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Perceptions and management of vulnerabilities in daily medical work. West-African situations, Global perspective

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This paper explores the interactions between structural poverty and production of medical care in Burkina Faso. This country represents other African countries with the same structural poverty. These interactions are examined based on healthcare professionals' perceptions as well as the factors responsible for the vulnerabilities affecting their medical work. A qualitative approach is used to analyze the materials using two temporalities set thirty years apart (1990-1994 and 2020-2021), based on long-term ethnographies on public health care institutions, opinion of care-giver relationships, semi-structured interviews, and physicians' life histories. The results focus on the vulnerabilities affecting physicians' work consisting of patients' social characteristics, shaping their capacities and disabilities to support caregivers in implementing care. Interpreting the individualized dimensions of vulnerabilities makes it difficult to use learned knowledge and care for patients. This goes beyond the recurrent lack of technical and financial support to provide care; it is a systematically vulnerability but so common that it becomes a minor issue in way caregivers deal with the difficulties to be overcome in caring. These results and their permanence at a thirty-year interval suggest that these ways of thinking about vulnerabilities prevent caregivers from seeing them as part of a common condition shared with the patients and their relatives, affecting them in a common way in implementing care. This research underlines that these "pejorative" conceptions prevent the emergence of a victim figure that patients and caregivers could share, since they commonly suffer from poor working and care conditions that are acceptable in many of the world's poorest countries.

Key words: Health professional, poverty, Africa, care, vulnerability, poverty.

INTRODUCTION

Among the factors structuring medical practice in the majority of low-resource African countries is the structural poverty impacting the organization and performance of national health systems. They are structurally underfunded,

with an impact on public health infrastructures that must regularly deal with the lack of equipment and technical resources (Forster et al., 2020). They suffer from lack of maintenance of current resources, they have no or too

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few pharmaceuticals at affordable costs for the populations, and human resources are scarce. However, health personals are confronted with a double burden: the need to manage infectious and parasitic diseases still present in these contexts of poverty (Martini et al., 2011), and at the same time to respond to the challenges of managing chronic non-communicable diseases such as diabetes (King et al., 1998; Motala, 2002; Kengne et al., 2013), cardiovascular pathologies and cancers, the prevalence of which is increasing throughout the world and which entail high management costs. The medical needs are huge, linked in particular to environmental changes, including ways of life in urban and peri-urban areas with uncontrolled growth, more frequent and destructive natural disasters as well as demographic changes in contexts where the population is largely very young but where the proportion of elderly people is growing.

Financial supports is provided by private funds or partnerships established within the framework of bilateral or international cooperation, both in and outside the traditional system of international solidarity. For example, chemotherapy costs are covered for children in several African countries. Nevertheless, the financial costs of sustaining health systems and infrastructures remain one of the challenges for health policies in low-resource countries.

Numerous studies have long quantified these links between structural poverty, fragility of sustainable resources and the performance of health systems (Dussault, 2008; Harper, 2010). A set of indicators are classically produced in particular by the WHO and the World Bank, such as life expectancy, mortality and morbidity rates, the number of general practitioners and specialists per capita, the number of hospital beds available. These data expose some realities while reminding us that this mass poverty operates at all levels of the functioning of these societies, from the most political to the most intimate, at the heart of the experiences of patients and their families who need care and who suffer from these conditions.

These situations are also exposed in more qualitative ways. This is particularly the case with recent ethnographies of care in non-Western hospitals, recounting with rigor and sensitivity of the painful experiences of patients and caregivers who struggle amid severe resource shortages in Africa (Mulemi, 2010; Livingston, 2012; Wendland, 2012), in Oceania (Street, 2014), in Asia (Banerjee, 2020), in South America (Worthington, 2015). Others examine these links through the lens of the differentiated and unequal management of specific pathologies such as HIV/AIDS (Farmer, 1999; Nguyen, 2011).

It is well established in the literature on health care systems in low-income countries, including those in Africa, that this structural poverty and these lacks in terms of techno-scientific and biomedical supports

involve both local and global histories and politics in relation to one another. It can also be known that, the composition of care is impacted and that patients and their relatives, facing their own financial precariousness, are exposed to care trajectories characterized by strong inequalities. This context produces what Fassin has theorized as the inequality of lives (Fassin, 2018), in other words incorporated inequalities. But this phenomenon also confronts caregivers with immeasurable material, medical, moral and at the same time emotional uncertainties while they must strive to make biomedicine work under such conditions. In this perspective, this paper focuses on the subjective experience of doctors in one of these mundane places of poverty (Street, 2014) and high pressure in which caregivers work: that of Burkina Faso, a francophone West African country. The aim is to show how the massive poverty impacts on the reasoning that doctors use in their daily work to provide care. More precisely, the paper aims to portray their perceptions of the vulnerabilities to which these contexts of poverty expose their work, their attempts and the care they can provide to patients. A central argument is that once we take these perceptions as our field of enquiry, we have a better chance of understanding why doctors do not do what people expect of them. And we are most likely to gain insight into the effects of these severe resource shortages on the ordinary violence to which both caregivers and patients are exposed.

Structural poverty and perceptions of vulnerabilities

It is necessary to clarify what is meant by vulnerability, a polysemic concept yet useful for the production of scientific knowledge. It includes both: 1) the damage produced by a context that exposes people to risks: for example, under-equipped infrastructures that create vulnerable care contexts because they cannot accommodate all the patients who need them, 2) the propensity to suffer these damages: we will consider the degree of exposure of individuals to this context of disturbance, and to the dysfunctions that it may induce, 3) the capacity to respond: we will consider vulnerability due to a lack of adaptation or insufficient capacity to cope with this context (Timmerman, 1981). These three dimensions are constitutive of vulnerability understood both in its material and contextual aspects that escape the actors who are exposed to it, in the forms and degrees of exposure, and in the connections that these actors construct with the damage that potentially affects them. This concept can be applied to physical spaces (the vulnerability of territories, buildings or infrastructures exposed to environmental dangers will be studied), to social spaces or groups (individual and collective vulnerabilities in relation to lifestyles and social relations will be studied). Its interest is to underline that situations

of vulnerability are as much the product of exposure to risks or harmful factors as the product of the ways in which each person represents these factors and reacts to them.

Research questions

It is therefore fundamental to explore how daily medical work combines these material dimensions and their effects on the everyday relationships between doctors and patients. In doing so, doctor's conceptions of what they experience, on one hand, and the ways in which they think about the situations in which they are engaged on the other hand are being revealed. This article therefore answers the following questions:

- 1) What are physicians' perceptions of the vulnerabilities that affect and weaken their work and, consequently, the effectiveness of the care they can provide in a context of structural poverty?
- 2) What are their interpretations of the causes and actors responsible for these vulnerabilities?
- 3) What are the implications for care situations when doctors must strive to make biomedicine work?

Justification of the study and theoretical framework

This paper takes its cue from an epistemological approach of contemporary biomedical practices but not limited to pragmatic as well as moral, affective and ethical issues. The purpose is to question the adaptations that shape the ways of conceiving, practicing medicine and investing one's role. These are processes classically linked to the functioning of professions, including the health professions whatever the territories of practice (Lindenbaum and Lock, 1993; Gawande, 2003; Lock and Nguyen, 2010), long theorized in the sociology of professions (Hughes, 1958; Freidson, 1973; Berg and Mol, 1998). Everywhere, doctors share the same theoretical role: delivering care, which is what people expect of them. But they are involved in this role by dealing with their environment, their history and its reminiscences, such as that of racism which sometimes continues to affect relations between health professionals (Digby, 2013; Mclsaac, 2019), or patients' fears (Sams et al., 2020). They deal with the material and social resources available, which influence their decisions (Berg, 1997), the meanings and affects involved. Institutional poverty and resource shortages encountered in Burkina Faso are heuristic, this paper argues, for exploring how local logics resulting from these work contexts influence the ways in which physicians imagine themselves and their work. Reasoning and correlatively medical knowledge born in the process of action, also referred to as experiential knowledge, are made and spread at this local scale. Their effects in terms of the

production of vulnerabilities and violence that cross the worlds of care must be documented by anthropology. This is crucial for understanding the different faces of contemporary biomedicine, as expressed through the work of health professionals.

METHODS AND CONTEXT

The following is based on two temporalities of inquiry:

- 1) Two years of field research in Burkina Faso (September 1990 to July 1991, April to December 1992, September 1993 to January 1994). Throughout this period the author made observations of ordinary work situations, medical activities, care relationships and practices in urban and peri-urban areas. The sample included hospitals in the country's two main cities, Ouagadougou and Bobo Dioulasso, and a medical center on the outskirts of the capital. In addition to informal discussions, 91 semi-structured interviews were conducted with general practitioners and specialists. The topics covered during the interviews included their professional culture, the relationships with other health care actors (paramedical staff and traditional practitioners) and with patients, the adjustments made in health care practices in relation to the lack of resource and the economic precariousness of patients, and in relation to their culture.
2. At an interval of 30 years, these data were reconsidered on the basis of two biographical narratives that took up these themes while expanding them; these biographical narratives were based on a series of interviews that were conducted between June 2020 and August 2021 with a pediatrician and a general practitioner, one practicing in the capital, Ouagadougou, the other in a suburban city.

The materials were collected in Burkina Faso. This West African country is still classified in 2021 as one of the 46 poorest countries in the world, according to United Nations criteria. The World Bank estimates that in 2015, 20.7% of the population was undernourished. Life expectancy has increased: it was estimated at 47 years in 1995 (WHO, 1996), at 61.2 years in 2018 (WHO, 2020). Yet nearly one child in 10 dies before the age of 5. According to UNCF (2021), the infant mortality rate is 88⁰/00, and the maternal mortality rate remains high: 341 per 100,000 live births. The share of the population under 15 years old represents on average 45% of the population, just over 3% is over 65 years old. The Burkinabe government invests little in health infrastructure and welfare, except for primary health care. The ratio of doctors per capita is 1 per 15,350 inhabitants in 2016, while the standard defined by the WHO is a minimum of 1/10,000.

A universal health insurance scheme was passed in 2015 but its implementation has stalled. Since then, a system of prepayment has forced patients to pay for care in order to be covered. Only children under 5 years of age receive free health care.

A comprehensive method research

The study was based on a qualitative research approach and, in particular, the medium of « thick description » (Geertz, 1973), the only one able to investigate, in a comprehensive way, aspects of medical work whose meaning cannot be grasped by quantitative measurement. The approach used a range of methods describe above to focus on the subjective meanings through which health practitioners interpret their working conditions and their effects. In this paper, the situations are described and analyzed from the perspectives of the actors. This is to reach the subjective meanings and the representations attached to medical work.

RESULTS

All the factors mentioned below are those discussed by all the doctors interviewed in the two periods. Three registers of vulnerability are highlighted: they integrate the responsibilities of patients in the daily difficulties in providing care, in several forms.

Vulnerability due to lack of resources

The doctors interviewed highlight the difficulty of building up their daily work in public health infrastructures where the resources for working are reduced to a minimum. Often, even the essentials are missing to perform basic procedures during consultations, such as stethoscopes that doctors have to buy themselves. Therefore, from the diagnostic phase onwards, the immediate concern is whether examinations are necessary to confirm a diagnostic and move forward with a treatment proposal. A general practitioner said:

In my medical center, the only tests available are blood tests! There are no X-rays available. And let's not talk about scanners! Even in the university hospitals centers, sometimes there is only one machine and it has been broken down for months. So either we do nothing or we send the patients to the private sector, but a scanner is a month's salary! Who can afford that?

When patients have to be hospitalized, another problem arises: the availability of beds in public health centers. It is common for patients to wait on the floor for a bed to become available; sometimes they have to be asked to go home without any care because there is no room to admit them, which is a terrible human situation as this doctor summarizes:

Imagine getting them to the hospital and telling them to go home! It's terrible for everyone.

The gap between the theoretical training received and the reality of practice conditions does not allow doctors to practice their profession in the manner they have been trained. A pediatrician explained her experience as follows:

We are trained as if we were going to work without any constraints. We learn technical gestures that we will never do because we don't have the right equipment. We learn that we have to ask for certain tests and we will never see the results because they cannot be done here.

In this context, failures are frequent; they are measured by the death of patients or by the interruption of hospital care at the request of the relatives. This work situation is unrelated to any intention of the patients. However, their

responsibility is represented as engaged when some of their attitudes add, according to the doctors, to the difficulties and harshness of these care conditions, or even produce them. The comments point to forms of unwillingness that combine a lack of resources and a passive attitude. A doctor described his experience in the following manner:

They lack money, that's for sure. But even someone who cannot afford it can come to a health center first because he does not know in advance how much the care will cost. And if they can't pay because they are poor, then their responsibility is limited. But sometimes they don't even come, they just sit at home! And when they do come, it's too late, there's not much you can do.

This passivity turns against these doctors because they are being asked to act without having the means to do so. The same professional continues:

There are patients to whom you ask to go for tests and they say no. I do not have the money; manage to treat me like this.

Medical practice is therefore made up of trial and error, of late treatment, of choices made under restrictions, of breaks in the care trajectories. And when situations of death arise, doctors systematically ask themselves whether, under better conditions, they could have gone beyond what they did.

Vulnerability linked to patients' cultural references

A second register of vulnerability reinforces the first: that of the cultural representations with which sick people think about illnesses and interpret their causes. The doctors' point out that for most of the population, illness always refers to a supernatural cause; there is always something or someone responsible. The consequences for their work are multiple and multifaceted. First, this leads to late recourse to biomedicine, which is regularly used after the recourse to traditional healers. This is despite the circulation of knowledge that concerns African societies involved in the changing processes of the 21st century. Traditional healers may also prescribe treatments that complicate biomedical care and sometimes lead to death. A doctor described this situation in the following way:

The mothers have to wash the children with decoctions. But sometimes they also give it to drink, and it paralyzes the intestines. Until the child dies. But the doctor cannot tell the mother that she is responsible for this death that would be accusing her, with serious consequences for them and for us.

These cultural references may also lead to the refusal to

follow medical recommendations. Doctor R. gave the following example:

The Fulani are often anemic because of their diet. But they refuse to give blood for transfusions because they think they have little blood in them because they are thin. But that's their body type! So when a child needs blood and the family is asked, they would rather see the child die than give blood.

These cultural identities are therefore presented in turn from the point of view of the complications they cause in care. Sometimes the comments are more accusatory; they refer to some cultural norms whose effects are criticized in terms of the way in which the value of life is considered. This is particularly present in the comments on fathers' relationship to their children's health. That pediatrician suggested:

Is this someone who really wants his child to get well and is going to pay for it? If he dies, he has others since he is a polygamist.

Vulnerability due to lack of public support

A third modality of this vulnerability suffered at work concerns the lack of support received by doctors in their struggle to improve health care standards. All of them mention the strikes and collective mobilizations they initiate to obtain better working and care conditions. The population is accused of not supporting them while they struggle amid severe resource shortage. A pediatrician said that:

It's the population that is blamed. We tell them that when we go on strike, they are there to complain whereas we are doing this for them. But instead of supporting us, they criticize us, they resent us. When the politicians criticize us, the population follows: we are the bad guys!

Similarly, the doctors regret that the population does not understand the delays in treatment, one of the difficulties of everyday work, and they are frustrated by this "inability":

They say that we make them wait in public hospitals, whereas in the private sector it goes faster. Of course, it's quicker when the infrastructure is working. But in a public hospital, when only one surgical block is in working order for traumatology, for neurosurgery, we can only be delayed for months.

These results underline that for doctors, the challenge of providing quality care and the vulnerabilities that weaken the efficacy of their work are therefore linked to the lack of resources that the state provides for their work, but also to the attitudes of patients and more widely of the

population. Their ability to provide care is considered in terms of what they feel they have lost in terms of the conditions and quality of their work, in relation to what they have learned and what is being done elsewhere. The quality of interactions between caregivers and patients is therefore perceived as disturbed by the latter. Patients are seen as agents who reinforce the difficult conditions of care for these caregivers. As a result, for doctors interviewed, successful caregiving is an extraordinary situation, not an ordinary one.

The importance of sick people and their relatives is thus recognized in the construction of medical practices, but in ways that would disrupt the care relationship.

DISCUSSION

These results highlight several elements of the relationship between the production of care and the structural poverty. They are related to this specific context but refer to dimensions that are more general.

Vulnerabilities suffered and in the meantime constructed

Vulnerabilities that weaken medical practices and care relationships are partly material, as the doctors pointed out. Nevertheless, they are also the result of caregivers' perceptions of them, through their ways of thinking and prioritizing the reasons why they cannot practice as they have been trained to do. These perceptions take part in the production of the strengths and weaknesses of daily medical work because it relies on them. It is fundamentally shaped by these perceptions, which have concrete implications. This is crucial for understanding the nature of medical practices and care relationships, and the ways in which doctors engage with biomedical practices. I will highlight two of these implications.

First, it is noted that these perceptions incorporate the material conditions in which they are embedded. But they are also based on implicit assumptions that go beyond the situations of daily action. Thus, in this African country, as in Europe or in North America, doctors expect care relationships to be based on people who hold full responsibility for their choices, which refers to the Euro-American model of the person and personhood. These conceptions are those with which they are socialized (Freidson, 1970; Delvecchio-Good, 1995; Agrawal, 2002). However, in the context of Burkina Faso, these conceptions produce a disqualifying knowledge about patients based on a reified culturalism, a flaw that has shaped the history of public health in South countries. An ambivalent relationship emerges between health workers and the responsibility of the sick and, more broadly, of the Burkinabe population for the vulnerabilities that weaken the medical practice.

The danger is that, in places like Burkina Faso where access to medical services remain expensive and sometimes impossible to afford, patients are sometimes situated as victims of their social condition, of economic insecurity that complicates care and delays treatment, and sometimes as responsible for disruptions in care trajectories, failure to comply with medical requests. Doctors' point out the problems linked to the consultation of traditional practitioners and the lack of interest in children in polygamous families. This is, according to them, because of the culture they choose to follow, as "children of tradition", rather than subscribing to the biomedical knowledge. This interpretation is part of a very individualistic perception of people and their choice.

Secondly, in a related way, practitioners generate a form of unmitigated otherness between themselves and their patients. This partition prevents them from seeing the vulnerabilities described as constitutive of a condition they share with their patients. Because they also undergo these vulnerabilities being unable to care as they have learned and without the possibility of resisting to produce sustainable change. This distinction between « them » and « us » then prevents the emergence of a victim figure that could be shared between caregivers and patients, and which could support common collective mobilizations. This ambivalence at the heart of conceptions of patients' responsibilities in this complicated context of care leads doctors to shift onto each individual, each family, and the pressure of structural constraints (Quesada et al., 2011) that they are nevertheless subject to in common. They are confronted with the need to provide care for some and to be cared for others, without having the means to do so and by deviating from the biomedical model. Responsibilities are performed at a collective level, involving states, national and international public policies, without making them the alpha and omega of all analyses.

Therefore, the adjustments made under duress by the caregivers in their daily work are the counterpart of a structural violence (Aijmer and Abbink, 2000; Farmer, 2004) that limits their capabilities to act. Part of the migration of African doctors to Northern countries is related to this (Blacklock et al., 2013).

From structural violence to ordinary violence

These experiences invite anthropology to discuss how to move from an analysis in terms of structural violence to an analysis in terms of ordinary violence. I suggest that this approach is appropriated to express the painful experiences of patients and caregivers in the terms of those who are caught up in them, in different ways but at the same time with common sufferings experienced in the ordinary care relationships. The WHO has also identified the difficulties linked to the functioning of health systems, such as the lack of equipment for treatment mentioned by

the Burkinabe doctors, as one of the seven categories of abuse that health systems suffer in low-resource countries. This is an interesting position taken by this international organisation, as many phenomena of violence are not always identified as such for the people who experience them, as well as for those who participate in producing them (Scheper-Hughes, 1992). Moreover, at no time was the term "violence" used by either the cared-for or the carers interviewed. Should the same restriction be applied to researchers who analyse these phenomena?

Studying everyday experiences in relation to care is precisely the appropriate place for an ethnography that leads to an understanding of how social forces - which imply a macro logical reading of structural violence - articulate with micro-contexts of action to shape perceptions and interpretations of lived situations that potentially produce social suffering and daily violence. It can be hypothesised that these situations of structural poverty produce ordinary violence through the ways in which they shape carers' perceptions of the responsibilities of patients in their difficulties in delivering care as others may do in other contexts. Structural poverty therefore occurs without the caregivers, in their working environment, but it is at the same time embodied through their perceptions of the situations they experience. This is undoubtedly a contemporary expression of the social drama of work, a concept theorised by Hughes (1976). From this perspective, we can suggest that doctors take part, obviously without intention to harm, in these offences against human dignity that patients and their relatives suffer in their difficulties to obtain care, with implications directly inscribed in the bodies amputated from care and years of life. These are all traces of this ordinary violence incorporated.

These care situations and the medical work that takes place in them should undeniably be included in the phenomena that can be described as violence (Farmer, 2004; Das et al., 2001; De Verteuil, 2015). For people can speak of a toxic environment, that has become ordinary. Toxic is not understood in the usual sense of the term (exposure to environmental risks that affect health), but with regard to the impossibility for doctors to consider the part they play in these deleterious vulnerabilities and in the production of a medicine of the poor, some of the causes of which they situate in the socio-cultural and economic characteristics of patients. This does not prevent many doctors from showing empathy and concern for others, which takes several forms in their daily work. The most frequent is their participation in the costs of treatment. However, these attitudes remain occasional and do not call into question what is more collectively and daily lacking in quality and humanity in the medicine they are led to practice under constraint.

From African situations to an anthropology of care between North and South

These situations described from a West African context expand the knowledge of the variety of contemporary ways of experiencing care, both for the people being cared for and for the caregivers. These experiences, both of cure and care in low-resource countries, appear at first sight to be very different from those most commonly experienced and analysed in Western contexts. However, as long as they do not make an arbitrary distinction between the societies of the North and the South when thinking about issues of health vulnerability, the case of Burkina Faso reminds people that therapeutic realities and the vulnerabilities that run through them are jointly political, medical, ideological; they are first crystallised in everyday social relations before being related in care relationships. They are therefore produced with the cooperation, sometimes deliberate, sometimes undergone, sometimes thought and sometimes ignored, of people involved, in the South as in the North.

Bringing this process into light through ethnographic descriptions and with the participation of those among whom we came to work has a considerable implication. Because taking into consideration the multiple ways of practising medicine in the North and the South, of constructing skills and abilities, of thinking about responsibilities means taking part in populating our daily lives with other histories, other ways of inventing one's profession, and sometimes of undergoing it; other policies of life and other ethics are also exposed and confronted. Knowing this diversity is a necessary support to be able to imagine and produce new conditions of care defined as acceptable on the basis of deterritorialised and globalised references and models. It is also a condition to imagine new capacities to deviate from routine experiences in order to reduce inequalities in production and, jointly, in the use of care in the poorest countries.

Conclusion

In the tradition of medical humanities, but also of science studies, one of the functions that anthropology can fulfil with its specific tools (Strauss and Corbin, 1990; Fassin, 2013) is to reveal how this eminently political register of structural poverty shapes doctors' conceptions of their profession and extends into care practices. The intention is to break down the self-evident and neutral character of these conceptions, which still seem to take the place of a shared culture within the health professions. The aim is not to judge them. On the contrary, it is to give an account of their conditions of production, of their ramifications in lived experiences, and to suggest some of their extensions, which are still not very visible. We can then identify the problems that they generate or lead to, such as the inability to think about shared vulnerabilities,

to retain a perspective that goes beyond the classic division of the status of health professionals and patients to place carers and cared-for in a symmetrical position. In these south societies, where becoming a doctor leads to a strong social ascension, this prevents assertive forms of collective mobilization and struggle for dignified conditions of care. What would this conversion of the gaze make doctors and patients commonly capable of?

In a reflection that includes questions of global health and the circulation of knowledge, this West African situation reminds them that the training of doctors follows protocols and includes unified knowledge beyond the socio-cultural contexts in which it will be mobilised, as the doctors interviewed in Burkina Faso and elsewhere point out (Wendland, 2004). However, this single biomedical model, structured around theoretical knowledge, can only produce its effects through the work of individuals who endeavour to inscribe it in care situations that are sometimes very distant, both materially and ideally, from those that have shape this model, its history and its ethical benchmarks. This makes the practice of biomedicine and its effectiveness always in tension between the collective and the singular, despite a universe of common references and knowledge.

CONFLICT OF INTERESTS

The author has not declared any conflict of interests.

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