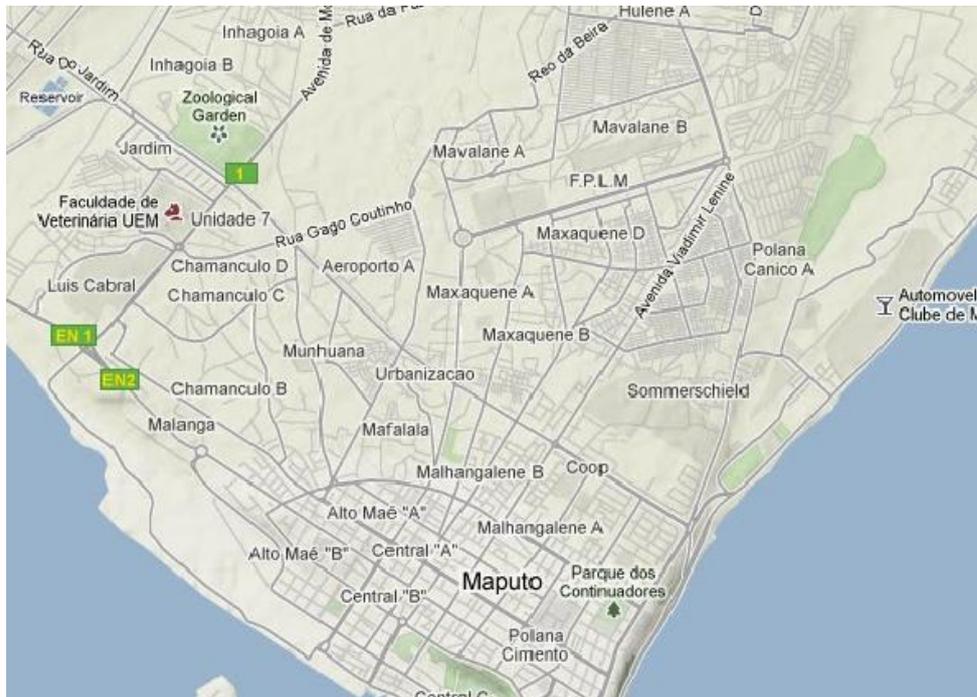


Figure 2: Map of Maputo City (Source: Google maps)

Known as the *Cidade das Acácias* (City of the Acacias) and *Pérola do Índico* (Indian Pearl), Maputo is home to a diverse population of people from other places in the country as well as abroad (ibid). According to the 2007 Maputo Census 98.7 per cent of the city's population is Mozambican, with the Portuguese and South African populations coming in second and third with 17.5 and 13.6 per cent, respectively (INE Census Data 2009, www.ine.gov.mz, 21.08.2010).

There are various reasons why Mozambicans travel to South Africa. Southern Africa has a long history of cross-border migration. Cheap labour has often been sourced from Mozambique and other countries in the region by South Africa for work on that

² For the purposes of this research *Maputo*, refers to Maputo City, as opposed to Maputo Province.

country's farms and mines (McDonald *et al* 2000). Since 1994 growing cooperation between the two countries has made the movement of Mozambicans to South Africa and vice-versa a regular occurrence.

There are various ways to enter South Africa: from Ressano Garcia/Lebombo, which takes people straight into South Africa through Mpumalanga, and from three other borders at Namaacha/Lomahasha and Goba/Mhlumeni. These go through Swaziland into Kwazulu-Natal. In addition there is the Ponta Douro/Kosi Bay border which takes travellers straight through to Kwazulu-Natal. It takes on average one to two hours to get from mid-city Maputo to the country's borders, with the exception of Ponta Douro, which is further from the City than the other border posts.

1.3. Contextualising healthcare in Mozambique

Mozambique is considered to be one of the poorest countries in the world (Cronjé 2003, INE & MISAU 2005). Since the Rome Peace Accord of 1992,³ in the aftermath of a sixteen-year civil war, and following on from a ten-year war to gain independence from colonial rule, Mozambique has been in the process of recovery. The interrupted education of a whole generation, the devastated infrastructure, not to mention large numbers of displaced people, and a broken economy, are some of the issues that the country has had to deal with since its first multiparty democratic elections in 1994. One of government's top priorities has been rebuilding the devastated healthcare infrastructure which has proved to be an enormous challenge.

1.3.1. Cycles of devastation and recovery

After independence from Portugal in 1975, and after over 500 years of colonial rule, and ten years of war for independence, the socialist Frelimo government nationalised healthcare services "to ensure that facilities would be put in the service of the people, with basic provision provided free of charge (CASE 2000: 1)." For Frelimo healthcare was a top priority (Newitt 1995). While emphasising primary healthcare, the new government struggled to rebuild health infrastructure. In 1975 there were 113 hospitals, 120 health centres and 326 health posts (www.ine.gov.mz, 21.08.2010). By 1977 the

³ In 1992, the Rome Peace Accord between the ruling party, FRELIMO, and RENAMO forces, was signed, ending a civil war that had erupted soon after independence from Portugal in 1975.

number of hospitals had decreased drastically with only 39 working hospitals, while there had been an increase in health centres and health posts to 253 and 455, respectively (ibid).

Large numbers of doctors (most of whom were Portuguese) left just before independence, and the 500 doctors in 1970 were reduced to 80 in 1976 (Hanlon 1990: 56). With serious deficits in personnel and infrastructure, Frelimo relied on foreign doctors and on the training of lower level medical personnel in order to expand healthcare into the rural areas (Newitt 1995). Training paramedical workers who would work at village level was given top priority, and during the period between independence and 1982, only 100 doctors were trained (Hanlon 1990: 58). Yet in the early 1980s there were some significant improvements in primary healthcare in rural areas. Within two years, from 1979 to 1981, the number of rural doctors rose from 36 to 56 (ibid).

There were, however, many obstacles to the attempted expansion of health for all. In the most remote rural villages throughout the country village health workers were recruited to work at health posts a few times a week and to be available for emergencies. These workers were not paid by the government but supported by the village. However many abandoned their posts to move to the cities in search of prosperity and due to lack of support from poor villages who were expected to support them. The attitudes of healthcare personnel were also problematic. Most health workers had been trained in colonial times and had what Hanlon (1990: 65) described as “a continuing colonial mentality,” where they looked down on those whom they considered to be poorer and less educated than themselves. Attitudes of nurses towards pregnant women, for example, were punitive and very far from supportive (ibid). The governing party was also highly criticised for not compromising on their own and their families’ health. As Hanlon (1990: 69) argued, “people are clearly willing to use whatever rank or power they have to obtain what they see as better health care,” and it was more likely for a minister’s child to be sent abroad than a peasant’s child. When it came to equal opportunities in healthcare it seemed the elite were not always willing to compromise.

Yet Frelimo still claimed some overall improvements in the health sector. Frelimo was highly committed to supporting equality between women and men (Newitt 1995). The Ministry of Health's collaboration with the Mozambican Women's Organization (OMM – *Organização da Mulher Moçambicana*), saw to it that local women's groups encouraged women to attend clinics, engaged in discussions on nutrition and family planning, and helped set up crèches (Hanlon *ibid*). However, the country, although independent, was still in the midst of a war. During the mid 1980s Frelimo's enemies, the rebel forces Renamo, backed by the Rhodesian army and South African Defence Force (Cliff *et al* 1986), aimed to destabilize the socialist Frelimo government. Frelimo had “retained popular support mainly due to its major expansion of health and education, so Renamo attacked schools and health posts, even killing patients in their beds (Hanlon 2005: 274).” A consequence of this was that many people in rural areas became afraid of going to schools and health posts. By the late 1980s improvements in healthcare were overshadowed by the fact that the government was unable to continue to offer services free of charge and fees were re-introduced (CASE 2000). The devastation of the health infrastructure was evident in the fact that by 1994 there were 21 hospitals compared with 39 in 1984 (www.ine.gov.mz, 21.08.2010).

1.3.2. Healthcare re-examined

Through its Health Sector Recovery Programme, the government has, with the aid of bilateral and multilateral partners, been rebuilding the network of health services (Chao & Kostermans 2002). Yet, although many improvements have been made in the last sixteen years, the National Health System (NHS) provides services to only part of the population and mostly in urban and peri-urban areas. There are “notable problems in service delivery, including low technical quality, shortage of drugs and equipment, low staff morale, and illicit charging for drugs and services” (Pannenberg 2004: vii). Other challenges faced by the NHS include poor administrative systems, weak financial and supply systems, “unclear allocation criteria result[ing] in inequities and inefficiencies, in resource allocation; and inconsistent implementation of user fee policies [all of which] create... unfair financial burdens on users (*ibid*).”

The estimated life expectancy of a Mozambican for 2010 is recorded as being 48.5 years (www.ine.gov.mz, 21.08.2010) due in part to diseases such as malaria, HIV/AIDS

and Tuberculosis that can be prevented and/or treated for those with access to formal healthcare services. Yet these diseases kill thousands of people each year, in a country where article 94 of the Constitution, states that “all citizens have the right to health care and medical assistance under the law, as well as the duty to promote and defend health” (CASE 2000: 2). The Ministry of Health, responsible for organising the NHS, has as one of its objectives the provision of good quality health services, at least at the level of primary healthcare. Yet Mozambique’s basic health indicators seem to fare far worse than other sub-Saharan countries (Chao & Kostermans 2002).

Maputo boasts most of the improvements made to the NHS in the last sixteen years. It is also where one of the biggest and most specialised hospitals in the country, the HCM, can be found. It is important to note that the HCM, across the road from the Ministry of Health, has a private clinic (*Clinica Especial* – Special Clinic) within its facilities that, with its high costs of consultations and procedures, caters to those who are willing to pay for supposedly “better” conditions, less waiting time and more efficient services. However, hospital personnel work across both public and private spaces, which is not unusual since local doctors work interchangeably in public and private sectors.

1.3.3. The Mozambican national health system

In Mozambique, formal healthcare service providers are divided into four levels (MISAU & WHO 2006):

1. Health posts and health centres (formal health service but mostly in peripheral areas)
2. Rural and General (District) hospitals (primarily providing preventive care, surgical, maternity and laboratory services)
3. Provincial Hospitals (receive referrals from the rural and district hospitals and also provide medical training facilities)
4. Central and Specialised Hospitals (located in Maputo, Beira and Nampula)

The three sectors comprising the public health structure involve central, provincial and district levels of organisation. The Central Ministry of Health, situated in Maputo City, distributes resources to the provinces, formulates standards, monitors and controls hospital activities, and defines targets and objectives, among other tasks (MISAU 2010,

www.misau.gov.mz, 21.08.2010). The NHS is dominated by the public sector and covers only part of the population, primarily those people residing in urban and peri-urban areas. The private for-profit sector is essentially confined to major cities.

In theory, when one feels ill one visits either a health post or centre, which refers you to a rural or general hospital. However this seldom happens. Due to a variety of circumstances⁴ people usually go straight to general or central hospitals, where they sometimes encounter problems regarding lack of referrals. In Maputo this process works in a similar way. As mentioned, Maputo has one of the biggest hospitals in the country, the HCM. There are two other central and specialised hospitals in the country, one in Beira, in the centre of the country, and one in Nampula, in the north of the country.

There are other hospitals within Maputo and its periphery, including the Military Hospital that offers free services for the military, but is also utilised by non-military patients. The Heart Institute (ICOR) is a specialised hospital but general consultations are also done there. Both the Military Hospital and the Heart Institute are situated in an affluent part of the City. The Institute is funded partly by the state, but also operates as a private institution. Maputo has a number of specialised and general private clinics. In Maputo private clinics form a significant section of the health system, catering for middle and upper-class families and offering medical services at prices that the majority of the population cannot afford.

1.4. Literature review

Growing attention has been paid by anthropologists to how biomedical technologies conjugate with material inequalities to create novel markets that have intensified and accelerated the commodification of the body and its futures... These markets are emblematic of the process by which the poor trade in their long-term health for survival, while the rich, although increasingly shielded from most disease threats, are able to purchase better health (Nguyen & Peschard 2003: 449).

⁴ Although I think this would be a pertinent area of research for the Ministry of Health, the women participating in the research had their own opinions and feelings about how the system of health should work and why they would never go to health posts. This is discussed in Chapter Four.

When I began thinking about the issues I would examine in my research, the question I asked myself was “Why focus on the minority of individuals who make up the Mozambican middle-classes?” Most of the health research I had read focused on poor people’s experiences and their lack of access to basic primary healthcare. I wondered if it would be pertinent to find out what was happening amongst a more privileged class and whether this would contribute to Anthropological research.

I then came across a book called *Critical Medical Anthropology* (Baer & Singer 1995: 5) in which the authors describe the task of medical anthropology as “emphasiz[ing] the importance of political and economic forces, including the exercise of power, in shaping health, disease, illness experience and health care.” In a given society or country, no one is exempt from the political and economic forces that govern and shape their decisions. Citizens (and non-citizens) are affected in a variety of different ways, and although the lower classes are more prone to what Farmer (1999, 2005) terms “structural violence”, it is vitally important to understand how different strata in societies live out their everyday lives. The decisions people make, given the strictures of the everyday, in turn affect the shape of society and the outcomes for social services and structures in the future.

1.4.1 Thinking critically about healthcare service delivery and choices

Travelling through Maputo City, one can clearly see the disparities between how the rich and the poor live. Shantytowns have begun to appear, not only on the periphery, but also within some affluent parts of the city. Although one could argue that the new mansions and luxury houses are built next to slums, what the tourist sees is the stark juxtaposition of wealth alongside destitution. Social classes do not exist in isolated spaces. Critical medical anthropology allows for an understanding of the issues surrounding health, illness and treatment at different theoretical levels, from an attempt to describe the state of macro-level political economy and its effects on the structures of health service delivery, to the micro-level accounting of individual experiences in relation to illness and health. Although my research predominantly focuses on middle-class women’s individual experiences with healthcare, one cannot begin to understand

social inequalities in Mozambique without a holistic view of the society and how it reacts and adapts to global pressures in today's increasingly globalised world.

Nguyen and Peschard (2003) show how far apart the rich and poor fall on the spectrum of health. While the self-defined middle-class women who participated in my research consider themselves to be "well-off" rather than rich, and with opportunities that are not available to most, they have the choice of buying (or at least attempting to buy) what they perceive to be "better" healthcare services, and often exercise that choice. I wanted to consider what the implications of pursuing "better" healthcare services were. What at first glance appeared to be a straightforward search by middle-class women for "quality" care seemed to bear a more elusive social dimension linked to ideas of self and what it was appropriate for middle-class women to do, and be seen doing.

Middle-class Mozambican citizens have access to information on health and health service provision as well as the resources to utilise a variety of them. That in turn enables them to "shop-around" in search of what they consider to be acceptable services. It is possible that this is one of the ways in which inequalities continue to grow, as wealthier people do not see any radical improvements in local public healthcare, but seek solutions to their own health problems elsewhere. Many poor people have endured the shortcomings of the healthcare system and view with a degree of cynicism the idea that the system could radically improve.

Mechanic and Rochefort (1996) point out that throughout the world access to mass communication, particularly television and films, and increasing levels of education, make it inevitable that possibilities for certain social groups will extend beyond local situations and national borders. Although, ideally, everyone should have a right to the same level of healthcare and should be able to search for alternatives, this is hardly what happens in reality in so-called developing countries.

Helman (2000: 84) argues that, for indigenous forms of healing in "non-industrialised societies, health is conceived of as a balanced *relationship* between people, between people and nature, and between people and the supernatural world." Yet for "Western communities, definitions of health tend to be less all-embracing, [although] they also

include physical, psychological and behavioural aspects (ibid, emphasis in original).” Health, then, is a socially inflected term, and its definition may alter, depending on different changes within a given society. Helman fails to account for the fact that many non-industrialised societies have been significantly influenced by Western societies, especially during colonial rule. As Baer *et al* (1997: 29) argue, for almost all developing and politically independent nations, “Their colonial inheritance and their neo-colonial situation impose healthcare [systems] modelled after [those] found in advanced capitalist societies.” And these systems in turn reproduce class distinctions at all levels (macro-social, intermediate social, micro-social and individual), thus creating disparities in healthcare. Healthcare systems have to be adapted to fit particular contexts. Most people in poorer nations do not have the same opportunities and resources as people in richer nations, and some healthcare systems are bound to benefit a few citizens and alienate others.

1.4.2. In search of medical pluralism

As suggested above, one cannot discuss Mozambique’s health services without discussing those consequences of modernisation, development and globalisation that allow for healthcare pluralism. A few years ago, traditional healers were popular in the Mozambican media, and finding a way of getting practitioners to work alongside biomedical health personnel became an objective for the Ministry of Health. Today these healers provide the only access to healthcare for marginalised communities (Mozambican Independent Television – TIM www.tim.co.mz, 26.08.2010). Most middle-class Maputo women with whom I worked relied on biomedicine and tended to shun “traditional” forms of healing. Yet certain types of knowledge passed down from mothers and grandmothers were evident in some of their everyday health practices.

In his description of healthcare pluralism in the United Kingdom, Helman (2000: 51) discusses three overlapping sectors, namely the popular, the folk and the professional sectors. The popular sector refers to “the lay, non-professional, non-specialist domain of society, where ill health is first recognised and defined and health care activities are initiated (ibid).” This sector includes all therapeutic options that fall outside of consultation with an expert healer, such as self-medication and self-treatment, advice by friends or relatives, or other “experts” “in the know.” Here, the family becomes the

main arena of healthcare, and the main providers of health are usually mothers and grandmothers (ibid). This model applied to a significant extent in my research, as most healthcare decisions made by participants were based on conversations with family or friends. It is such networks of relationships that middle-class women make use of before deciding to go to a hospital or clinic. The information they receive via these networks is informal, based on general notions about health and healthcare services.

The folk sector that Helman (2000: 53) refers to as “especially large in non-industrialized countries,” is the sector where “certain individuals specialize in forms of healing that are either *sacred* or *secular*, or a mixture of both (emphasis in original).” Although professional in their own right, folk healers are not counted as part of the overall mainstream scientific medical system. Their position is an intermediary one between the popular and professional sectors (ibid). Helman (2000: 53) describes most folk healers as sharing “the basic cultural values and world view of the communities in which they live, including beliefs about the origin, significance and treatment of ill health,” yet this may not always be the case, especially in today’s increasingly globalised world. Middle-class women in Maputo have access to a folk sector that encompasses a variety of new alternatives that include not only *curandeiros* (traditional healers) but also acupuncturists, and different types of yoga, herbal doctors from outside of Mozambique (from India and China), and many more in the field of homeopathic medicine. These practitioners while not necessarily sharing cultural values with their clients, are readily available to share different kinds of health knowledge.

The professional sector is considered to be “the organized, legally sanctioned healing professions, such as modern Western scientific medicine (Helman 2000: 58).” In Mozambique, scientific medicine, or biomedicine, is the basis of the professional sector, although at times the Ministry of Health has worked closely with the Association of Traditional Healers (AMETRAMO – *Associação de Médicos Tradicionais de Moçambique*), especially regarding the AIDS epidemic (www.tim.co.mz, 26.08.2010). In most Western countries practitioners of biomedicine enjoy a higher social status and better income, than most other practitioners (Helman 2000). The same cannot be said for developing countries such as Mozambique, where doctors working in the public services often survive by taking on additional work in the private sector, as well as

finding other forms of income (see Ferrinho *et al* 1997, 1998, 2004; Hanson & Berman 2004). The latter reality further compromises the healthcare system.

1.4.3. Health inequalities and unequal consumers: privatising healthcare

To say that there are great disparities in access to healthcare around the world is nothing new. Sen (2005: xvi) argues that the “inequalities of power [within global health systems] in general prevent the sharing of different opportunities,” and “can devastate the lives of those who are far removed from the levers of control.” He further adds that even the lives of those in power “are dominated by decisions taken by others.” Middle-class women in Mozambique are under pressure to survive at a time when achieving a specific social status has much to do with outside forces, and “decisions taken by others (ibid).” Access to more information on health has not only made women more knowledgeable, but has helped to instil in them doubt about their own definitions of “quality” and “status.” Global standards are now easily accessible and are therefore to be aspired to.

Farmer (2005: 221) has noted that “[l]ocal and global inequalities mean that the fruits of medical and scientific advances are stockpiled for some and denied to others,” and “structural violence” is experienced by “all those whose social status denies them access” to the above advances (Farmer 1999: 79). Such violence renders certain people, especially poor women, invisible and silences their voices. Such women rely on the inadequate services available to them. Poor people have little, if any, social and economic rights. They struggle for access to basic healthcare, education and even clean water that people on the other end of the economic spectrum often take for granted.

Farmer’s statements suggest that health inequalities are not contained within borders and that globalisation has led to inequitable access to quality services. While one can argue that everyone has rights to healthcare, and the number of declarations signed worldwide is evidence of the fact that the fight for human rights is a global movement, according to Farmer (2005: xxv) these declarations are “exhortatory and largely unenforceable.” Mozambique, like so many other countries, is a signatory to rights declarations, yet the disparities of health within the country are not being thoroughly challenged and addressed. If those who have the power to make changes within the

public health system simply choose other alternatives, they are further contributing to local health inequalities and maintaining the status-quo, albeit unwittingly.

For many Mozambican citizens the private sector offers an alternative to public hospital services. The sector comprises “all practitioners, goods and services that are privately owned, produced and financed” such as privately financed hospitals and clinical services (Humphrey & Russell 2001: 330). In this sector the line between patients and customers is ultimately blurred. As Whyte (2002) observes, being customers gives patients leverage in deciding what medicines they want and what they can afford. Moreover, with their status they can “expect to be treated with civility – since the provider is concerned with [them] in his business endeavour (Whyte 2002: 186).” Nevertheless, there is no guarantee that a person will receive the “best” possible treatment, or that such treatment will be available within a given context. For the Mozambican women interviewed in this study, the pursuit of “quality” healthcare in their country was not always guaranteed no matter how many resources they had available to them. This often precipitated their travels abroad to access healthcare services.

1.4.4. Women and their bodies

As I have argued above, people are turned into consumers within the health system. We cannot, however, look only at consumers of services and ignore those physiological, social-cultural and political issues that make, women in particular vulnerable patients, even when they consider themselves to be educated and/or wealthy. We cannot discuss women and women’s health services without looking at what Ginsburg and Rapp (1991) refer to as the “politics of reproduction” and is centred on the female life cycle. Medical control exerted over the female body by Western or biomedicine makes it a vehicle for oppression and subordination. Thus in healthcare service provision one could say that women are not only consumers, but they may also be consumed by the mechanisms put in place to control their “re-productivity.”

Much has been written about women as “both subjects and objects of reproductive science (Franklin 1997: 120).” A whole body of feminist scholars have thoroughly dealt with the issue of new reproductive technologies and how the medicalisation of

reproduction devalues women's experiences (Doyal 1993; see also Abel & Browner 1998, Franklin 1997, Hanson 2001, O'Neil & Kaufert 1995). Yet some scholars make the assumptions that medicalisation is received in the same way in every developing country. In places where for long periods of time the quality of healthcare has been considered, and perceived to be, poor, medical advances in technology may be welcomed by women who do emphasise their "sophistication" rather than their objectifying qualities in relation to "quality" health provision. Critiques of "western medicine" often do not take into account what technology means to people in a resource depleted society such as Mozambique.

My research will work with the idea that "the relationship between women and medical expertise is fluid and complex (Abel & Browner 1998: 322)." Complexity makes allowance not only for documenting moments of women's resistance to mechanisms that control reproductive labour, but also for recognising how women use technologies to empower themselves within societies. What concerns this study is how middle-class women in Maputo are constantly negotiating a healthcare system they believe is inadequate for their needs.

1.5. Chapter Outline

The thesis is divided into six chapters. These are outlined below.

Chapter Two introduces the research field and the study participants. It offers a brief description of the medical institutions visited and explores the methods used for gathering data. It concludes with a section on ethical considerations in relation to the study and details reflections on the fieldwork.

Chapter Three begins by exploring the experiences of middle-class Mozambican women within Mozambique's healthcare system. It describes how they are sometimes forced to navigate a system of health where public and private services overlap. The chapter describes how women make use of personal contacts within hospitals and clinics and even resort to bribing medical staff to ensure that they receive "quality"

treatment. Women make use of talk, stories⁵ and rumour in order to inform their choices. These stories form a major part of the criticisms women make concerning Mozambican healthcare services.

The issue of over-medicalisation of women's reproduction, an issue with which feminist scholars are concerned, is explored in **Chapter Four**. The chapter examines women's journeys to private clinics in South Africa. It discusses what technological advances mean for a country such as Mozambique and to women's identities as "modern" middle-class women. The chapter looks at how some Mozambican women rely on technology and are empowered by those improved medical advances not available to them at home. In this case, women do not see themselves as objectified or stripped of agency by biomedical expertise, but seek it actively.

Chapter Five shows how Appadurai's (2008) notion of the "imaginary" combines with identity formation and aspiration towards certain forms of status and notions of "quality" in healthcare. For middle-class Mozambican women what is abroad becomes a powerful aspect of the imaginary. Women constitute themselves through what they are able to acquire, be it the "best" education or the "best" healthcare services. Finding their answers abroad means being able to go beyond local inadequacies and upholding aspirations in relation to modernity.

The **final chapter** concludes with a discussion of the precarious nature of pursuing gynaecological care in Maputo and the reasons for going abroad in search of the often elusive "better quality" healthcare. Middle-class Mozambican women become consumer and distance themselves from the poorer public in the same way that certain neo-liberal health policies contribute to global health inequalities.

⁵"Stories" here refer to accounts of other people's experiences regarding healthcare, as opposed to legends, stories told and handed down in a particular cultural context.

Chapter Two: The Research Process

I conducted my fieldwork in Maputo City, Mozambique, for a period of seven weeks between May and June 2010. The first part of the chapter considers the nature of the field. I then introduce the fifteen main participants in the study and the hospitals and clinics that I visited throughout the research process. I end by discussing the ethical issues encountered in the research and conclude with reflections on being a researcher in my own country.

2.1. *The Field*

Fieldwork... helps define anthropology as a discipline in both senses of the word, constructing a space of possibilities while at the same time drawing the lines that confine that space (Gupta and Ferguson 1997: 2).

At one time the anthropological field-site was looked upon as a singular location, with outside influences often been ignored and not considered at all. Nowadays the field-site can no longer be seen as homogenous or isolated (Gupta and Ferguson 1997). Marcus (1995: 98) argues that “single-sited research can no longer be easily located in a world system perspective.” Thus in a world where people are constantly moving across borders, whether voluntarily or forcibly, a researcher has to consider how field-sites react and adapt to, and/or even resist, outside influences. I conducted fieldwork in Maputo across a set of dispersed sites including homes, coffee shops, clinics, hospitals and offices. These were spaces in which the women I interviewed lived, conducted their business and spent their leisure time. Yet these women repeatedly broke out of the confines of a notion of containment of borders and of localities. Their lives, and especially their healthcare experiences, were not confined to the city of Maputo or even to the country.

Although during my research I was not able to travel to South Africa with any of my research participants, South Africa was in many ways part of the field-site. For some of these women, including myself, South Africa was a place they had made their own through their dependence on it. Mozambican women’s interaction with healthcare in

Maputo and in South Africa showed the complexities of establishing a field-site within a world where borders are no longer considered barriers, and lines that demarcate spaces are often imagined and confined to the researcher's mind.

2.2. *The Institutions*

The *Hospital Central de Maputo* (HCM) is the biggest and most specialised hospital in Mozambique. Local health centres and posts, as well as other hospitals in the country, refer patients to it when appropriate. It is also a training hospital attached to the Faculty of Medicine at Eduardo Mondlane University. I visited the hospital once every week to conduct participant observation. I divided my time there between the maternity buildings, where most of the obstetrical and gynaecological consultations are held and the *Clinica Especial* (a private clinic). On some occasions I accompanied participants there.

The *Clinica Especial*, or Special Clinic, is situated within the main HCM hospital buildings, and charges private clinic prices for consultations. There are also other private areas within the hospital, where people pay for private rooms and supposedly individual and "better" treatment. Here I met a few people in waiting rooms: receptionists, nurses and other medical technicians with whom I often had brief conversations.

I also visited three clinics in Mozambican suburbs with some degree of regularity. My choice of clinics was completely random, although I found that some of the participants visited clinics B and C. Clinic A was situated in one of the most affluent parts of town, and was infamous for being expensive, even for basic procedures such as malaria tests. Access to clinics during fieldwork was not without difficulty. Clinics B and C were situated a few blocks away from each other in the same area. Here I was able to speak to people in waiting rooms, but access to Clinic A was a little more constrained. Nevertheless, I continued to visit it as one of my research sites.

2.3. *The research participants*

Although I consider everyone I spoke to in the field to be a research participant, the fifteen women with whom I interacted the most will be introduced in detail in this

section. Prior to engaging in the field, I contacted women in Mozambique through email, explaining the background of my research and asking whether they would be willing to participate. I stated that I was looking for women between the ages of 21 and 35 who considered themselves middle-class. I received a few replies from people who were interested in participating and I planned on contacting them as soon as I returned to Maputo. In order to protect the major participants' identities, pseudonyms have been used in the thesis and some details about their lives have been omitted.

Yara was a 32 year-old woman engaged to her boyfriend of four years with whom she shared a flat. She was working at a non-governmental organisation (NGO) as an administrative assistant. Although she considered herself to be middle-class, Yara belonged to a prominent ruling elite family. She did not have any children, but when she was nineteen she gave birth to a baby girl who died shortly after birth. At the time of research Yara was finishing her tertiary education through night classes .

Matilde came from a prominent Mozambican family in private business. At 28, she worked for a state company while finishing her degree in management and accounting. Matilde was brought up by her father's mother after his death when she was eleven. Matilde continued to live with her grandmother and regularly saw her mother and other siblings.

I met Stella while she was studying at UCT. She divided her time between working and studying, and although her job sometimes took up most of her time, her main priorities were her studies. At 27, Stella was single, much to her family's chagrin, as her brother and sister already had five children between them.

Elena was a 30-year-old lawyer, married with a two-year-old son and another baby on the way. She found out she was pregnant soon after agreeing to participate in the research. Elena was brought up in Mozambique and subsequently moved to France in her teens with her father and brother. In 1998 she returned to Mozambique and enrolled in an international school. She was fluent in Portuguese, French and English.

Thirty-three-year-old Regina had an honours degree in International Relations and worked for an NGO. She was married with one child and had recently interrupted her Master's degree when she found out she was pregnant with her second child. She told me she was due to give birth in September 2010. When I met her, Regina was quite unhappy in her job, and was thinking of leaving work entirely.

I met Sheila by chance when I visited a private clinic. She was 32 and married. When we met at the clinic I could see that she was pregnant with her third child. Sheila divided her time between working at her father's clinic and staying at home with her children. She had recently started a university course, but postponed it when she discovered her pregnancy. Her father was a well-known doctor in Maputo.

Monica, 31, was a lawyer who completed her degree in South Africa and soon after returned to work in Mozambique. She worked for one of the biggest state-affiliated companies in the country. At the time of the study Monica was engaged to her long-time boyfriend and planning to wed in 2011. She lived at home with her mother and other family.

Thirty-four-year-old Patricia was unique among the research participants for making use of all three kinds of facilities available to some mothers and children in Maputo: she had given birth in a public hospital, at a private clinic in Maputo, and at a private hospital in South Africa. She had three children, the youngest being four months old. She was coordinator of an NGO.

Teresa, a 31-year-old divorcee, was finishing her tertiary education. She had an eight-year-old son from her marriage, and lived with her sister who had recently given birth in a local public hospital. Her mother had lived in Europe from the 1990s with her husband and regularly came to Mozambique to visit.

I met Katia by chance at a dinner. After I explained my research she wanted to participate. At 25 and single, she worked as a programme assistant in an NGO. She had lived abroad most of her life and returned to Mozambique in her late teens. She went to

university in the United States before coming back to Maputo to find a job. She had worked in her current position for less than a year.

I met Eliza, 23, when she was working at a private clinic I visited. After a brief conversation she agreed to be a participant in my research. During the day Eliza studied tourism at a local institution and worked in the afternoons and evenings at the clinic. She was brought up in Mozambique and had never studied abroad. Her uncle was part owner of the clinic she worked in.

Twenty-four-year-old Iva had already completed a degree when she decided she was unhappy and wanted to become a doctor. She became a full-time medical student, making use of the South African medical system, despite the fact she was able to use most local medical services available to her, often for free, in Mozambique. Like many of the other participants, Iva had completed her first degree abroad and, with family spread throughout various countries in Europe, she continued to travel extensively.

After returning from Europe where she had completed her degree, Dora began to work in her family's private company in a managerial position. At 34, she was married and had an eight-month-old baby boy. Dora's family were quite well known in Maputo, and Dora was aware that her relatives had given her a lot of opportunities while she was growing up. Although she received a scholarship to study abroad, her family had been very supportive throughout.

Dora referred me to Claudia, who had just given birth in the HCM. Claudia was 35 and this was her first child. She and Dora had studied together overseas. Although not married, Claudia was in a long-term relationship with the father of her child. She worked in a state institution in a supervisory position. She was the only woman out of all the participants who had given birth in a public maternity ward from choice.

Karina, recently married, was expecting her first child at the end of June 2010. At 26, her education had been provided by private schools in Mozambique and in Europe. At the time of research she was unemployed and was looking for something more

challenging to do after she had her baby. Karina was planning to have her baby in South Africa, and most of her consultations were conducted there.

2.4. Methodology

During the research period, I met regularly with most of the fifteen women described above. We talked about their experiences with gynaecological and obstetrical services in Maputo through open ended conversations in the locations I have already mentioned. I spent a lot of time in hospitals and clinics engaged in participant observation, recording how hospital personnel dealt with their patients. Through spending time in waiting rooms, I was able to speak to other people. All people with whom I spoke were informed that I was doing research and that their contributions would be kept confidential and anonymous. Our conversations revolved around the amount of time patients waited to be attended to, attitudes of staff and doctors towards patients, and various aspects of gynaecological consultations. Some people found it easy to engage with me. Others were not so forthcoming about personal issues.

Wade (1984: 214) argues that researchers “use several strategies for establishing field relationships and pursuing data collection by announcing sponsorship of the research, by assuming a particular role and by selecting initial research subjects.” I have already described above how I selected the initial study participants. Some of my field relationships had been previously established. This was an advantage when I arrived in the field because I had limited time to conduct research. The women in my research project were happy to participate despite the fact that I could not compensate them for their time. They saw the stories they shared as a way of challenging the current conditions of healthcare in Mozambique.

Some of the assumptions I had about different institutions were proved wrong. I suspected I would experience some difficulty in getting permission to undertake research in the some of the public hospitals that I attended, specifically the HCM. However there were no particular problems with access. Van der Geest & Sarkodie (1998) discuss the problems of conducting anthropological research in hospitals: researchers may be seen as intruders and doctors and nurses may want to protect patients’ privacy as well as their own. At the HCM, I did not negotiate consent with

staff but preferred to sit in waiting rooms with patients. I did my best not to interfere with hospital activities and was cautious about how I approached patients. I usually started a conversation and then explained my research. If the person was willing to continue I obtained verbal consent before beginning my inquiry.

At first I was fearful that explaining too much of my research to medical personnel at hospitals and clinics would arouse suspicion. On the few occasions I was approached by staff, it was often by a concerned nurse wondering if I was waiting to see a doctor. I had no problems as long as I was not harassing patients, and these I only approached occasionally. I relied on open ended questions, but had a few questions typed out so that some people would feel a little more comfortable. All participants were constantly asked for their consent. At the clinics I attended, I spoke to personnel I found on duty on my first day there, explained my research and showed my credentials. At times this process had to be repeated when new personnel were in charge.

Whenever possible I spent time gathering information in both the Maputo public library and the Eduardo Mondlane University library. I also tried to find archival material on health issues at the Ministry of Health and the Faculty of Medicine. This proved difficult as there was a severe lack of systematic information. At certain places the information existed but had not been adequately organised for public access.

Apart from the fifteen main participants, I spoke with nineteen other women across the different institutions. I also spoke to three doctors and five nurses, as well as various other members of the administrative staff. I also interacted with a few medical students whom I met at the HCM.

2.5. *Ethical issues and reflections*

My top priority as a researcher was to ensure the protection of participants in the study. The research therefore complied with Anthropology Southern Africa's *Ethical Guidelines and Principles of Conduct for Anthropologists* (2004). I gained verbal consent from all participants and constantly reminded them of their rights as willing participants. They were all informed prior to our conversations, interactions and interviews, of their rights to privacy and confidentiality. I discussed the fact that I would

use their contributions, but would ensure that they were not referred to by name. Because Maputo is a small city, where people know each other through a variety of social networks, it became vital to ensure that people could not be easily recognised.

When I accompanied participants to their consultations, I documented the events preceding the actual consultation and waited with them for the doctor. The participants went into the consultation rooms alone and afterwards I would have a conversation with them about their experiences. The participants were informed that if they did not want to share specific information with me they did not have to. The process of research had as its main aim to make the participants comfortable and never to attempt to force information from them.

There were many times during the course of the research process when my assumptions were challenged and I found myself having to reflect deeply on conducting research in the place I called home, and among people whom I knew. As a middle-class Mozambican woman, who makes similar use of different healthcare services, I identified with and knew some of my participants and they in turn identified with me. This made it easier for me as an insider to ask sensitive questions and to engage more deeply with women's lives. I was not only a researcher. I was also a fellow "victim" of the system. Like them I had stories to tell about negotiating my middle-class identity within Mozambique and beyond. I was able to establish a rapport that other researchers may not have achieved. Yet it is also dangerous to be an insider for there are things one takes for granted, and thus perhaps does not probe deep enough.

Although in some aspects I was an insider, I was also an outsider. I was the researcher who wanted to find out about aspects of women's private lives. I knew some of the research participants, but at best as acquaintances. In this sense I was also potentially a threat. I was someone who came to listen to stories in order to compile information that would be documented, and perhaps not even used to improve the current situation. I brought the promise of someone who might be able to contribute to some changes, but I also held sensitive information that some people may not have been entirely happy to divulge.

Kusow (2003: 592) argues:

The insider/outsider distinction lacks acknowledgment that insiders and outsiders, like all social roles and statuses, are frequently situational, depending on the prevailing social, political, and cultural values of a given social context.

Like Kusow above, I reject the complete distinction between insider and outsider in research and, as my own experience in the field shows, I occupied both these positions in different situations and at different times. I had to be able to negotiate between these two roles not only in order to gather data for my research, but also to ensure that the women who told their stories felt their contributions were valuable.

Women who have experienced childbirth are far removed from my own lack of experience in this regard. There were some women who spoke about infertility in ways that were closer to my own experience. The process of negotiating my own feelings concerning female healthcare services, as well as identifying with the participants in my research, is reflected throughout the research.

Chapter Three: The pursuit of healthcare: experience, rumour and critique

3.1. *Navigating Mozambican healthcare systems*

When I arrived in Maputo in May 2010 to start my research, all the local news channels were discussing the same issue: the appalling quality of healthcare services in public hospitals. Although this was not news to anyone, people were shocked when one-year-and-seven-month-old Jossefa Aurelio died in his mother's arms while waiting to see a doctor at a Maputo hospital. According to reports, Jossefa and his mother Helena had arrived at the *Hospital Geral de Chamanculo*, a hospital on the outskirts of Maputo (used mainly by people living in peri-urban areas), at 12pm⁶ and the baby had passed away at three that afternoon without ever being examined by medical personnel (Luis 2010, AIM News 31 May 2010). Others who had been in the queue had noticed the distress of both the mother and her baby and urged her to go into one of the consulting rooms to ask for help. She did so and was subsequently shouted at by one of the cleaning staff who, as she was cleaning the floors, told her to leave (AIM News *ibid*).

On hearing Jossefa's story on the news a few days after his death, Maputo City Governor, Lucilia Hama, along with vice-Minister of Health, Nazira Abdula and City Health Director, Maria Benigna, paid a visit to the hospital concerned, where they were treated as badly as Jossefa and his mother, ironically by the same staff member who was unaware of who the women were (Luis 2010). The Ministry of Health subsequently opened an enquiry into the events of the 12th of May, and on the 31st May issued a press release stating that the director and administrator of the hospital had been dismissed (AIM News 2010). Often mishaps in local hospitals went unreported. Jossefa's case was different because it garnered media attention and led to action being taken by those in authority.

Since the end of the civil war great improvements have been made within the healthcare system. There continues however to be a scarcity of resources, at least within public

⁶ Accounts differ stating the mother and child may have arrived as early as 8 in the morning. Here I use the time specified in the Ministry of Health's official press release.

hospitals. Privatization of local healthcare services has not offered much of an alternative to middle-class women, as will be seen below. In Maputo “going private” is still an ambivalent process, as private and public healthcare sectors overlap in significant ways. Often doctors working long hours within the public healthcare system work within private clinics that are situated sometimes within public hospitals. They depend on private clinics for extra employment to ensure they are able to maintain a particular lifestyle, perhaps one that they see as “worthy” of their profession. Public hospitals and private clinics are thus in many cases interdependent.

Doctors manoeuvre within the two systems in order to make ends meet. The starting monthly salary for a doctor in the public sector has recently been increased to 20,000MZN, roughly 550USD and 3,825ZAR, from what was previously half that amount (Interviews: Iva 29 May 2010, Eliza 17 June 2010; personal correspondence with Mozambican doctors). Furthermore, equipment within public hospitals is often used for patients being treated by private medical practitioners. For example, people are sent from private practices to the main hospitals for x-rays and other tests. The arrival of independent laboratories has to some extent curbed the dependence of the private sector on hospitals such as the HCM.

The chapter illustrates how women’s negative and positive experiences have helped to create a practical body of understanding that has enabled their negotiating of the system. Part of this negotiation has involved talk among family and friends in which women sought advice about institutions and doctors or gave advice based on their own experiences. Often messages in the media and stories spread through rumour contribute to women’s decisions as regards seeking healthcare. In the following section I relate women’s experiences within hospitals and clinics in Maputo, describing their particular consultations around pregnancy and childbirth, as well as other gynaecological problems that required hospitalisation. I argue that the perceived inadequacy of the local healthcare system is built out of women’s direct and indirect experiences within it. The women’s accounts paint a picture of the problems they encountered and how these contributed to a sense of alienation and disillusionment with local services. The second section of the chapter deals with the role of talk emerging from the women’s stories in

their decision making, and how such talk contributed to increased distrust and fear of Mozambique's healthcare services.

3.1.1. Public places

I begin by relating Matilde's experiences.

I met up with Matilde at 8am on a Tuesday morning in front of the HCM. She was planning to book an appointment to see a gynaecologist and had agreed to let me accompany her. Although Matilde came from a prominent Maputo family of private business owners, she liked to pay her own way for most things. We arrived at the maternity wing of the Hospital where appointments were made. The room was full and chaotic. There were chairs randomly placed in the room, and some people chose to sit on them rather than stand in the chaos of various queues. We sat on some of the chairs. We had to remember how many people were in front and behind us, and in what order. Several queues formed as people sat intently watching the repeat of the previous night's *telenovela* on a small television placed in the room.

An argument ensued between a man who had been queuing for his pregnant wife and a woman who got up from her seat to claim her place in line. The receptionists carried on their work as if nothing was going on. Eventually the noise subsided and Matilde reached the head of the queue where she was told she could not book an appointment without a current file. If she did not have one, she would have to open one. For this we would have to go to the archive room on the other side of the hospital. We rushed to the archives where Matilde was asked if she had ever been to the hospital. She had been hospitalised there sometime in 2000 when she had malaria. As we waited I wondered if the file would ever be found. A man in front of Matilde had just been told his 2009 file was lost. When the search yielded nothing, Matilde was told to open a new file. We returned to book the consultation, which could only be done from 7.30 to 11am. Half an hour later Matilde booked her appointment for the following Wednesday.

We returned on Wednesday afternoon fifteen minutes before her appointment and sat in the waiting room as it slowly filled up. By 3.15pm there were 25 people waiting for the doctor. Matilde's appointment was at 3pm. An hour later there was still no sign of the doctor. Another waiting patient asked the nurse what the problem was and she replied that the doctor had not yet arrived. I looked around the room and there were no indignant looks; no one in the room was surprised as I was. At 4.45pm, the nurse returned to explain that the doctor was in South Africa and would not be coming. Most of the women in the waiting room got up and left. Matilde went over and asked the nurse whether this was new information. The nurse ignored her question and told her to come back the following week. (Field notes: 25 and 26 May 2010.)

Compared to most other women's experiences within the public health system, Matilde's experience was quite mild but it highlighted some of the major problems that women complained about during my fieldwork. Among these were the bureaucratic entanglements that Matilde encountered in order to make an appointment, including the loss of her original file at the hospital, a file that later reappeared. The time Matilde had spent waiting for a doctor who never arrived, could be docked from her salary at work. The extremely onerous experience of spending a whole morning and a further two afternoons trying to see the doctor compounded by the indifference and rudeness of the nurse who had refused to answer any of her questions, caused both Matilde and I to wonder whether she would have fared better going to a private clinic.

The fact that Matilde was not able to see the doctor showed a lack of coordination on the part of an institution that should have ensured the doctor's presence at the time stipulated. The doctor herself had not bothered to send a message timeously that she would not be available, and this lack of concern was also reflected in the nurse's behaviour. Given all these factors Matilde felt she had to stand up for herself and the other women in the room. The nurse however refused to acknowledge that the administration was to blame for the situation. Most of the women who had patiently visited the hospital the same day, some of whom were heavily pregnant, had no choice but to return the following week. Had there been any complications regarding any of the

pregnant women they would either have had to go somewhere else, or to have waited until the following week, in which case any risks attached to their pregnancies would have been exacerbated.

Some women found ways around the generally disorganised processes of the public hospitals. Claudia, 35, was one of the few women I met who gave birth in a public hospital, although she had all her prenatal consultations at a private clinic, where the length of time spent waiting for the doctor was shorter than in the public hospital. Her description of her time spent in the public maternity ward showed much of what many middle-class women consider to be the problem in such hospitals:

There were a lot of people. That's where the *povo* (literally the people but with the implication of marginalised poor people) go to give birth. And I was treated like everyone else. I stayed in those rooms. True, the sheets are not clean, there's blood in every corner... Without a doubt there are a lot of problems. You lie down on sheets that look dirty and they tell you they have been washed, but you can see they haven't. You don't have the doctor there with you at every moment, wondering how you are. No! They leave you to your own luck, but when they see it is time then someone comes by and checks you blood pressure and dilation. You can wait for two hours and think no one is paying any attention to you. (Interview: Claudia 15 June 2010.)

Claudia still preferred to give birth in the public hospital despite its obvious shortcomings. In the hospital she knew that if there were any complications with her birth the hospital had equipment at hand that could assist her. This was not always so in the private clinics. She was concerned with relative safety rather than with what she called "aesthetics." Claudia's and Matilde's stories already demonstrate some of the demerits of the public healthcare sector. Twenty-four-year-old, medical student, Iva agreed that if she had a choice she would "go private". She explained:

If you have to be admitted into the hospital – I would never be admitted to *Hospital Central*, because you would be in the wards full of people, I just

don't think it's worth it. I would go for a private room. (Interview: Iva 29 May 2010.)

The women above have not had any particularly bad experiences within public hospitals as regards their own healthcare. What disturbed them was the inadequacy of the service and the poor quality of hospital conditions. Yara's story was different. In 1999 Yara, at nineteen, gave birth to a baby girl at a public hospital who soon died soon after birth. She describes how, after her caesarean section operation, she thought that the complications she experienced were due to negligence on the part of the doctor:

They sewed me up with some thread that wasn't appropriate for my skin. On the third day I left the hospital and I went home... In the early hours of [the morning], I woke up to go to the bathroom and felt pus running down below. My boyfriend was staying with me and my parents then... When my parents got to me, I had a river [of pus] on the floor all coming out of my tummy. All that white pus. So my mother called [a] doctor [whom we knew well] and he said she should take [me] to the emergency room. So they [nurses and doctor] got to work... it was painful. They had to drain my stomach and I still had the C section wound. They had to really squeeze hard – really, really hard. You know when they give you a massage and that force that goes into it - it was twice more than that, so that they could get the dirt out. I was interned for one whole month, being drained of the pus each day. (Interview: Yara 29 May 2010.)

Yara still felt emotional and physical pain when she retold her story. Losing her daughter resulted in her drinking alcohol, although she claimed to have reduced her drinking more recently. After this experience in the public hospital she went to private clinics and abroad when she had serious health problems. At the time of research, Yara was engaged to a man she had been dating for some time and if she had children in the future, the likelihood of her having her baby in a public hospital was very slim.

Despite her experience, Yara's family still used public hospitals. Every now and then she paid bribes to medical personnel within healthcare institutions in the hope of ensuring that her relatives were properly cared for:

And then you have situations where you actually have to pay so that you and your family member can receive the minimum of human [dignity]. But not even that works, [because] sometimes people work in shifts. (Interview: Yara 29 May 2010.)

Indeed, nurses worked in shifts and each nurse or nurse's assistant often had to be paid to coax "better" treatment, as 32-year-old Teresa discovered when her sister gave birth in a public hospital:

We had to pay the midwife's assistant, and everything was fine and [my sister] was being treated well. But then there was a shift change and another bad humoured nurse came in. And [my sister] called us and we had to go and pay her as well. And they get a salary! And then my brother-in-law and I couldn't stop laughing because we had just paid the woman and there was a big A4 sign on one of the doors that said something about contacting the hospital with any complaints about bad behaviour on the part of the staff towards patients. (Interview: Teresa 22 May 2010.)

Teresa and her brother-in-law could see the irony of contributing to the perpetuation of corruption within the health system. They however believed that without a bribe their relative would not be fairly or properly treated. When Teresa gave birth at a private clinic she did not have to pay a bribe. Paying bribes in the public hospital seemed a better "investment" on Teresa's part since she hoped in doing so she would ensure better treatment and care for her sister.

To summarise some of the flaws women identified in public hospitals, Matilde's story showed the extent of disorder within hospital administration, the lack of communication on the part of the medical personnel between administrative and medical staff and an obvious disregard for patients. Most people expect to experience the conditions that

Claudia and Iva experienced. The overcrowding and the lack of cleanliness in hospital rooms are not unique to the Mozambican context. What is interesting in the above stories is the way in which the public feel they have no power to directly confront poor conditions within hospitals. The result is that poor treatment is not recorded and action is not taken against it.

Although Yara and her family believed that the death of her daughter and her subsequent infection were a result of malpractice, they did not launch a formal complaint with the hospital administration. Mullis (1995: 135) defines negligence in the medical context as “conduct that fails to achieve accepted standards of professional health care,” and malpractice as referring to “negligent conduct that harms a patient.” Most of the women interviewed agreed that local medical practitioners were often negligent, but few believed they could effectively lodge complaints.

Yara, given her traumatic experience, felt she wanted to seek healthcare for herself in private clinics in Maputo or abroad. Where she could not do so she thought using her personal contacts within the healthcare system would improve matters. Like Teresa, Yara found that bribing hospital personnel often made things a lot easier. Bribes, it seemed, offered women some sort of “insurance” by guaranteeing their own safety and that of their relatives. In the Mozambican healthcare sector the most common form of corruption is the bribe (Mosse & Cortez 2006). Mosse and Cortez (ibid) argue that Mozambican citizens pay bribes in almost every hospital department, from laboratories to pharmacies. The culture of poor governance and corruption undermines effective healthcare service delivery (Lewis 2006). Yet as long as deep-seated problems within the hospital system persist, such as the continuation of poor salaries paid to hospital staff and poor working conditions, people will continue paying bribes.

Although in some institutions certain protocols were put in place to curb corruption, specifically to ensure that cases of it were reported, both patients and personnel were unwilling to take up the suggestion. Patients were aware of what a bribe would offer them, as were personnel who used these bribes to supplement their salaries. Thus addressing corruption by putting up signs that encouraged its reporting was a futile attempt at dealing with such issues. Most of the participants were sceptical as to

whether changes would be made. In addition to monetary corruption, the experiences of the women demonstrate a lack of professional ethics on the part of the hospital staff as regards the ways in which they interact with and treat patients. Often these problems stem from staff members' own grievances specifically their dissatisfaction with the conditions under which they work. Medical staff therefore "transfer their dissatisfaction to their patients" (Mirhosseini & Fatahi 2010: 320).

For women who are able to afford it, the easiest answer when faced with these conditions, is to turn to the private sector. There is very little information on the private healthcare sector in Mozambique. This is because relevant data is lacking due in part to the absence of regulation of this sector (Hanson & Berman 1996). Does going to a private clinic and paying upfront reduce the likelihood that a corrupt exchange will occur? In the following section I explore some women's usage of private clinics.

3.1.2. Private spaces

In the field I visited three private clinics situated in prominent areas of Maputo City. Most of the research participants had been patients in at least one of them. All the private clinics I visited were general clinics, with specific time slots in which one could see a doctor, usually late afternoons and some evenings. This was to accommodate doctors who worked in public hospitals during the day. On arriving at a clinic what was most immediately noticeable about their differences from public hospitals were what I would call "aesthetic" differences. The clinics were situated in residential homes, bungalows or two-storied buildings which had been turned into medical facilities. There were usually few people in the waiting room, making the facilities far less crowded than their public counterparts. Most clinics conducted their own procedures, including assisting in normal childbirth, but some depended on outside independent laboratories or the HCM for sample testing and the use of x-ray and MRI machines.

Like Claudia, many pregnant women went through their pregnancies with a doctor at a private clinic and then ultimately gave birth in the HCM public or private ward with the same doctor, if possible, or the doctor on call on that particular day. With an international relations degree and a job at an NGO, 33-year-old Regina gave birth to her first child at a private clinic. She had been going to gynaecologists in private clinics

since the age of nineteen and now in her second pregnancy was not planning on changing that pattern. She did not have a regular obstetric-gynaecologist and as she explained, “I have a preference for a certain doctor, but when he is not available and it’s an emergency I’ll change. But even so I find myself mostly unhappy with the doctors and am currently searching for something better (Interview: Regina 27 May 2010).”

One option for women like Claudia who believed that the public sector was safer for childbirth, but were unwilling to join the *povo*, as she expressed it, was to go to the *Clinica Especial*. This was a private clinic within the public hospital and, although there were sometimes public protests against its existence, it stood apart from the other private clinics as it was hospital based. The facilities were the same, but people paid more money in order to receive a specific type of treatment: the kind that often allowed women to have a private room and a nurse at hand if they wanted to call her.

A former prominent doctor at the HCM, Dr. U, explained how a range of consultations worked:

The HCM had “special” consultations, “normal” consultations and the *Clinica Especial*. In 2005, when the new government came to power, special consultations were abolished. There was also a movement to abolish the *Clinica Especial* but it didn’t work. So the hospital carried on with “normal” consultations and the consultations at the clinic. Ideally the clinic was meant to offer a better, superior service than the normal consultation – better in so far as the income from the clinic could serve as an incentive for the employee, as you know the salary in the “normal” system is pretty low, people have to receive another subsidy in order to feel motivated. The expectation was that, when medical personnel were working at the clinic or with a “special” consultation, they would have extra motivation, they would be happier... with differential treatment – that was the term “differential treatment” for those people that could pay. Because, let us say they need there to be a difference. They don’t want to stand in queues; they don’t want to follow the “normal” method of going to health centre/post, general hospital and then the HCM. (Interview: Dr. U 09 June 2010.)

The clinic was thus born out of a need to give doctors an incentive, above their monthly salary, to work with more care and consideration towards patients. Clinics offered doctors the chance to live up to their ideas of the status of a doctor in society. Within an impoverished context, where there was an overall shortage of doctors, starting salaries were not commensurate with how doctors saw their own worth within society. In a study exploring *How African doctors make ends meet*, Roenen *et al* (1997) found that, apart from resorting to working in private clinics, doctors earned income from non-medical work, for example, commercial or agricultural work. Doctors had ceased to be “cultural icons” (Rylko-Bauer and Farmer 2002: 485). Their survival techniques sometimes verged on the criminal with theft of drugs for sale or barter on the side (Ferrinho *et al* 2004). For Mozambican doctors ensuring survival meant working across both public and private sectors. This had the effect of extending doctors’ workloads and thus further hindering their delivery of quality healthcare.

Elena, a 30-year-old lawyer, used the *Clinica Especial* for most of her health needs. Her company had an account with the clinic, enabling workers to frequent it at discounted prices and sometimes at no cost at all. Elena was pleased with her treatment there. She found a good doctor during her first pregnancy with whom she chose again to follow her second pregnancy. Elena explained that her doctor gave her his personal telephone number so that during the last months of pregnancy she could contact him if she had any issues. Elena nevertheless complained that sometimes she waited long hours without any information as to whether the doctor would eventually arrive. The waiting periods, sometimes lasting whole afternoons, often happened because doctors were performing emergency surgeries in the main hospital.

Sheila was a well-known doctor’s daughter. She had two daughters and at the time of research was three months pregnant with her third child. During her pregnancies she went to both public hospitals and private clinics, where she was always treated with enthusiasm when people found out who her father was. Her complaints were about the fact that hospital staff and administration lacked respect for other people. “They look at how you are dressed before they decide how to treat you,” she said (Interview: Sheila 12 June 2010). To Sheila, ethical behaviour and consideration for all patients was a big part

of what she thought was missing from the training of most medical personnel. For this reason she often preferred to use private clinics, where she claimed staff were more polite.

Sheila's experience of being treated a certain way because of who her father was, was backed up by Yara's statement that, in order to be well treated in hospitals or clinics, you had to know someone you trusted there. Yet that was not always the case, as Dora, 34, found out. Dora had many doctors in her family, and when it came to her experience of giving birth in a private clinic, their "status" was not of much use to her. She recalled what happened just after she gave birth to her son:

I remember one night I was crying in pain, I called the nurse to give me something because the pain was so strong... she gave me a Panado! And I fought the whole night and I woke up and the bed was wet, because I was sweating so much the whole night... The next day the doctor came... I told her about how the nurse gave me [some] Panado when I asked for something for pain... the doctor was shouting. You know the problem is the system... Why didn't [the nurse] phone the doctor to [say], "Your patient is in pain, what am I supposed to do, what am I supposed to give her?" She didn't do it. She thought in her mind, you know, that somebody with stitches, with a big cut can stand pain with Panado, can stop pain with Panado?! – Paracetamol, it's nothing! And [the doctor] said to the nurse, "Did you read the chart, what's written there? What's written there? SOS!" How many patients are in the same situation, sometimes on the edge [of dying]? And sometimes they die just because of a lack of medication, negligence... That's why you can't trust [local healthcare services].
(Interview: Dora 05 June 2010.)

What Dora experienced at the hands of the nurse may be viewed as a form of patient abuse. Most participants referred to being mistreated by nurses. Jewkes *et al* (1998), in an article *Why do Nurses abuse Patients? Reflections from South African Obstetric Services*, describe a study conducted in South African hospitals in which patients complained of either being neglected by the nursing staff or being verbally and

physically abused by them. Stories of mistreatment in the maternity wards of Maputo public hospitals are legion. Women's stories of such experiences circulate and compound critiques of the overall health system. Experiences that deeply affect people lead to a loss of trust in local institutions and personnel. The result is that sometimes those who have the means travel further-afield for care.

A week before I interviewed Dora she had gone to Durban with her son in order to see a doctor for a stomach problem that he had been having. She had been to two local paediatricians who had not, in her view, given her a satisfactory diagnosis and so she had taken the boy abroad. Her own experiences, similar to those outlined above, planted doubts in her mind, and by travelling abroad she was trying to ensure that her child received the best possible care. The fact that Dora had local connections within the healthcare system did not deter her from searching for alternatives abroad.

We can see from Elena's, Sheila's and Dora's stories that their experiences in private clinics in Mozambique were similar to those of the women who frequented the public sector. There being few distinguishing features between public and private healthcare services in Maputo, some women "juggled" between the two systems, trying through various strategies to ensure better healthcare for themselves. Social relations played a part in these and other women's decision making when seeking healthcare. Talk within families, with friends and colleagues about healthcare services were hugely influential in these kinds of decisions. In the following section I examine the role that talk, stories and rumours about local healthcare played in the women's decision making processes in seeking alternatives to the public healthcare system.

3.2. The role of talk, stories and rumour in decision-making

Whether in a store, along the road, at work, play, home or other community settings, when people are together, they are inclined to talk about events – those they have heard about or read about, those they have experienced directly, and those they imagine (Ochs & Capps 2001: 1).

The death of baby Jossefa was a major talking point during the first few weeks of my arrival in the field. People found reasons to relay their own painful experiences of

healthcare in Maputo and, while many were indignant about the situation, they were not surprised by such events. Stories often made their way through social networks, and because the Mozambican healthcare situation was so precarious, even if stories changed, people often believed them. Civil servant, Claudia, gave the following reasons for giving birth in a public hospital:

I made an evaluation... the most important factor was the fact that I wanted to have the baby at the hospital. Because when you have a baby at the private [clinic] and there is some complication, you are evacuated to the hospital. It's the place where all the conditions are created to support you in case of any complications. Therefore, [that was] my preference. (Interview: Claudia 15 June 2010.)

Claudia's decision to have a baby in the public hospital was not only because she thought it was far too risky for both herself and her child to give birth elsewhere, but because of a particular story she had heard. The story concerned a woman who died on the way to the hospital after a complication arose while she was giving birth at a private clinic. Although she did not know the woman, or the circumstances of the birth, she was adamant that she would give birth in the public hospital. This particular story had caught her attention and had influenced her decision.

The choice was very different for Teresa who, when she was pregnant with her first child, went for consultations to the public hospital. However an event occurred that was to alter her decision to give birth at the hospital and to change the way she viewed public healthcare services:

Once I [had an appointment], I went through the maternity ward [at the public hospital] in order to get to the doctor. When I got there I found some commotion in the corridor. So I asked a man... what was going on and he told me that a woman had given birth and then passed out. So apparently the midwife was under the influence of alcohol, and dropped the baby. It took a hit to the head. The nurse then puts the baby by the mother's legs and tells her the baby was born dead. But the woman was adamant that she had heard

her child crying. [Subsequently] the baby's father, a loud South African man, asked for an autopsy for the child and they opened a case against the midwife who had by then disappeared. They found the assistant to the midwife who had also been in the room and explained that the child had slipped from the midwife's hands. So after that, I never went back to the hospital [although I was six months pregnant]. I spoke to the doctor and transferred my files to a [private] clinic, and that's where I gave birth. (Interview: Teresa 22 May 2010.)

Teresa was not a witness to the event that left her traumatised. She heard it 'second-hand' from a man who had apparently been in the room where the event occurred. Later, when the story went public, she learnt more of the details. On the day of her consultation and finding herself amidst the chaos, she realised that her first reaction was one of fear and that she was willing to risk going anywhere else but the hospital for the delivery of her baby. She was not willing to come back to the place where another woman had lost her baby due to what she believed was gross negligence.

In contrast to Teresa, for Elena a private clinic outside of the hospital was unacceptable. She told me the story of a friend of hers who died giving birth in January of that year at a private clinic. The baby survived but the clinic was not equipped to deal with the complications that arose after the birth and the mother subsequently died. Elena wondered, "How come clinics are authorised to give birth without the proper conditions for emergencies? (Interview: Elena 14 June 2010)." Most women cited other people's negative experiences within the public healthcare system as influencing their decisions, but to Elena it was someone else's fatal experience at a private clinic that kept her at the biggest public hospital in the City. Elena put serious thought into weighing up her alternatives, considering the delivery of her baby at a private clinic to be potentially life-threatening.

Talk reinforced the widespread notion that maternity units in Maputo were dangerous, hostile places. Women were scared not only for themselves but also for their babies after the birth. Lack of security in public spaces also seemed to create anxiety for some women, as Dora explained:

They steal babies... I think you saw in the news the baby that was stolen there in the general hospital and they recovered it. They told me the story of another one that I think passed away and they couldn't recover the body. Weird stories, scary ones! You must look perfectly at the baby and take a picture and ensure that this is my baby and they are not going to take it. (Interview: Dora 05 June 2010.)

These were “scary” stories for women who had no alternative but to give birth in local facilities where safety was often a concern. Women took the stories they heard seriously. As Brenneis (1998) and Bauman & Briggs (1990) argue, stories construct particular social realities. Whether stories were told first-hand to individuals, or whether they were part of more wide-spread rumours and gossiping about Mozambique's healthcare system, they served as a mechanism to further distance women from pursuing healthcare locally. Ben Okri argues that “stories are always a form of resistance” (1993: 34, quoted in Ross 2010: 144). In many ways the stories that these women told about their experiences constituted ways in which they could convey their frustration with a system that seemed intractable. As Brenneis (1998: 280) argues, “stories both draw upon experience and engender it.” Middle-class women were constantly making meaning of their experiences through stories and trying to shape new experiences through the same means.

Although gossip and rumour are often used interchangeably in speech, and are both “genre[s] of informal communication” (Paine 1967: 278). Definitions vary according to context but generally, gossip often refers to stories about someone or something that are true, and rumours are usually falsified information. Rumour can be defined as “a specific proposition for belief, passed along from person to person, usually by word of mouth, without secure standards of evidence being present (Allport & Postman 1947: ix, quoted in Feldman-Savelsberg *et al* 2000: 167). Like stories, rumours are socially constructed. We often think of rumours as information that is inaccurate, incomplete, distorted or exaggerated but they also serve a social function as a way of connecting people within social groups (Kroeger 2003). Both rumour and gossip reinforce moral values and may lead to community unity (Tovares 2006). These definitions could apply

in a very particular sense to the stories about the inadequacies of public (healthcare) service provision by the Mozambican government, and when women identify themselves as belonging to a particular stratum of society, as being middle-class.

While Brenneis (1998: 280) argues that “stories both draw upon experience and engender it,” it could be argued that rumours fulfil the same function. In Mozambique it is often rumoured that hospitals and funeral homes are commercially linked, and that this could explain why so many people die at the hospital on a daily basis. Such rumours have been in circulation for many years and every so often are brought up in conversations about the general failure of local hospitals. On August 6th 2010, Mozambique Radio Online published a story entitled *Funeral agencies accused of ordering the “hastening” of patients deaths to gain a greater number of “clients”* (Radio Moçambique online 2010; own translation). The article goes on to explain that a meeting was held between a number of funeral agencies and the Mozambican Christian Council to discuss various public grievances that had been brought to their attention, including the fact that funeral agents were often strategically placed outside the hospital morgue in order to find clients (ibid). So what is thought of as a longstanding rumour perhaps has substance and relevance to everyday reality.

With stories such as the one above being aired in reputable media and published in sensationalist tabloids, it is easy to understand why women use rumour and stories as a basis for their critique of Mozambique’s health system. Their negotiating within the system involves building a working ‘body of knowledge’ based on experience and on “story-telling.” These mechanisms allow people sufficient understanding as to when to be extra cautious about certain places. They bear witness to the fact that the pursuit of healthcare can often be a precarious endeavour for the citizens of Mozambique.

3.3. Conclusion

It was the view of legendary Florence Nightingale that, “The very first requirement in a hospital is that it should do the sick no harm” (1859, quoted in Schule 2010). We all expect to be treated with dignity and respect when we are in search of medical care. In the best of all possible worlds a hospital should be a safe haven, where one will be well cared for. Women participants in the study perceived as negative many of the

experiences within public and private healthcare services in Maputo. Although there were varying degrees of negative experiences, from a doctor failing to appear for a consultation to the loss of an infant, the women were generally dissatisfied with the local level of care. Their decisions about healthcare, and ultimately about seeking alternatives, were influenced by negative experiences, whether their own, within and beyond their families, or that of others. Women conveyed information relevant to healthcare through stories, even though some of the stories may have been based on rumour.

Mozambican women continued to make use of inadequate services, attempting through personal influence and bribery to improve the care they receive. Women, when they could afford it, chose sometimes to go abroad in search of quality care, thus avoiding local problems pertaining to healthcare in Maputo altogether. This chapter explored how women have survived an imperfect system, even at times bending the rules themselves. They did so out of desperation, hoping to be treated with the degree of dignity all people, irrespective of class, should be entitled to.

Chapter Four: Seeking alternatives abroad

“The Maputo Development Corridor is today one of the most solid pillars for co-operation between Mozambique and South Africa.” President Joaquim Chissano – quoted in the Christian Science Monitor 1996 (Ahwireng-Obeng and McGowan 1998: 5)

Chapter Four examines how some women, because of the difficulties experienced in local health services in Mozambique, sought healthcare alternatives outside its borders, often in neighbouring South Africa. Women claimed to find there what was for them lacking in service provision at home. Going abroad was a way of avoiding the local healthcare that they perceived as inadequate. Such journeys may have seemed like a total rejection of local healthcare services in Maputo, but in fact provided an extension of possibilities for women within a flawed healthcare system.

I argue that these women were not passive consumers of healthcare but instead demanded a calibre of treatment that distinguished them from the majority of poor people both in Mozambique and South Africa. The theoretical core of the chapter is as follows: within industrialised so-called “western” countries, women’s movements are critical of the way birth and gynaecological procedures have become over-medicalised with control of women’s health firmly in the hands of medical personnel, who specialise in systematised invasive procedures. I will examine whether this holds true for Mozambican women seeking “quality” healthcare in South Africa.

The four women in this chapter all went through the public and private healthcare sectors in Mozambique and ultimately travelled to private clinics in South Africa. Katia and Stella’s stories deal with endometrial conditions that they both believed were incorrectly diagnosed in Maputo and with their search for answers. Patricia and Karina’s stories concern childbirth.

4.1. *Searching for relief*

Twenty-five-year-old Katia returned to live in Maputo after finishing her degree in the United States. She had never had regular periods, and experienced a lot of pain during her “time of the month.” Although she had regularly visited a gynaecologist from the age of eighteen, she had never in the course of these consultations mentioned how painful her periods were and assumed hers was the pain every girl experienced. As she described it:

Apart from all the pain once a month, it never really bothered me. I would enjoy skipping my periods. Wouldn't every woman?! Talk about a minor inconvenience!! It was only much later that I sought treatment. I'd had enough of the pain. (Interview: Katia 15 May 2010.)

Katia's pains gradually got worse until she sought help. She explained:

I couldn't walk some days. One day I woke up and I was in so much pain I couldn't move. I had to phone my mum's cell so she could come see me. After I got a bit better she sent the driver to come get me and I went off to the clinic... Lucky for me it was a day in which my doctor was actually available. I waited a while, but I finally got to see her. And she had my files with her... and she asked me what was wrong. I explained and I remember [drinking] lots of water thinking she might want to do an ultrasound.⁷ My bladder was seriously hurting. I told her I couldn't take the pain [of the periods] anymore and I didn't know what to do. She started scribbling away on a piece of paper. I thought she was probably going to examine me next. When she finally looked up, she told me that I had to go over to the *Clinica Especial*, where I had to book a laparoscopy.⁸ I wondered what that was. As I got to the door I asked her, what was wrong... I swear she said, “We'll worry about it when we get the results.” But I insisted as she looked a little grim. She said she suspected endometriosis. I was totally freaked out and

⁷ This is one of the common ways in which local obstetric-gynaecologists often check for uterus and ovarian problems (correspondence with a local doctor).

⁸ In gynaecology a laparoscopy may be used to inspect the outside of the uterus, ovaries and fallopian tubes in the diagnosis of various conditions including endometriosis and infertility. It involves a small incision near the navel (correspondence with a local doctor).

she could see it. I was quite furious as I left. I felt much uninformed.
(Interview: Katia 15 May 2010.)

When Katia got home after her doctor's appointment she immediately tried to find out more about endometriosis on the internet. Her mother called her aunt, a well-known local doctor, who suggested they go to Johannesburg, South Africa for a second opinion. There was also a history of misdiagnosis in Katia's mother's past that made her very distrustful of the local healthcare system, and shaped the way that Katia and her sister felt. In addition, Katia's mother had undergone a procedure to remove fibroids from her uterus that left her abdomen misshapen. In Maputo the family already used the private health sector, and whenever possible they would travel abroad for check-ups. When Katia's pain became unbearable it seemed like an emergency. She said:

I knew we had to go soon to a clinic in Johannesburg and we made the appointment the very next day – although there were a lot of issues, logistics. Mum didn't want to drive so we had to fly there. Then we had to book a hotel for a couple of nights and I wasn't working at the time, but Mum had to get leave. We still went the following week. And it was worth it. It turned out not to be endometriosis at all! (Interview: Katia 15 May 2010.)

In Johannesburg, Katia found out she was suffering from polycystic ovarian syndrome (PCOS), something that I was quite familiar with having recently been diagnosed myself. But it meant that her condition was treatable and she would not have to go through any surgical procedure. This meant that Katia did not have to worry about scarring or being unable to have children, something she worried about after her first diagnosis. She however acknowledged that in order to diagnose endometriosis a laparoscopy was usually the procedure. She concluded:

At the end I wasn't too mad, because the doctor in South Africa explained that the laparoscopy has to be done to diagnose endometriosis... But I spent at least an hour just talking to the doctor in South Africa and he managed to answer my questions, explain everything and do an examination. It was all I

asked for. And look at me now... I sometimes have a little pain, but I know ways to make myself feel better. That diagnosis was a blessing. (Interview: Katia 15 May 2010.)

Katia found the answers she sought in South Africa. She did not attempt to get a second opinion in Maputo. One of the benefits of Katia's journey to the South African doctor was that in conversation with the doctor she felt listened to. She was reassured that her pain was significant, yet it was not so bad that she would require surgery. In normal medical practice a patient would expect that a doctor would take time to gather her or his history. It was unlikely however that Katia would have had this treatment in Maputo. The question that remains is why Katia placed so much faith in the South African doctor. She never questioned his diagnosis. Would she have reacted the same way had he suggested surgery? Katia and her mother were willing to put their trust in the South African doctor's diagnosis although they had not known him previously, and had no history with him.

Unlike Katia, Stella's story ended in surgery, yet her experience and reasons for going abroad were similar to those of Katia's. Stella, 27, told me that her family had all but given up relying on the local healthcare system. Her family's most recent experience involved a visit to the HCM emergency room after her mother had collapsed. Stella recalled that her mother had been mistreated and was made to walk around the hospital for various tests when she could barely stand. The family's discontent with local health services could be traced back to Stella's grandmother who had gone blind following a complication from routine ophthalmological surgery. It was these incidents which discouraged Stella from using public hospitals.

Stella first went to Nelspruit for healthcare in 2007 after she and her family disagreed with a local doctor on the course of treatment he proposed for a small painful lump she had found on her breast. In the course of our discussions she recalled:

I went to a consultation [in a public hospital] about the lump in my breast, so... they asked me to do a general blood test... I was there from 8.30 to 12.30... waiting... waiting. Then I was seen by a doctor who was in a real

bad mood. Who didn't look at me and didn't even touch me. He asked what was wrong. He didn't do any analysis, and he just said, "Okay let's operate".... "No! I don't think so!" I left there and I went to tell my mum what the doctor had said and she said "No, go ask for a second opinion..." I mean the first one wasn't even an opinion. How can a person have an opinion without even touching a patient? (Interview: Stella 12 June 2010.)

I asked Stella if the doctor had at least explained what the problem was:

No, nothing... So I went to a gynaecologist in Nelspruit. He analyzed it and he said it didn't seem so worrying, because it was an independent mass that wasn't attached to the wall of the breast - I mean it was a hollow mass. But he couldn't give me any concrete information because he was just a gynaecologist, so he sent me to a surgeon. And the surgeon explained that when you are about to have your period your whole body prepares itself... before you have the period.... Even the breasts grow. And some tissue accumulates. But... when the period goes it also gets back to normal. But in my body it kept accumulating. So he gave me some pills to help it break down, or something, I can't recall, and helped with the pain, because there were stabbing pains. He said he wasn't going to operate. (Interview: Stella 12 June 2010.)

This was Stella's first experience with doctors abroad. She was given pills to help the mass break down. No biopsy was performed to establish whether the lump was cancerous. Her pain eventually stopped, as the lump disappeared. Stella and her family were happy that there had been no operation. Much like Katia, the idea of an unnecessary bodily invasion was one that they were not willing to accept. A few years later when she experienced severe pain in her abdomen she returned to the same gynaecologist in Nelspruit. Stella recounted:

I went to the doctor in Nelspruit. I never even thought of coming back here. I mean, there were so many memories of things badly done and bad

treatment, I never even thought maybe I can go back. No! I didn't even think of it... I went to Nelspruit because of the pain I was having with the period cramps. The doctor there said I needed to be operated on. I put the money together... and I went to get the operation done. And the routine consultations I also get done there. (Interview: Stella 12 June 2010.)

Stella was operated on to remove fibroids from her uterus and did not doubt that she needed the operation. There were certain factors that ensured that the second time an operation was suggested, Stella did not hesitate. She felt detached from the local doctor who had paid little attention to her, and who gave her no explanation as to why he decided, without any type of analysis, that she needed an operation. In contrast, the Nelspruit doctor had given her answers that she deemed acceptable, and had managed to solve her problems and take away her pain. Saving her money and later going for an operation in Nelspruit seemed justifiable in this case. Unlike the previous situation with the doctor in Maputo, Stella had complete trust in her Nelspruit gynaecologist. A lack of trust, due to a historically unstable relationship between Stella's family and the local health system, played a part in her dismissing the local doctor's diagnosis.

Katia and Stella had never had children but hoped that someday they would. To try to ensure that this was a possibility in future they did everything in their power to protect their fertility. Unlike most of the women whose stories were told in Chapter Three, Katia and Stella were not predominantly concerned with hospital conditions, or how politely they were treated; they were concerned with receiving correct diagnoses and appropriate treatment that would hopefully secure their future as potential mothers.

4.2. An ordinary or a luxury birth

During her first pregnancy 34-year-old Patricia worked for an NGO located in a rural district in Mozambique. She visited a local health post and rural hospital for regular check-ups. She described the conditions of the health post as quite appalling and said of the staff that their, "bad attitudes were expected" (Interview: Patricia 16 June 2010). Patricia would not have chosen to go to rural facilities, but her only other option was to travel long hours to a nearby city, where the conditions may have not been that different, or to travel further to Maputo which at the time was not possible. After

visiting local rural facilities in the build up to the birth, she gave birth to her first child in a rural hospital.

Patricia's next two pregnancies were different. Her second child was born in the *Clinica Especial* in Maputo, where she underwent all her consultations up until and including the birth. Although she acknowledged that there were differences between the rural clinic and the hospital that she frequented during her first pregnancy, and the private clinic in Maputo, she recalled that staff attitudes in both places were similar. When it came to her third pregnancy Patricia was sure that she wanted to have her child abroad, limiting herself to minor check-ups at local private clinics. Up until her eighth month of pregnancy all her consultations were conducted in local private clinics. She then travelled to South Africa in her ninth month to give birth at a private hospital. Patricia complained about the amount of money she had to spend in giving birth privately in South Africa and explained that if her and her husband's medical aid had not covered it she would have given birth closer to home. The fact that her husband worked in South Africa at the time of the birth influenced their decision to have the baby abroad.

For Patricia, the differences between the two countries at the private health level were vast. She explained that in South Africa she was treated like a queen. She felt more in control of her situation than she had done in her first pregnancies. She fondly recalled her feet being massaged. For some people, including Patricia herself, a foot massage may have seemed like an extraordinary luxury, but for others, accessing private healthcare was a choice they made, even when they did not have access to medical insurance. In Mozambique only a few companies had medical aid schemes, although it was a growing industry. Some private companies and international NGOs made it possible for people like Patricia to have babies in private hospitals in South Africa.

Karina, 26, and recently married to a medical doctor, was not concerned with the cost of her imminent birth, although she did not have medical insurance. She was determined to have her baby in South Africa. She had been going for consultations there since she was a teenager and had chosen to have her child with the same doctor. Like Katia, Karina's mother started going to Nelspruit for consultations years before taking her daughter with her. Karina explained why her mother went to a doctor in South Africa:

...my mother [was] looking for better conditions, etc... Not only for that but for the *atendimento*⁹... What really counts is that human contact, the preoccupation with your situation. That's what makes me travel kilometres and kilometres and go through stresses just to have that. Sometimes here you don't find that. Sometimes the doctors are so, so busy that they forget how very important public relations are. First it was my mother, then I went next to do gynaecological check-ups once a year. (Interview: Karina 9 June 2010.)

I wanted to know why Karina insisted on giving birth in South Africa. For Karina there had never been any doubt that she wanted to have the baby abroad and this decision was cemented shortly after her wedding, when she began to have contractions and was forced to visit the Central Maputo Hospital in Maputo. She told me:

At the time [I was pregnant] we didn't worry about having a doctor here... If I hadn't had contractions just after the wedding, I wouldn't have seen a doctor here. It just happened that because I had the contractions we left here at dawn and went to the maternity ward [at the HCM]. (Interview: Karina 9 June 2010.)

When Karina and her husband arrived at the hospital they managed to find an obstetric-gynaecologist her husband knew who told them what medicine was needed and that it was not available at the hospital. Karina's husband then rushed to a clinic where he knew a doctor, and he was able to acquire terbutaline, used in delaying premature labour. The "wheeling and dealing" in getting the correct medication for Karina, reinforced her decision to have her baby in South Africa. She said:

So you see the gaps? You need things and you don't have them. Or what if I had arrived there being a nobody (*uma zé-ninguém*)? I would have had the baby on that day. It wouldn't have postponed. Imagine if I didn't have any

⁹ Directly translates as 'treatment' but refers also to the hospitality and warmth afforded to people when they go to a particular place such as hospitals, restaurants, etc... 'how people are treated.'

buying power, how would I go to the clinic to buy something like that at ridiculous prices? They would have left me there, and if it took too long, [they would have done a] C section. (Interview: Karina 9 June 2010.)

Once Karina was in a local healthcare facility she negotiated her way around it as best she could with the help of people she and her husband knew. Her knowledge of how to make the best of the incoherent local services was extremely important as it was not possible to travel for healthcare on every occasion across the border.

Karina, it seemed to me, was fortunate in having a doctor for a husband. She was prepared to travel to Nelspruit a few weeks before her due birth date. Some women who go abroad are not only searching for “better” treatment by medical staff, but for situations in which medical supplies and technological equipment are easily accessible. Karina, like Katia and Stella, perceived there to be huge deficits in terms of technology and other advancements in the field of healthcare in Mozambique. This was particularly disturbing to Karina and Patricia, and other women, in the face of possible complications in childbirth.

4.3. Seeking improvements in healthcare: the search for new technologies

In industrialised countries feminist concerns with control over reproduction are evident and have much to do with the fact that women are controlled by a set of bio-medical technologies, norms and standards that detract from women’s embodied knowledge. There are a few points to be made in a discussion of middle-class women and their search for healthcare in Mozambique concerning medical and technological interventions.

Authors like Biehl (2004) and Navarro (2009) have argued that globalisation and the dominance of a neo-liberal world order have led to gross social and economic exclusion of some populations. Neo-liberal public policies “benefits the dominant classes to the detriment of the dominated classes (Navarro 2009: 429).” The poor and vulnerable in particular are relegated to the margins of society, or what Biehl (2004: 476) refers to as “zones of abandonment,” denied access to proper healthcare and allowed to die. The

International Monetary Fund and Structural Adjustment Policies have had a detrimental effect on the ability of states to deliver services to their citizens. Health inequalities have increased between and within countries (Navarro 2009). Increasingly, health services have become commoditised so that only the rich are able to access quality healthcare. In the case of Mozambique, because middle-class women are able to buy healthcare, the ill-health of poor people to some extent becomes invisible to them.

With their aspirations of “modernity” middle-class women in Mozambique have expectations beyond what is available to them within their own national borders. Globalisation has contributed to the expansion of women’s wants and needs, and made their local situations seem inadequate compared to women like themselves in other places around the world. Seeking alternatives to Mozambican healthcare services, especially in this case, has become a way of skirting worsening local conditions.

Women’s “responsibilisation” (Rabinow & Rose 2006: 209) becomes twofold in the Mozambican context: responsibility in pursuing new developments in bio-medicine and in attempting to acquire the best possible healthcare, and responsibility in performing and reiterating their middle-class status, and with it their aspirations of being modern women within an increasingly globalised world. In this process the problem of subjectification arises where middle-class women, although privileged, remain biopolitical citizens, their pursuit of health shaped by hegemonic structures within the medical establishment. Despite this I argue that these women are active in constantly informing themselves about medical issues and in choosing various health options. In this case, responsibility is related to meaningful citizenship.

Rose and Novas (2003: 10) argue that specific practices that have been made routine by biomedicine, such as amniocentesis and ultrasound, “show that judgements of value concerning certain features of the bodies and capacities of citizens have become inescapable – even if it is the individual citizen and her family who must carry the responsibility for the choice now rendered calculable for them.” Although it seems as though the choices women have are limited, especially regarding “routine” medical care, to middle-class Mozambican women responsibility to and for themselves as biological entities equates with responsibility in maintaining their social status. Such

“judgements of value” (ibid) are the reason why women search elsewhere for “better” services when they are unhappy with what is available to them locally.

As mentioned above, feminist scholars have argued that the use of new reproductive technologies has rendered medical intervention inevitable when it should not always be so. There is never any guarantee that women will make use of the technologies available to them in order to ensure there are no problems with their pregnancies and births. In her research, Rapp (1993) found that pregnant women weigh up a variety of competing claims on labour and maternity. Similarly, in her study on women and childbirth in the USA among lay middle-class women, middle-class health professionals and poor women, Lazarus (1994: 26) found “a spectrum of opinions... from a desire for the most advanced technology to a desire for the least invasive, ‘most-natural’ birth possible in a hospital.”

In Mozambique, although women do not have access to a vast array of reproductive technologies, they go through monthly scans and weigh-ins during pregnancy. The use of amniocentesis is only for cases where the doctor suspects something may be wrong with the pregnancy.¹⁰ Yet most women claimed that they needed to come to the hospital every month in order to ensure that all was well with their babies and their pregnancies. To them, monthly visits to clinics and hospitals meant fewer complications at birth. Some theorists have argued that increased medicalisation of women’s reproductive health has made women “willing victims of modern medicine, as they have been convinced of the need for medically assisted childbirth, reproductive technologies and frequent screening examinations” (van Wijk *et al* 1996: 715). These theorists fail to see that some women are willing participants in a range of pre-birth procedures and should not always be seen as victims of modern medicine.

From the evidence I found in following the stories of middle-class women in Maputo it seemed that women did not feel subjected to technology. On the contrary, procedures were symbolic of a certain thoroughness in care-giving and became attached to a certain social status which overrode any sense that women were controlled and objectified. Perhaps it was the very subjection to these technologies that made them feel

¹⁰ Personal correspondence with a local obstetric-gynaecologist.

empowered. In order to achieve a particular status in society, some participants believed that one had to keep abreast of the times.

For the pregnant women I spoke to a hospital birth was the best way to ensure that their children came into the world in safety and with “proper” care. As Abel & Brown (1998: 316) point out, “women seek biomedical information partly to explain their own experiences... [and] to gain a sense of control by knowing what to expect.” Furthermore, travelling to South Africa was more than a matter of choice and had to do with maintaining social status within local Mozambican social circles. Journeys that women undertook abroad required both time and money. They were journeys that not everyone was able to make, in the same way that not every Mozambican citizen was able to visit a private clinic. The ability to pick and choose and “shop-up” within healthcare services enabled certain people to claim or maintain a certain status in society, as was the case with most of the women in this research study.

As we have seen for Katia and Stella, finding relief from their afflictions was critical. Although Karina was not in any immediate danger, she sought treatment that would end the pain she experienced. Some of the women in the study were brought up frequenting bio-medical institutions and did not think any other choice was viable. As van Wijk *et al* argue, “Good quality health care strengthens the self-determination of women and should acknowledge women’s responsibility over their bodies as a basic right (1996: 715).” It is important therefore to look at the ways women negotiate and use modern medicine to make choices concerning the state of their bodies and the ways in which these are intertwined with notions of self and social status. The stories of the women in the chapter demonstrate the extent of their determination in seeking “better” care, and reveal them to be active participants in assessing their state of health in collaboration with medical personnel.

4.4. Conclusion

Women carry the responsibility not only of taking care of their own bodies, but also of ensuring that their families are healthy. Thus the accounts of privileged middle-class Mozambican women cannot be discussed outside of the historical, political and social

contexts that have shaped them as political citizens. The women I interviewed searched for options because of their circumstances, not as women without resources, but as women who perceived themselves to be without adequate options for healthcare locally. As some scholars have shown, there are strong arguments against the medicalisation of certain medical procedures concerning women and their reproductive lives. However there exists another dimension that should be examined. Those cases where women feel empowered to access such technologies in a context where they are otherwise not readily available to them show that the issue of over-medicalisation is not a straightforward one. Middle-class women in Mozambique have welcomed advances in biomedicine and seek them not only as a means of protecting themselves and their children, but also of living up to their expectations of being “modern” women.

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Chapter Five: Across the border: consumption, identity, status and the imaginary

Chapter Five begins with a brief background to the state of healthcare in South Africa. It follows with a few more accounts from women about their reasons for travelling abroad, accounts in which the line between being patients and consumers becomes blurred and which demonstrate the argument that women's identities are intertwined with their levels of consumption and what they are able to afford. The "social imaginary" (Appadurai 2008, Taylor 2002) becomes vital to constructions of women's identities in a context where they are able to maintain a social status that differentiates them from the majority of the Mozambican population who live in poverty. In this way middle-class women become 'blind' to the marginalisation of poor people in their own country and abroad.

5.1. A brief history of border crossings with South Africa

For many years men and women have migrated to South Africa from other countries in Sub-Saharan Africa such as Lesotho, Zimbabwe and Mozambique for labour purposes, and in more recent years as refugees. Historically Mozambique was one of the countries that supplied, and continues to supply, cheap labour to the South African mines and farms (McDonald *et al* 2000). Although the topic of the thesis is not migration *per se*, it serves to illustrate that even before the end of the civil war in Mozambique and of apartheid in South Africa, cross-border movement was already a characteristic of the ties between the two countries (Adepoju 2003).

More recently the reasons for "migration," or various kinds of movement of people across the border for short-term trips to South Africa, have included visits to family, friends or to doctors, or for the purpose of shopping. In these sorts of journeys, people crossing the border could be described as "visitors" or "tourists" in pursuit of various services and goods (McDonald *et al* 2000: 822).

5.1.1 Problems in the South African health system

Although since 1994, and the establishment of the first democratic state in South Africa, some improvements have been made in reshaping the South African health system – for example, giving people access to primary care – South Africa is still afflicted by its own health inequities. These are due to the legacy of apartheid, where access to quality healthcare was confined to a small white elite (Coovadia *et al* 2009). Health dynamics in South Africa are different to those of Mozambique, because South Africa has had a history of entrenched legalised segregation, ending in a negotiated settlement that inaugurated a democratic state and in which its health infrastructure remained intact. The country stands apart from its neighbours in sub-Saharan Africa in terms of trade and economic growth (Ahwireng-Obeng & McGowan 1998). It is also often a destination for migrants outside sub-Saharan Africa. Apart from food and other commodities, South Africa offers many Mozambicans “better” educational opportunities.

Even after the establishment of a democratic state, South Africa is still struggling with huge health inequities, such as “interprovincial and urban-rural differences in access to health” (Coovadia *et al* 2009: 9) similar to those in Mozambique. Historically black South Africans, “mostly in peripheral and extremely poorly resourced homelands” (Chopra *et al* 2009: 835), received grossly inadequate care. The movement of black men from town to countryside and vice versa, and the subsequent marginalisation of women and children together with the impoverishment of the countryside, are part of the legacy of South Africa’s exploitation of black people, where, in the area of healthcare, whites were rewarded and blacks carried the burden of health costs (Marks 2002).

The problems that continue to plague the South African healthcare system, specifically regarding the gaps in access to healthcare, were systematically ingrained for years during apartheid. Although the South African health system has undergone radical change since 1994, improvements have often been overshadowed by the gravity of the HIV/AIDS epidemic and the local politics surrounding it (Chopra *et al* 2009). For many South Africans the end of apartheid has not necessarily meant the end of the “poverty” and “powerlessness” Marks (2002: 18) describes. The South African public health system is an illustration of the country’s history of inequities, one in which citizens are

made to feel, and to a large extent remain, excluded from the state to which they lay claim.

According to Gibson (2001), many of the complaints made about South African public hospitals involve the experience of long waiting periods before being attended to, not dissimilar to some of the complaints made by this study's participants about healthcare services in Maputo. Harrison (2009: 29) argues, in relation to South Africa, that "there are still significant inefficiencies in the health system stemming from poor quality of care" and that such "weaknesses are endemic" within that country. Despite these problems, South Africa is a major destination for Mozambican women who seek improved healthcare services, usually in private clinics where treatment is considered to be much better than that available in the South African public healthcare services or in Mozambique. The women interviewed seldom, if ever, used public healthcare services within South Africa. Had they done so, they may have found similar problems to those experienced at home. Although a number of participants in the study argued that some public hospitals in South Africa had better facilities than private clinics in Maputo, these women had the privilege of being able to use private institutions that do not share many of the problems faced by public hospitals at home.

Growing inequalities in South Africa are reflected in the huge differences between public and private healthcare there. South Africa's medical private sector is much more developed than those in most of its African neighbours (Castro-Leal *et al* 2000), which makes it a prime destination for people from other countries seeking such services. This sector covers less than sixteen percent of the population although it boasts a number of doctors and nurses much higher than that of the public sector (McLeod 2005: 138). The difference in conditions and facilities between the two sectors is obviously significant, and although there are many Mozambicans who cross the border to South Africa in search of healthcare and who visit public hospitals, middle-class women claim the private sector suits their search for "quality" care.

5.2. *Journeying to South Africa*

In this section some of the participants describe their experiences of going to private clinics in South Africa, and their reasons for doing so. Their encounters with doctors

abroad demonstrate some of the differences between local healthcare in Mozambique and that offered by private South African clinics.

I spoke to Monica, a lawyer in her early thirties, who explained to me why she often goes to South Africa for consultations:

I don't think the doctors get involved with you as a patient [here]. You think, "Okay he's just doing his business." He just gets there and asks you what's wrong. [You say], "This and this and this and this..." "Okay, just take these [pills] and in two days come back." He doesn't explain why you have to take that thing... Why? As a patient you want to be cared for. I want to feel, "He cares for me, he's my doctor." But I don't feel that here. (Interview: Monica 20 June 2010.)

For Monica the lack of warmth from her doctor seemed to be one of the main reasons why she goes to South Africa for medical consultations and treatment. Monica had other complaints about having to wait for hours beyond the time scheduled for her appointment. Concerning her need to have conversations with her Mozambican doctor about her state of health, she said:

I go to the gynaecologist and he asks, "What's wrong?" [I say], "I've got this" and he's like, "Okay..." He doesn't even carry on a conversation. You want to have a continuing conversation... and not feel like you're answering an interrogation. I want them to be more compassionate, or something of that sort, so that you feel, "Yes I'm going to my doctor!" I always say to myself I want to have kids but then I start thinking, "Do I really want to [give birth] in Mozambique?" Because you want to be able to talk to your gynaecologist, "I've got this, I've got that." But no, because you feel that they are just there for business. You end up going to South Africa for those little things – for the extra attention. (Interview: Monica 20 June 2010.)

The "little things" that Monica spoke of make a big difference to most people seeking medical care. In Chapter Four Katia explained how she felt when the doctor she saw in

South Africa had taken time to get to know her. One could say that it was necessary and important for him to do so as she was a new patient and he needed to have a detailed history, but Katia had never spent “satisfying” time with a local doctor. Monica and Katia found that, in their interactions with local doctors in Maputo, the doctors lacked rapport and empathy, and that they were positioned by the doctors as faceless patients, or as *povo*. They claimed that the doctors were treating them like *povo*. This implied that doctors had little time for them and did not treat them with the respect these women thought middle-class women deserved. This perception also shows how middle-class women disassociate themselves from poorer citizens and strive to differentiate themselves from the wider population.

Scott (1997: 47) argues that patients “are unlikely (unless desperate) even to try to communicate adequately with practitioners who are unable to establish a rapport with them or evince sympathy/empathy or compassion.” Part of the humane treatment people expect has much to do with how they are spoken to, how they are made to feel during a consultation, whether they feel completely safe and comfortable and whether they feel respected.

Dora, a 34 year-old first time mother and businesswoman, explained how private healthcare in South Africa meets her expectations of being treated appropriately as a middle-class woman:

[Durban is] fantastic... there is definitely no comparison. The clinic we go to has... everything. You know where you have to go, you don't wait there the whole day; and they have time for you, they write a prescription and send [specimens] to the lab, they phone you when the results are out... Here, if you don't go to the lab to pick up your results, they won't phone you... you will never know. Sometimes you don't even get the results back before your appointment with the doctor... you must make sure you have plenty of time, weeks even. They will just tell you, “You know ma'am we had some problems with something.” “When will they be ready?” [you ask] “They are fixing it maybe tomorrow.” And you've lost your appointment, and you don't know when you can get a new one. You're lost. And we are in a

situation now where you must have friends inside the system. You must have doctors that are your friends and nurses that are your friends, because you don't need to queue too much, if you're still waiting for the results, they can go there and find out what is going on. That's why many people go outside to South Africa for treatment. (Interview: Dora 5 June 2010.)

We could say that women like Monica and Dora are looking for the “little things,” the emotional dimensions of care. They stress the importance of rapport, of eye contact between patient and doctor, of being well informed about their condition and being made to feel as if they count as human beings. These forms of consideration are expected, at least at private clinics in Maputo, but some women are seldom satisfied with their experiences. They look to South Africa as the closest place that can give them what they seek, and the experiences they have there often meet their expectations, ensuring that they continue to return whenever they deem it necessary to do so.

A few months after Dora gave birth, for example, she began to notice that her baby had black stools “the colour of petrol” (Interview: Dora 5 June 2010). She explained:

I was scared. I thought it may be something to do with his blood, something haemorrhaging inside his tummy. And I asked her to check the stools, to send to the lab, but she didn't do it. She said, “You mustn't worry.” But we are parents, it's our firstborn, it's normal for us to get worried, to be anxious... and you must pay attention as a doctor to what parents think. [Doctors] must have this sensibility maybe. Because as doctors, the feelings they have, they have knowledge; they've seen the same situation. It's not the same for [first-time] parents. Send them to a lab, just to calm the parents down. If they come to see you, it's because they think they need your help, at least for something, so give them peace, something to relax and not worry so much. Do an exam[ination]: if it comes back negative... perfect, they paid for it, you don't have to pay; you only have to follow up. (Interview: Dora 5 June 2010.)

Dora took her son to a paediatrician in Durban who examined the baby and determined that there was nothing wrong. Dora was satisfied that she did not have to search for any other opinions. It seems that Dora mistrusted the local doctor's diagnosis and it may be concluded that most of the participants felt the same way. But the participants did not have any complaints about local doctors' knowledge. Among the research participants, Karina, for example, is married to a doctor, Iva is studying to be a doctor, and most of the other participants had doctors in their families. It was the inattentiveness of local doctors that most women complained about. They objected to being treated as if they were just another patient. As Dora further explained:

Every patient is special, is unique... we have lots [of clinics] but no quality and you definitely pay [extra] or else you don't see results. That's why I think maybe more than 50 percent of Mozambicans are going to Nelspruit, Durban, Pretoria, and Cape Town looking for that quality. It's not because we don't have good doctors. The problem is they don't pay attention to patients. And when you are sick you become the most stupid and complicated person. You always want your things to be sorted out at once, clean and clear. (Interview: Dora 5 June 2010.)

Dora, Katia (see Chapter Four) and Stella (see Chapter Four) wanted second opinions when they sought help and advice on their and their families' medical problems. All three found reassurance in South Africa and thus continued to go there for further consultations. Patricia gave birth abroad, "out of convenience," and Karina was adamant that she would have her baby abroad. Women kept returning to South Africa because their expectations were met, and, as a result, they often recommended that a family member or friend also go abroad.

Some women risked not going to a doctor locally, even if they felt ill, until they had sufficient means to travel. This was the case with Stella, whom, it will be recalled, experienced painful cramps for several months. Although her pain was gradually getting worse, more than two years after her operation, she was willing to suffer through the pain until she found some time to see her doctor in Nelspruit, rather than going to a local doctor. She not only imagined that as soon as she had time to travel to Nelspruit

her problems would be solved, but she was also able to do everything in her power to ensure that this became a reality.

In their narratives women constantly blurred the lines between being patients and being consumers. As we have seen, they went to local private clinics and, when they considered service there to be less than satisfactory, found other options, no matter the cost. Chanda (2002: 158), writing in relation to Mozambique, notes that “affluent patients... seek specialised high-quality treatment overseas in hospitals in industrialised countries or in neighbouring developing countries with superior healthcare standards.” Yet from women’s stories it is the “differential treatment” that Dr. U speaks of in Chapter Three that plays a significant part in the reasons women choose to “go private” and ultimately to South Africa. In a world where they can afford the best cars, have houses furnished with furniture from Bali, for example, and wear the latest designer clothes, middle-class women also become active consumers of healthcare services.

5.3. *Consuming healthcare*

The fact that women have a place in mind where they expect better treatment, not only in terms of the human dimensions of health care, but also in terms of comparatively better health infrastructure, is enough for some of them to consider travelling to South Africa to purchase such services. However, as Kangas (2007: 295) argues, technologically advanced medicine “is more than a consumer good... it is an emotional and moral good as well.” In this and previous chapters women’s narratives suggested ways in which such positive emotional and moral dimensions were often missing from their interactions in local clinics and in the hospital. Qualities such as these they hoped to find abroad. In interesting ways money and the more human dimensions of biomedical healthcare become intertwined, a combination that may seem contradictory, and yet that are uncannily and paradoxically conjoined in a predominantly capitalist world-order.

Middle-class Mozambican women have entered that particular niche where the question that Pellegrino (1999: 244) poses, “Is healthcare a commodity?” leads us to conclude that for these women it seems to be so. But Pellegrino (ibid) argues against health becoming a commodity, a view that is upheld also by Rylko-Bauer and Farmer (2002:

477) who argue for healthcare as a right rather than as a commodity. This is the conundrum in which much of the world lives today. Many poor people do not have access to basic healthcare services, yet others are free to pick and choose better forms of healthcare. John Stoeckle (2000: 141) argues that “corporate practices in a market economy are transforming health care services into medical commodities for a public eager to buy.” Thus there is an eager public of middle-class women, discontented, often with good reason, with what local healthcare services have to offer them.

Culyer (1971) argues on ethical grounds that health should not be viewed as a commodity to be bought. He writes that “there can be no doubt that health care is not the same thing as other economic goods” (Culyer *ibid*: 191). In this context we need to consider in specific terms what a commodity is. A straightforward definition would be that “a commodity is a socially desirable thing with a use-value and an exchange-value” (Gregory 1982: 10 quoted in Stone *et al* 2000: 5). If use-value refers to the value a certain commodity or service has to the user (Stone *et al* *ibid*), then we can say that healthcare has use-value. However exchange-value “refers to the value of the thing for obtaining other things or for generating currency” (Stone *et al* 2000: 6). In this case it seems healthcare only has use-value and no exchange-value. Yet when we look at how often pharmaceutical companies and corporations have ensured that medicine accumulates wealth for some, while those who do not manage access continue to die, we may conclude that healthcare has an exchange-value.

Writing on the commoditisation of services, Appadurai (1996: 55) states that “it is only in complex post-industrial economies that services are a dominant, even definitive, feature of the world of commodity exchange.” Due to globalisation this is fast changing in countries such as Mozambique, where consumption of the latest international trends is on the rise. Commodities allow people to live within a particular lifestyle. As Lupton (1994: 112) explains:

The active choice and consumption of commodities is integral in the creation and maintenance of... identities. Individuals define themselves by the clothes they wear, the cars they drive, the brand of alcohol they drink, and the food products they consume.

And we may add the healthcare services they pursue.

Middle-class women in Mozambique often define themselves by the kinds of healthcare they pursue and are able to purchase. Therefore, as much as we can argue that healthcare services do not fall within the realm of goods, we cannot ignore that increasingly there is a dangerous shift towards the commoditisation of healthcare (Pellegrino 1999, Rylko-Bauer & Farmer 2002) and that such a shift ultimately leaves healthcare at the mercy of global markets. Yet such commoditisation is only possible because people create those markets and see themselves as consumers.

Mackintosh (2003: 5) argues that “Globalisation in the sense of market integration affects health and health care by two routes: via the general ‘opening’ of the economy to trade and investment, and via specific changes in the health care and health finance sectors themselves.” The “opening” that Mackintosh speaks of also allows the movement of people across borders in search of what they perceive as not being delivered by their state. In their identification as middle-class women who took part in this study, the women do not necessarily see themselves as consumers of healthcare services, but most realise they are part of an elite with the resources to live beyond their country’s means. Gell (1996: 112) argues that “consumption involves the incorporation of the consumed item into the personal and social identity of the consumer.” It is the negotiation involved in maintaining a specific social identity that leads Mozambican women to consume healthcare abroad, where acquiring quality care, and being seen to do so, reinforces their sense of status in society.

5.4. *How important is status?*

[T]here are people that go to South Africa. I think these people have a complicated pregnancy and perhaps it’s sensible to go to South Africa, or they have lots of money. And it’s a luxury (*é capricho*). (Interview: Claudia 15 June 2010.)

Out of nineteen other women (apart from the main participants) briefly interviewed in the course of the research process, eleven used only public services within

Mozambique. Although they did say they waited long hours and were often ill-treated by staff, they did not seem to find this problematic at all, but saw it simply as part of the system they were in. To them it was simply what was expected of the hospital setting. It is important to note that these women had lower levels of education than the other participants interviewed and who regularly travelled abroad. This illustrated that level of education was a significant factor in how certain services were perceived.

Access to healthcare is not experienced in the same way across socio-economic divides. As Karina remarked in Chapter Four, things would have been very different for her had she been “a nobody.” It is women’s socio-economic status within society that allows them to have a degree of choice in accessing healthcare services. Farmer (1996, 2004) and others have discussed at length issues of structural violence and how the poor suffer from systematic violence exerted on them from above. Middle-class women in Maputo live far from the social marginalisation that so many other women, some of whom are their neighbours, suffer. Yet socio-economic status has to be constantly negotiated and the greatest disparities occur within a health system that serves only a limited purpose for these women. Furthermore, part of middle-class women’s insecurity seems to stem from the fact that the healthcare system judges people according to their wealth, where better conditions can be accessed as long as one pays for them. Healthcare becomes part of the list of something to be attained, such as a superior quality of education.

In Mozambique middle-class children are often sent to private schools or boarding schools abroad, usually in South Africa. For some parents it is important that their children are educated in English. Although the number of local English-speaking private schools in Mozambique has increased since the 1990s, many parents hope that their children will eventually continue with their tertiary education abroad, usually in South Africa. It appears some Mozambicans perceive South Africa as a place filled with resources, and healthcare is just one of these for those who have the money to pay. Using healthcare services in South Africa is one of the various ways in which women perform and maintain their middle-class status and reinforce their status as respectable citizens distanced from the *povo*.

5.5. *Maintaining identities and the social imaginary*

“The image,” “the imagined,” “the imaginary” – these are all terms that direct us to something that is both critical and new in global cultural processes: *the imagination as a social practice*. No longer mere fantasy (opium for the masses whose real work is elsewhere), no longer simple escape (from a world defined principally by more concrete purposes and structures), no longer an elite pastime (thus not relevant to the lives of ordinary people), and no longer mere contemplation (irrelevant for new forms of desire and subjectivity), “the imagination” has become an organized field of social practices, a form of work (in the sense of both labour and culturally organized practice), and a form of negotiation between sites of agency (individuals) and globally defined fields of possibility (Appadurai 2008: 50, emphasis in original).

Appadurai’s argument is important not only to this chapter, but for the entire thesis. As we have seen in the case study material presented, middle-class women are able to imagine possibilities for themselves beyond what is available to them locally and to actualise possibilities through the journeys they undertake. Although these journeys are taken individually (or with family members), these women are part of a collective of middle-class Mozambicans who search for the same possibilities, based on a collective experience of a flawed local healthcare system, and negotiated through connections and conversations.

The maintenance of identities for middle-class Mozambican women is rooted in “social imaginaries” defined as “ways of understanding the social that become social entities themselves, mediating collective life” (Gaonkar 2002: 4). People imagine their lives, and the contexts in which they live in particular ways. Collectively, and perhaps implicitly, they decide what makes them different from others and how they as people should act, in accordance with these implicit rules and regulations. Taylor (2002: 106) argues that “what starts off as theories held by a few people may come to infiltrate the social imaginary, first that of elites, perhaps, then of society as a whole.” Such an imaginary is both socially and historically created (Gaonkar 2002, Taylor 2002). We have seen in previous chapters that women made up their minds about the Mozambican

healthcare system based on their experiences as well as on stories and rumours shared with others. These experiences led to a particular perception of the local healthcare system, which many women chose to flee. Being a middle-class woman had certain connotations which defined women's identities.

For middle-class Mozambican women their constructions of self involved drawing on an imaginary in which South Africa was perceived as a place in which various forms of plenitude met expanded expectations of themselves. The possibilities that South Africa presented were many, and with the right opportunities and connections they were often achievable. The world for these women therefore became a place in which they were able to circumnavigate local problems and to fulfil their expectations of "quality" care as consumers for whom notions of quality, emotional and moral considerations conjoined with means. Most of the research participants were independent women who had completed, or were in the process of completing, their tertiary education. Most were also employed in well-paying jobs which enabled them to afford the lifestyles they desired.

Mozambican women's low opinion of local medical services was supported by the fact that they had access across the border to something more "acceptable." Within Mozambique a highly specialized clinic inaugurated by the President, and with luxury suites attached, was opened in Maputo in May 2010. Because it is so technologically advanced, it is not dependent on Maputo's Central Hospital for equipment (though it is perhaps dependent on their medical personnel). Although some people were happy to see it open, and hoped that perhaps it would bring some healthy competition and perhaps improvements to the already existing private clinics, others believed that as long as the staff remained the same as in other establishments nothing would change.

5.6. Conclusion

Globalisation and trade in healthcare services has allowed Mozambican locals of a particular class to not only expand their imaginations of what is possible for them personally as individuals, but also to expand their social imaginary as middle and upper class Mozambicans. By constantly searching for such alternatives beyond their own borders, they constitute themselves as consumers of healthcare services. Instead of

ensuring that local healthcare improves, they leave those who cannot access healthcare elsewhere to face the very appalling conditions that they perceive as inadequate to their own needs.

As Arjun Appadurai suggests, we live in a world of “global flows” (1996, 2000) and such flows play a huge part in the lives of middle-class Mozambican women and their aspirations as global citizens, so much so that they are often blind to the endemic poverty surrounding them. Many of the participants had at some point lived abroad, and even those who had not, had at least travelled to some extent. Access to education, information and technology ensured they were better informed than their poorer counterparts. They had the ability not just to imagine, but in many cases to attempt the realisation of their aspirations.

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Chapter Six: Conclusion: beyond borders

The thesis has described how the women with whom I worked perceived public and private healthcare services in Maputo and why they sometimes chose to travel across the border to seek such services in South African cities. My conclusion attempts to consolidate the research findings and offers some recommendations for the way forward.

In the preceding chapters I attempted to show that Mozambican middle-class women were at the helm of their own choices in determining what healthcare services they used. Their wealth and status gave them access to a wider choice of healthcare services than was available to poorer members of society. In their journeys to access “better” healthcare services, the women interviewed searched for the latest advances in biomedicine. Although many theorists have argued against the over-medicalisation of women’s lives, specifically with regard to reproduction, in societies like Mozambique, where the latest biomedical advances are not readily available, technology was sometimes sought not only as a symbol of status, but also as a sign of modernity.

Women in Mozambique found themselves living in a complex environment where they often chose not to confront directly the limitations with which they were presented, but to go beyond national borders where, although they may have encountered different sorts of barriers, such as different language use, there were also advantages in their border crossings. The women did not see advances in medical technology and expertise as invasive and controlling, but rather as empowering. The data has shown that women with resources welcomed efficient medical expertise, especially since it augmented their identities as “modern” women who could afford to make “rational” choices about their lives, including their healthcare.

We can advance the ethical argument that healthcare services should not be commoditised, and that perhaps private healthcare services automatically commoditise healthcare, but the research has shown that women were willing to pay for what they perceived to be the “best” care. They positioned themselves as consumers of healthcare

services, able to negotiate or juggle access to healthcare, both locally and abroad. Just as the utilisation of new developments in biomedicine becomes symbolic of “modernity” for middle-class Mozambican women, so does accessing healthcare abroad. Such journeys also set them apart from the rest of the population who some have described dismissively as the *povo*, perhaps revealing their own fears of having to live with the everyday difficulties experienced by most Mozambican citizens.

The distancing between Mozambican middle-class women and their poorer counterparts are a result of neo-liberal policies that continue to shape power dynamics in poor countries. Such policies cater to those who can afford it at the expense of poorer classes, thus ensuring that health inequalities persist. Privatization of healthcare services, for example, only benefits the dominant classes with money and power. In this way citizenship becomes meaningful to some while others are abandoned. Without the revision of such policies, citizens in the so-called developing world will remain at the mercy of global markets; healthcare inequalities, globally and within countries, will persist; and, for some people, accessing healthcare will become a more precarious venture than it already is.

Based on my data there are two recommendations I believe would challenge the current system and perhaps lead to short and long-term changes. The first of these is institutional and involves the improvement of Mozambican healthcare infrastructure, including training more medical personnel and investing in medical equipment. My data shows that medical expertise is not lacking, but favourable conditions of work affect the attitudes and efficiency of personnel. The second relies on a partnership between the government and the people where education is used to empower the *povo*. Education plays a major part in teaching the public about their rights, specifically regarding services available to them. Both recommendations are likely to help curb the ongoing corruption in the healthcare system. Challenging the system is important in order for changes to occur. Going abroad is unlikely to improve the general “quality” of Mozambican healthcare services.

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