



Exploring ‘Therapeutic Citizenship’ as a Governmentality of Health Issue in adhering to Antiretroviral Treatment (ART) for Primary and Secondary School Teachers in Zambia

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Abstract: *The psychosocial concerns of HIV medicalization and bracketing of wellbeing in medical sense should not just be ‘normalised’ by clinical approaches. HIV medicalisation has become the basis of normalisation among citizens without being questioned. Therefore, the aim of this paper is to examine the extent to which HIV governmentality as mediated through a ‘therapeutic citizenship’ status, among school teachers, especially those on antiretroviral treatment (ART), have an effect on their everyday and development in Zambia. Semi-structured interviews with 41 (20 females and 21 males) purposively sampled HIV positive teachers in Zambia aged between 25 – 55 were conducted in western and southern provinces. Transcripts were processed using NVivo Pro 12®, following an inductive thematic analytic methodology. Results indicate that though a treatable illness, HIV has both latent and visible varying effects based on locality, language, gender, age, career, health care provisions, policy and social strata. Findings show that HIV has strong effect on individual identity and collective affect through past experiences, present events and medico-social uncertainties; stigma is still high and a big problem hindering disclosure; treatment access and adaptation are hard for some people; anxieties and mental health issues/stigma are high but unattended as they are outside set diagnostic medical categories; knowledge and information is averagely low. The governmentalisation of health through ART seem ‘de-normalising’ for 60% of participants who think ART is a form of ‘pharmaceutical colonialism’ that is stagnating Zambia’s national development. In the conclusion and final proposition, this paper shows that HIV can seem like a disappearing disease yet the challenges for ART are more medico-social and psychological than physiological. Since antiretroviral drugs increase life longevity, research focus and policy interventions should now shift from quantity (span) to quality of life on ART.*

Keywords: ART, HIV, Governmentality, Therapeutic Citizenship, Teachers, Zambia

1. INTRODUCTION

While there is an increasingly good understanding of ART factors that determine effective HIV treatment, there is less understanding of the daily experiences and needs of macro and micro managing the conduct of life on ART. The persistent difficulties of living with ART, despite improved physical health has necessitated new and frequent HIV treatment guidelines and policies that seek to adopt best-practice models around the world. Using a psychosocial, medical practice and material perspective, this paper starts to unpack the governmentality elements in the HIV therapeutic citizenship context of influencing treatment practices at both macro and micro scales of managing long-term illness by the state and affected individuals in Zambia.

The phrase ‘conduct of conduct’ implies understanding of how ‘subjects’ are made and ‘power’ is exercised by individuals and groups through a given culture. In relation to HIV/AIDS in Zambia, the appointment of focal persons in districts, provinces, and schools in addition to other HIV projects endorsed and supported by the ministry of education is in itself creating a health education culture and governance model in the sector. The ministry of education in Zambia has also introduced HIV/AIDS topics in various curricula, promoted creation of clubs for learners and series of HIV workshops for teachers.

This therefore overshadows some psychosocial issues in the governmentality of health and illness in the treatment age, which is the focus of the next section. The occupation HIV risk of teachers led the ministry of education in Zambia to develop its own AIDS work policies in schools, as noted in other comparative works (Bennell 2003, Mulubale, 2019a). This institutionalisation of an illness such as HIV is similar to having a constitution that governs actions and behaviours of a given population. More and more positive teachers are now engaged in the HIV school community by sharing their experiences even becoming activists through ‘technologies of the self’ (Foucault 2008) of living with HIV and on ART while performing their roles. Thus, through confession – disclosure – technologies they become respected participants of the broad HIV community in and outside their schools. Zambian schools’ administrators appear to be consciously, though slowly, making their school communities as safe havens with reduced risk behaviours and reduce stigma for teachers as well as learners who are receiving HIV medication (Kelly 2000; World Bank 2009; Mulubale, Rohleder & Squire 2021).

The paper begins with a review of conceptual issues around therapeutic citizenship and governmentality and the relationship between medicalization and HIV treatment practices. Second, I explain and rationalize the methods that were deployed to conduct the study. Third, the results are explicated, through a thematic-analytic methodology. Fourth, findings are discussed, exploring the how and whether teachers living on ART and HIV represent new and effective kind of health governance for citizens, especially by the state.

2. GOVERNMENTALITY AND THERAPEUTIC CITIZENSHIP: A THEORETICAL ANALYSIS

Therapeutic citizenship is contextualised here as ‘biological conditions’ that shape public life (Petryna 2010) as well as individual and collective claims made on the basis of medical pluralism (Nguyen 2008). The notion is expanded by drawing on a framework of a key concept of governmentality – conduct of conduct (Foucault, 2008). Therefore, governmentality in relation to HIV therapeutic citizenship refers to patterns of control over who has citizenly rights – for instance, to treatments and services – and what the conditions are for those rights – for example, adherence, reflectiveness and understanding (Nguyen, 2010). Identity in relation to HIV therapeutic citizenship refers to people’s fluctuating sense of themselves as HIV positive and ‘undetectable’, and yet also as having many other important intersectional identities. Chronicity in relation to HIV therapeutic citizenship refers to normative ideas of physiological, medical and social progression through diagnosis, successful treatment and acceptance – still accompanied by progression through denial, illness and stigmatisation.

The concept of governmentality is concerned with technologies of the self. The management of a chronic health condition includes technologies of medicalisation, and at times of chronicity and identity these are all directed at individual subjects. But in the African context, a singular subject focus of medical interventions seems hard, as they do not emphasise local communities and kinship groups. This refusal appears to be problematic for the notion of governmentality, which in much contemporary literature put the self above others – although they may not necessarily operate in this way.

Many investigations in the social sciences have been inspired by Foucault’s conceptualization of government. He used the term ‘governmentality’ to define a particular way of managing people in the modern history of Europe, in relation to the idea and practices of the state. He later amended the theory to capture procedures used to govern people beyond political and administrative levels (Bulley 2014). Foucault’s perspective of government is embedded in his notion of governmentality. He defines governmentality as constituting of a variety of techniques that encompass political government, forms of self-regulation (technologies of the self) or the ‘conduct of conduct.’ Emphasis on ‘conduct’ implies ‘regulation of behaviours’ (Bulley 2014:1; Burchell et al. 1991).

The consequences of disease for the collective and individual are diverse. Governmentality here is about exploring the diverse ways in which people (teachers inclusive) on curative treatment (and others) feel and are controlled – disciplined, not only within and around a ‘medicalising’ clinical encounter, but also in perceived expectations from their own social milieu such as those of a school. Foucault’s concept of governmentality has advantages in theoretical terms of understanding how HIV

positive teachers in Zambia manage themselves and are governed by school rules. The concept typically reveals indirect as well as direct medical and other techniques by the state, civil society and medical practitioners for leading and controlling individuals without being responsible for any unexpected outcomes of HIV medicalisation technologies. It is through these wide ranging and often invisibilised techniques that the treatment of HIV is done. There is an increasing tendency to portray social and psychological phenomena as normal medical problems (Nye, 2003). This is due to the fact that medical governance [is one form of the naturalization of HIV that] is now shifting responsibility, for citizens’ health, in nations from the state into the domain of individual self-management and sufficiency (Squire, 2010; 2013). At the same time, governments operate powerfully medicalizing governance at the national policy level. The HIV work policy for teachers in Zambian schools, developed in 2005, is an example of state-intervention on health matters affecting individuals but has the potential of disrupting activities at a larger scale (Ministry of Education 2012).

3. METHOD

To explore participants representations of governing life on ART, a qualitative approach was employed. This qualitative approach allowed the exploration and understanding of the medical-social phenomena of representations about participants’ meanings as well as insights about living as HIV citizens. Thus, qualitatively assessing the health of a population in relation to HIV could have been satisfactorily done without any consideration of effects and meanings of daily medication in a governing such a lifelong chronic condition (Wahlberg and Rose, 2015:61). With the above reasoning and building on the conceptual framework of governmentality and therapeutic citizenship, this study empirically engages with Zambian teachers’ HIV representations using a mainly qualitative approach.

The tabulation of the sampled population is as follows: 41 HIV positive teachers (21 men and 20 women) with age range of between 25 and 55 who were from both urban and rural localities of Southern and Western Zambia. Participants were also selected on the basis of their being in work and living at home but not physically frail. It is important to note that the demographic categories – gender, age, teaching years, qualifications and location – were all collected at the end of the interview, so that these categories (see table 1 below) were not foregrounded to participants as significant for the research, at a time when I had no means of knowing their significance, if any.

Table1. *Participants demographics*

Gender	Age			Location		Education			Teaching years			Diagnosis period	
	>20	>30	>40	Urban	Rural	Cert.	Dip.	Deg.	>1	>10	>20	Early	Late
Men (n=21)	2	9	10	12	9	2	16	3	6	10	5	5	16
Women (n=20)	0	8	12	8	12	0	20	0	7	6	7	12	8

Semi-structured interviews were used in this study. The semi-structured interviews employed here were flexible in that they allowed me to alter the sequence and even the phraseology of questions (Ritchie and Lewis, 2003:110). The interview format that this study utilised was one-to-one and each interview lasted for a period of 20–50 minutes, usually without a break, although participants were free to take a break at any time. The semi-structured interviews followed a question guide, although the order of asking questions was not important (Patton, 2002). The interview schedule did not try to be exactly the same for each participant, but aimed to follow what each participant talked about. The interviews were conducted in a distraction-free place that participants preferred.

The ways in which research begins is with constructing suitable questions. The nature and focus of the questions in this study were a guide for my interest in the subject. The dialogue between researcher and participants delved into how things were going, what challenges and successes were being faced, and how things could be better. The interest in remaining close to the real experiences of informants required that questions be framed openly. This probing approach was in pursuit of exploring contradictions, inconsistencies and apparently ‘irrational’ responses. These questions moved from the general to the specific, so as to strengthen arguments with not only information but also examples.

4. DATA ANALYSIS

This study utilised thematic analysis of data. It was selected due to the highly flexible nature of this analytical framework (Braun and Clarke, 2006:78). Given that this study interests involved ascertaining patterns of meaning, thematic analysis was an appropriate approach as it helped describe and organise data beyond objectives of study. The analysis also allowed for a diverse and complex approach of appreciating qualitative data (Braun and Clarke, 2013).

The coding process of data was done through NVivo. Given the overlapping issues from the transcript, some excerpts were coded to more than one category of themes shown in the discursive section of this paper. The whole analytical procedure is summarised in table 2 below.

Table2. *Six steps of data analysis*

1	Transcribing interviews
2	Feeding transcripts into NVivo
3	NVivo coding
4	Creating generalcategories of themes
5	Connecting the codes to thematic classifications
6	Selection/identification of themes and merging them with the data

In thematic analysis patterns of data are mainly identified using a bottom-up and/or top-down method (Frith and Gleeson, 2004). An inductive approach that included, bottom-up and deductive analysis of data and top-down strategy was applied in relation to the literature. The various areas were shaped by interpretations distinguished through themes operated through with prior theoretical considerations.

5. ETHICAL CONSIDERATION

Ethics approval for this study was obtained from the UK, University of East London’s ethics research committee. Also, permission to do the research was sought and given by school head teachers and community health care-based contact persons. During fieldwork, an information sheet, oral explanations about the study were given and consent forms signed by potential participants beforehand.

6. RESULTS

The findings shown here represent participants’ views on the governance of HIV treatment. The different views to be explained by key thematic areas, which contain connections with of the psychosocial, medical and material elements of what was said by participants. In the next section, I begin with findings about some general perspectives on effects of living with HIV and ART as given by participants.

Managing the effects of being HIV positive and living on ART

Some negative experiences in participants’ responses cited above surfaced in relation to how they managed to live with the virus and on ART. Some interviewees argued that it was through knowing about self-care techniques, while others held the view that social factors were useful in their quest for a healthy life. Table 3 shows the key responses around factors that shaped how most participants described their condition and its management.

Table3. *Strategies for dealing with HIV and ART*

Ways of adapting to ART	Women (n=20)	Men (n=21)	Total (N = 41)
Exercise	2	0	2
Diet	6	4	10
Keeping busy	6	5	11
Time factor (conscious)	5	2	7
Beliefs	5	3	8
Acceptance	0	6	6

It was interesting to note in transcripts that 11 (27%) participants mentioned the issue of keeping themselves busy – for example, belonging to faith groups, which was discussed in relation to belief or religion as a form of strategy to overcome HIV challenges. When asked about how she mitigated some of the hardships caused by the treatment she was receiving, one participant stressed the importance of being active:

Nalu (Woman, 31): Keeping self-busy and not focus or thinking of the bad part. I have to keep myself busy. Mostly it’s teaching and talking to other people.

Twenty-nine per cent of participants agreed that physical exercise and eating nutritious food were important for immunity-boosting despite being on ART. However, few talked about being able to exercise or following a balanced diet. In Table 5.8, it can be seen that acceptance, both from others and from oneself, was significant in the management of HIV, especially after diagnosis.

Participants’ personal, microsocial and meso-institutional support sources

In the interview process, respondents were asked about the available forms of support structures for living with HIV and on ART, support here being the material, medical and psychosocial forms of help that participants received due to their HIV status. As can be seen in the data in Table 5, support bases were complex and depended on personal and social relations and one’s available means for self-help – a category discussed later. Social support (family and friends) for half of 31 (76%) informants was transformative, while for 10 participants support was regarded as either absent or very low.

Table4. *Frequencies of key sources of help*

Support sources	Women (n=20)	Men (n=21)	Total (N=41)
Family and friends	12	19	31
Government/donors	9	8	17
NGOs	4	2	6
Media	1	1	2
Church	1	1	2
None	8	2	10

Views around support mainly surfaced in respect of family and friendship. The majority of the 31 respondents who commented on this issue noted that it was mainly messages of encouragement, and for 16 out of the 31 informants material assistance such as food was received. Among the 31, it was not entirely HIV positive family and friends who accounted for positive experiences such as being very supportive and accepting. As Nalu commented:

Nalu (Woman, 31): I have this friend who helped nurse me after I gave birth through caesarean section. I don’t have parents. She was on the bedside, so I just had to tell her that ‘me I am like this’. But unfortunately, or lucky enough, she is also like that. So that is when she also opened up to me and said, ‘even me, I am like this’. So that makes the two of us, then we keep each other. Since stigma is there in Zambia... so we decided to keep each other’s secret. There is another friend of mine who is negative that is supportive. She supports, she says, ‘it’s not a death sentence, you still have a lot to achieve’.

The majority of participants stated that either friends’ or family support – and this included spouses who were HIV negative – had helped them cope with their HIV condition in a positive way, while others had poor relationships with their families and attributed the lack of support from family to their poor health recovery. Seven women in the sample claimed that their divorces had been caused by revealing their status to their husbands; only one man attributed his wife’s decision to divorce him to his positive status, as she was tested negative.

The observation emerging from the theme of positive social support is that in the absence of family support, friends were mentioned as being supportive. For example, Mwangala described how family relationships were negative and friends were more supportive:

Mwangala (Woman, 49): My family that knows that I am sick, [...] some keep away from me as if I am dented. It is not the same. Now, with my friends there is not much difference, because there are some friends of mine that I share information with, we share secrets and they know my status. We share information.

With only friends not family, and being acutely ill and a single widowed parent, Mwangala faced mental and physical health that became worse, even in the midst of her ART. It is important to note that friendship support was strongly reported by informants in rural areas due to absence of family, and in urban localities due to stigma. Family interaction after diagnosis was reported to decrease anxiety. But six informants who discussed not receiving any form of family support reported signs of depression, isolation and suicidal thoughts, particularly in their early stages of diagnosis. Perhaps relatedly, participants who had withdrawn at anytime from taking ART medicine indicated limited or lack of any form of family support.

Mostly, those who had been married for a long time enjoyed high support even after the diagnosis of HIV in themselves and sometimes their spouses too. However, unmarried informants spoke of their worry and problems in finding a partner to support them socially, emotionally and even materially.

Participants also emphasised positive support from the Church. More women (12) than men (five) talked about the religious practice of going to church as an important aspect of their lives. Faith groups provided not only spiritual guidance but also social services, even to those who had not disclosed, and material support to two participants who were public about their status. Consider Emonda, who said the following:

Emonda (Woman, 35): I have received support from church. I have received food supplements. They would get people who are positive and supplement their diet on a monthly basis. I also got an opportunity to get sponsored to do the teaching course through the church.

Thus, in between the state and the NGO, the support for HIV resource provision was the Church. Some interviewees reported, however, that the Church was not ideal for opening up, due to the moral tradition of religion. Sitondo said:

Sitondo (Man, 42): When someone is diagnosed with HIV, then that particular person is more of a sinner.

It was reported as uncomfortable for 50% of the participants to disclose their status at their places of worship. However, specific Churches, such as the Catholic and Seventh Day Adventist, were reported by two participants to be supportive through material provision and empowerment programmes for people that had disclosed their status at church.

Ten participants who spoke of not having support represented a category of self-support. Use of religious belief and personal earnings was reported by individuals who said they had no sources of support. Overall, these results legitimised the importance which people living with HIV attached to support that was psychosocial as well as medical. However, one's career could also have a specific bearing on one's health.

Being HIV positive and interacting within the school space

HIV positive teachers in this study revealed that workplace and colleagues' support was lacking, rendering the school a space that silenced HIV/AIDS-related discussions due to stigma among colleagues and learners. Some interviewees agreed that ART enabled them to be physically well enough to teach, but offering support to HIV positive learners was hard, as they (teachers) needed support themselves.

In accounts of living with HIV as teachers, the workplace in schools was described as having some power imbalance between those on ART and those who were not. Participants also discussed their HIV condition in connection with (non-)isolation in their professional lives. Table 6 illustrates the various levels of relationships and effects of structural interconnectedness.

Table 5. Groups of relationships and participants’ positive and negative encounters

Occupational interaction	Negative	Positive
Colleagues	30	21
School administrative support	9	10
Leadership roles/promotions	4	26
Programmes/policies	9	8
Parent-teacher associations	2	4
Pupils/teaching concerns	2	28
Locality	4	3

When compared with 61% disclosure to family and friends, which includes colleagues at the workplace, the 30 participants’ negative encounters can be associated with the reported restricted HIV disclosure in schools. However, confession to being on ART at the workplace seemed to be connected to particular encounters, such as seeking permission for a hospital appointment, and for the majority it was through meeting their colleagues at the hospital during drug refills. Consider Ngolwa’s statement:

Ngolwa (Man, 52): There are two or three more people who know, though we don’t talk about certain issues. I only discuss health issues with one. [...] We are in the same department. At one time he wanted to be driven so that he could collect his drugs, and I gave him a lift. On the way back he asked me, ‘do you know what this is?’ I told him I know because I take the same. From there onwards we became close.

Seventy-three per cent (30 participants) indicated that they felt isolated from their colleagues. Twenty-one reported that they had good interactions with workmates – but exclusively with those who were HIV positive, as opposed to those who were negative.

7. DISCUSSION

The findings presented above suggest that ART management is a macro-societal and meso-institutional issue of how HIV is governed among primary and secondary school teachers. For example, government policy on mandatory HIV testing for everyone who visits a hospital with an illness, as well as the formation of HIV teacher associations in Zambia, are both forms of governmentality. Similarly, personal initiatives to teach others about HIV signify a testimony aimed at creating positive public attitudes about ART and being HIV positive. Take for instance Maata, who openly spoke about her status at work, which depicts a mesolevel of HIV governmentality.

The results here demonstrate a form of HIV governmentality that is integrated into a person’s professional and social life. The governmentality illustrated in Maata’s remark is more psychosocial than biomedical. However, the results show that participants failed to successfully and interactively merge their medical life with other aspects of their social and work life.

At a micro level, participants outlined their long-term and short-term experiences of HIV and their different experiences of ART. The psychosocial and physiological impact of ART governance relies on the curative nature of HIV medicine. This study has shown that participants were controlled by clinical encounters, which extended the biomedical effects and effects on social and mental well-being in their communities and at work. Through the findings on short-term experiences of ART, the concept of governmentality helps us to understand that these HIV positive teachers saw their health condition in physiological terms, and thus the manner in which they managed themselves was centred on the body and not the mental side effects of ART.

Managing physical, mental and social life while on ART is best viewed through the lens of governmentality. Exercising, following a balanced diet, keeping oneself busy and socialising with others are forms of conduct on self-care or self-regulation. Similarly, findings on behavioural changes due to HIV relate to a ‘conduct of conduct’ (see chapter three) that allows groups to be distinguished as peculiar through ART medicalisation culture, as also shown by Bulley (2014) and Nye (2003).

ART is entrenched in events that describe the body. The identification of ART’s workings on the body signifies control and indirectly fosters a restricted social life that secures membership of a

medically defined community. Although useful in sharing information on self-care (see also Campbell et al., 2012), support groups are a source of demotivation and misinformation about the long-term effects of ART on the body. By sharing negative experiences and even death, fear and uncertainty about being on ART arise in these communities.

This research found that participants’ power was determined by state help or lack of it, as well as by uncertain international help, especially around medication resources. These results are in agreement with those obtained by Endicott (2019), which show that the HIV pandemic is about power or its absence within a state. Also, resource availability is part of power against the framing of the uncertainty of help from national and international agencies.

Participants’ accounts of limited resources demonstrate views of state institutions’ lack of capacity to deal with biomedical needs for a large HIV positive populace. Prioritising HIV over other chronic conditions by government and local or international organisations in Zambia exemplifies HIV governmentality’s wider and far-reaching effects. The provision and building of specialised HIV departments in hospitals is not only maximising choice in biosocialisation but also reinforcing a sense of difference between HIV positive and negative citizens. Thus, the majority of participants positioned themselves as being part of a long-term national project through medical government support programmes.

Macro manifestations of HIV medical governance include the relationship between the state and participants. The institutionalisation of HIV treatment supplies and the prioritisation of ART supply position the state as a custodian of population control. For example, findings show that while participants’ health had moved to the domain of self-management, there was still state provision, especially through medical resources. The politicisation of HIV was noticed in responses about different levels of governance. The state-participant connection is a national issue of HIV governmentality, which is driven primarily by the state’s role in treatment and care services, as also stated by Squire (2016). I move on now to consider views about HIV internationalism and power within and against the state.

In referring to Africa and donors from abroad, as noted in the results on support, participants were aware of HIV as a global project of governmentality. Therefore, claims and rights were stated by participants to both the nation-state and international agencies. For example, HIV governance through global policy frameworks and interventions, such as the 90-90-90 goals, is a clear indication of the national governance of HIV as adopted from international action plans. However, the need for locally made medical interventions, as seen in the findings, can be associated with the absence of information about the workings of ART and the benefits of external interventions. The fact that the government cannot reach disadvantaged groups with HIV, especially in rural Zambia, has resulted in fewer or no biomedical tools for tackling and managing HIV chronicity burdens (De-Graft et al., 2010). In the next section, chronicity is explored as a theme in relation to the findings.

The findings suggest normalisation effects and illustrate the power of ART medicine governance. This research found that power to work due to ART adds to normalisation, as individuals are able to take part in community affairs just like those who are HIV negative; this finding is supported by Lock and Nguyen (2018). The focus on effects of medicine on physical health by participants confirms a neglect of mental health issues in HIV care, which are present but ignored, unknown and untreated by the affected individuals. The power of ART is normalising, but only to the extent that it reduces infectivity and improves physical health, as shown by Flint (2015) and Mulubale (2020a). The power of normalisation adds not only to identity but also to professionalisation.

These findings suggest that aspects of the body are changed by ART, and these changes are not recognised by Western medicine, even though they are socially reinforced. Medicine’s effects on the body can be associated with the transformation, not reduction, of stigma. Additionally, HIV governmentality cannot ‘normalise’ life on ART due to the culturally, socially and historically symbolic exceptionality of the disease, which is still seen as deadly but no longer as a fatal crisis – even though ART has changed HIV governmentality into an extraordinary social condition, as also identified by Moyer and Hardon (2014). The role of medicine in normalisation is a physiological construct of health and illness that neglects non-biological processes of functionality, as described by Won (2017).

This research found a lack of informational resources among participants on medicine and sexualities. There is a relationship between the body and ART. Although HIV care is about the individual, lack of informational resources renders the effects of ART collective by extending them to unsatisfied sexualities and a limited social as well as work life, as found by Endicott (2019) and Persson et al. (2017). Resources in biomedicine are uncertain due to manifestations that need to be acted upon every day in health and illness management, as shown by Mulubale, Rohleder & Squire (2022).

The uncertainties reported within the governmentality theme were mainly due to lack of medical resources, ART side effects and fluctuating health conditions. The findings confirm that living with a chronic health condition offers no certainty on resource requirements at any given moment, and has unprecedented medical side effects on the body, as also found by Cooper et al. (2013). This is because strategies adopted through medical treatments and health against potential risk outcomes can be driven by socio-political factors (Foucault, 2008; Novas and Rose, 2000). These results reflect those of Flowers (2010) and Squire (2013), who also found that medical normalisation in HIV and ART is connoted in terms of physical health, not state or social relations.

The findings here provide evidence that teachers who are HIV positive experience some level of (de)professionalisation through ART governmentality. Literature reviews have indicated that there are no studies that explore and examine this finding about ART (de)professionalisation. Similarly, no research highlights the descriptions of medicine based on opinions of those who are living on ART. On one hand, the demands of living on ART can be (de)professionalising to some extent, as side effects and hospital appointments disrupt the work of participants. On the other hand, and as seen in chapter five, ART governmentality is enabling: participants were able to do their job due to the power of the HIV treatment, which was primarily reported to be effective in improving physical health and abilities.

Nonetheless, the medicine was described as a ‘demon’ by some participants, if only to signify the difficulty and time-restricting nature of ART’s demands. The representations of ART as an integral part of everyday living are problematic not only for the body, but also for the medicine demands that limit social, economic and profession life, as also found by other studies (Persson et al., 2017; Won, 2017; Lock and Nguyen, 2018). The findings suggest that medicine is restricting, socially and professionally: hiding or not hiding, and hence socialisation when on ART, appears contrived and hard. The findings indicate that chronic health conditions managed by daily medicine, such as ART, have positive and negative effects on individuals’ and groups’ social and professional lives – a feature of ‘biological citizenship’, as shown by Rose and Novas (2005). Biologically based socialisation develops over a period of governmentalisation of health or intervention.

8. CONCLUSION

The results on HIV governmentality indicate a level of biopower identity and the lack of it in ART. The strategies for managing chronic conditions such as HIV make social integration non-monolithic due to a network of medicalisation. This signifies a process of healthcare that positions and supports state as well as self-management practices of everyday medical needs (Mulubale, 2019b). Therefore, society as a whole is transformed due to the utilisation of biomedical technologies, which extend effects beyond individual bodies.

There is a sense of closed time related to ART, which is a chronicity issue. The time restriction of when to take medication is affected by place and surrounding people. This research found that ART has a strong time closure, which conflicts with being in a non-hostile space at the specific time of taking the medicine. The notion of safe spaces shows a sense of closed time that is psychologically created through social interactions and can be associated with mental health issues, such as anxiety when it is time to take medication in a hostile place such as a school.

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