Contemporary health care systems, local worlds and limited options: On agency and choice within Mozambican infertile couples' therapeutic navigations

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ABSTRACT: In this article I explore the intersections between Mozambican infertile couples' reproductive intentions and their local and transnational therapeutic itineraries in the quest for conception. Based on ethnographic fieldwork in Maputo, Mozambique, and carried out in and out of clinical settings, my aim is to shed light into the constraints and agencies within such therapeutic itineraries, as well as into local stakes on reproduction and infertility, particularly on how these manifest in everyday lives of women and couples. To do so I propose the concept of therapeutic navigation which pins down the social and therapeutic ways in which people manoeuvre and attune their treatment choices to socially and structurally determined fields of opportunity in order to profit the most from temporary life conjunctures and move towards a therapeutic objective – in this case, overcoming infertility and having a child.

1. Introduction[1]

In Mozambique, parenthood and reproduction are socially embedded processes. As reported elsewhere (Inhorn & van Balen, 2003), there are great expectations regarding fertility and a couple's capacity to reproduce once in a stable relationship (Faria, 2016). In this context, reproductive difficulties pose a crisis situation for couples (van Balen & Bos,

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2010), not only because they represent the inability to fulfil a personal desire, but also because of the complex relationships – with birth and in-law families, as well as in everyday life social circles – that are entangled in reproductive intentions.

In the southern region of Mozambique – where Maputo is located, the city where the research underlying this article was conducted – the predominant kinship system is patrilineal, and high reproductive expectations are often felt strongly by couples, though by women in particular (Mariano, 2014). Despite the fact that Maputo is a transforming urban context, and taking exceptions into account (Faria, 2016), women living in the city may suffer social consequences if they find themselves in an involuntarily childless relationship. These consequences may include pressure to reproduce coming from in-law families, marital tensions, and marginalization and stigmatization regarding familial and social circles (Gerrits, 1997; Inhorn & van Balen, 2003; Mariano, 2014; Faria, 2016). In this context, once a lack of fertility is suspected, women, or couples, immediately seek ways to circumvent it.

In this article, my aim is to explore the intersection between Mozambican infertile couples' reproductive intentions (Browner & Sargent, 2011) and their local and transnational therapeutic navigations in the quest for conception (Inhorn & Patrizio, 2015; Inhorn, 2014). As I will show, these treatment seeking and uptake processes reveal structural constraints (Schütz, 1972), local stakes (Kleinman, 2006) and grounded agencies. The latter are largely shaped by contextualized pragmatics and choices manifest in the everyday interactions between patients and particular healing instances (Kleinman, 1978; Granjo, 2009; Mariano, 2014).

Drawing on the development of previous studies on infertility, as well as on parenthood, motherhood and reproduction in sub-Saharan Africa, it is possible to observe an increasing focus on agency (van Dijk *et al*., 2007), generally analyzed as part of a broader picture and often emphasizing suffering and structural violence rather than individual or collective action or navigation (Chapman, 2010; Mariano, 2014). Taking into account the importance of these perspectives in the depiction of structural inequalities (Farmer, 2004) and the prevailing trend of stratified reproduction (Ginsburg & Rapp, 1995), I came to understand how important it is, especially within a geographical site where few social studies on infertility have been conducted (Mariano, 2014; 2004; Arnaldo, 2004), to account for biographical agency and the social and medical aspects intersecting fertility treatments. To do so, I propose the concept of

therapeutic navigation (Faria, 2016), which, inspired by Vigh's notion of social navigation (Vigh, 2009), pins down the ways (involving socialities and therapeutics) in which people manoeuvre and attune their treatment choices to socially and structurally determined fields of opportunity in order to profit the most from temporary life conjunctures and move towards a therapeutic objective – in this case, overcoming infertility and having a child (Faria, 2016).

Among my respondents, agencies and pragmatism were contextualized by a slowly changing transnational social matrix: a macro-social context – field of possibilities – that affected the disposition of their grounds of action – grounds of navigation – towards their parenthood project. In this sense, by moving through uncertain and transforming social environments, my respondents were acting inside structurally shaped fields of possibility (Schütz, 1972; Velho, 2003) that constrained but did not prevent them from acting. These fields of possibility were the 'spaces' in which people dwelled in order to implement their biographical project (Schütz, 1972; Velho, 2003) of having a child, and the differences between them were largely determined by people's different backgrounds and social class.

My respondents were always acting in pursuit of the realization of a reproductive intention, and akin to the slowly changing transnational and local arenas that they inhabited, their projects also transformed. They were attuned to momentary circumstances (Velho, 2009; Vigh, 2003) inevitably connected to complex healing contexts that can be looked at through the lens of the 'medicoscape'. The concept of medicoscape emphasizes the interrelations between individuals, organizations, practices and artefacts within particular national and transnational contexts of agency framed by different policies, powers and healing regimes (Dilger *et al*., 2012; Hörbst & Wolf, 2014: 184). In this sense, while relating to broader global and local contemporary economic and social states of affairs, as well as to national contexts and to the fluidity that these matrixes encompass, it is possible to assert that Mozambican infertile couples' therapeutic navigations can be analysed as agency processes, where different localized vectors, entangled with different medicoscapes, intersect. The latter include therapeutics as well as local stakes regarding reproduction and healing that interact with fertility treatments and are unveiled in patients' therapeutic choices and navigations.

The research underlying this article covered mainly biomedical infertility treatment seeking and uptake. Nevertheless, through patients' accounts, both traditional and biomedical healing instances came to be included, both in the research and in this article, namely

traditional healing, biomedical healing at home (in Maputo) in the public and private sector, and biomedical healing abroad in South Africa's private sector fertility clinics close to the Mozambican border (Faria, 2016). The medicoscapes that Mozambican couples travelled through were thus transnational ones, including Mozambique (Maputo) and South Africa – two countries with different health care systems and unequal access to health care resources (WHO, 2014a; 2014b).

Despite the fact that both Mozambique and South Africa struggle to provide medical coverage for their populations, Mozambique has significantly fewer resources and depends much more on foreign cooperation programs in many health care provision areas (Faria, 2016; MISAU, 2012). In Maputo, the private health care sector is not as developed as in South Africa. Despite some recent growth, fed mainly by international partnerships, the private health care sector in Mozambique is yet to provide high-tech medical procedures, including assisted reproduction technologies (ARTs) (Gerrits & Shaw, 2010; Mariano, 2014; Faria, 2016; 2015). In Maputo, at the time of my research, there was only one clinic providing selected assisted reproduction treatments (in-vitro fertilization – IVF, but not intracytoplasmic sperm injection – ICSI) to infertile couples, treatments which were unavailable in the public hospital. The private health care sector in South Africa is, by contrast, well developed and clinics in the country not only provide high-tech medical and surgical procedures – including state-of-the-art ARTs – but they also target medical travellers (Scheper-Hughes, 2011).

As I will show, my respondents' therapeutic navigations marked a point of intersection of many different aspects. Patients' therapeutic itineraries departed from a country with deficient biomedical treatment provision in general – and in terms of infertility treatment in particular – and with a poorly resourced and rundown public health care sector. In this context, for those who could afford it, they could access the growing private health care sector in the region, which included in its service provision state-of-the-art ARTs in South African clinics. Aside from public health providers in Maputo and private health providers in Maputo and South African cities close to the border, traditional healing was also part of the medicoscapes framing my respondents' therapeutic navigations. While relating to each of these healing universes, their agency was influenced by their own ideas about kinship,

parenthood and reproduction, and furthermore by their economic power, which enabled or restrained their access to certain modalities of infertility care.

My respondents' therapeutic navigations included different healing regimes and kinds of medical interactions (between patients and institutions, or simply between patients and practitioners or healers), and materialized in dissimilar medicoscapes. While unfolding in such complex personal and contextual matrixes, Mozambican couples' quests for fertility were characterized by certain freedoms framed by particular life configurations – in particular, the limitations and possibilities to choose treatments and the activeness of patients in their interactions with chosen healing instances.

Below, I introduce my research methods. The third section then comprises a description of the sites where my respondents looked for infertility care – the public hospital, the private clinic in Maputo, and private clinics in South Africa. Following the descriptions of the medical sites, I present two short examples of therapeutic navigations for infertility treatment. Finally, in the last section, there is a discussion of therapeutic navigations and the dynamics of constraints versus freedom of choice in the particular medicoscapes and moral worlds (Kleinman, 2006) through and in which Mozambican infertile women and men moved and dwelled.

2. Methods

This article is based on a socio-anthropological study about Mozambican infertile women's and couples' infertility treatment seeking and uptake processes in Mozambique and South Africa. The research underlying the article was based in Maputo, Mozambique, and was conducted over a period of 9 months in 2013. It included periods of ethnographic fieldwork in one private fertility clinic in the city – the only one providing ARTs in the country at that moment – and one public hospital. A total of two Mozambican practitioners and 25 female infertility treatment patients (previous or current) were interviewed. The interviews were audio recorded upon permission and were transcribed verbatim during and after the fieldwork period. Adding to this, periods of participant observation in clinical sites were also carried out and registered. Despite the limited number of respondents, the sample was consistent enough to function as a basis for socio-anthropological reflections on various

aspects of medical interactions from the perspective of patients attending public sector fertility consultations, as well as those resorting to ARTs in the private sector, both in Maputo and through reproductive travel to South Africa. All data were analysed using a qualitative analysis software and in comparison with the reviewed literature.

The 25 interviewed women had undergone fertility treatments between their early 20s and mid-40s. Women attending the public hospital and private clinic in Maputo were recruited at the clinical sites themselves. Women who had engaged in reproductive travel in South Africa were recruited through snowball sampling as well as in the private clinic in Maputo, where I met women who had previously engaged in reproductive travel. Aside from the clinical sites in Maputo, the research covered three clinics in South African cities close to the Mozambican border – Pretoria, Nelspruit and Johannesburg – which Mozambican couples attended.

The research focused on the phases of treatment in which women or couples were attending biomedical facilities. Traditional healers were therefore not part of the study's focus or sample, though resort to traditional healing was accounted for in the research and is included in this article, as the cases below will show, since it was a common therapeutic option for women or couples before, during or in between biomedical treatments, independent of their socio-economic background.

3. Medicoscapes on the ground: On public and private infertility health care provision in Mozambique and in private South African clinics

In this section, I will present contextualized ethnographic descriptions of (some of) the biomedical sites that my respondents attended throughout their quests to overcome infertility. Descriptions include the public hospital and the private clinic where I did fieldwork in Maputo, as well as accounts of South African clinics. The characterization of the clinical sites in Maputo is based on participant observation, and the characterization of South African clinics is partly based on observation (made in visits) but mostly on patients' descriptions of clinical sites and of their experiences within such spaces.

3.1. Maputo: The public hospital infertility consultation

The first time I visited a public health facility in Maputo, I had scheduled a meeting close to the maternity ward operation room of the city's main hospital. I entered the big modernist building, that looked like a late 1950s or early 1960s construction, and went up a couple of flights of stairs to the 4th floor, where the maternity ward was located. Once I got there, I saw a busy health care assistant cleaning up a massive quantity of water off the worn out blue linoleum floor of the ward. As I observed her and the overall space, I could not help noticing the missing pieces of the soaked old floor, and the stains of humidity expanding along the ceilings and walls. The ward was full and occasionally a hospital bed passed by with a patient lying on it. Doctors were also running around the corridors. Although I had an idea of how different public and private health facilities could be, it was only then, while waiting for my meeting, that I faced empirically the overwhelming dimension of the resource gap between the two sectors.

In the hospital where I did my fieldwork, the working and consultation rooms were fair. The building was old, hot and had a visible lack of maintenance, but however frail the general infrastructures might have been, everything in the surroundings of the infertility consultation room looked well maintained and organized. Infertility consultations always took place in the same rooms, separated from the waiting patients by a closed wooden door; this door was occasionally opened, a woman would be called inside, and the door would be closed again behind her. Once inside, there were three open consultation cubicles facing a longitudinal pathway where patients and doctors circulated. There was one doctor sitting behind a desk in each one of these open rooms and a chair for the patient on the opposite side of the desk. To get to the frequently used scanning machine, patients had to cross other consultation cubicles. The director of the gynaecology service and infertility consultation – Dr. Macamo – was always running around supervising and attending to patients. I never saw him sit long at any of the desks; rather, he moved around asking and answering questions.

In these busy rooms, practitioners had many patients to attend to, which, as happens in many big hospitals, meant that the consultations and recommendations for treatment were quick, with little time for extensive questions. Adding to the fast pace of the consultations, the language spoken was Portuguese, which some patients did not speak fluently. This kind of organization for the infertility consultations was likely to influence patients' perceptions of

both the hospital and the treatment. They commonly perceived biomedicine as a modern[2] institution, but frequently took treatments as a series of steps to be accomplished and paperwork to be processed. In this rational medicalized context, patients frequently sought support from one another. Through networking with peers – other infertile women – and by sharing their experiences for mutual support, my respondents informally improved their knowledge about medical diagnoses and treatments to a certain extent. When in doubt, women related more closely to nurses and other medical staff than to doctors. They would pose more questions about treatment procedures and steps to these members of the medical staff than to doctors themselves. Occasionally – if the health professional could – these side interactions with medical staff would be in dialect (Ronga or Shangana), and they normally took place on the other side of the abovementioned wooden door, when nurses or staff came outside to call another patient in or to forward documents to another hospital department. The women waiting outside would then ask, sometimes simultaneously, their questions about the next (bureaucratic or therapeutic) step of their treatment.

In the public sector, patients were diagnosed by gynaecological exam, scan and pre-scheduled diagnosis, or, if necessary, corrective laparoscopy. Blood testing and other exams were prescribed and, according to my respondents, outsourced. As Dr. Macamo told me, although the conditions to treat female hormonal causes of infertility existed in the hospital, it was difficult to deal with cases of masculine or mechanical (mainly tubal) infertility, for which IVF was likely to be the most appropriate option in therapeutic terms. For cases of suspected hormonal infertility – among which the most common were ovarian cysts or uterine fibroids, which was the case for some of the women I encountered – hormonal medication would be prescribed as an attempt to reduce obstructions (such as cysts or fibroids) in the women's reproductive system.

For mechanical causes, hormonal medication is unlikely to work, thus women in the public sector were left with the only option of corrective laparoscopic surgery and had no access to ARTs. For male infertility, the process was complicated. Although diagnostic means for sperm examination were available[3], when facing a situation of male factor

[2] This perception of modernity regards the progressive post-colonial socialist ideology advocated by FRELIMO. For more information on notions of modernity in Mozambique, see (Arnfred, 2011; Cavallo, 2013; Faria, 2016).
[3] In the public sector, diagnostic sperm examination normally took place in exam laboratories located outside of the hospitals.

infertility, doctors frequently did not have enough resources to treat it with medication (as medication stocks in the hospital's pharmacy were often poor), or to circumvent it with other suitable technical procedures (such as ARTs). According to Dr. Macamo, in (rare) cases of couples where the sperm quality could be enhanced with medication (e.g. mild oligospermia), and where the female reproductive system was in order, intra-cervical insemination with the husband's sperm was possible, but intra-uterine fertilization was not. More complicated cases would be discussed by the medical team in the quest for the best available option. In the public hospital, treatments and consultations were cheaper than in the private sector, and came to 1 MZN (0.01 EUR) per appointment.

Among my respondents using the public sector biomedical infertility services, therapeutic impairments went beyond the material and physical aspects of healing. Adding to the hospital's scarcity of therapeutic resources to treat non-hormonal or male infertility causes, men were frequently absent from the infertility consultations and marital instability among infertile couples was common. In such situations, in order to continue their (frequently socially demanded) quests for parenthood, interaction with biomedicine required (but also enabled) women to challenge the same matrix of values that likely triggered their treatment seeking to begin with (Faria, 2016). By contrast, for middle class and cosmopolitan women using private sector infertility care, including ARTs, male participation in treatment was not as challenging. In these cases, as described below, adding to the patients' social and couple disposition to uptake treatment together, there were more and better resources for diagnosis and treatment procedures than in the public hospital.

3.2. Maputo: Infertility consultations in the private clinic

In Maputo, private sector infertility consultations took place in a clinic where different areas of medical expertise were provided. As I approached the old building in a busy corner of the city's downtown area, the clinic would almost go unnoticed if it was not for the sign above the main entrance, located in a gallery where street sellers and others offered their services. Once inside the automatic glass door, I followed the stairs up to the first floor where the gynaecology rooms were located. There, in a very simple waiting room that at the time was lacking air conditioning (something that all of the other clinics I visited had), some

women were already waiting their turn, watching television while nurses passed back and forth and the receptionist's phone rang non-stop. After a while the doctor arrived, the faces of the waiting patients lit up, and consultations began. The average time of each consultation was higher than in the public hospital, and despite the long waiting times, these were still shorter than in the public sector[4]. Although the equipment did not look as new as in other private health facilities I visited, both in Maputo and South Africa, my overall impression of this clinic was that it worked swiftly and did not lack any essential materials or staff to provide patients with the diagnosis and healing procedures they needed. However, due to the scarcity of health professionals, in the case of an emergency in the public hospital, the doctor could eventually have to interrupt consultations and attend to such occurrences, after which consultations would be resumed if possible.

The women in the waiting room would be called one by one into the consultation rooms by a nurse, and the doctor took his time with each one of them – there was enough time for doubts and questions in each consultation, and to explain the medication prescribed and what it was for (something that did not happen as often in the public hospital or even in the South African fertility clinics). In the private clinic in Maputo, the consultation style and conditions as well as the patients' behaviour echoed Lupton's (1997) idea of the patient-client: empowered patients who can make their own choices about important steps in their treatment. After their consultations, patients were forwarded to the reception desk to pay for the appointment and schedule further consultations, exams or ART procedures. The costs of treatment in the clinic were 1,500 MZN (21 EUR) per consultation and 60,000 MZN (828 EUR) per IVF cycle, with exams and medications added to these costs. Among the patients in the private clinic that I had contact with, husbands were generally cooperative and the couples acted as a team in the pursuit and uptake of treatment.

This clinic had its own laboratory for assisted reproduction techniques and provided all ART treatments with the exception of ICSI (Mausse *et al*., 2014), which during the time of my fieldwork was only being provided in South African clinics. Although more economical than the treatments in South African fertility clinics, the prices in this clinic were still

[4] The average waiting time for an appointment at this clinic was slightly unpredictable as the doctor also had to attend to emergencies in the public sector and thus her presence in the clinic could be delayed or suddenly interrupted. Nevertheless, once the doctor started consultations, the average waiting time was about 30 minutes to one hour.

considerably more expensive than in the public hospital. The doctors working in the private infertility clinic in Maputo had been eager to establish the space and to offer an almost full range of ART treatments, and step by step it seemed as if they were succeeding. However, they faced a number of difficulties, including, according to Dr. Macamo, the local instability of resource access, financial flows and compromised sponsorships. Furthermore, the difficulties in forming international partnerships made the process of establishing a state-of-the-art ART clinic time-consuming.

Despite being the best possible option available in the city of Maputo and in Mozambique at large, and despite providing patient-oriented treatment, the private clinic in Maputo was at the time of my study yet to attain the technological level of many of its South African peers. Nevertheless, many women and couples preferred to pursue treatment in their own country and considered reproductive travel only as a last option. Others, by contrast, opted for reproductive travel as a first option, and would consider treatment at home in Mozambique only in case all else failed.

3.3. South Africa: Sites of reproductive travel

For couples undertaking reproductive travel to South African fertility clinics, therapeutic itineraries were geographically longer and economically more demanding, but offered all of the available state-of-the-art procedures to circumvent infertility and achieve a pregnancy. Yet even for these travelling patients, where all of the resources and diagnostic and treatment means were available, the chances of success were still small (Vayena *et al*., 2002)[5]. Dr. Macamo, while talking about travelling patients, mentioned how success rates in state-of-the-art clinics are still only around 30%.

The South African private fertility clinics I visited looked different from both the public hospital and the private clinic in Maputo. They had comfortable and air conditioned waiting rooms, more than one consultation room in use and, as speciality clinics, these sites frequently had fertility information pamphlets lying around in the common spaces. Despite being private sector institutions, however, the way in which my respondents described the

[5] Assisted reproduction success rates vary widely according to a woman's age and fertility problems. However, even for women of reproductive age and/or with apparently simple fertility problems, for whom IVF would most likely be successful, treatment outcomes are never predictable and average success rates are never high.

workings of the fertility clinics resembled much more the functioning of a public hospital, with short meetings (less than 10 minutes) between patients and doctors, and with nurses taking care of most of the social part of the treatment.

Several of my informants mentioned how these sites were quite business-oriented and how doctors even attended to two different couples at a time, in quick consultations where the latter interacted mostly with nurses. Teresa was a mother of IVF twins, together with her husband Mohammed. They had sought treatment in a fertility clinic in Johannesburg, where they had reached a successful pregnancy. While explaining to me her experience, she told me about the organization of the fertility clinic's consultation and medical staff:

> *You know what the doctors do? They have two offices, you are in one of those, and it's the nurse that tells you everything. The doctor is all 'Oh yes, oh we can do this, we can do…' whatever he says. And I only saw the nurse looking at him. Then there is another door, and he goes and checks on the other patient waiting in the other room. So, he [the doctor] is walking from office to office. He stays with you five or six minutes, 10 tops!*

Unlike in the private clinic in Maputo, where consultations were slightly longer and the doctor was the one doing most of the talking with the patients, in the infertility clinics in South Africa that my informants attended, the situation was often as Teresa depicted. According to their accounts, medical interactions in these sites were short, rational and cold. Doctors attending couples in two different consultation rooms simultaneously was something that only happened (according to my respondents) in one clinic, but certainly all of them mentioned the general lack of contact with the doctors and the business-like structure of the clinics. In these sites, the treatment cost for a simple IVF cycle was 35,000 R (2,136 EUR). This was without exams and consultation, which ranged from 700 R (43 EUR) to 2,800 R (171 EUR) for the former, and 1,000 R (62,31 EUR) for the latter. Adding to institutional and other cost-related obstacles, for patients undergoing reproductive travel there was yet another difficulty: consultations were held in English, a language that several of my informants, especially the less well-travelled women, were not fluent in.

In spite of the generally cold and impersonal functioning of the fertility clinics in South Africa, they were equipped with state-of-the-art facilities and experts and were the clinical sites where the most ART options were available. These ranged from basic insemination with

the husband's sperm to surgical procedures, all sorts of IVF (including ICSI), use of donor gametes and surrogacy. Therefore, despite repeatedly mentioning how cold and profit-oriented these sites were, many women/couples relied on them as their best possible option for conception with biomedical help. Like the couples attending the private clinic in Maputo, most of my respondents undertaking reproductive travel sought treatment as a couple and, with few exceptions, men were supportive of their wives.

As seen in the descriptions above, the health care provision contexts involved in this research, and in Mozambican women's and couples' therapeutic navigations, were different in terms of both resources and the medical interactions they engendered. These contexts form part of broader medicoscapes that include international health care agendas and local priorities, particular legal frameworks and policies, and modes of operation (Faria, 2016; WHO, 2014a; 2014b; MISAU, 2012), all of which affect local contexts of health care provision. Infertility care is particularly affected, as it is not considered a priority for the region under study, either at the national or international level (ICPD, 2014).

Below, I will explore two particular therapeutic trajectories framed by these conjunctures, and which reveal the possible agencies and therapeutic choices within them: the case of Candida, a woman who resorted to traditional and biomedical healing in the public hospital, and Camila and Felisberto, a couple that was attending the private clinic in Maputo when we met and were considering attempting ARTs in South Africa in case the treatment at home was unsuccessful.

4. Choosing and constrained freedoms: Navigating unequal medicoscapes

Mozambican women's and couples' therapeutic navigations in the quest to overcome infertility normally started with homemade concoctions, often recommended to women by their mothers or sisters. After these first steps, they then resorted to traditional healing and/or biomedical treatments. Treatment choices were constrained by economic as well as conjuncture factors. The latter were normally related to expectations of treatment efficacy and costs, but also involved negotiations over the local stakes regarding reproduction and infertility (Kleinman, 2006), where choice also responded to a desire for secrecy about reproductive impairments, normally on the part of women, for whom infertility, independent

of its origin (i.e. male or female caused infertility), could bring about tensions or social hardships.

4.1. Navigating choices to overcome infertility: between traditional healing and biomedicine

Candida and I met at the public hospital. She was 36 years old. Despite having a teenage daughter she wanted to have a child with her current husband. This man was not her daughter's father, from whom she had separated years before, and they wanted to consummate the relationship by starting a family. Facing the absence of a wanted pregnancy, she had decided to look for help. Her therapeutic pathway had begun more than 6 years before we met. Having started by looking for a traditional cure to her reproductive impairments, Candida navigated multiple forms of healing all in the quest for a child. During our conversation she explained:

> *Yes, yes. Traditionally we make tries, we go there [to the healer] and we take, take [medicines], but nothing (...) I tried different times (...) we take some liquids of roots that we boil and drink, and also a washing preparation. I took it but I am tired (...). Until now I only did traditional [treatments]. I had tried to start here [at the public hospital] already in 2008, but there were doctor transfers, and with all the confusion I ended up not knowing where to buy my medicines, because I needed a prescription. So I stopped coming to the hospital then. (...) When I was going to the traditional healer, I did not come here. Because I thought I would be intoxicated with a medicine from here, another from there (...) It would be a mess and I would end up not knowing which medicine was not working, so I take my time in each. If it is traditional [it] is that part, if it is the hospital [it] is another.*

As seen in the above quote, Candida's choice was affected by being worn out with the preparation and taking of traditional medication. However, even after deciding to pursue biomedical care for infertility, Candida was faced with the change of medical teams that left her disoriented and contributed to her dropping out of her first treatment (Gerrits, 1997; Gerrits & Shaw, 2010). Nevertheless, she had eventually returned to the public hospital and had stayed in treatment, at least at the point when we met. She explained how her decision to

stick to biomedicine was not only influenced by being tired of traditional remedies, but also by issues of cost and trust.

> *Here you pay nothing. While in the traditional healer [curandeiro] you pay and spend a lot of money for nothing. One consultation is 750 MZN [10.30 EUR], without counting the medicines he tells you to buy. Here I don't pay anything besides 1 MZN [0.01 EUR] for the consultation ticket. (...) I leave home at 5 [am] and at 6 I am here, and the appointments start at 7:30.*

Candida's case shows how, among other factors, there were everyday life pragmatics connected to infertility treatment choice. In her case, besides being tired of traditional remedies, biomedicine was also chosen for economic reasons. The fact that a medical appointment was a lot cheaper than any other kind of healer made it an appealing solution for infertility, particularly in a situation where she was funding treatment alone. Furthermore, it shows how trust in the treatment provider and the methods' success is also an issue when it comes to therapeutic choice (Rodrigues, 2016).

My respondents' switch to biomedical health care was often due to experiences with ineffective traditional treatments, to the degree of social exposure that the traditional medicine involved, to issues of (dis)trust in the healers (Faria, 2016; Pfeiffer, 2002), and finally to treatment costs. As with most women in the public hospital, Candida funded the consultations herself. In the public sector, it was common for women to uptake treatment alone as far as possible. This was because men did not usually contribute to treatment unless they were willing to pursue it together with their wives, which was not common among the women I met in the public hospital. In this context, and despite being economically dependent on their husbands, the low cost of the public sector consultations made it accessible for women without incurring catastrophic expenditures. Public hospital infertility consultations required a symbolic contribution, and despite the long waiting times, it was considered a fruitful attempt to circumvent infertility. Even in cases where women like Candida needed to travel in the chapa (collective transport vans) for one hour or more to get to the hospital, they did not seem greatly bothered by the transportation times and fees, while seeing it in the light of possible treatment success – an expectation that most of my respondents maintained, mainly through word-of-mouth accounts of the positive outcomes of modern biomedical treatments. Nevertheless, it was common for women, or couples, to hop

between biomedical and traditional healing. Candida's case shows that movement as well. If by the time I met them in the hospital or clinics my respondents had chosen biomedicine, this was the case for the time being, and in future life configurations they could decide to change therapeutic options once again.

For my respondents, and at the time and place we met, biomedicine was considered rather convenient as a treatment option. In this sense, despite being further away from most of my respondents' homes than local traditional healers (Granjo, 2009; MISAU, 2012; Mariano, 2014), they saw biomedical infertility treatment as a more reliable therapeutic option in terms of medication, cost-effectiveness, reliability and anonymity.

Among public sector users, the options were fewer than for private sector users, and despite being able to choose, they had restricted fields of possibility in which to do so. Nevertheless, they still navigated their options for conception by attuning their projects to their fields of possibility (Schütz, 1972; Velho, 2003).

4.2. Navigating choices to overcome infertility: Transnational biomedical arenas and technology

Camila was attending the private infertility clinic in Maputo. When we met she had been together with her husband, Felisberto, for 10 years, but it was only after five years of being together that, upon deciding to get married and build a family, their lives were hampered by infertility. They were a well-off couple living in Maputo, with enough resources to attend the private infertility clinic in the city and to consider a potential future visit to a South African fertility clinic in case their current treatment failed.

It was the fact that she did not get pregnant that triggered Camila and Felisberto's quest for both traditional and biomedical healing options, and various sorts of herbal and pharmaceutical medicines. At different biomedical appointments, doctors told Camila that she was fine and that her infertility was likely to be hormonal. Felisberto, an attentive husband who cooperated in every step of the different treatments, was also healthy and medical doctors could not find any problems with his reproductive system. The couple kept looking for a solution during the following five years of marriage, and by the time we met they were still in treatment. Despite the absence of a definitive diagnosis, they kept pursuing

their family-making project. However, by the time we met, Camila had visible proof that something was not normal with her reproductive system. As she told me herself, she was constantly bleeding: "I don't have any pain, and it is not a lot of bleeding, but still, when I take traditional remedies and clinic medication it doesn't stop. (…) How will I ever get pregnant with this bleeding?"[6].

After different attempts by Camila and Felisberto to fulfil their desire for a pregnancy through different healing modalities, they decided to opt for treatment in the private sector, which they could afford. Since it was available in their own country, they decided to give it a try in the private clinic in Maputo and to leave the option of reproductive travel open in the event of an unsuccessful treatment at home. Camila explained:

> *The hypothesis, the last one I had was here. After, if I see it doesn't work, I will look [for treatment] somewhere else. My hypothesis is also that maybe later we can look for an artificial treatment [ARTs]. People always say that in South Africa they have it, so it was that what we wanted. The last, really last [option] is that one, after this, it will be there.*

Camila's expectations were high, as this would be her last home-based attempt to circumvent her infertility. The bleeding worried her, but still she relied on biomedicine and assisted reproduction as the best accessible means to attain her objective. Like many other women, after uncertain therapeutic itineraries aimed at achieving pregnancy, Camila longed for a positive result, or at least for a hope-giving diagnosis, where somebody would tell her exactly what had to be fixed in order to make her and Felisberto parents at last.

Being a parent was perceived differently by people from different social backgrounds. For some of my better-off informants like Camila and Felisberto, parenthood was a strong desire, while for others, especially women from more traditional backgrounds, reproduction, although equally desired, was also a social requirement. Nevertheless, expectations about diagnosis and a positive outcome of infertility treatment were equally high. However

[6] Idioms of physical affliction normally include reference to bleeding, blockage or pain. Although attending biomedical health facilities, women's descriptions were much more focused on bodily sensations than on biomedical diagnosis, and if they spoke about the latter, they normally related it to the sensation that had led them to the doctor.

elevated, these expectations were frequently disrupted throughout winding healing pathways, materializing in dissonant medicoscapes and involving uncertain clinical turns. In many cases, there were limitations to the treatments available, and each couple's situation was specific. Even when they had the possibility to go abroad, state-of-the-art ARTs could be unable to solve the problem. For Camila and Felisberto, this was yet to be confirmed.

Camila and Felisberto's case shows that beyond the possibility to choose to use ARTs, there was yet another possibility: opting whether to engage in reproductive travel or to pursue ART treatment at home. For women like Candida, both of these options were very unlikely and the public hospital would probably be the final stop in their biomedical therapeutic navigations. Having local, transnational or hybrid[7] therapeutic itineraries, women's hopes and expectations were managed according to each clinical site and the respective treatment opportunities[8]. Moreover, the combination and/or changing of clinics was used as a rupture point along an unsuccessful therapeutic pathway, in order to start a 'fresh' one and thus reset previously disrupted hopes. By changing or coordinating clinical options, women restored (at least partly) their ideas of possible conception. Although aspiring for the same result, lower class women did not have access to ARTs, and therefore their scope of possibility was narrower than for middle class and cosmopolitan women attending private clinics at home and abroad. For all of these women with an identical objective of having a child, the means to attain this objective were conditioned by their socio-economic status (Ginsburg & Rapp, 1995; Velho, 2003; Vigh, 2009).

5. Discussion

Within Maputo, and between Mozambique and South Africa, public and private sector infertility services were very different. The public hospital in Maputo tried to help as many women as possible at a very low cost, making infertility treatments easily available to women or couples with limited resources. The treatment options at this site were, however, very

[7] By hybrid therapeutic itineraries, I mean the simultaneous combination of infertility care and treatment in South Africa and further consultation in infertility clinics at home.

[8] From basic hormonal therapy to the full availability of ARTs, including intracytoplasmic sperm injection and surrogacy. Donor gametes were not normally sought after, as for most of my respondents, especially men, genetic relatedness was very important in their parenthood project.

limited, and no ARTs, not even IVF, were available. In this way, when women accessed biomedical infertility care in the public hospital, their choices were restricted to corrective, hormonal and basic infertility treatments. By contrast, private sector infertility services offered a range of ART options; in Maputo, this included basic IUI and IVF, and in South Africa all possible ART options were available, including ICSI and surrogacy.

The two cases provided above shed light on Mozambican women's and couples' therapeutic navigations through unequal healing landscapes, and their underlying motivations and expectations. The examples also depict the choices that women or couples made according to the amount (and use) of social connections and economic capital that they could draw upon in their quest for a child. Women's and couples' therapeutic navigations towards reproduction entailed overcoming various personal and conjuncture obstacles. If the economic capacity of a couple did not determine the ways in which they perceived infertility, it did determine to a great extent the kind of solutions that they had access to.

While analysing the therapeutic itineraries of people from various socio-economic backgrounds to overcome couple infertility, I realized that the main class-based difference – which did not include exceptions, incongruities or changes – was that of therapeutic choice. This resonates with other authors' accounts of inequalities in access to infertility treatments (Inhorn & van Balen, 2003; Inhorn & Patrizio, 2015) and aligns with Ginsburg and Rapp's (1995) notion of stratified reproduction. For my respondents, treatment choice and navigated medicoscapes (Hörbst & Wolf, 2014) were to a great extent class-based: wealthier women or couples could resort to traditional healing, to the private fertility clinic in Maputo that provided some ARTs, and/or to reproductive travel to South African private fertility clinics offering all ARTs. Poorer women could only resort to traditional healing and to the public health care sector in Maputo, which provided mainly corrective treatments and no ARTs.

These differences affected women's and couples' therapeutic navigations and thus determined the broader field of possibility that they could access to implement their parenthood projects (Schütz, 1972; Velho, 2003) through infertility treatments. Despite the low success rates of ARTs, seeking a pregnancy without them further reduced the possibility of success. Notwithstanding the existing economic inequalities affecting access to treatment (especially regarding access to private sector ARTs), within the therapeutic fields of possibility that my respondents could access, they used various temporary therapeutic

options. This meant that women or couples could resort to healing pluralism, in the sense that they used traditional or biomedical treatments at different stages of their therapeutic navigations (Kleinman, 1978). Furthermore, when attending the private sector, they could choose different clinical sites both in and beyond Mozambique.

If social class determined to a great extent the therapeutic terrains through which my respondents navigated, it did not fully affect their treatment choices in each specific field of possibility. Depending on their economic capacities in terms of accessing more or less high-tech infertility treatments, women or couples used all of the resources and options within their reach in their therapeutic navigations. The conditions that enabled some Mozambican women with the funding capacity to attend private clinics for infertility care were not available to everyone. In this context, economic capital as well as social connections – such as transnational informal social networks, supportive family networks or other infertile women who provided advice – were important tools in shaping women's or couples' treatment seeking trajectories (Faria, 2016).

With their therapeutic trajectories departing from within an overall fluid society, where many things transform quickly and where people's everyday lives intersect with various local and global ideas, practices and institutions, my respondents' stories encompassed both challenges and mutations; challenges coming from hampered parenthood projects, and mutations coming from the non-linear paths that were their quests for parenthood. In fact, change and flexibility were a constant in my respondents' navigations towards conception. From ideas regarding gender to notions about womanhood, parenthood, healing and family making, my respondents were constantly attuning their parenthood projects to the possibilities of the context in which they were trying to realize it. In this way, while attempting to overcome an affliction, their strategic navigations in a transforming urban matrix were flexible, yet also represented vectors of broader contextual transformation (Faria, 2016; 2015). In this sense, Mozambican women's and couples' therapeutic quests to overcome infertility departed from particular moral worlds (Kleinman, 2006), where local values and practices are often (re)examined according to particular situations – in this case, living in an infertile relationship. Taking into account the familial, marital and social dimensions involved in reproductive intentions and parenthood expectations, my respondents

were looking for a way to have a child, while simultaneously challenging and negotiating local socialities and values in the process.

Freedom within contemporary health care systems is constrained, not only due to personal financial and informational asymmetries, but also because of national health care provision contexts. These create structural constraints in terms of access to treatments – in this case, infertility treatments and ARTs. However, even within constrained fields of possibility (Schütz, 1972), people navigate their best options at any given moment, and thus often change their therapeutic choices and pathways according to what seems to be more a suitable treatment in a given situation. This is done through a process of reasoning that involves various factors, including family relations, religious background, treatment experiences and word-of-mouth stories of success. So even regarding major structural and national inequalities, there are always contextualized pragmatics and choices taking place within therapeutic navigations, and these stem from the intersection between intimate and non-intimate life conjunctures for patients and their experiences of interaction with medical systems.

Mozambican infertile women's and couples' therapeutic navigations shed light on the strategies used and the obstacles faced in fulfilling a reproductive intention, and on how people try to overcome these obstacles by taking advantage of constrained freedoms.

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