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# Communicative trust in therapeutic encounters: users' experiences in public healthcare facilities and community pharmacies in Maputo, Mozambique

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## ABSTRACT

Interactions between healthcare users and providers are an essential but often problematic element in therapeutic processes. In many settings worldwide, there has been a general recognition of the importance of adopting care approaches that understand patients as active agents, moving away from traditional paternalistic forms of interaction. Research shows that improving the quality of communication in therapeutic encounters fosters mutual understanding and cooperation in healthcare processes, helping to create the grounding conditions for building trusting relationships. But what are the communicative mechanisms through which trust in healthcare providers is cultivated? Going beyond the traditional 'doctor-patient' dyad analysis, and using data from a mixed-method study on medicine use in Maputo, Mozambique, this paper explores healthcare users' experiences and interpretations of their interactions with public healthcare professionals (medical doctors and prescribing nurses) and community pharmacy workers (pharmacists, technicians and other attendants). The analysis evolves around various communicative and relational aspects, emphasised by users as meaningful and underpinning different qualities of care, competence, integrity and trustworthiness. These attributes were assessed based on a combination of verbal conversation and information exchange, together with the use of other (non-verbal) situationally valued artefacts such as biomedical tools and communicative rituals performed by providers. This study shows that despite healthcare providers' different attributes of competence and authority, it is mainly their communicative performances during interactions that influence whether (symbolic) trust has the space to evolve or crystallise. Moreover, while performing certain rituals may be an effective form of communication, the lack of other (verbal and non-verbal) communicative elements during the interaction may compromise patient trust in what is being prescribed or advised. Efforts to improve the quality and responsiveness of healthcare services centred around citizens' needs should take users' perspectives into account and pay particular attention to these communicative and relational dimensions.

## 1. Introduction

Interactions between healthcare users and providers have long been recognised as a fundamental, yet often problematic, element in therapeutic processes. As a classic theme in medical sociology and anthropology, discussions around communication and on the often-asymmetrical interactions (and agendas) during therapeutic encounters are well known since early academic literature in the field (e.g., Freidson, 1970; Zborowski, 1960; Zola, 1981). In the last decades, the relevance of understanding trust in healthcare relationships has captured increasing scholarly attention, especially in 'Global North' (e.

g., Mechanic, 1996; Hall et al., 2001; Brown, 2009), but also in 'Global South'. In these latter settings, attention to socioeconomic structures, to articulations between (in)formal sectors and to the implications of trust in health-seeking practices has been more salient (Birungi, 1998; Gilson, 2003; Russel, 2005; Topp and Chipukuma, 2015; Rodrigues, 2016; Ackatia-Armah et al., 2016; Hampshire et al., 2017; Hamill et al., 2019).

Despite the vast literature on communication in therapeutic contexts and growing attention to the importance of trust in such interactions, the focus on the 'doctor-patient' dyad is still predominant. Yet, the changing doctor-patient relationship – and the declining dominance of medical doctors – has brought to the fore the importance of looking at other key

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relationships in the healthcare process (Bury, 1997; see also Pilnick et al. (2009) for an overview of conversation analytic studies in this field). Particularly in contexts where access to public health services is more limited and the doctor-patient ratio is low, attention to the role of other providers, such as community health workers (e.g. Ackatia-Armah et al., 2016), or community pharmacists (e.g. Gilbert, 1998), and their relationships with local populations becomes even more relevant.

While medical doctors are central institutional figures in therapeutic contexts, the growing reliance on medicines as privileged solutions in modern contexts of ill-health management, and associated health commodification processes (Nichter, 1989), have increased the relevance of pharmacies in individuals' therapeutic itineraries. With the proliferation of pharmacies and pharmacists' expanding roles in the community (e.g., Gilbert, 1998; Weiss and Sutton, 2009; Yariv, 2015), these have become not only important points of access to pharmaceutical products, but increasingly a 'gateway to care' (FIP, 2017). In many settings, such as Maputo, Mozambique, where the current study took place, community pharmacies are often sought as primary healthcare consultation points, and sources of information, advice and treatment (Ferguson, 1981; Kamat and Nichter, 1998; Logan, 1988; Patterson, 2015; Mayora et al., 2018; (Rodrigues, 2020)), especially for minor ailments. As researchers have noted, the relative social proximity of pharmacy workers often contrasts with the highly asymmetrical relationships within public healthcare settings (Sánchez, 2016). Thus, while going directly to a pharmacy is often a pragmatic way of avoiding or coping with overloaded, ill-equipped and/or geographically remote public health services, especially in low- and middle-income countries (LMICs), such a preference also tends to incorporate a social and interpersonal relational dimension which, as this study will show, is important when seeking healthcare.

Using a 'communicative trust' analytical approach (Brown, 2008), this paper aims to add to this growing literature by looking at particular communicative elements emphasised by healthcare users in Maputo as meaningful and important to them when interacting with public healthcare professionals (medical doctors and prescribing nurses) and community pharmacy workers (pharmacists, technicians and other attendants). While attending to the dynamics involved in healthcare-seeking practices, especially when managing common symptoms, this analysis will explore how individuals relate with these providers; how they perceive their role and competencies, and what expectations they have on their performance in therapeutic encounters.

### 1.1. Significance of communicative trust in healthcare interactions

Trust is an essential mediator in therapeutic processes (Calnan and Rowe, 2008). Besides its *intrinsic* significance in defining the meaning and value of healthcare user-provider relationships (Hall et al., 2001), trust is essential for enhancing cooperation and mutual understanding (Mechanic, 1998), in helping the acceptance of new ideas and changing practices (Ackatia-Armah et al., 2016), and in influencing patients' treatment-seeking behaviours (Russel, 2005). As a process involving both cognitive and affective dimensions (Lewis and Weigert, 1985), trust is often associated with expectations regarding others' intentions and abilities to act in the interest of the trust giver (Misztal, 1996). In the context of healthcare interactions, it regards "expectations by the public that health care providers will demonstrate knowledge, skill and competence; [and] that they will behave as true agents (that is, in the patient's best interest) and with beneficence, fairness and integrity" (Davies, 1999:193). How such expectations are shaped, and the interpretation of how they may materialise in practice, need to be understood within the context in which these therapeutic interpersonal encounters take place (Calnan and Rowe, 2008:7).

Interpersonal trust in healthcare providers is developed within a complexly entangled web of other relations and interactions (Gilson, 2003; Meyer et al., 2008; Rodrigues, 2016), which include the medical system that frames their practice and the healthcare organisation where

the practice takes place. Yet, as discussed elsewhere (Rodrigues, 2016), direct interactions – or experiences mediated by trusted members of individuals' close social networks – are fundamental in developing trust relationships, as they result in more concrete forms of experiential knowledge (Brown, 2009; Brown and Calnan, 2012).

As an inherently reflexive and relational process (Möllering, 2001; Gilson, 2003; Brown, 2008), which builds on and changes through daily interactions and experiences (Rodrigues, 2016:402), trust is deeply entangled with communication processes – where trust is both an *input* and an *output* of such communication (Thiede, 2005:1460). It is, however, through the process of communicative interaction that trust may develop (Thiede, 2005; Brown, 2009). Thus, effective communication remains a central feature in therapeutic interactions (Mechanic 1996, 1998) and is essential to legitimate providers' authority as knowledgeable, competent, caring and trustworthy agents (Brown, 2008).

Efforts to improve user-provider communication have become central to patient- or person-centred care approaches. Understanding patients as active agents in their own treatment, these approaches stress the need to improve providers' communicative and active listening skills, and to go beyond patients' physical complaints by encouraging them to express their concerns, feelings and expectations regarding both their problem and its therapy (Stimson, 1974; Stewart et al., 1995; Stevenson et al., 2000). While this may not necessarily involve equal participation in decision making in clinical contexts (which may also not always be what patients look for when they consult a medical doctor (see e.g. Lupton, 1997)), it does, however, imply an effort to find a common ground with patients so that they are involved and feel that their concerns are being addressed. Such an orientation towards cooperation and mutual understanding reflects a form of 'communicative action' (Habermas, 1987; Scambler and Britten, 2001), based on a two-way interactive process, which creates the underlying conditions for building trust (Brown, 2008).

Many of these principles are, however, frequently absent in therapeutic encounters (Stevenson et al., 2000). This has been particularly observed in resource-limited settings, where unresponsive care and providers' poor (and sometimes abusive) attitudes towards patients have been reported (e.g. Topp & Chipukuma, 2015; Camara et al., 2020). Moreover, improving provider-patient communication is often sought as a way to improve patients' adherence to prescription treatments (Donovan and Blake, 1992:507). Such an instrumental use of communication distorts the underlying principles of what communicative and patient-centred actions entail. Such distinctive styles resonate with a concordance versus compliance approach to practice (see Stevenson and Scambler, 2005). While concordance presupposes that both the patients' and professionals' perspectives are acknowledged and negotiated, in a compliance approach communication is tailored to mainly reflect professionals' views and goals.

Communication can take various forms and includes both verbal and non-verbal elements. While oral or written information exchange is essential, other communicative elements such as voice tone, facial expressions, body language and even silence can sometimes be more significant or meaningful. Equally or perhaps even more important in a therapeutic relationship, is the contextual *metacommunication* and the share of *tacit knowledge* through what Nichter and Nordstrom (1989:379) have framed as 'empathy': "a sympathetic understanding of [patients'] illness experience and state of well being in the context of their lifeworld". Such empathy can only be achieved through a communicative approach that seeks to contextualise and socially situate individuals' experiences, concerns and needs.

Ritualised forms of communication also have a special place in medical practices and especially in therapeutic encounters (e.g. Turner, 1969; Helman, 1984; Elks, 1996), where healthcare providers and other involved social actors, are expected to perform in certain meaningful ways. Physical examination (Lupton, 1997), the use of medical technologies and diagnostic devices (Rosenberg, 2002), and the act of prescribing at the end of the consultation (Whyte et al., 2002), are well

known examples of communicative rituals in therapeutic encounters. As the empirical examples in this paper will show, performing such rituals, particularly in specific meaningful situations, is also a way of communicating care and thus enabling more trustful relationships, especially when combined with other communicative elements.

Such an understanding of trust, founded upon communicative action, is what Brown (2008:351) has designated as communicative trust, which helps highlight the communicative mechanisms through which users come to trust in healthcare providers. And so, efforts to improve patient-centred approaches need to appreciate how the articulation of these interactive elements take place in therapeutic encounters.

In Mozambique, problems around user-provider interactions in the public health sector have been recognised and efforts are being made to improve the quality and humanisation of healthcare services (MISAU, 2016). However, as further developed in the following section, various challenges remain. This paper aims to contribute to discussions around ways to improve healthcare user-providers relationships, by looking at how interpretations around communicative trust in therapeutic encounters are shaped, and the effects of these relational experiences in healthcare seeking considerations.

## 2. Research setting and design

### 2.1. Setting

This study was conducted in Maputo, the capital of Mozambique. After the initial successful implementation of a primary health care strategy following the country's independence in 1975, and improvements in the population's access to public healthcare and essential medicines (Barker, 1983), the sector was badly affected by a weakening economy, a lack of material and human resources and a civil war (DHS, 2013) which lasted until 1992. Despite significant improvements in service utilisation and coverage in the last decades, Mozambique's health sector still faces numerous challenges, including limited human resources, equipment, medicines and uneven access to quality health services across the country (PESS, 2014–2019).

Insufficiencies in healthcare human resources (HHR) represent one of the main challenges to improving quality and equity in service provision (MISAU, 2016). Despite significant increases in HHR in the last 15 years, Mozambique is still one of the countries with the lowest ratio of health technicians per inhabitant (MISAU, 2016). Maputo city, although equipped with fewer healthcare facilities per inhabitant when compared to other provinces, has the highest ratio of health technicians/population, with a total of 3278 providers in 2019 – most of them health technicians, followed by nurses and medical doctors (MISAU, 2020).

Besides various challenges regarding HHR' availability, geographic accessibility and training quality, also problematic is public healthcare providers' *acceptability* among the population (MISAU, 2016), particularly in terms of how they interact with patients. Lack of courtesy from health staff (CEP & N'weti, 2016) and examples of disrespectful and abusive situations in clinical encounters have also been reported, mostly in sexual and reproductive health care or maternal care encounters (MISAU, 2016). The recognition of these problems led to the creation of a national programme to improve the quality and humanisation of healthcare services, through improved training curricula for healthcare providers in professional ethics and deontology, and complementary mechanisms to reinforce respectful treatment, among other measures (MISAU, 2016). One of the dimensions of service quality is 'patient-centred care and humanisation', defined as "care that respects and is sensitive to individual patient preferences" (MISAU, 2016:51).

As argued in CEP & N'weti 2016, hearing healthcare users' voices is as important as training more healthcare technicians or reducing provider/population ratios. Users' perspectives would inform policy formulation and evaluation of interventions in line with users' expectations and needs. Making services more responsive to citizens might also "generate conditions to improve the image and confidence of

citizens over the health services." (CEP & N'weti, 2016). Such perspective is much in line with the aims of this paper, where the voices of citizens and their trust in health services are analysed.

The introduction of neoliberal policies in the 1980s and the 1998 Medicines Law (*Lei do Medicamento* (nr. 4/98)) has expanded the private pharmaceutical sector in the country. In 2012 there were a total of 293 pharmacies in the country (a 120% increase over 10 years), 60% of which were concentrated in Maputo (MISAU, 2012), and the numbers continue to grow (SARA, 2018). This proliferation of pharmacies, especially in the capital city, has enabled wider access to pharmaceutical products, and also to the counselling services of pharmacy workers. Most of those working at private pharmacies in Mozambique are pharmacy technicians (72%), followed by pharmacy agents (27%), servants (9%) and only 2% are pharmacists (SARA, 2018). The low number of highly qualified pharmacists seems to sometimes be balanced by high numbers of technicians who often have many years of experience of contact with the population.

### 2.2. Data and methods

The analysis draws on qualitative and quantitative data, collected during a total of 10 months of fieldwork divided into two phases. As part of a broader study on medicines use in Maputo city, the first phase of data collection (2013–2014) included observations of client-provider interactions in pharmacies in five different neighbourhoods, exploratory interviews and informal conversations with practitioners from different health-related organisations, and seven focus-group discussions (FGDs,  $n = 42$ ) with individuals from the community. These qualitative and more exploratory data informed the design of a household survey, conducted in 15 randomly selected neighbourhoods in five municipal districts in Maputo city ( $n = 265$ ). The respondents were aged between 18 and 87 (mean 34), nearly two-thirds (68.7%) were female and most were employed (37.7%) and/or students (27.9%). The questionnaires were administered by undergraduates studying sociology at the Eduardo Mondlane University (UEM), who were trained, supervised and accompanied to the neighborhoods by the author.

The second phase of fieldwork (2016) included the collection of more in-depth qualitative data, through repeated follow-up interviews (2–3 encounters) with 17 healthcare users. These were selected from the list of participants in the survey and in the FGDs who had formally agreed to be individually interviewed. They were selected based on their sociodemographic characteristics and medicine use practices, with an attempted balance in terms of sex (nine men and eight women), age (21–59), school level (from 10th [secondary] grade to university studies) and from 10 different neighbourhoods. The aims of these interviews were manifold, including to contextualise and further explore the practical reasoning behind and/or experiences with medicine use (prescribed or obtained over-the-counter), different therapeutic trajectories (following a similar logic used in a previous study, see (Rodrigues, 2010); (Lopes et al., 2012)), therapeutic interactions with different healthcare providers, access to and use of different sources of information regarding different health conditions, prescribed treatments or (other) available therapeutic options. The interviews were conducted in Portuguese. Additionally, 10 key informants (health providers and a personal trainer) were interviewed. Apart from the face-to-face application of the questionnaires, all the remaining data was collected by the author.

The quantitative data were analysed using IBM SPSS Statistics 20 and allowed the identification of the main consumption and therapeutic itinerary patterns considered in this paper. While drawing from data across all the different methods described above, the quotes used in this paper result exclusively from the in-depth interviews. The interviews were recorded and transcribed, and the quotes used were translated by the author, taking into consideration their contextual meaning. A thematic content analysis (Green and Thorogood, 2014) was used, allowing the identification of the main analytical dimensions. Different themes



were generated through an iterative process and a phenomenological analytical approach (Schutz, 1970) was used to interpret the data, privileging individuals' understandings of their everyday experiences.

The research project was hosted in Maputo by the Department of Sociology (through the Health and Society Research Group), Faculty of Arts and Social Sciences, UEM. It received formal ethical approval from the Institutional Committee on Bioethics for Health at the Faculty of Medicine and Maputo Central Hospital (CIBS\_FM&HCM), and the required administrative permissions. Written informed consent was obtained from all participants in the FGDs, household survey and individual interviews. All other informants gave oral consent.

### 3. Findings

Discussions with users about their interactions with healthcare providers evolved around various communicative and relational aspects, underlining different qualities of care, competence and trustworthiness. Users assessed these attributes based on a combination of the conversational and information exchange dimensions of the interaction, together with the use of other situationally valued artefacts and communicative rituals performed by providers. The analysis starts with a brief overview of public healthcare facilities' and community pharmacies' role in individuals' therapeutic trajectories, especially when managing common symptoms. Expectations about the services delivered in each of these healthcare 'access points' (Giddens, 1990) are then articulated with discussions about participant's concrete experiences in interactions with provider.

#### 3.1. Therapeutic trajectories and pragmatism in everyday decisions

To explore the most common therapeutic trajectories when managing common symptoms such as fever, cough and diarrhoea (identified during the exploratory stage of this research), study participants were asked to recall the steps taken the last time these symptoms occurred. This strategy was used in both the household survey and the in-depth interviews (though other situations were further explored during the interviews).

According to the household survey, the percentage of respondents reporting the occurrence of these symptoms in the previous month confirmed their high prevalence in the community: fever (36%), cough (36%) and diarrhoea (20%). With some variations, around one third or more of the respondents tried to first treat at home each of the three conditions (32.1%, 40.2%, 33.8%, respectively), which in many cases included the use of home remedies, traditional medicines or pharmaceuticals they had at home (see (Rodrigues, 2020)). For most respondents who decided to seek healthcare outside home and beyond their family and social networks, public health facilities (healthcare centres or hospitals) appeared as the first option in 41.8% of fever, 18.3% of cough and 16.9% of diarrhoea cases, followed by community pharmacies in 8.0%, 14.5% and 6.5% of the cases, respectively.

Although pharmacies do not seem statistically expressive as a first option in these trajectories, the in-depth qualitative data revealed that they have a more prominent role in individuals' therapeutic practices (whether before, after or in place of going to a public healthcare facility) than the survey allows to capture. While public healthcare facilities were generally considered as the most 'appropriate' place to go when feeling ill, community pharmacies were often sought as pragmatic and quicker solutions for managing a variety of conditions, especially in situations perceived as non-severe:

*"The problem of the hospital is the waiting time. It's what often makes us give up and try to go to the pharmacy. When we are badly ill, is when we gain patience to wait for the doctor."* (male, 42)

In some cases, the circumstantial financial situation also played a role:

*Those days when I don't have the time, and know that in the hospital I will not get the medicines, I prefer to go to the pharmacy, if I have money at that moment. But if I don't have the money, I go to the hospital."* (female, 29)

The various constraints of going to a hospital or health centre, which included long waiting times, the short consultation time, and the recurrent lack of medicines, often made community pharmacies a more convenient and pragmatic option. In persistent or perceived severe situations, however, healthcare centres or hospitals were often referred to as the place to go.

#### 3.2. Imperative of technology? The importance of biomedical techniques in therapeutic processes

The availability of a vast array of diagnostic tools in public healthcare facilities was often mentioned as an attractive feature, especially when a less 'superficial' condition required a more 'in-depth' examination. The appreciation of medical technology in such situations was present in most narratives:

*"The doctor may have more options; he has more alternatives. You can go through that machine that you get in there to see what's happening. Usually when we go to a pharmacist it's because it's a superficial thing. You have a persistent headache, just to hold it for a while. So, the advantage with a doctor is that he can perform an in-depth exam, while the pharmacist only gives a hunch, perhaps to mitigate."* (male, 39)

*"I know that in the hospital any little thing has a solution. If it's not one thing, they'll perform an X-ray to see what else I have more, they'll analyse me, they'll know what I really have. Something they'll do to me. Only then they'll give me pills."* (female, 57)

As 'tokens' (Giddens, 1990) of modern medicine, these 'biomedical techniques' – including both the artefacts and related procedures to diagnose and treat (Hadolt et al., 2012) – were seen as important instruments for a more accurate diagnosis and, in some cases, for managing uncertainty. Performing such examinations was often seen as a form of care (see also Whyte, 2004) and the central role in articulating the diagnosis process was placed on the medical doctor. They were the gatekeepers to such technologies and the ones who held the ability to interpret their results. Through different biomedical techniques, doctors were given the power to 'see things' that other providers did not, giving them more 'credibility':

*"I think the doctor is a bit more credible [than the pharmacist]. First, because it is him who detects the type of problem that the person has. (...) Maybe because of habit, when we arrive at the hospital, the doctor gives a paper to go to the laboratory. You go to the laboratory, make the analyses, return and deliver them to him. He already has a notion. Hence, that whole process creates a greater credibility in the doctor. Because he is the one who sees things, he is the one who has to investigate, then you bring the answer, he has the conclusion and the solution. So, I think there's credibility in the doctor for all of this."* (male, 39)

As illustrated in this quote, the ritualising procedures involved in 'investigating' the problem(s), often mediated by the use of laboratorial tests or clinical exams, gave healthcare providers credibility, and were a central feature in the process of trust in their solutions (see also Rodrigues, 2016:397–8). The reference to 'maybe because of habit' suggests a routinised practice in therapeutic encounters, which helps shape patients' expectations from these interactions.

Expectations around certain technical procedures were particularly relevant in specific situations, especially when these represented a perceived risk. As the household survey showed, among the three common symptoms indicated above, people tended to go directly to the hospital more often in case of fever. During the interviews, fever was also often mentioned as a concern that needed further analysis. Despite

various interpretations of fever, its combination with certain symptoms was frequently described as a concern which needed a laboratorial test:

*“If she’s not breathing very well, and she’s coughing, I already know that my daughter has asthma. So, I already have the asthma drug at home, I can give it to her. There’s a pharmacy right next door, I can buy it. But if she also has fever, I don’t know why she has fever .... This I have to find out with analysis.”* (female, 25)

One of the main concerns was the possibility of having malaria:

*“I think it’s fear. People know that with malaria they will die. It’s very present, you have examples, you have the neighbour who’s gone ... it’s present, it’s concrete. It is concrete.”* (male, 36)

The ‘concreteness’ of malaria burdens and risk in individuals’ everyday lives was very present in the community, and the sociocultural contingency of such risk perception (Douglas and Wildavsky, 1982) is highly embedded in these people’s lived experiences (Schutz, 1967). As a result, the possibility of having malaria was often mentioned as a reason for going to the hospital. In some cases, individuals would recognise the symptoms due to previous malaria events. But the advice to go to a public healthcare facility for the test was also sometimes received in community pharmacies.

As a leading cause of death in Mozambique (PESS, 2014–2019:33), but also a problem in which the government and international aid agencies have greatly invested in terms of prevention and management, the awareness of the need to test and treat malaria promptly was present in all the study participants’ accounts. According to the Government’s case management guidelines, febrile patients or malaria suspects should be tested, and antimalarials cannot be prescribed without a positive test result (Candrinho et al., 2019; Salomão et al., 2015). This has moved expectations away from access to antimalarials alone, towards the need for a laboratorial or rapid diagnostic test (RDT) - the *technological means* to get proper treatment. As one participant said “Fever always results in malaria.” Thus, when individuals fear they (or their children) might have malaria, the non-prescription of a test by the healthcare provider often conflicts with their expectations:

*“I don’t like it [when they don’t do analysis]. They give me the [medication] prescription, but I’m not happy. I like to do analysis. Because ... I explain: ‘I have a headache’. And the doctor prescribes me a medicine. [The pain] continues and I’m not well. I’m feeling malaria, imagine it’s malaria pain! It’s happened to me once. I went back with the prescription and explained that I wasn’t well. They did the analysis and it was malaria! See? So, they gave me malaria medicine. Three days later I was fine.”* (female, 29)

As a mandatory step to get access to malaria treatment, the use of tests became not only an expectation but also a ‘moral obligation’ (Koenig, 1988):

*“When you find a good person, they don’t deny [prescribing the tests]. When they aren’t a good person, they deny: ‘you have the prescription to buy the medicines!’. It depends on the nurses.”*

As the quote above suggests, the willingness to prescribe tests is not only perceived to be a form of communicating good care, but also reveals the providers’ integrity as a health agent who has their patients’ best interests in mind. The contextually situated meaning ascribed to these tests helps to explain how such technologies became one of the main reasons for going to the hospital in the presence of certain symptoms, such as fever; and is illustrative of how expectations and notions of good care shape individuals’ interpretations of their therapeutic interactions with healthcare providers.

### 3.3. Prescribing as an (in)effective form of communicating care

With medicines occupying an increasingly central place in modern

contexts of ill-health management, the act of prescribing as a ‘closing ritual’ at the end of a consultation constitutes another (often) effective form of communication (Whyte et al., 2002). It shows that the patients’ concerns are being addressed and that a solution is being provided, even when uncertainty about the diagnosis prevails (Comaroff, 1976; Pellegrino, 1976). Yet, while in some situations a prescription alone may fulfil both providers’ and patients’ goals and expectations (cf. Sachs, 1989), this is not always the case. As well as expressing criticism of the non-performance of medical exams, most study participants also described their encounters with public health prescribers as too short and highly prescriptive, leaving ‘no room to create any relationship’ between them:

*“The diagnosis is made very fast because I think they have many people to look at ... so there is no room to create any relationship with them. It’s a very technical thing, really. So, it doesn’t feel like going to the hospital.”* (male, 34)

*“What I don’t like is to be there, talking to a doctor and, before I’ve finished talking, he already wrote the prescription. When I haven’t finished explaining what exactly is happening! So, that’s one of the things that made me hate going to the hospital. Because they give me the same thing they give to everybody.”* (female, 25)

The examples above are illustrative of what many participants described as typical interactions with medical doctors or prescribing nurses, mainly characterised by a disruptive form of communication, and not giving space for individuals to fully express their understandings and concerns. The promptness with which providers prescribed medicines raised doubts about their competence and by implication their prescribed solution. As a 35 years-old man wondered: “*is he actually writing what I really feel?*” Such impersonal and unbalanced encounters were pointed out as reasons for their reluctance to use public services.

Most study participants also discussed how they rarely received what they considered to be enough information about their health conditions and prescriptions, which prevented them from getting actively involved in the treatment decision – at least, inside the consultation room. In some cases, prescriptions were still followed due to the recognition of doctors’ authority, expressed in the following quote by reference to the ‘wearing a white coat’, a well-known ‘ritual symbol’ (Turner, 1969) associated with ‘science’, ‘expertise’ and ‘credibility’ when used in a clinical context (Helman, 1990):

*“What can we do? It was the doctor who said it, he’s wearing a white coat (laughs). I have to respect the white coat.”* (female, 25)

Furthermore, most study participants said that even in situations of doubt, or disagreement with the therapy, they did not feel comfortable asking questions, as this could be considered disrespectful and questioning the providers’ authority. In some cases, this resulted in patients dismissing their prescription, once outside the consultation room. For example, one participant with malaria described how a first prescribed dose of chloroquine did not seem to be working and was causing an allergic reaction. He went back one week later hoping to receive a different medication. Despite explaining the side-effects, along with the persistent malaria symptoms, he received the same prescription. He ended up self-medicating. When asked why he had not told the doctor that he was unwilling to take the same medication again, he replied that he did not have the ‘courage’ to ask for a different prescription:

*“At that time, I don’t know if it was negligence or what they had studied, but people feared facing health agents ... And to challenge someone or question them orally, I can’t imagine the answer that person could give you. So, that’s what kept me from approaching. It’s not just me, it’s general. ... They are working for the population, they work with people, they needed to have affection for the people, but [the reality] is different. ... So, we avoid these clashes with them. In fact, I didn’t get the courage to ask.”* (male, 35)

By reflecting on healthcare providers' lack of approachability, this participant stressed how he expected health agents to show more affection. This goes beyond expectations on the technical skills of providers, to include more caring and affective competencies at a personal level. It also describes a lack of 'empathy' (Nichter and Nordstrom, 1989), reinforcing the social distancing between these social actors, reproducing a more historically rooted vertical interaction (cf. Hanlon, 1984 [1984]:65), and undermining the process of a trusting relationship.

#### 3.4. Community pharmacies: from social proximity to other perceived forms of communicative trust

The authoritative form of interaction with prescribers was sometimes contrasted to a less vertical relationship with pharmacy workers. In many cases, some of the above information gaps were filled at community pharmacies:

"No, [doctors] hardly explain. One or another may explain, but not always. (...) Many times, the doctor just writes a prescription and says 'go buy this'. Maybe you leave the doctor's office without knowing what you're going to buy, because that's written in a medical way and people aren't always able to read. So, you'll know what was prescribed maybe in the pharmacy." (male, 39)

"When you go to the hospital, a doctor makes the diagnosis ....He writes and doesn't give you any explanation: 'you take these papers and go to the pharmacy.' ... Many times, in public hospitals, when we get to the [hospital] pharmacies there aren't medicines. Many times, the paracetamol is over. Often you have to go outside, to the pharmacies outside. So, what happens? Outside we ask questions, you have the freedom to ask. It's not like in the hospital. I don't know if maybe because it's a business." (male, 35)

While interactions and information exchange were often limited in public healthcare facilities, in community pharmacies most participants felt less intimidated about asking questions – not only regarding the medication they had been prescribed (and sometimes discuss alternatives to it), but also about their health condition. As the expression 'maybe because it's a business' suggests, the commercial context in which these therapeutic interactions take place also redefined the roles played by each social actor, helping to reduce the hierarchy between them. As the 'patient' in the pharmacy becomes more clearly a 'client', and given the high number of pharmacies across the city (which increases competition), individuals felt more empowered to negotiate their own treatment' options.

Despite the proliferation of pharmacies across Maputo city, around half of the participants said they usually went to the same ones. Individuals' preferences were based on a combination of criteria, including opening hours, geographic location, the medicines available and their prices, and the quality of interactions with the staff. Underlying many of these more pragmatic and financial choices were different elements of trust, regarding both the pharmacy and the pharmacy workers. Some participants emphasised their familiarity and close relationship with some of the staff:

"They are practically friends, we're from the same block, we know each other. I know almost everyone; these [pharmacy] workers have been there for many years" (male, 50)

Others highlighted other relational aspects which helped the process of trusting both the staff and the medicines they sold or recommended:

"I've always gone to two pharmacies that are in neighbourhood "X". ... It's where I've bought my medicines. I don't buy in any other pharmacy I find, no. I really prefer to buy there." (male, 23)

In this latter case, despite having recently moved to a new (though

not far) neighbourhood, and now having other pharmacies closer to his new house, this man keeps going back to the same pharmacies:

"It gives me more confidence. Why do I trust them? Because everything I buy there from that person, everything they've given to me, that they've prescribed, has worked. So, that's why it motivates me more to buy at these two pharmacies, because it's a place where I buy medicines that work. ... [Also] the people I buy from are fixed, they work there. I never saw strange people there, except for the cashier, or some other person. But the people who assist me are always the same. ... So, they're people with whom I've already interacted more. Any questions I have, they clarify. So, it gives more confidence."

As highlighted in this quote, repeated interactions with the same pharmacy staff, good communication and information exchange, and the efficacy of the medicines recommended or sold (as verified through his own bodily experience), were amongst the most relevant aspects for trusting and being loyal to those specific pharmacies. This also highlights the importance of building up a trusting relationship over time, through continuity of care (also cf. Ackatia-Armah et al., 2016; Mechanic, 1996), which contrasted with the public system where people were rarely seen by the same doctor.

Participants highlighted different criteria for evaluating pharmacy workers' competence. In some cases, the presence of qualified pharmacists, even if only sitting 'in the back', was mentioned as a basis for selecting a trustworthy pharmacy.

"I see what kind of pharmacy I go to. Because pharmacists nowadays have a minimum [training] course. But there are real pharmacists who look like doctors. Thus, there are pharmacies that really create some confidence. We have some, like the Pharmacy "X", where we see that the owners of the pharmacy are there, they are doctors, and they are there in the back. Any question, they answer. There, I feel confident." (female, 38)

The reference to 'real pharmacists who look like doctors' is illustrative of the symbolic trust in medical doctors and of what they represent, as a source of credibility, when evaluating other healthcare professional categories. This participant went on to add other communicative qualities of reliability, less grounded on providers' formal accreditation, and more related to the reputation and popularity of certain pharmacies, as well as to the dynamics and perceived efficiency of their workers.

"There're places we see .... A pharmacy that's always full, with 20 pharmacies around? Why is that, if the prices there aren't different from the others? The person arrives there and says: 'I want this and this'. [Starts gesticulating with her arms showing fast movements] One goes and gets them, the other goes there, even the cashier is there! I ask: 'Hey, how's the one for the skin called?', she replies: 'SKDerm' and I ask 'how much is it?' and she knows the price. So, it's a pharmacy where one sees that 'these people here are really ... [starts nodding]'. While there are others where the staff is still thinking 'oh, I don't know if I have this', and is stuttering, and shows a medicine of 200 [Meticals] while there's one of 10 [Meticals]. Then one begins to think 'hmm, this one here doesn't know'."

As other participants also highlighted, pharmacy workers' promptness in answering questions, and their active search for more affordable solutions, were also ways of evaluating their competence. The above participant also pointed out the importance of recognising the packaging of the products being sold in trusted pharmacies, especially when compared to less regulated markets:

"All [the products] we see there, are things that we see [on TV] ... Lately we have TV shows that we watch, those boxes are the same. [Besides] it's not on the streets, these are places we know the inspector goes in to control it. So, there's more or less that confidence."

Emphasis on the similarity of medicine boxes sold in pharmacies to those seen on TV, as a perceived criterion of reliability, underlines the



relevance of commodification processes associated with these products. Just as brand names are important symbolic aspects of efficacy (see e.g. Van der Geest and Whyte, 1989; Tan, 1995; Baxerres, 2011), so is the packaging. Examining the packaging for signs of quality in medicine outlets has also been observed in other settings (e.g. Hamill et al., 2019). Thus, having products with such recognisable characteristics available in these regulated (through inspections) shops was a material form of communicative trust.

The above criteria for evaluating the trustworthiness of a pharmacy or its staff were particularly relevant also due to users' awareness of the ambivalent roles of community pharmacy workers, as both healthcare providers and sellers. Thus, while choosing a pharmacy based on the price of medicines was a mere financial advantage for some, for others it was also a criterion for credibility, indicative that certain pharmacies were not looking *only* for profits. Likewise, in some cases, directing their clients to public healthcare facilities in situations perceived as going beyond their competence and in need of medical assistance, was also an indicator of reliability:

*"That pharmacy is good. I don't like the ones that want money, where we come and they already want to give you the medicine. Once I went there to buy antibiotic. They said 'no, this antibiotic has to come with the hospital prescription'. And they didn't let me buy. At the time I was upset (laughs) but then I thought 'ah, they did the right thing'. I'm not a nurse, I'm nothing, how come I wanted to take those pills? Then I went to the hospital and they didn't even give me those pills! See?" (female, 29)*

Although antibiotics are a prescription-only medicine, they were available over-the-counter in many pharmacies in Maputo (Rodrigues, 2020; Torres et al., 2020). While the competitiveness between pharmacies often resulted in pharmacists feeling pressured to sell them, in order to keep clients happy (Rodrigues, 2020:8), in some cases, as in the example above, not selling such medicines was perceived as trustworthy action.

#### 4. Concluding discussion

This paper sought to explore individuals' experiences and interpretations of their interactions with providers in both public healthcare facilities and community pharmacies in Maputo. The analysis focused on communicative rituals and relational processes around diagnosis, prescription or therapeutic recommendation practices, which are central in medical practice and, as illustrated in this analysis, are indicative of different qualities of care, competence and trustworthiness.

As both a category and a process (Blaxter, 1978), diagnosis is at once a ritual in therapeutic encounters and a form of communication that brings legitimacy to both the prescriber's and medical system's authority (Rosenberg, 2002). As a category, diagnosis adds meaning to the illness experience and helps guide and determine the subsequent steps in therapeutic procedures. The increasing use of technological tools within the repertoire of 'biomedical techniques' to assist in medical diagnosis has reconfigured users' expectations not only of medicine (Rosenberg, 2002), but also of providers' performance of such procedures. As examples from Maputo have shown, expectations over the use of biomedical techniques were high, and were one of the main reasons for going to a public healthcare facility. The prescription of laboratory tests and medical exams was seen as means not only to get more accurate (and trustworthy) diagnosis but also to get access to certain treatments (as in the case of malaria). Thus, in situations perceived as requiring more 'in-depth' examination, providers' use of such diagnostic tools showed that they have their patients' best interests in mind. Hence, as a process, diagnosis expresses providers' competence and care. This involves both an active examination of the problem through certain ritualising procedures, as seen above, and a two-way dialogue with healthcare users about their condition – which was not always present in the situations reported in this study. Such a conversational dimension

and information exchange, however, are not only a fundamental component in quality of care and in patient-centred approaches, but also a patient's right (cf. MISAU, 2007). The absence of such a communicative approach from providers, as illustrated in several examples, caused discontent among healthcare users and also created doubts regarding their medical/clinical assessment in certain situations. In some cases, this resulted in users not following their prescriptions and finding other solutions.

As previously discussed, trust is a social and relational process (Möllering, 2001; Gilson, 2003; Brown, 2008; Rodrigues, 2016) which combines both cognitive and emotional dimensions (Lewis and Weigert, 1985 - see also Hamill et al., 2019 for a discussion on how such bases of trust are articulated in high-risk contexts). Indeed, as illustrated in this study, individuals' expectations about healthcare agents go beyond their purely technical skills to include other caring and affective competencies. However, the disruptive communication described, and the perceived lack of approachability of many healthcare providers, excluded the possibility of developing a shared understanding of the therapeutic situation. This further reproduces (and reinforces) the social distance and understanding gap between patients and providers. While providers might have patients' best interests in mind, without further efforts to improve their communicative interactions, both verbal and non-verbal, their 'intentional actions' may not be interpreted as appropriate from the patient's point of view (Misztal, 1996:24), negatively affecting the consolidation of a trusting relation.

The extension of this analysis to community pharmacies, which play an important part in individuals' therapeutic trajectories, whether before, after or in place of going to a public healthcare facility, added other layers to the phenomenological understanding of communicative trust. Contrary to the usual one-off encounter with providers in the public system, repeated contact with the same pharmacy workers was an important source of reliability (as also observed in Ghana, both with community nurses (Ackatia-Armah et al., 2016) and with dispensers in medicine outlets (Hamill et al., 2019)); it enabled a gradual familiarity between user and provider, a continuity of care, and allowed users to repeatedly reassess the efficiency of providers' work and the efficacy of the medicines they sold or recommended. Pharmacy workers, moreover, played an important role in filling some of the information and communication gaps between patients and public healthcare providers. As often members of the community themselves (see also Logan, 1988; Kamat and Nichter, 1998), many pharmacy workers were socially closer to their clients, were more aware of individuals' lifeworld concerns, and knew the language which would best convey their advice. This does not mean that people trusted more in pharmacists than in medical doctors or nurses; expectations over their competence and their services were different and users were aware of the business interests behind the counter. Indeed, as shown, users also considered and looked for other qualities (e.g. medicines' prices) and dynamics during client-provider interactions as 'signs of trustworthiness' (as also observed by Hampshire et al. (2017) in herbal clinics in Ghana and Tanzania). Yet, their intermediate position – as part of the community and as trained and/or experienced pharmaceutical care providers – made them a valuable resource for users, which could potentially be explored more as access points to care and information in health policies.

Finally, the availability and use of different symbolic elements of credibility, such as medicines' brands and boxes which are recognisable from other legitimate sources, underlines the relevance of commodification processes associated with these products as they become a material basis of communicative trust. It also adds to the importance of incorporating a material dimension within research on trust (as also previously suggested by Pedersen et al., 2016). More research is needed to deepen understanding of the meaning ascribed to certain objects and materials in different contexts and settings, how and what they communicate, and their role in the process of trust. Further in-depth research should also look at other medicine providers, including those in the informal sector, and pay attention to the downside of trust,



particularly when business-oriented communication strategies are used by providers ('signalling' their trustworthiness) as noted by Hampshire et al. (2017), in contexts of high informational asymmetries.

Individuals are actively engaged in therapeutic processes, whether regarding their own or those of their family and community. While prescriptive forms of interaction, as described in this paper, exclude individuals from their treatment decisions inside the consultation room, once outside they are the ones who decide. As examples from Maputo showed, despite a general confidence in medical doctors' competence and authority – illustrated by participants when they discussed doctors' ability to articulate the diagnosis process, referred to signs of expertise (or ritual symbols) such as the use of a 'white coat', or used doctors as a point of reference to assess pharmacists' credibility – it was mainly professionals' communicative performance during the interactions that determined whether such symbolic trust had space or not to evolve or crystallise (also cf. Rodrigues, 2016). Therefore, while the performance of certain rituals, such as a prescription or medicine dispensing at the end of a therapeutic encounter (whether in a clinic or in a pharmacy), may be an effective form of communication (Whyte et al., 2002), the lack of other communicative elements may compromise the trust in what is being prescribed or advised. If users feel they are not heard or properly examined, if they leave the consultation room with doubts or concerns, if the prescribed treatment is not adequate to their lifeworld or lived experiences, they may consider the prescribed therapy as inappropriate and search for other solutions. This in turn may also shape their healthcare-seeking practices and therapeutic trajectories in similar future situations. Therefore, efforts to improve the quality and responsiveness of healthcare services centred on citizens' needs should take users' perspectives and experiences into account and pay particular attention to these communicative and relational dimensions.

#### Credit author statement

CR conceived, designed and executed this study. The manuscript was also conceptualised and written by the author.

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