MEDICINE IN THE MEANTIME

THE WORK OF CARE IN MOZAMBIQUE

Ramah McKay

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Introduction

Care and the Work of History

In May 2013, doctors in Mozambique's Serviço Nacional de Saúde (National Health Service) went on strike. In the capital city, Maputo, emergency services remained open, as did private clinics, but many public health services were limited or closed completely. The strike was the culmination of months of slow-burning frustration over raises—many doctors in the public health service earn as little as $500 to $600 a month—and benefits, especially access to state-owned housing. Within days, footage of doctors marching from Maputo's Central Hospital was broadcast on media and circulated via text message, Facebook, and blog posts. Images showed strikers with tape on their mouths to symbolize the government's lack of response. Many protestors carried paper plates inscribed with the words "hunger" and "empty" or signs with slogans like "We are tired of counting our coins at the end of the month!" The South African newspaper the *Mail and Guardian* quoted a frustrated health worker who said, "We are exposed to a lot of sicknesses. Every day we are covered in blood, piss, and everything. But the president doesn't respect what we do" (AFP 2013a).

In June 2013, not long after the strike ended, I arrived at Clínica 2 for the first time in over a year. Centro de Saúde da Cidade 2 (or Clínica 2) is a small, busy public health center on the northern edge of Maputo where I have conducted research since 2006. Set behind a brick wall and just off a main road, near a popular open-air market and a roundabout that serves as a public transport hub, the clinic is both centrally located and tucked away. When I began research there at the end of 2006, the clinic buildings had been newly painted with funds from UNAIDS and the European Union. The new paint job, however, failed to hide noticeable differences between the older buildings—built in the early 1990s, when funds for postwar reconstruction

rehabilitated many public infrastructures—and a slick new building at the back that housed the clinic's HIV/AIDS program. There, a big-screen television played the Cartoon Network in a colorfully appointed waiting room, patients relaxed on comfortable chairs, paintings hung framed on the wall, and wide windows allowed dappled sun to spill through cheerful curtains. Reflecting the prominence and inequalities of transnational funding for medicine, clinic infrastructure also pointed to a paradox at the core of this book: the unequal and uneven material and social ramifications of "global health."

That afternoon in 2013, however, it was public, rather than transnational, health funding that was a topic of conversation when I sat down with Dr. Luísa, a staff psychologist with whom I had spent many hours over the course of my research, she immediately remarked, "I suppose you've heard about the strike." In her late fifties, Dr. Luísa had salt-and-pepper hair that was always neatly set. Her sensible blouses, skirts, and shoes peeked out from beneath a precisely pressed white coat. Reading glasses and a small gold cross hung around her neck. Dr. Luísa's persona was far from the image of rabble-rousing recent medical graduates or disgruntled *serventes* struggling to make ends meet; she often seemed to me to be an exemplary civil servant. Moreover, the last time I had seen her, she had been working with an American non-governmental organization (NGO) partner that supported Clínica 2. I hadn't expected to hear her articulate support for the strike. But when I asked her about it, she exclaimed, "The government is always talking about how we already have annual raises . . . but these raises, really! For someone who is earning all right, to get an additional 500 MT [US$20 a month], what is that? And for someone earning little and who receives an extra 50 MT [US$2], an extra 100 MT [US$4], *what is that?* 100 *meticais* [US$4] when you have to pay for milk, for bread, for transport. . . . That doesn't help at all." These small amounts were not just useless, she went on to say, but "insulting" and "disparaging," evidence of how the government "discounts" the value of public health work. These insults were all the more acute given celebratory headlines, in national and international newspapers alike, that trumpeted Mozambique's booming resource economy and rapid economic growth. Signs of new wealth were visible everywhere in Maputo's landscape—from expensive new cars to luxury ocean-view apartment buildings. In this context, the government's claims that doctors' salary demands were unsustainable rang hollow.

Despite my initial surprise, talking with Dr. Luísa about the strike helped me to understand how medical practice, career opportunity, and professional desire are being transformed by Mozambique's changing economy and by the

changing institutional and aspirational context of medicine in Mozambique. Much attention has been paid to the role of NGOs and global health projects in Mozambique, where more than half the national health budget is provided by foreign donors and organizations (Pfeiffer 2013). Aiming to provide and extend care to patients, especially those with HIV or other chronic diseases, NGOs have facilitated a dramatic expansion in access to medication in Mozambique over the past decade.

Clínica 2 was just one example of how transnational funds have created partial transformations in the provision of public health. When I first arrived, for instance, NGO-sponsored programs supported patients with HIV/AIDS, tuberculosis, and malaria, and provided food support to eligible families, while basic and emergency medical services were provided through the National Health Service. Yet for all the visibility of transnational organizations, resources, and projects, the passion with which clinic staff responded to the strike served as an important reminder that long histories of health work, public employment, and earlier governmental projects continued to inform how health has been delivered at Clínica 2 and by whom. As I conducted fieldwork, first in Maputo and then in rural Zambézia province, I came to see how Dr. Luísa and others drew on their own experiences with caregiving, support, and medical treatment as they worked amid transient transnational medical regimes.

Stories of global health have often focused on epidemiological experience and on the therapeutic materials (like medications) that enable physical well-being, extending life expectancies as they do so. Medical care at Clínica 2, however, was facilitated not only by pharmaceuticals, X-rays, and medical tests, but also by relations among family, friends, colleagues, and neighbors; by norms of public employment and practices of market exchange; and by the prices of milk and transportation. These relations are the subject of this book.[1]

A proliferation of health entities was easily visible in the landscape of central Maputo during the time of my fieldwork. A brief walk down the leafy streets that surround the Ministry of Health, for instance, takes one past the headquarters of development and relief organizations such as Doctors without Borders, World Vision, the Red Cross, Samaritan's Purse, Save the Children, and the offices of newly established "global health organizations," as well as a host of smaller medically oriented NGOs from the United States and Europe. In some ways, this abundance of agencies reflected the expansion of funding

for "global health," which grew from approximately $6 billion worldwide in 1990 to almost $30 billion in 2013 (IHME 2014).

Many of the NGOs whose offices line Maputo's streets receive (or have received) funding from the United States' Presidents Emergency Plan for AIDS Relief, known as PEPFAR—a package of U.S. government funding mechanisms that deliver clinical support, medical goods, and services to Mozambican clinics via nongovernmental organizations. In 2007, for instance, PEPFAR distributed more than $200 million in Mozambique, an amount equivalent to 60 percent of all total spending on health (Pfeiffer 2013), in addition to funds provided by other large transnational agencies and organizations, such as the Global Fund for AIDS, Tuberculosis, and Malaria and the Gates Foundation. In those years, as much as 50 percent or more of the national budget came from transnational donors (S. Jones 2009), and many aspects of medical care were facilitated by transnational funding. The abundance of organizations also reflected Mozambique's position, since the mid-1980s, as one of Africa's major recipients of foreign aid, particularly for health (Cunguara and Hanlon 2012; World Bank 2015; Vassal, Shotton, and Reshetnyk 2014).

More broadly, the surfeit of organizations reflected how sub-Saharan Africa has become an important site of nongovernmental, bilateral, philanthropic, and private investment and extraction, responsible for both new medical resources and the creation of deeply unequal market opportunities. Aiming to provide and extend care to patients, especially those with HIV or other chronic diseases, nongovernmental interventions facilitated a dramatic expansion in access to medication in Mozambique during the first decade of the twenty-first century. Though efforts were made to integrate these resources into daily practices at the clinic, the lines between NGO projects and public health were easy to discern. When I first arrived, for instance, NGO-sponsored programs supported patients with HIV/AIDS, tuberculosis, and malaria, and provided food support to eligible families, while other programs and basic and emergency medical services were only available through the National Health Service. As transnational and nongovernmental dollars flowed to neatly circumscribed programs that were implemented in—but often administratively separate from—public hospitals and clinics, public and nongovernmental visions of care sometimes seemed uncomfortably entangled under the same clinic roof.[2]

Among the most visible of transnational interventions at Clínica 2 was the Psychology Office where I first met Dr. Luísa, a sunny room compactly organized around a four-person table. Glass-fronted bookshelves ran along one side, and a cache of worksheets, books, papers, and office supplies were stacked

inside them. The triplicate forms, full bookshelves, and smart new furniture gestured immediately to funding from an American NGO whose logo was emblazoned across all of those three-part forms. In addition to underwriting medications, diagnostic tests, lab supplies, and office staff, the NGO paid the salaries of three psychologists, who occupied the small office at the end of the hall. The funding that made the Psychology Office possible also distinguished the clinic from otherwise similar public health spaces elsewhere in the city. Indeed, Clínica 2 was sometimes described as exemplary among clinics in Maputo. Just before I began my research, one of their American NGO partners had hosted a visit from Laura and Jenna Bush, wife and daughter of then U.S. president George Bush, during which the First Family had played and cuddled with young patients who were carefully screened to ensure a vision of healthfulness and success. If these particular visitors were illustrious, such visits were not unusual. In fact, images of American students, researchers, "voluntourists," and celebrity visitors to African hospitals have become somewhat ubiquitous (Benton 2016); I imagine many readers can recall similar images.[3]

At Clínica 2, transnational connections were evident in the presence of expanded staff, better diagnostic equipment, and a wider array of social and psychological as well as medical supports. In an interview, a Dutch woman called Ena, who lived in the neighboring city of Matola, and who brought her adopted daughter to the clinic for treatment, commented, "When I was told there was a Psychology Office, I couldn't believe it. I thought, 'I am in Holland.' I have never seen anything like this [in Maputo] before!" Ena's surprise seemed a reaction not only to the clinic's relative material plenty but also to the provision of—or the aspiration to provide—high-quality care and mental health services to relatively poor patients more frequently targeted by programs to control infectious disease.[4] Just a few minutes away, in the Department of Mental Health at the Ministry of Health, staff members decried the lack of transnational interest in their work and the absence of resources. As if the Psychology Office itself were not unusual enough, Ena told me that she was impressed by the range and ready supply of medications at Clínica 2; though she used to import medications from Holland, she was now confident that she could get what she needed there, or certainly at a private pharmacy downtown.

Despite the overwhelming presence of NGOs at Clínica 2 when I first arrived, over time I saw that it no longer hosted such a wide and robust array of nongovernmental programs. Amid a contraction of health funding around the world, in Mozambique new health policies reasserted state authority, while corruption scandals, political conflict, and allegations of state violence

called broader aid projects into question. By 2011, the physical structure of the clinic no longer conveyed the transnational abundance visible on my first visit. First the cable hook-up, then the television itself, disappeared. The waiting room and consultation spaces began to show signs of wear. The computer that had temporarily facilitated office work was taken to higher-priority settings. More urgently, the smooth and untroubled delivery of medications that recalled "Holland" for Ena had been interrupted. As PEPFAR funding to the clinic dwindled and then abruptly ended, public health staff were dispersed across the center or sent to work at other health clinics and hospitals in the city; some left for jobs with other organizations. Remaining staff grumbled about the increased workload and restricted resources.

These transformations were particularly striking since, in interviews, NGO staff consistently spoke of expansion, of "scaling up" their programs to encompass more and more patients. By 2013, however, the clinic's main source of support had switched its attention from Maputo's urban clinics to health centers in rural districts, and many NGO personnel had moved on. Within a decade, many transnational actors had shifted to concerns with "health systems strengthening" and noninfectious disease, and some programs moved away from interventions in health altogether. Yet the conditions that had motivated them to intervene in Clínica 2 to begin with—high rates of HIV and TB infection, poor capacities for diagnosis and treatment, poverty in surrounding neighborhoods, and inadequate staffing—remained. Despite some infrastructural improvements, the clinic was now comparable to most other public clinics around Maputo. Before long, the clinic was being run entirely through the public system and with public sources of funding.

Over time, I came to see how the sedimentation and erosion of nongovernmental resources, practices, and even clinical norms shaped the experiences of workers and patients, as well as the meanings of labor and care that were instantiated at Clínica 2. I began to understand how clinic staff and patients worked between the (often transitory) resources of nongovernmental intervention and longer experiences of medical labor and alternative forms of care. Not only did these rapid shifts pose challenges to health workers and patients; they also made clear how public policies, state spaces, and market forces were central to the provision of care and thus to the strategies of patients as they moved in and out of the clinic. As I returned to interview, observe, and simply chat with doctors, nurses, psychologists, and patients over time, I was reminded not only of the entangled public and nongovernmental nature of medicine in Mozambique—as transnational NGOs provided care in public

spaces, and a multitude of agencies and institutes intervened in care in different ways—but also of the quickly shifting nature of interventions in a context of political uncertainty and recurrent crises. In 2015, I stopped by Clínica 2 one day to find, unexpectedly, the clinic's head nurse, a fifty-nine-year-old woman named Elsa, and Nilza, a younger colleague, poring over portraits of clinic patients taken during Laura and Jenna Bush's visit in 2007. Ignoring the celebrity visitors, Elsa and Nilza were discussing patients who had died in the intervening decade. As transnational resources flowed and ebbed, and the lives of those under treatment were sometimes shortened as a result, seasoned medical workers at the clinic, like Elsa, drew on their long experience to navigate the vicissitudes of clinic practice.

This book traces the lives and afterlives of two medical projects in Mozambique. During the last two decades and through the course of my research, efforts to enhance "global health" expanded the medical resources available to patients and workers in Mozambique, yet these projects often gave rise to deeply divergent understandings of what care *means,* what it *does,* and *who* does it. Central to these competing visions were differing ideas about the kinds of relations—among staff, patients, medical technologies, friends, kin, organizations, food, and pharmaceuticals—that were involved in the provision of care, and about the spans of time (acute or sustained, short-term or cyclical) over which care might endure. Whereas health regimes prioritized individualized and bodily definitions of health, patients were also enmeshed in webs of relation that made their medical care possible. While nongovernmental projects envisioned discrete interventions shaped by short-term (if repetitive) funding cycles, the resources they made available were shaped by past experience and by future imaginations of health and well-being.

To explore this constellation of issues, the book draws from fieldwork conducted at a variety of public health sites and with two organizations—the International Center for Health Care, or ICHC, an NGO formed in the year 2000 that supported care at Clínica 2 and at other sites in Maputo, Mozambique's capital city; and the Global Children's Fund or GCF, which had, since the 1980s, managed health and development projects in Morrumbala District, in Zambézia Province.[5] It also follows the patients and workers who moved through and beyond these clinical spaces. Through their experiences, the book investigates how global health NGOs shaped the work that care requires. The work of care was transformed, I show, by the sudden influx of resources

Map Intro.1 Mozambique, with the capital, Maputo, to the south and Morrumbala District to the north.

that NGOs brought with them; it was also molded by historical experiences that many Mozambican health workers (and patients) have developed in encounters with the state and NGOs over decades and by the relations, and practices of labor and livelihood, in which patients and workers have long been enmeshed. These relations have emerged through transnational processes, national health policies, and historical experiences alike.

The question with which this book is fundamentally concerned, then, is how care is made when medical materials, knowledges, and practices are shaped by a range of interventions constituted through diverse actors, aims, and temporalities. How do diverse modes of biomedical care articulate with one another? What do such articulations make possible and for whom? What complications do they introduce? How can attention to the relations through

which care is made possible help us to understand the effects and limits of transnational medicine today?

Care, Work, and Multiplicity

Why care? I use *care* in this book because of its proliferation as a technical term. The assemblages of pharmaceuticals, medical knowledges, social and nutritional supports, and community interventions deployed by AIDS organizations in Mozambique were known as "care and treatment" programs. Care, in this formulation, encapsulates all the material, social, epistemological, and medical work that accompanies pharmaceuticals. This work is my object of analysis. However, care also makes clear the close proximities between anthropological and global health vocabularies. In both, conceptualizations of care not only draw attention to health inequities and serve as calls for action; they also reflect normative political claims about what the state is or should be (see also Redfield 2012) and serve to index caring subjects and subjectivities in ways that are raced, classed, and gendered (Bailey and Peoples 2017, Benton 2016, Page and Thomas 1994).

Many anthropological accounts of humanitarianism, welfare, development, and global health have shown how efforts to "care" have unintended effects: they may entail the surveillance or policing of those they aim to assist (Donzelot 1979); they may forestall political claims or demands for recognition in ways that are ultimately problematic or counterproductive (Fassin 2011, Ticktin 2014); they may reflect the "need *to* help" rather than the desire *for* help (Malkki 2015). Though care is often assumed to connote an emotional orientation and moral value, caring—especially care offered to "distant strangers"—may also presuppose and reinforce inequalities of race, class, and national origin (Boltanski 1999).

One approach to navigating the uses and limits of care comes from scholars working in the tradition of feminist science studies have written that care is better seen not "as a (preferably 'warm') relation between human beings" but rather as a "matter of 'tinkering'" (Mol, Moser, and Pols 2010). Care, in this view, is embedded in situated practices and processes through which interrelatedness is made possible, "a matter of various hands working together (over time) toward a result" (Mol 2008: 18). Amid the diversity of caregiving actors in Mozambique, who is to say that the various hands of Jenna Bush, Elsa, Ena, and Dr. Luísa, even my own, are working toward the same end? Still, I share this approach to care as a matter of practice. I too am interested in how care

comes to matter, for whom, and in what ways. While critical accounts have shown how subjects of care are constructed through processes of class formation, gender identity, and race, so too are *caring* subjects. Caring—in global health imaginaries but also in the clinics I studied—was often most easily embodied by foreign or expatriate, often white, middle class, and professional women (Page and Thomas 1994, Benton 2016). As a result, as transnational medical economies intersected with public and state-run medicine, clinics were partially and temporarily "white public [health] spaces" (Page and Thomas 1994; see also Brodkin, Morgen, and Hutchinson 2011).[6]

To understand the experiences of Dr. Luísa, Nurse Elsa, and others, then, I focus on two aspects of care. One is the *work* that enables care and that care enables. Spaces like Clínica 2 were simultaneously sites of nongovernmental and public health interventions, and they were locations in which a variety of caregiving strategies were enacted: from the access to pharmaceuticals that Ena and her daughter valued, to the new forms of professional practice available at the clinic, to the forms of long relation that marked Nurse Elsa's contemplation of the photograph. Different modes of seeking care, or of caring for others, required different kinds of work. Like the emphasis on improvisation and tinkering that have characterized many understandings of care, in and beyond Africa, my ethnography emphasizes care as a set of practices—yet these practices were structured by health systems and interventions, incentivized through salaries, gifts, or relations, and shaped by the material resources that they enabled. As a result, I focus on *work* to highlight how care was entangled with, not separate from, economic processes and to show how medical resources and caregiving practices were situated in relation to broader projects of making lives and livelihoods.

Second, in the chapters that follow, I conceptualize this plurality of relations to and of care in terms of *multiplicity.* Multiplicity describes how singular objects and practices (a written diagnosis, a clinical archive, an old photograph) may enact multiple and sometimes competing modes of care: Does a diagnosis enable prescriptions and rest, or promises of profit and the market? Does the photograph depict a former first lady or a former patient? How is care itself at once public and nongovernmental, medical and more-than-medical? I use *medical multiplicity* to describe how diverse, deeply unequal actors and institutions come to be invested in the objects, actors, and practices of medical care. Medical multiplicity thus describes how transnational medical projects are structured by and produce practices of care (enacted, for instance, by public health workers, family members, or friends) that are simultaneously rendered external to it. Frequently, these actors and practices are perceived as a

threat to the modalities of care that NGOs advanced; absent or incompetent public health employees, unreliable family members, or truculent community volunteers were seen as putting NGO interventions at risk. Yet these social relations were necessary to and frequently produced by health interventions themselves. In other words, multiplicity is not an idiosyncratic aspect of Mozambican medicine—an "African" aberration. Rather, it is central to transnational biomedicine today.

My approach draws from recent attention to ontologies of medical practice around the world. Scholars, for instance, have recently argued for attention to the ontological multiplicity and instability of medical objects (Street 2014) and diseases (Livingston 2012). Annemarie Mol (2002), for example, has demonstrated the multiplicity of the body, suggesting that an ostensibly stable object—such as the leg of a woman or man suffering from atherosclerosis, who will need surgical interventions and daily care—is in fact multiply and differently constituted for the patient, the surgeon, the domestic caregiver, and other actors who experience, diagnose, or treat atherosclerosis. These approaches emphasize how health objects are folded together with other objects of healing (e.g., Langwick 2011); for instance, a photo comes to be at once a memento and a clinical record. They also draw attention to how the material infrastructures of global health create new possibilities for health and care, for instance, by making new therapies available (e.g., Nading 2014; Redfield 2008). Rather than simply describing a diversity of medical practices and actors in the clinic, then, multiplicity shows how care emerges when patients and workers bring medical goods, categories, and materials into relation with political institutions, practices of livelihood, and even emotions.[7]

The existence of many modes of healing is also a central theme of Africanist literature on medical pluralism (Olsen and Sargent 2017).[8] On the one hand, biomedicine has a long history in Africa, not as a foreign import but as a field of practice; medical and development practices are as "African" as they are "Western" or "global" (Comaroff 1993). On the other hand, literature on medical pluralism has shown how patients, families, and health workers have long moved between diverse systems, epistemologies, and practices of care in a search for therapeutic efficacy (for instance, Feiermann and Janzen 1992; Granjo 2009; Janzen, Leslie, and Arkinstall 1982; Langwick 2008; Meneses 2004). This literature has shown how "health" is not limited to physical well-being, but encompasses financial, domestic or relational, spiritual, and bodily experiences. These accounts make clear that the health of individuals is inseparable from the relations in which those individuals are embedded.

While the literature on African healing and medical pluralism makes these relational dynamics of health particularly prominent, similar attention to relations was not entirely absent from biomedical practices at Clínica 2. When staff asked patients about their families and resources for support, they too embedded care in relations, and they too, as I show in chapters 4 and 5, had to account for the economic and social constraints that patients faced. In other words, biomedicine, too, makes room for relations. Together, ontological and pluralistic approaches highlight how "medicine" is never a singular ready-made thing but is always enacted through situated practices informed at once by transnational flows of funding, materials, and knowledge, and by located (not necessarily "Mozambican") practices of care.

By characterizing the institutional scene of this book as multiple, I focus on the ways that the state public health structures, and transnational practices are entangled. Rather than describing a quality of "Mozambican" or "African" medicine, multiplicity describes how transnational medical actors presume and rely upon, while also distinguishing themselves from (and even compromising) public health systems. It describes how the public system comes to be at once necessary and rendered external to transnational projects. A specific example may make this clear. From one perspective, the apparent fragility of public health services at Clínica 2—crowded facilities, a lack of space and staff—appeared to demonstrate the need for transnational assistance; from another point of view, public health centers are necessary locations in which "global health" care can be delivered.[9] The ICHC could focus on select diseases and populations *only* by presupposing other, more capacious, and usually more public entities within which their interventions could be staged. No one would advocate for a health system that treated only a single disease, unless they assumed other entities would provide other forms of care, and no one would advocate for short-term interventions unless other structures provided more enduring forms of care. It was only because Elsa *remained* that NGO staff could come and go. Health projects thus both relied on and presupposed institutions, actors, relations, and entities that were rendered external to transnational processes and projects. This way of providing medicine, in other words, takes for granted *and* produces a temporally and institutionally plural field.

Despite the transnational nature of these politics, however, "African" examples proliferate in both ethnographic and health literature. The persistence of "African" representations of global health speaks not so much to epidemiological "facts on the ground" as to historical processes of pathologization that have long figured Africa as a site of difference, disease, and lack (Chabal and

Daloz 1999; Comaroff 1993; Meyers and Hunt 2014). Ethnographers, though critically attuned to the historical conditions through which these representations are produced, have also played central roles in generating these representations and images. Alongside my attention to health work in and out of the clinic, then, I also show how anthropological engagements help to stabilize the forms of difference that distinguish care in Philadelphia, Maputo, or Morrumbala. How and when does ethnographic research disentangle those who are assumed to provide care (global experts and NGOs, for instance) from those who receive it (patients, public health systems)? How is ethnography, and how are ethnographers, participant in the practices of care that make up transnational medicine today? Attending to care as relational work, I hope to keep such stabilizations in abeyance.

Finally, throughout the book, I attend to how time shapes both the work of care and ethnographic practice.[10] On the one hand, as I returned to interview, observe, and simply chat with doctors, nurses, psychologists, and patients over time, I saw how practices of care both shifted and persisted despite the institutional instability of many health projects.[11] On the other hand, even as NGOs like the ICHC made medical resources available in new ways, they also frequently evoked a future without aid. In these imagined futures, certain kinds of medical care were imagined as fully public, the domain of a capacious and caring state.[12] To my surprise, these futures converged with and even reflected critical political sensibilities that have animated ethnographic and journalistic assessments of the problems of transnational assistance (Easterly 2006; Moyo 2009). In so doing, these narratives constituted state and transnational actors as separate and easily distinguishable. Attending to time therefore helped me to see not just temporal change but temporal politics (Gonçalves 2013), as invocations of past and future helped to shape the politics of care, and of ethnography, in the meantime.

Time, Care, and History in Mozambique

Why were staff and patients navigating between different kinds of public health institutions with such different and transient possibilities for care? How did the institutionally multiple landscape of care at Clínica 2 emerge? The historical, political, and economic forces that gave rise to the landscapes of care that Dr. Luísa and others now traverse were topics of frequent discussion, debate, and analysis—not only by anthropologists but also by medical practitioners and policymakers in Mozambique. Early in my fieldwork, for instance,

I spoke with Joe, the expatriate country director of an American philanthropic foundation. Sitting at a pleasant sidewalk café around the corner from the Ministry of Health, Joe described how he had participated in writing early drafts of Mozambique's "Strategic Plan" for HIV/AIDS, which delineated plans for treating and caring for AIDS patients. It also outlined the assemblage of institutions, including the public health system, international NGOs, and local associations that would participate in the provision of care. It described both what was to be done—providing access to medication—and how that was to be accomplished: through a consortium of local, national, and transnational organizations and institutions. In this way, the document reflected and enacted the kinds of institutional multiplicity that came to characterize global health interventions in Mozambique.

Many observers, including Joe, noted to me that Mozambique's strategic plan was different from (and an improvement on) strategies enacted in neighboring countries because it emphasized Ministry of Health spaces, such as Clínica 2, as sites of care, even when that care relied on funds, drugs, and doctors provided by NGOs. Though the Strategic Plan aimed to organize and entrench multiple actors within the public health system, it also demonstrated what Joe described approvingly as an "ideological commitment to a single national health system, not divvying up the health system between different NGOs and missions." In this way, public systems remained discursively and spatially important, even as the forms of care they were providing relied ever more heavily on nongovernmental and transnational resources.[13] That Joe praised this commitment, I would later come to see, was not too unusual. Many observers, Mozambican and expatriate, saw transnational medical interventions as eroding public health capacities and they valued efforts to enshrine and promote the Ministry of Health as the ultimate health authority. As the director of Clínica 2 put it, "In the name of supporting . . . [many NGOs] are just weakening an already-weak system."

These debates were shaped by high levels of donor spending on health in Mozambique and a national history in which nongovernmental and foreign actors have played important roles. Explanations for the high levels of foreign assistance the country has received have included political stability and high rates of economic growth. With headlines like "The Mozambique Miracle" (Kaminski 2007), the country has often profited from an image of "hope" and "potential" (see, e.g., USAID 2008) in much media reporting about transnational aid. The International Monetary Fund named Mozambique one of a

handful of "frontier economies" in recognition of its low levels of development and rapid economic expansion (Lagarde 2014).[14]

This narrative was shaped by Mozambique's emergence, in the early 1990s, from two successive and brutal wars. The first, against Portuguese colonial rule, came to an end in 1975. Shortly thereafter, fighting emerged between the then-socialist ruling party, FRELIMO, and an opposition group, RENAMO, supported by apartheid South Africa and white minority-ruled Rhodesia (now Zimbabwe).[15] I describe the legacies of the war in more detail in chapter 3. With the signing of peace accords in 1992, Frelimo (formerly FRELIMO) and Renamo (previously RENAMO) became the ruling party and major opposition party, respectively, a transition in which transnational and humanitarian actors played crucial roles.

In subsequent years, the narrative of a successful transition to peace and democracy reinforced foreign aid investments, and Mozambique would be frequently described as a "donor darling." This narrative often overlooked the inequalities that accompanied and have been exacerbated by the processes of economic reform and development that donors and NGOs promoted. For instance, a report by the United States Agency for International Development (USAID 2008; see also S. Jones 2009) opens by citing Paul Collier's notion of the "bottom billion," a term he coined to describe inhabitants of countries that experienced no or negative income growth during the 1990s (Collier 2007). It shows how donor narratives often framed Mozambique as at once successful and desperately poor.

> Mozambique resides near the bottom of the bottom billion . . . [and] is still recovering from the effects of a protracted civil conflict that ended sixteen years ago and destroyed much of the country's key infrastructure while delaying investment and development of basic services. Continuing peace and stability, however, coupled with economic growth averaging nearly 8% for the last five years, offer hope for a more prosperous Mozambique. . . . Relative to governance problems in many countries in Africa and judged by its record of stability and growth since the end of its civil war in 1992, Mozambique appears to be a success story. (USAID 2008: 1)

From this vantage point, Mozambique's "success" appeared to coexist seamlessly with its spatial localization near "the bottom of the bottom billion." The contradictions this entails, however, profoundly shape the struggles of public workers like Dr. Luísa and of the patients she served.

Recently, these celebratory narratives have collapsed. New horizons of capital investment and the intensification of inequalities of wealth and power not only sparked resentment among health professionals like Dr. Luísa but also rekindled political animosities. In 2012, fighting began between Renamo forces and the Mozambican military and paramilitary forces in central Mozambique. In July 2015, residents of some districts fled to Malawi in fear of political violence, echoing experiences during earlier iterations of the conflict (which I describe in chapter 3). Political conflict, human rights abuses, a debt scandal, and the suspension of international loans and assistance have called narratives of success and state transformation into question. For more than three decades, however, donor literature described Mozambique as a "poster child" of international reform and a safe and attractive site for philanthropic investment. Indeed, as I show in chapter 2, a great deal of work has gone into making health projects and health workers the "right place" for donors to put their money. As a result, for more than a decade, global health investments seemed to offer important possibilities for constituting care in ways that were at once public and "global."

Glory Days of Public Health

Such imaginings were deeply shaped by the medical and political history of Mozambique. Central to Joe's assessment of the Strategic Plan was his conviction that locating transnational interventions in existing public health programs and spaces was important. He noted that the plan's emphasis on the Ministry of Health was "a good long term—like 30 year—strategy." He also linked the ministry's strong sense of national autonomy to legacies of the "civil war, when health centers were completely trashed . . . targeted, plus a legacy of 'the glory days of Samora,' who was very anti-mission." Joe thus situated contemporary health practices within a historical frame shaped by conflict and by the lingering influence of Mozambique's charismatic first president, Samora Machel. His comments recalled historical aspirations to state-run health care provision as well as legacies of restrictions on the activities of religious missions that have long been central actors in the provision of medicine in southern Africa (Comaroff and Comaroff 1991; Ranger 1992). In this recounting, Mozambique's centralized, socialist past created the infrastructures and political orientations on which the country's biomedical future could be imagined.

Invoking the "glory days of Samora," nongovernmental actors like Joe (and his expatriate and Mozambican colleagues) demonstrated political

commitments to the state. They recalled an inspiring, if partial, historical narrative that emphasized not only "Samora" but also a moment of hope in efforts to expand primary health care in Mozambique and around the world. By 1978, for instance, more than 90 percent of Mozambique's population had been vaccinated. This feat was particularly remarkable since, by 1976, only a year after independence, the country had only an estimated 60 medical doctors, down from 289 just four years earlier (Vio 2006).[16] Reflecting this lack of medical capacity, FRELIMO's initial plans for the health service emphasized an expansion of health posts into rural areas, the training of midlevel medical staff, and the promotion of community health workers. In the era of the World Health Organization's 1978 Alma Ata Declaration with its campaign to realize "Health for All" and to promote primary and preventative care, these efforts reflected not only a socialist vision of public health but also an internationalist ideal that privileged state responsibilities for medical care and grassroots services. By the early 1980s, the World Health Organization had recognized Mozambique as a model of primary health care (Walt and Melamed 1983).

Referencing this hopeful historical moment, Joe's comments showed how the history of medicine in Mozambique created ideological and concrete structures that remain important to the provision of care. Recalling the past, Joe articulated an appealing (if nostalgic) vision of, or ambition for, national, autonomous, and grassroots medical services that captured nationalist aspirations of the time (Prince and Marsland 2014). The "glory days of Samora" could thus be heard as a sincere invocation of a moment when primary health care ideals offered new hope for international population health. This nationalist vision was shared by health workers like Dr. Luísa and Elsa for whom medical service had offered an opportunity for both professional and national advancement. This history also informed Joe's sense of the past as glorious and his conviction, which I shared, that public commitments to primary health care were "a good long term—like 30 year—strategy."

Yet to invoke the "glory days" was also ironic. First, because the horizon of public commitment seemed to be continually receding, and seemed to offer little now, in the meantime. Second, because these efforts were almost impossible to extricate from bitter, contested, frequently violent struggle over the politics of health. Indeed, the history that Joe offered in our conversation was a relatively partial or truncated account. In Mozambique, nongovernmental institutions—from corporations to churches—have played significant roles in areas such as health, education, and labor regulation (even tax collection and law enforcement) since the colonial period. A tenuous, decentralized, and

privatized system of administration aimed at the brutal extraction of wealth has been described as a hallmark of the colonial Portuguese administration, from the landing of the first Portuguese soldiers and traders in northern Mozambique in the late fifteenth century.[17]

More critically, legacies of governmental intervention and socialist governance, sources of nostalgia for some, are recalled ambivalently or resentfully by many who experienced this period as one of violent governmental intrusion. While the medical achievements of the socialist state were impressive by some public health measures, they were also part of a brutal remaking of daily life that many Mozambicans feared and resisted. Many socialist projects, such as efforts to resettle rural populations in planned communal villages, were resented (West 2005). Communal villages, for examples, were not just new ways of constructing rural towns but were also locations in which campaigns against "traditional" thinking could be waged (Borges Coelho 1998; Israel 2014). These efforts engendered bitterness among citizens who found their ways of living, forms of authority, practices of healing, and spiritual beliefs subject to criticism, violence, and reform in the name of a socialist ideal. Recalling past "glory days" thus overlooked how legacies of state intervention in Mozambique were received with ambivalence and resistance by the populations to which they were directed.

These struggles were compounded by Mozambique's position on the violent fault lines of the Cold War. Apartheid-era destabilization policies made the socialist project particularly volatile (Minter 1994), and health practices were at the heart of both revolutionary (socialist) and counterrevolutionary politics.[18] By the late 1970s, RENAMO had begun attacks on sites of governmental authority, including health posts.[19] The war disrupted salaries, medical supplies, and infrastructural support. Staff shortages left those who remained with increasing workloads even as wages fell precipitously. With neither salaries nor medical tools to support them, many health centers were abandoned and others were physically destroyed.

By the mid-1980s, less than a decade after it had received WHO accolades, concerned observers described the public health system as in a state of near total collapse (Cliff and Noormahomed 1988). Rural populations were affected not only by war but also by conditions of extreme drought that coincided with the worst years of fighting (Macamo 2006). By the time peace accords were signed in 1992, it was estimated that two million Mozambicans had died and more than six million people had been displaced from their homes (Finnegan 1993; Lubkemann 2008). Subsequent efforts to repatriate refugees were, at

the time, the largest planned movement of refugees in the world (Crisp and Mayne 1996).[20] The traumatic impacts of displacement and violence remain evident in many places, including Morrumbala, one of few district capitals to have been controlled by RENAMO military forces.

Historical legacies also informed the experiences and aspirations of health workers in Mozambique. Nurses like Elsa, who entered nursing school at the beginning of the socialist period, had witnessed both the birth of the public health system and its dramatic transformation over the course of their medical education and careers. Some spoke proudly of how their contributions to the socialist project had been recognized by the state in public ceremonies and awards. Some recalled the material constraints and ideological rigidity of the early health system. Many recalled how the urgent need for care during times of war opened unexpected opportunities for training and experience—for instance, as doctors trained nurses in techniques and practices beyond standard nursing curricula in order to expand possibilities for care.[21] Despite the sad context of this education, such experiences also represented moments of professional accomplishment and were sometimes recalled with pride. More commonly, though, legacies of conflict are recalled with sorrow, anger, or disgust (Gengenbach 2005; Schuetze 2010).

Remaking Health

The war also had indirect reverberations in health policy. Institutional reforms, enabled by the conflict, reorganized political and social life in ways that dramatically affected possibilities for health and medicine. By the late 1980s, the conflict was drawing to a close. Soviet support for socialist projects in Africa, including financial and military support for FRELIMO, was dwindling. The devastating effects of a drought further stretched FRELIMO's political and economic resources. At the same time, foreign support for RENAMO similarly declined. By the late 1980s, FRELIMO signed international agreements that would restructure the state and economic policy in exchange for loans from the International Monetary Fund (Chingono 1996).[22] Though international development and media narratives described Mozambique as a "miracle" and "poster child" for economic reform, such claims also belied the highly mobile and repetitive nature of such imagery and of International Monetary Fund policies and their effects across multiple countries.

These processes of structural adjustment entailed the remaking of public medical programs. Amid efforts to "shrink" state budgets, public services

were curtailed. Medical services, once free though often underfunded, now required payment on a "fee-for-service" model. Patients were required to pay larger fees to receive even primary and preventative care, and free and low-cost medical programs were to be phased out (Cliff and Noormahomed 1993). Salaries for public workers, including health workers, were cut. Funds for hospitals, clinics, and equipment were restricted. In retrospect, it is clear that these cuts had devastating consequences on health in the southern African countries that adopted these policies. These policies both weakened health systems and exacerbated the spread of disease, including HIV/AIDS, tuberculosis, and malaria—the very diseases that global health agencies would later emerge to combat. They institutionalized and intensified medical and social inequalities (in the case of Mozambique, see Pfeiffer and Chapman 2010, 2015), worsened public health outcomes, and reduced life expectancy (Deaton 2013).

In this context of curtailed public spending, new agencies, from Pentecostal churches (Pfeiffer et al. 2007) to nongovernmental organizations (Duffield 2001),[23] came to play larger roles in the provision of care. Indeed, NGOs were central to the vision of care that emerged through and in the wake of these political changes. In the year 2000, newly adopted international frameworks, such as the Millennium Development Goals (MDGs), which aimed to halve world poverty and halt the spread of HIV/AIDS, gave renewed impetus to transnational investments in health. A growing number of global health agencies, and the expanded and dominant role played by financial institutions such as the World Bank and the International Monetary Fund in setting world health policy, further linked new economic approaches to health outcomes.[24]

Global Health and the Futures of Care

The story of care in Mozambique is thus a transnational one, driven by international financial policies and transnational agencies. Yet, as I show in chapter 1, it is also a story of the state. Even as NGOs took on new roles in medical provision, national health policies were also transformed. Efforts to expand services to rural populations and to calculate and extend life expectancies not only improved population health but also demonstrated Mozambique to be an appropriate site for transnational investments. In some cases, the state seemed to no longer aspire to the provision of care but rather to make populations available for humanitarian intervention.

These new aims were reflected in changing norms and practices of public health. For example, instead of training cadres of medical workers as in the

late 1970s, NGOs expanded the use of community volunteers. As described in chapters 1 and 2, "community-based" and "grassroots" projects promised low-cost distribution of medical information and goods, but did so by multiplying the channels through which care was delivered. Expertise and authority often remained in the hands of expatriate doctors and aid workers. At the Ministry of Health, the work of managing donors and meeting multiple, often conflicting, donor requirements took time and energy away from the implementation of health services (Brugha et al. 2004; Biesma et al. 2009), as staff had to prepare unique plans for each donor or agency (Oomman et al. 2007). And as shown in chapter 6, new regimes of evidence-based medicine, rooted in global metrics rather than in local standards or expectations of care, not only accompanied but often seemed to *drive* the forms of care and intervention that NGOs made available (Adams 2016).[25] These changes in health policies and actors made important treatments accessible. Yet for many medical workers, they entailed mixed consequences. Employees of and actors involved with NGOs expressed an uncertain perspective on how their work contributed to and profited from the problems of primary health care that they also aimed to ameliorate.

In my conversation with Joe, for instance, he not only reflected on the positive aspects of working in Mozambique; he also described the work of supporting public health as riddled with practical ambivalences. Though he asserted forcefully that medical care "*should* be driven by the Ministry of Health," he pointed to political and technical constraints on the ministry's ability to do so, exacerbated by donor institutions' demands that initiatives expand rapidly despite overstretched public health resources. "For example," Joe explained, "In our rural initiative, wanting to get five hundred people on treatment—you have to be able to say [to your donors] 'it's not gonna happen.' When you have one doctor for 300,000 people and he's hardly there anyway 'cause he's going for training and conferences [sponsored by NGOs] and the nurses are taking bribes and you have people dying in their beds . . . , you *can't*. But because there are [donor] commitments, you *do* it."

Later in our conversation, Joe elaborated on this theme, commenting that "funders don't get it. Development organizations might, but these are the people—like the Norwegians—we like to lambaste for lacking innovation." Yet if donors didn't "get it," Joe was also skeptical of the approach taken by the minister of health at the time, who was known for taking a critical public stance toward the activities of NGOs. The minister, he noted, "wants a completely independent health system, with no foreign support. He basically acts

like it is *already* 2030." Contrasting the technical and financial demands of donor programs (which he described as pressure to "save lives and report numbers") with the real conditions of his work, Joe located the limits of good intentions in the space between unreasonable donor expectations and an almost apocalyptic portrayal of rural health centers. In his view, there was little room in global health for persistent and time-earned attention to local projects.[26]

On the one hand, the contradictions that Joe identified were scalar—processes of rapidly increasing and expanding the scope of programs were known as "scaling up." But they were also temporal, located between what Joe described as a seemingly nostalgic public imaginary rooted in "the glory days of Samora" and a future horizon marked by aspirations for "a completely independent health system, with no foreign support" that Joe saw as an unreachable, subjunctive future condition—as if it were "already 2030." Despite Joe's ideological sympathies, then, he seemed to see global health as precariously situated between nostalgic echo and future horizon, and his sympathies did little to change his practices now, in the meantime.

In his example, Joe illustrated how political and economic inequalities complicate the provision of public health via transnational interventions. Taking a perspective frequently understood as progressive and self-critical, Joe imagined a public future—"2030"—in which the provision of care was disentangled from the vicissitudes of intervention and in which NGOs no longer "call[ed] the shots" (Hanlon 1991). Such a position was not uncommon among thoughtful nongovernmental actors, as well as policy-makers, medical practitioners, and scholars with whom I spoke. Yet the temporal horizons of these critiques were often shaped by a sense of urgency (patients "dying in their beds") that both obscured the longevity of NGO intervention and disavowed transnational responsibility for the future. This book is ultimately concerned with an account of health work and care that does not rely on the disentanglement of institutions, the purification of public health, or the end of intervention, as in the dream of "2030." Rather, it asks about the possibilities that are made in the meantime.

About the Book

Ethnographic Locations

Over the course of my fieldwork, I interviewed, talked with, and accompanied medical staff (expatriate and Mozambican), community health and develop-

ment workers, and patients and their families. In Maputo and Morrumbala, I aimed to understand how the presence of new transnational medical and scientific regimes articulated with long-standing political formations, public health practices, and livelihood strategies. In both places, by engaging the disparate workers—such as nurses, psychologists, and data entry clerks—as well as the patients and family members that these projects assembled, my fieldwork traced how a range of actors moved between, sought help from, and made claims upon the dynamic and multiply-constituted field of transnational health intervention in Mozambique.

In Maputo, I followed the work of the International Center for Health Care, an AIDS care and treatment organization started in the year 2000 by faculty at a large midwestern U.S. school of public health. Operating in eight countries around the world, the ICHC provided visiting and permanent medical, psychosocial, and supervisory staff along with funding for resources such as medical materials, treatment plans, and protocols (as well as everyday clinic items such as computers, photocopiers, paper, and pens) in a dozen clinics in Mozambique, where most of their activities were funded by PEPFAR. I conducted fieldwork in two of these, an urban hospital and Clínica 2, a peri-urban clinic, following programs that included pediatric and family care as well as the affiliated community interventions that were tasked with evaluating, monitoring, and sometimes intervening in the "social determinants" of health such as poverty and with providing moral support for the ill.

In Morrumbala, I accompanied the Global Children's Fund, a European development organization that had recently taken on new global health practices, transforming itself from a broadly focused aid agency to a more narrowly focused medical organization. Supporting both the local hospital and community-based health programs, the Global Children's Fund, or GCF, similarly provided staff, training, supervision, and material resources to support AIDS programs and psychosocial interventions in Morrumbala District, as well as intervening in a broader array of community- and child-based health issues. Like the ICHC, the U.K.-based Global Children's Fund was part of a national pilot program to formally incorporate child and family-friendly health policies into Ministry of Health programs.

Ethnographic mobility—moving between programs as well as through and *out* of clinical and institutional spaces—was important for ethical and pragmatic reasons as well as for analytic ones. For instance, engaging patients and workers outside clinical spaces allowed for more wide-ranging (and sometimes more nuanced) conversations. These helped me to situate medical practices

within broader domestic, social, and political arrangements, and also helped to distinguish my small-scale, ethnographic study from some of the larger scientific and clinical studies also conducted in clinical places. Following two projects and thinking across multiple sites also allowed important contrasts to emerge—in Maputo, for instance, "global health" often seemed to be the provenance of mostly white, transnational, well-educated and well-paid medical experts (see also Crane 2013); in Morrumbala, expatriates often played walk-on roles within a wider range of Mozambican staff (not necessarily "locals"), many of whom had come from the public health service.[27] It also pointed to commonalities. For instance, in both places, health "projects" assembled a diversity of often cosmopolitan workers (whether nurses, technicians, doctors, administrators, or janitors) and enacted a surfeit of relations (treatment, surveillance, exclusion, governance, employment, claims-making, or profit-generating).

Moving across my fieldsites, then, I have focused less on clinics and projects as bounded units of analysis, nodes for comparison, or instances of a top-down "logic" of global health. Rather, I've considered them as partially connected ethnographic sites. The practices I observed in Maputo mapped fairly neatly onto many critical definitions of global health—many clinic practices focused on select, diagnostically bounded conditions, emphasizing the provision of treatment and of medical expertise, and driven by HIV/AIDS care as a point of departure. By contrast, the care I accompanied in Zambézia was much more ambiguous or intermediary, informed by the development history of the district and of the organizations working there as they sought not only to tackle new medical problems but also to recruit new sources of funding and opportunities for intervention through "global health" projects. Thinking across programs and locations thus helped me to see how transnational and humanitarian biomedicine takes a global health form at some moments and in some places, but may also look more like humanitarianism, development, or public or private medical care at others. A multi-sited perspective therefore helped me to see how new and transfigured ways of evaluating, diagnosing, and responding to problems of poverty and ill-health were historically imbricated with preexisting approaches. As a result, this book highlights the *difference* it makes to realize development, welfare, and humanitarian projects through medical interventions. What does it take to realize medical projects within a global health rather than a developmentalist, humanitarian, or public health frame? What does such a frame enable, and what does it forclose?

Structure of the Book

The remainder of the book unfolds in six ethnographic chapters. Chapter 1 introduces GCF's community health projects as a means of exploring the entanglements of public, para-public, and nongovernmental health entities in Morrumbala. Despite the outsize impact of NGOs in the district, public institutions remained important, not only to patients and public health staff, but also to GCF. Yet the role of the state in the day-to-day work of providing care was not always or not only to provide health services. Rather, the state was often an important location for and coordinator of interventions, charged with making subjects and populations available for intervention. Because transnational concerns with global health have introduced notions of "vulnerability" as key means of distributing and accessing care, often in ways that depart from earlier models, this availability was frequently constituted in terms of epidemiological populations and humanitarian assessments of vulnerability. In a context of political entanglement, recognition by humanitarian actors came to be a central means by which patients and community members were "seen" by the state.

Chapter 2 extends this attention to community health projects, focusing on how ideas about "community" transformed local political and social relations into NGO resources. "Community" was a central concept through which global health projects were enacted. Envisioned and described as a seemingly "natural" social arrangement, community in Morrumbala has long been conceptualized on the basis of specific political histories. As a result, just as global health projects are entangled with contemporary political relations (as described in chapter 1), so too do they rest on political legacies of colonial rule and socialist liberation and contestation. For volunteers, "community work" meant mobilizing and packaging social relations in ways that were historically resonant, highly specific, and deserving of remuneration. Generating, mobilizing, and documenting community became a site of intense struggle between Morrumbala residents and volunteers who understood their participation *as work*, and therefore deserving of salaries, and global health projects that imagined community as a site of solidarity and voluntary labor.

While the second chapter highlights the longevity of state discourses of community, chapter 3 demonstrates the longevity of humanitarian medical interventions as well. Despite the insistence of NGOs that their interventions were short term, "not forever and not for everyone," the experiences of many volunteers, health workers, and patients suggested that NGO projects were in

Intro.1 Clinic courtyard on a quiet afternoon.

some ways "perennial" (Fassin and Pandolfi 2010), recurring frequently over decades. By drawing on historical experience of and engagements with NGOs, I show that NGO recipients demanded interventions that facilitated (rather than interrupted) the social relations on which they relied.

Chapter 4 focuses on the provision of food support to the ill in Maputo and Morrumbala. As food moved between clinic and kitchen, household and market, it illustrated how patients and workers worked to produce robust and meaningful forms of well-being. These forms of well-being went beyond a physical conception of health (a concern with the biological or bodily life) to encompass instead life as it is lived. In this context, cultivating health meant enabling and facilitating the relations through which the daily work of care was provided and nurturing the (often deeply gendered) bonds through which claims to care could be made. This work of cultivation was particularly important because of the ease with which organizations and projects arrived and departed. In such a context, relational labor transformed temporary interventions into future possibilities.

In addition to transforming possibilities for access to care, NGOs can also transform the experiences and aspirations of medical workers and the subject

positions that medical labor entails. For many public health workers, new opportunities for employment coexisted with new frustrations and challenges. In chapter 5, I contrast the experiences of differently situated health workers to show how the transformation of public health is also remaking the aspirations, class positions, and professional hierarchies of medical labor and produces rapidly shifting professional identities.

In the final chapter, I return to consider how multiplicity is situated in relation to transnational investments. Through a focus on the informational and knowledge-producing practices of NGOs in Maputo and Morrumbala, I show that the multiplicity of medicine—at once public and nongovernmental—also produced important gaps in the generation of knowledge and attendant possibilities for care. In the end, attention to how care and medical resources flowing in one direction were supplanted by information and data—including ethnographic data—flowing in the other demonstrates that the entanglements of medicine in Mozambique are deeply unequal; those best positioned to make use of interventions are often those who are already in positions of power. Throughout, and in the afterword, I also aim to critically interrogate the role of ethnography and of anthropology as fields adjacent to and often deeply implicated in these practices of humanitarian biomedicine and global health, sometimes in ways that unsettled my analytical and ethnographic comfort zone.

NOTES

Introduction

1 The names of all organizations, clinics, and individuals, as well as some geographical indicators and locations, have been changed to ensure the confidentiality of the people I spoke with, the patients they served, and the families and communities with whom they worked.

2 Mirroring these entanglements, studies in anthropology, critical development, and related fields have emphasized how transnational investment in medicine has transformed the provision of public health, the development of public capacity, and the meanings of health and citizenship, as the nation-state (for instance, the Serviço National de Saũde) overlaps with the transnational (such as foreign NGOs) (e.g., Hanlon and Smart 2008; Pfeiffer 2013; Geissler 2015). Scholars have raised important questions about what these overlapping and unequal medical regimes mean for citizenship, rights, and politics (Nguyen 2010); about how humanitarian approaches to care can also produce new exclusions (Fassin 2011); and about how global circulations of medical technologies shape and produce new ethical dilemmas (Redfield 2010).

3 Variants of this photo—the (young, white) American woman with (young, cute) African patients—are today banal commonplaces, and a frequent target of pointed humor. For instance, an article at the satirical news site *The Onion* jokes about "6-Day Visit to Rural African Village Completely Changes Women's Facebook Profile Picture." The apparent familiarity of global health spaces is important to keep in mind, since it helps to stabilize assumptions about what health *is*, emphasizing some aspects of clinical care and obscuring the racialized inequalities through which care is assembled (see also Benton 2016).

4 I thank João Biehl for his observations on this point.

5 In order to protect the anonymity of my informants, I use pseudonyms for both organizations and individuals described in this book. I have also changed identifying details and some descriptive passages are drawn from general observations rather describing specific places and individuals.

6 As Lisa Stevenson notes, "Shifting our understanding of care away from its frequent associations with either good intentions, positive outcomes, or sentimental responses to suffering allows us to nuance the discourse on care so that both the ambivalence of our desires and the messiness of our attempts to care can come into view" (2014: 3).

7 There is also a rich anthropological literature on multivocality and polysemic meaning, informed by the work of Victor Turner (e.g., Turner 1967) and elaborated on to describe how symbols, places, and practices may be interpreted, explained, or made meaningful in multiple and even competing ways. Central to Turner's symbolic analysis is attention to the ambiguity, dynamism, and complexity of symbols as well as to their interconnection with a variety of processes. Many of the practices and objects I describe *are* polysemic—for instance, the photograph—and I have endeavored to bring this attention to ambiguity and change into my analysis as well. Nevertheless, my emphasis is on how singular practices may do (and be intended to do) different things for different actors, rather than on meaning or interpretation.

8 Literature on the historical longevity and complexity of medical practice and research in Africa (including Comaroff and Comaroff 1991; Flint 2008; Fullwiley 2011; Hunt 1999; Iliffe 1998; Livingston 2012; Marks 1994; Tilley 2011; Wendland 2010) clearly shows that care-giving practices are always moral and political endeavors, shaped not only by scientific knowledge and medical norms but also by social, political, and economic relations.

9 When some clinics were built by NGOs without "coordination" with the Ministry of Health, they sat empty and unused (de la Fuente 2014).

10 There is a rich anthropological literature on "states of emergency" and humanitarian intervention (Fassin and Pandolfi 2010a; Bornstein and Redfield 2011). Moreover, consideration of emergent short-term temporalities is not restricted to humanitarian action alone. Janet Roitman, for instance, has recently unpacked the temporal and political dimensions of "crisis" (2013). Exploring macroeconomic and prophetic doctrines in Africa, for instance, anthropologist Jane Guyer (2007) has outlined the convergence of "fantasy futurism and enforced presentism," showing how "the near future may be evacuated" (410) as time comes to be structured around "an instantaneous present and an altogether different distant future" (417). Of course, she notes, the near future "is still—and newly—inhabited. The ethnographic and comparative analytical question is, how?" (410).

11 Global health and humanitarian medical projects are frequently motivated by temporal notions—for instance, by "emergencies" that connote a sense of urgency around the need for immediate action (Redfield 2013; Scherz 2014); other projects may be motivated by eradicating diseases understood to be anachronistically persistent in a modern world. Humanitarian projects, unlike development initiatives (Calhoun 2010), are often assumed to be fleeting and transitory.

12 As a site of nostalgic, contested, or ambivalent memory (Geissler 2015; Mbembe and Roitman 1995; Tousignant 2013; Droney 2014), and of practice, professional aspiration, and even stability, the state remains an important site of medical work and care (Whyte 2014). Some have suggested that these political formations constitute a "para-state," to capture how "the state, albeit changed or in unexpected ways, continues to work as structure, people, imaginary, laws, standards, and so on (Geissler 2015: 1), even as others have described nongovern-

mental actors as humanitarian "para-infrastructures" that provide state-like services (Biehl 2013).

13 The document both confirmed and confounded analyses of interventions that have emphasized the evacuation of the state by transnational institutions.

14 The revelation, in early 2016, that the Mozambican government had contracted nearly $2 billion worth of undisclosed loans from Credit Suisse and the Russian bank VTB complicated these triumphant narratives. The so-called secret debt led the IMF and major European donors to freeze all future lending; it also highlighted just how compelling narratives of unrivaled growth had been.

15 Initially an acronym for the *Frente de Libertação de Moçambique (Mozambican Liberation Front),* FRELIMO refers to the organization prior to independence and to the party following independence through 1992. Initially named the Mozambique National Resistance, later Resistência Nacional Moçambicana, RENAMO similarly refers to the organization between 1976 and 1992. Following the signing of peace accords and adoption of a multi-party democratic system in 1992, the parties became Frelimo and Renamo, respectively. Use of earlier names and orthography thus refers exclusively to events prior to 1992.

16 By some estimates, 85 percent of the medical staff and resources developed by the colonial state remained in three major urban areas (Maputo, Beira, and Nampula), where they had served the white colonial population almost exclusively (Vio 2006).

17 Even as Portugal consolidated political control in the nineteenth century, colonial authorities continued to lease large tracts of land, and cede responsibility for administering these lands, to private concessionary companies under the control of Portuguese, British, and other European directors. Portuguese rule, through the mid-1970s, was rooted in practices of forced labor (Isaacman 1996), coercive labor migration (Lubkemann 2008), and a plantation-based agricultural economy (Vail and White 1980). In central Mozambique, including Morrumbala, nonstate authorities—from the owners of *companhias* to the traditional authorities known as *mfumos* and *regulos,* often installed and backed by the colonial state—were responsible for much of the political administration in the territory. Complexly entangled relations between private, often transnational, entities and the state thus have a long history.

18 Despite important historical and contextual differences, Alex Nading (2014) and P. Sean Brotherton (2012) have explored similar revolutionary and counterrevolutionary dynamics in Nicaragua and Cuba, respectively, showing how these legacies continue to shape and inform the practice of global health.

19 Although global politics profoundly shaped RENAMO's emergence, the armed campaign also captured the disappointment of rural citizens subjected to disruptive and exploitative development plans (West 2005), excluded from development and government (Adam 2005, Dinerman 2006) and frustrated with local hierarchies of authority (Geffray 1990). Relying heavily on forced conscription as well as on resentment of the government's antipathy to long-standing religious,

political, and social formations, antigovernment opposition escalated into a brutal civil war throughout the early 1980s.

20 Of the 1.5 million refugees outside Mozambique's borders, at least one million went to Malawi. By 1990, Mozambican refugees constituted one-tenth of Malawi's population, then the largest refugee population in Africa and the third largest in the world (UNHCR 1996). Those who remained in Morrumbala District were concentrated in the district capital. Those who crossed to Malawi were received by UN agencies together with twenty-two implementing partners, including the Malawian Red Cross and local and international NGOs.

21 For instance, Marta, a retired nurse who now volunteers for a community health program in the Maxaquene neighborhood of Maputo, recounted how an Italian doctor had trained her to handle high-risk pregnancies and deliveries, so that she could better assist pregnant women in Zambézia during the war.

22 Since the late 1980s, processes of political and economic reform driven by international agencies such as the International Monetary Fund and the World Bank, global governing bodies including the UN, and transnational actors including both NGOs and corporations have dramatically impacted the development of policy and the delivery of public goods and services in states around the world. These processes have been particularly evident in poor countries, where access to funds, including international loans, has often been contingent on the adoption of policies and governmental practices developed and enacted by transnational actors. As NGOs became increasingly powerful actors over the 1980s, 1990s, and 2000s, scholars pointed out the political ambiguities that resulted, as responsibility for core governmental functions became vested in transnational agencies.

23 To many, NGOs appeared to arrive in Mozambique as part of a package that included economic and political changes with often dire public health consequences. Observers described "swarms of new 'non-governmental organizations' . . . taking advantage of the shift in donor policies that moved funding for projects away from mistrusted state bureaucracies and into what were understood as more 'direct' or 'grassroots' channels of implementation" (quoted in Ferguson 2006: 38). As state functions were outsourced to NGOs, skilled state functionaries left the public sector for more lucrative private sector or nongovernmental employment, compounding the devastation of public services.

24 Examples of global health agencies include the Gates Foundation; GAVI, the Vaccine Alliance; and the Global Fund for AIDS, TB, and Malaria.

25 Today, many public health initiatives, especially in fields that garner international attention, are enacted through "partnerships" between foreign organizations and the Ministry of Health. Yet despite the mutually supportive connotations of the term, critics have pointed out that the unequal institutional and political relations through which partnership is often enacted frequently evokes long-standing colonial legacies of inequality and even exploitation (Crane 2013).

26 The disjuncture between situated conditions of care and broadly defined global health targets was not restricted to his project (see also Pfeiffer 2004) or to

Mozambique. One study of PEPFAR across three countries suggested that funding allocations were "remarkably consistent" across diverse epidemiological conditions and health systems, "suggest[ing] that global earmarks and donor conditionalities were driving funding allocations regardless of countries' diseases, health needs, and priorities" (Biesma et al. 2009; Oomman et al. 2007).

27 How medicine intersected with race, class, gender, or national origin shaped the relations of care available in different places. It also impacted the kinds of subject positions available to me as an ethnographer; see chapter 4.

Chapter 1: Governing Multiplicities

1 There are many evocative accounts of the Mozambican war (e.g., Finnegan 1992), and some portray in clear and occasionally dramatic terms the forms and effects of violence that the war entailed (Nordstrom 1997).

2 In contesting Paula's right to the house, Paula's in-laws cited both local tradition, through which the house would pass to Castigo's family, and only recently overturned property laws, written by the Portuguese, under which women could not own personal property (Obarrio 2014).

3 Paula's experience serves as a reminder that there are many forms of care, and many "saviors," in Morrumbala that exceed therapeutic or biological forms of government and are thus concerned not only with bodily suffering.

4 "Unlike the concept of citizen," Chatterjee (2004) notes, "the concept of population . . . does not carry a normative burden. Populations are identifiable, classifiable, and describable by empirical or behavioral criteria and are amenable to statistical techniques such as censuses and sample surveys" (34). Chatterjee describes membership in such populations as a form of political society, partly facilitated by "the rise to dominance of a notion of governmental performance" whether enacted by the nation-state or by international agencies "that emphasize the welfare and protection of populations" (47).

5 Extending this approach, anthropologist Austin Zeiderman has described a *bio*-politics of the governed, in which being identified "as vulnerable lives at risk and in need of protection" becomes a necessary precursor to "becom[ing] rights-bearing citizens" (Zeiderman 2013: 82). For instance, Zeiderman shows that for the Bogotá residents he studied to "demand . . . rights to protection, housing, food, and employment . . . [they] first had to be recognized as belonging to the population guaranteed entitlements on account of their vulnerability" (79).

6 This approach importantly points to diversity within political domains commonly marked as "formal" or "modern" (Santos 2006: 63), a perspective that I extend to consider biopolitical dimensions of government. Rather than the *dis-articulation* of plural orders, however, I am concerned with the interconnections and productivity of multiple biopolitical forms at work in community health.

7 This was not true of everyone. For instance, one of the GCF volunteers whom I knew best had initially lived in nearby Tete Province, near his wife's family, who