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Therapeutic Citizenship and the Teaching Profession: New Theoretical Approaches of Zambian Teachers Living with Human Immuno Deficiency Virus (HIV) and on Antiretroviral Therapy (ART)

by

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Abstract

Teacher training, teachers' economic status, their use of effective pedagogy and many other factors have been chronicled extensively by various scholars across disciplines in research on education in developing countries. However, teachers' experiences of illness and health conditions as key actors in implementing the development agenda of many countries in Africa, have received very limited attention. The HIV and AIDS burden in sub-Saharan Africa (SSA) is higher than available resources to deal with the pandemic effectively (Kharsany et al., 2016) while the number of people living with the virus and on ART in SSA countries, such as Zambia, remains high (UNAIDS, 2017). This article discusses HIV positive teachers' medicalisation in the Zambian context. It makes a theoretical appraisal of the dynamics of health in this HIV treatment era, viewing the era as leaving the AIDS pandemic between two streams: a disappearing tragedy and a treatable illness with latent psychological, social and economic effects (Lichtenstein, 2015:858). The above proposition in this paper is supported by three fundamental concepts which can be summarised as: governmentality, identity and chronicity. These three concepts, when effectively synthesised, offer new ways of understanding the medical solutions, normalcy, and their limits in the everyday living of teachers who are on ART. Based on this theoretical analysis and its relation to existing empirical data, the central argument in the paper is that teachers' daily lives seem to be filled with the socio-political and economic consequences of HIV medicalisation and that these consequences seem to shape and limit how teachers manage and make sense of their acquired 'therapeutic citizenship' status.

Keywords: Identity, Chronicity, Governmentality, Teachers, Therapeutic Citizenship, HIV, Development, Zambia

Introduction

The United Nations' Sustainable Development Goals (SDGs) are aimed at eradicating poverty by 2030, with SDG number three focusing on 'good health and well-being'. One target under this goal is to reduce HIV and other diseases. The Human Immune Deficiency Virus/ Acquired Immuno deficiency Syndrome (HIV and AIDS) is still a national disaster and hindrance to development for many sub-Sahara African states (United National Development Plan - UNDP, 2016; United Nations Acquired Immunodeficiency Syndrome - UNAIDS, 2014). Through the integration of Millennium Development Goals (MDGs) into its monitoring and evaluation processes, most African nations, including Zambia, have made good progress in the fight against HIV and AIDS. The combined efforts of international and local stakeholders on achieving MDGs has reduced the threat of communicable and infectious diseases on social, economic and human development. Moreover, action to attain the MDGs led to community-based and multi-sectoral approaches to national responses on such diseases as HIV and AIDS in most SSA countries. However, diseases like HIV, through its complex medical needs, still poses a serious threat with varying effects to individual wellbeing and national development in sectors like agriculture, mining, health, and tourism, as well as education (Central Statistics Office -CSO, 2014; UNDP, 2010).

In relation to education, Target Five of the 2014 UNESCO Muscat agreement on Global Education for All (GEA) admonishes that by 2030, 'all learners acquire knowledge, skills, values and attitudes to establish sustainable and peaceful societies, including through global citizenship education and education for sustainable development.' Target Six challenges all governments to 'ensure that all learners are taught by qualified, professionally – trained, healthy, motivated and well – supported teachers' (UNESCO 2014:3). Reports indicate that HIV and AIDS has a strong effect on work (UN Chronicle 2011), given that the most affected or infected are those who are in the productive years of life, in relation to paid and unpaid work.

This article aimed at discussing some theoretical issues around HIV positive teachers' medicalisation and normalisation in the Zambian context. Ren (2002) defines medicalisation as a social practice which transforms behavioural, emotional, and physiological human conditions to an entirely medical problem of Western medicine. Additionally, medicalisation is a process of unending treatment of the body which has an effect on the mind and behaviour of an individual as well as actions of a group (William and Gabe, 2015). It is important to note that medicalisation involves process because in relation to any health conditions, there can be degrees of it. The normalisation of HIV, on the other hand, is both medically oriented in the sense that people living with HIV when treated are 'normal' in physiological bodies, and socially framed even when they are on treatment (Squire, 2013:90 – 104). Thus, therapeutic citizenship is an arena through which trends of HIV medicalisation and normalisation can be understood.

The paper is divided into four sections. The first part, after this introduction section, gives a methodology which demonstrates and justifies the approach that was followed on the study. The method section is followed by brief definitions of some significant concepts. The second section is about an account of the Zambian health and HIV situation in relation to development and teachers. This account is given in line with some notions of medicalisation and normalisation that are defined in the next section. In the third part, we engage identity, governmentality, and chronicity in understanding how teachers govern their health in the light of HIV in Zambia. The fourth and final section uses notions of identity, governmentality, and chronicity as entry points into a theoretical inquiry aimed at understanding and re-conceptualising or extending conceptions of 'therapeutic citizenship' and their implications for development narratives in general.

Conceptual Method

Antiretroviral drugs have helped to increase longevity; the research focus must now be more on qualitative (rather than quantitative) empirical explorations of conceptual accounts to explore how people living on medication can find meaning when living with HIV as a chronic condition. Quantitative research gives morbidities – death and illness rates and their causes - but not details of experiences of living with a chronic, and yet still potentially fatal illness. Thus, assessing the level of a population's health cannot be satisfactorily done without qualitatively considering the economic, political, social and psychological effects of living with a disease that requires daily medication (Wahlberg and Rose, 2015:61). Here, the focus is on a preliminary step towards such qualitative investigation: examining the conceptual framework within which qualitative investigation can proceed.

Since teachers are the largest group of government employees in Zambia, the impact of HIV treatment on teaching, whether disruptive or positive, make this a national and development issue. Moreover, the additional complexities of living with a chronic condition also render it unlikely, as with HIV itself, to be understood fully by quantitative study alone. The downside effects of HIV on the socio-economic fronts are vast and well documented. However, enhanced antiretroviral therapy (ART) coverage for teachers has largely been seen simply as cost-saving in Zambia (Risley et al., 2012: 12).

With the above justification in mind, this study is the first stage of the conceptual project to empirical investigation conducted by the author (Mulubale, 2019). In these studies, the author engages accounts of representation and experiences of teachers with HIV in the Zambian context. An argument is made that suggests a new theoretical synthesis of issues around health, development and what it means to be a Zambian teacher on ART. It is hoped that this discussion will also shed light more generally on the complexities of lives lived with HIV and antiretroviral therapy (ART) in the current and future epidemic, in sub-Saharan Africa (SSA) and elsewhere (Kharsany, 2016). In the section that follows, let us define and contextualise HIV.

Understanding and Contextualising HIV

Human Immuno Virus is an infection that weakens the immune system of the human body and once acquired leads to life-threatening problems and consequently, death. However, treatment with antiretroviral (ARV) drugs can slow or stop the development of HIV into AIDS and can reduce infectivity. There has been immense investment in combating the HIV and AIDS epidemic (Whiteside, 2016), in treatment, care, and in reducing transmission, which occurs via particular sexual, reproductive and drug use behaviours and which is socially driven (Squire, 2010; Whiteside, 2006; Whyte, 2015).

HIV and AIDS is on the global development agenda. For example, the MDGs' eight international development goals had a specific and exceptional focus of combating HIV and AIDS, Malaria and other diseases on goal number six. In 2015, a strategic plan for 2016 – 2021 was released, by the United Nations programme on HIV and AIDS (UNAIDS), in line with the current Sustainable Development Goals (SDGs), which call for strengthened global response in HIV prevention, diagnosis and treatment (UNAIDS, 2015). In parallel, country-based actions are aimed at working towards an integrating version of HIV testing and treatment services into a range of care flows to reach the UNAIDS'90–90–90 aims: by 2020, 90% of all people living with HIV to identify their status, 90% of those who know they are HIV positive to have access to treatment, and 90% of those on antiretroviral therapy to have undetectable viral loads.

As mentioned, the social drivers of HIV transmission are powerful, and poverty is prominent among them. Most people living with HIV and in developing countries are poor. About 78 million people have been infected from the time the first case of the epidemic was documented, and an estimated death toll of

35 million people world-wide has been linked to AIDS (UNAIDS, 2016). The majority of those living with and affected by HIV are poor, and most poor people who are HIV positive are in developing countries of East and South sub-Saharan Africa. These blocs account for over 19.4 million people living with HIV, recording about 790,000 new infections at the end of 2016. About 51% children and 61% adults are receiving ART and over 420,000 deaths were AIDS related in 2016 (UNAIDS, 2017; UNDP, 2016). There has been progress in HIV treatment efforts around the world in spite of challenges. People living with HIV in underdeveloped nations have benefited most from generic drugs and scale up projects. Yet in spite of nationally, regionally and globally driven programmes in the fight against the pandemic, there are ongoing debates regarding how HIV has problematised life expectancy, deepened poverty, decreased socio-economic development and fractured education and health systems (UNAIDS, 2016; Whyte, 2015).

Human Immuno Virus treatment can produce some psychosocial as well as physical challenges. For example, stigma which is often taken as the labelling and devaluing of individuals based on undesired differences that increase social isolation (Squire, 2007:123). Treatment has reduced stigma due to the social acceptance that comes with the healthy physical appearance of HIV positive people who are on ART. Now, stigma appears to have taken a new form that stems from discrimination on basis of being on ART. Discrimination against medicalised people in HIV is a social identity issue because it attaches unwanted labels through moral appropriation on an HIV positive person (Goffman, 1987). Thus, medicalisation can possibly include cultural and social processes of categorising people on the basis of their health condition and treatment needs (Stutterheim et al., 2017). Although some gains have been recorded in the fight against the pandemic in Africa and Zambia in particular, the disease still poses a serious threat with varying effects, ranging from individuals' well being to national development in sectors like agriculture, mining, health, and tourism, as well as education. Zambia may not meet the 2030 health related SDGs and GEA deadline. One instructive example of such potential failure will ensue if development and well-being issues around HIV for teachers in schools are not investigated and fully addressed (Kelly and Bain, 2003). In this and based on conceptual context, HIV positive teachers do experience some 'on and off' episodes of wellness and illness both physically and mentally, but how this affects their roles in schools can possibly be explored.

Using the concepts of governmentality, identity, and chronicity, the article attempts to ascertain the dynamics of health in this treatment era that seem to be leaving the AIDS pandemic between two streams: a disappearing human tragedy and a treatable illness with latent long and short-term psychological, social, and economic effects (Lichtenstein, 2015:858). The emphasis here is on the second 'stream' with the first 'stream' a kind of memory that needs to be considered and that is often 'disappeared'. The two streams are thus unequal because the first stream is now much weaker due to advancement in treatment technologies. The next part introduces, defines, and qualifies the key concepts that are employed in this paper.

Defining and Outlining the Importance of Key Concepts

Many investigations in social sciences have been inspired by Foucault's conceptualisation 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).

Identity is a concept that is often applied in a broad sense. It has been used with ambiguity in exploring the collective present, past histories, and life subjectivities in socio-political contexts (Goffman, 1968; Turner, 2000). Most of its usage concerns processes of populations-cohesion that is driven by both political and social connotations of individual uniqueness, group representativeness, belonging, power acquisition and recognition. Identity in relation to disease can be framed around prevention, care and long-term treatment (Cruz, 2005). That is why when a specific disease awareness engendered through biomedicine becomes a conscious health issue, it sets up grounds for socio-political manifestations of identity around that condition. The politics of identity in health and disease relates to the state of bodily and mental capabilities that make people be considered socially normal and abnormal among what are supposed to be equals in society (Pallesen, 2014).

Chronicity of disease, as the term suggests, is the characterisation of a health condition's relationship with time, space, and life events. Although chronicity as a concept can be traced in Western societies which embrace individualised identities more than collective ones, it has been successfully applied in many non-western cultural contexts to examine the impact of chronic diseases (Manderson and Smith-Morris, 2010). Curtin and Lubkin (1995) define chronicity in relation to illness as the irreversible presence, accumulation, latency of disease states or deficiencies that involve the total human environment of supportive care and self-care, maintenance of function, and prevention of further incapacitation. The theory of chronicity generally deals with long-term subjectively experienced medical conditions of everyday life, which may or may not have a cure.

When critically synthesized in relation to HIV's therapeutic citizenship, a way of conceptualising subjects in relation to socio historical particulars of medicalisations and normalisations of HIV (Nguyen, 2008; Patterson, 2015), the above concepts offer new ways of understanding medical solutions, normalcy, and their limits in the everyday living of teachers in Zambia who are on ART. The notion of ‘citizenship’ signifies taking part in the public life beyond the conventional political sphere. According to Marshall (1950), citizenship entails an individual’s full participation in public affairs and denotes an interaction among citizens. It also signifies a relationship between the individuals and the state. Contemporary developments and problems have led to an expansion of the concept and practices of citizenship (Turner, 2000; Johari, 2009, Steenbergen, 1994:2). Patterson (2015:1) defines therapeutic citizenship as ‘biopolitical membership that includes claims and ethical projects that emerge from techniques to control and manage bodies. In some contexts, therapeutic citizenship includes activism and claims-making against local, national, and international power brokers.’ As a concept, ‘citizenship’ is useful in exploring some challenges and successes of personal and group identity. Thus, ‘therapeutic citizenship’ is a phrase that highlights the biopolitisation of populations and self-management of bodies, especially in illness, involving making of claims through local and international channels (Richey, 2006; Nguyen, 2010; Whyte, 2012).

Thus, medicalisation and normalisation, although different and sometimes in conflict, are the overall theoretical context within which identity, chronicity and governmentality are considered within the therapeutic context of HIV citizenship. First, in order to build from an integrated theoretical framework, the medicalisation and normalisation of HIV positive teachers in Zambia is conceptually explored and examined here.

Zambian Teachers: Progress, Problems and Prospects of ART

HIV positive teachers’ situations cast light on contemporary discussions of the African states. These national-states appear not to be much better but off course, different from colonial times, because of the autonomy that they now possess. Although according to Whyte (2015), some governments of SSA countries in this neoliberal era are perpetuating and transforming into some kind of ‘para-states’. For instance, Zambian teachers are on government payroll but many of them who are HIV positive have complex treatment and resources needed that are largely met by donor provision of free ART drugs. The first case of HIV and AIDS in Zambia was reported in 1984. Due to the impact in terms of number of new diagnoses, high deaths tolls, short life expectancy, in the past – by 2004, the government of Zambia declared HIV and AIDS an emergent national issue and committed itself to providing free ARV treatment for at least 100, 000 people by the end of 2005 (Mweemba et al., 2010). The effect of chronic conditions, such as HIV, on individual well-being and national development largely remain under-researched, both quantitatively and qualitatively, in Zambia. This paper sets out some theoretical groundings for that work.

The current state of HIV in Zambia is that over 1.2 million people are living with HIV/AIDS (UNAIDS, 2016; UNDP, 2016). With the prevalence rate standing at 12.4% and 59,000 new infections annually, 67% adults are on ART and there are slightly over 21,000 AIDS related deaths yearly (UNAIDS, 2017). The Ministry of Health in Zambia recently increased access to treatment by creating 68 new sites in addition to supplying drugs to all existing ART sites nationwide. Assessment laboratories for monitoring of HIV-positive patients are present in almost all provincial hospitals, districts and community clinics. The number of people, teachers included, dying from HIV/AIDS related illnesses, when compared to the pre-treatment era, has drastically reduced (from 66,272 in 2003 to around 21,000 in 2016) due to early diagnosis and free provision of ART in Zambia (Ministry of Healthy - MoH, 2015, National AIDS Councill-NAC, 2009, UNAIDS, 2017). The figures above shows how the Zambian population is slowly being, moved towards the 90-90-90 goals (UNAIDS, 2017) of near-universal and effective HIV testing and treatment, which also has preventative effects, since effective treatment correlates with lack of transmissibility, or as UNAIDS now puts it, undetectable = untransmissible [U=U] (The Lancet, 2017). This increasing emphasis on medical solutions may indicate the medicalisation of HIV in Zambia, which would in turn have implications for national development.

The clinical claim of having a ‘normal’ and ‘healthy life’ when on ART is contested, particularly in relation to psychosocial issues. The notion of normalcy as perceived in medical spheres seem to be problematic in the eyes of some social science researchers such as (Kippax, 2010; Squire, 2013:67). The concerns around HIV’s medicalisation and contemporary neglect of social ‘well being’ – broadly understood (Harper, 2009), indicates that, the epidemic cannot and should not be ‘normalised’ by clinical medical approaches. Whitside (2006), Squire (2010; 2013), Whyte (2014) and Patterson (2015) all testify as to how deep and far-reaching the crisis of HIV is, and how it is far from being over, even in the treatment era. Human Immuno Virus like other conditions such as cancer and TB is slowly shifting discourse paradigms from that of fatal illness towards, in this case, that of chronic illness accompanied by the complexities of taking medication lifelong and living a ‘positive’ life. The need to shift from a clinical and epidemiological focus to exploring more social scientific ways of understanding the impact of disease is born from the idea that illnesses are not only something people acquire and die from but also something that individuals, such as teachers, live with in the , long-term.

In Africa, including Zambia, teachers work under hard economic conditions with very low pay. Teachers can have some cash income but they are not as rich as other professions they help shape through teaching pupils who become the needed human resource in various fields (Abdukareem, 2001; Bennell and Kwame, 2007; Buckler, 2016). Many HIV positive teachers' lives are relatively healthy and yet there remain facing medical difficulties, economic constraints, and a social stigma. The interaction between the duties and difficulties of teaching as a profession, unfavourable socio-economic conditions, and navigation through this chronic condition (Sabina, 2013) and the effects of ART medication, makes teachers' lives, in and outside school, an important subject that needs to be studied. As observed by Mweemba et al. (2010:2), 'in Zambia, HIV and AIDS studies have focused on knowledge, counselling, behaviour change, mother-to-child transmission, and clinical presentation but there are few published studies which examine the effects of ART and HIV/AIDS on populations' activities of everyday living'. The difficulties faced by teachers on ART in Zambia can be assumed to be around their health uncertainty, self or public stigma within the school communities, and limited or no access to social and medical support networks beyond the medicalised 'normalcy' provided by ART.

A teacher is a significant facilitator for national development. Teachers in Africa bear a great obligation to yield the right kind of skills and behaviour not only for job creation but also to fill-up positions so created (Buckler, 2016; Okemakinde et al., 2013; Wanekezi et al., 2011). Teaching as a profession positions individuals as agents of development because of their role in imparting knowledge and crafting skills in learners. The pedagogical approaches that teachers use in the teaching process such as participatory learning, lectures, debate, role play, group work, question and answer, are vital in increasing attainment levels and enables leaners develop important skills for life after school (Capel et al., 2016; Farrant, 1980). To achieve such learning outcomes, education systems thrive when classroom teachers are motivated and efficient (Cohen, 2009). According to Wanekezi et al., (2011) the skills, creativity, and industry of people, in Zambia will be difficult if not impossible to build without healthy teachers and more generally, an HIV positive population of civil servants.

What does the process of HIV 'underdeveloping' public services look like? There have been few systematic studies that explore how the processes work out within particular sectors, especially for those affected by HIV and AIDS themselves. The high level of HIV related complex treatment challenges can possibly diminish prospects of quality assurance in Zambia's education system due to loss of experienced teachers, shortages of teachers and restricted human capital expansion (Siameja, 2011:89). The quality of education in rural areas appeared especially compromised because few teachers, particularly those who were HIV positive and needed treatment, were willing to be stationed in remote schools with no access to either transport or good health facilities. Some of these difficulties are exacerbated by lack of choice by teachers regarding the location of their deployment.

From the above, we can see the complex interaction of the private and public divide of illness and health. The means of representations are significantly an identity issue when dealing with long ill health conditions and medication. The effects of health and illness may better be understood from individuals as members of a much larger social setting and profession such as teaching. With the above perspective in mind, identity construction around illness and health is discussed in the next section.

Identity: Sense of Self and Relationships in Living with a Disease

The above issues render identity, as contended by Allahar (2001), a political and psychological construct that is socially located within relationships and individual codes of conduct. Historically, devised set of cultural and socio-political standards facilitate the creation and sustenance of any form of identities. The complexity of identity in health is rooted in the ever-shifting and uncertain health consequences of HIV diagnosis. According to Woodward (2003), formation of social and political groups within nations is mainly precipitated by shifting identities of the self. But this is contested as there are different facets of identity beyond the 'self' around which groups can mobilise for various reasons and different times. The concept of the 'self' generally refers to an entity with psychosocial and physiological dynamism (Pallesen, 2014). The self-derives from what people think, feel, and know about themselves based on experiences and shared communal norms (Berzonsky, 2011). In this regard, identity allows integrated ways of both thinking and acting about the social and the personal; that is the lived experiences and related social facts which together create an internalised self-image (Woodward, 2003). Yet in medicalisation, individuals define themselves and develop a sense of belonging through various diagnostic categories and the nature of their treatment such as ART, which bring people together through shared aspects that can be genetic in terms of having HIV. In this regard, HIV positive teachers who rely on medicine in order to function, may define themselves in relation to their viral identities and are less likely to be concerned with professional value identities such as pursuing their pupils' well-being, due to their own health burden (Tao, 2013; Buckler, 2016:171, Flowers, 2010:114).

The pivot between biomedical identities is imbedded in relations of the state and the infected individuals and their interaction among themselves and within communities. The self and collective identity is even made more visible through the demands for recognition based on chronicity, discussed in detail later, of daily struggle that requires policy makers and services providers' intervention. That is why the HIV medicalisation process is somehow directed by decision-making and support channels to integrate HIV diagnosis into the everyday life.

Identity, when contextualised in relation to health, draws much consideration on individual experiences and representations. Health and illness do interact with more general social 'labels' that become personalised, such as the image of an HIV positive person (Berzonsky, 2011:58). In many cases, lived experiences, especially of bodily illnesses, are used to construct routes and destinies for ordinary 'everyday' interaction within the broader social structures and inter-subjective relations of 'identity', over a life course. However, through diagnostic medical processes, one gets an aligned sense of self and collective identity. This is implicitly ratified by societal as well as medical discourses of 'normalisation' predicated by self-regulation, efficacy, esteem, and consistency.

The multiplicity of identity in biomedical processes leads to categorisation of populations. For instance, being HIV positive can lead to clustering of personal feelings of self-esteem and social co-constructions of identities that emanate from spaces such as schools for Zambian teachers on ART (Cast and Burke 2003; Munachaka, 2006; Flowers, 2010). Centrality of an HIV medicalised population is mainly through a shared, relational and a time mediated product of self-perception.

The dynamic consequence of shared societal values is, in politics, capable of inducing another sense of nationality called 'ethnic citizenship' whereas in biopolitics it can generate what we are referring to here as 'therapeutic citizenship' (Nguyen, 2008) discussed later. The notion of biopolitical identity and its linkage to various forms of 'citizenship' is twofold. First, the transition from individual illness awareness to health consciousness and second, the move from specific disease to formation of group-membership based on similar regimes (Collyer, 2015). In this view, identity is both a process and an outcome of deeply felt personal illness and public health records that give 'meaning' to biopolitical and social life (Wahlberg and Nikolas, 2015; Whyte, 2015; Nakata, 2013).

The extent to which an HIV citizened person can develop either a positive nor negative attitude towards their own identity is shaped by resistance of HIV normalisation amidst effective ART. That is why addressing people based on their biological condition in some communities is seen as stigmatising, discriminatory, shameful and undesirable in the search for social harmony and mental wellness for the affected.

Medical normalisation contravenes the many challenges that are faced by people with chronic conditions. Normalcy as drawn from medical discourses is a violation of medicalisation recognition as it foists identities that shelve psychosocial and sociocultural compositions of, for example, living with HIV and on ART (Flowers, 2010:115). Two differing schools of thought have generally emerged in identity studies which are applicable in illness and health related forms of identities. The first is the view that identity labels inspired by disease and chronic conditions, just like ethnic identity – in the African context (Mulubale, 2017), must not be embraced due to potential negative effects on individuals' self-esteem and the likely negative impact within communities (Whyte, 2012). The second position refutes the preceding contention and argues that describing populations based on health status and other biological characteristics as opposed to nationality, ethnicity, race, and many others, is a pillar upon which healthy nations can be built through knowing, prioritising and providing medical needs of some people in communities. The resources of a nation depend on the health of its citizens and health-related identities are part of building those resources (Marmot, 2015; Wahlberg and Rose, 2015:77).

In a multi-ethnic society where tribal identities are prevalent such as Zambia, they compete and often integrated with biomedical identities through language labels that are shaped by notions of 'sameness and difference' when it comes to health status. For biomedically distinct individual and group to join the mainstream society, they must first situate themselves as different (Flowers et al., 2006). Differences in HIV medical identity for professions like teachers, highlight the importance of social experiences that can facilitate the process of recognition and incorporation for excluded groups based on their health condition in work place policy. Health and illness representations cannot be given absolute visible 'meaning' for recognition and inclusion in diverse social and political structures because the impact of most medical transformations' effects are mental and thus hidden (Cruz, 2005; Flowers, 2010:116).

Since HIV is seen as a deadly disease due to lack of cure, its medicalisation has not reduced the likelihood that those who are positive are labeled as a social biohazard. Since people with many chronic conditions must make conscious adherence commitments to adhere to treatment for health or even survival, it is the institutionalisation of HIV, through laws, which make it and its medication different from other pandemics. This exceptionalism, and in some instances the history of the pandemic, impact self–presentation in professional spaces and social roles (Manderson and Smith-Morris, 2010; Flowers, 2010:117).

Nonetheless, identity derived from biomedicine appears problematic and compromising. Grouping HIV positive individuals based on their medical reliance may not promote societal singularity but can deepen the fragmentation of populations based on biopolitics within nations (Sabina, 2013; Nguyen, 2010, Parker, 2005). This has led to scholars, like Ecks (2006), claim that political [medical] pluralism - the presence of two or more peoples with the same [chronic health] condition - is a recipe for either social stigmatisation or the biomedically determined formation of groups. It is possible that people who suffer from certain illnesses are often given certain special opportunities, privileges, socially as well as politically excluded or included. Consolidation of identity founded on biological traits, for instance, sickle cell anemia, sickle cell trait, or Tay-Sachs disease, and medicinal needs, such as those around HIV, diabetes, or heart disease, can be useful for (re)distribution of available resources into and within the health sector, and as grounds for claims for these and other resources (Rose and Novas, 2005).

While chronic conditions do re-establish new forms of belonging through identity, it is a more often the case that long-lasting illness weakens social networks and interrupts relationships over time (Pallesen, 2014:237). Foucault's work, on for example, sexuality and governmentality, has inspired many identity movements. However, he was critical of the concept of fixed identities and its promotion, calling rather for the dissolution of identity because of the subjugations and power relations in play over and between different others (Bulley, 2014). Contrary to Foucault's support of elastic identities in response to, for instance, medicalisation, identity in biopolitics is significant for, in the first place, recognition, integration and participation in public life, being on ART is and can be used as criterion for the struggle of acknowledgement, inclusion and respect for those living an HIV positive life like some teachers in school.

Although identity theory is significant for understanding human action and their spaces of relationships, it seems flawed in determining the extent to which subjectively felt and not enacted identities can manifest themselves in medical discourses. As a concept, it mainly looks at self-image construction processes that are influenced by external entities, leaving out internal ambivalent identities, such as those with troubled HIV status adaptation. Individuals may at times deliberately process and evaluate self-relevant information before forming commitments and defining themselves, whereas sometimes they adopt and internalise the normative prescriptions of those around them and their cultures (Berzonsky, 2011). The accommodation of a medically determined identity is in itself drawn from individual physical and psychosocial histories of the impact of medicalisation over time. Indeed, in self-determination theory (Guardia, 2009), it is argued that identity-relevant obligations are controlled by natural factors such as bodily incapacitation due to illness, an idea that is consistent when applied in the context of teachers who are on ART in Zambia. Their personal health and illness trajectories from diagnosis to treatment is key in forming the grounds of their HIV status identities coupled with socially determined norms of being positive. Living a medicalised life, such as being on ART, is highly governmentalised. Thus, it confronts old identities, as it requires both expert knowledge and the formulation and implementation of intervention routines for a healthy life (Wahlberg and Rose, 2015). Moreover, many other identity constructions – related to gender, generation, age, religion, and class, for example, intersect with the HIV medical identities, biopolitically and perhaps, outside of governmentality also.

The idea of identity construction for HIV positive people has cause and effect links to the governance of medical regimes and interactions. It is the interface between the social and medical which is crucial in understanding the agency upon which medical images of HIV are crafted in social spaces, like the work place of a school for teachers. In this view of this, the conduct of medical practitioners and services users in managing an illness' positive identity that fits into social structures is testament to how ART has been normalised by biomedical constitutions. 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.

Governmentality: A Foucauldian Approach to Understanding Life on ART

Foucault's perspective of government is embedded in his notion of governmentality. He defines governmentality as constituting 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 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 and 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 and AIDS topics in various curricula, promoted creation of clubs for learners and series of HIV workshops for teachers.

The occupation HIV risk of teachers led the Ministry of Education in Zambia to develop its own AIDS work policies in schools (Bennell, 2003). 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, although slowly making their school communities as safe havens with reduced risk behaviours and reduce stigma for teachers and learners who are receiving HIV medication (Kelly, 2000; World Bank, 2009).

Foucault introduced the term medicalisation with reference to politically charged medical interventions during the 18th century. He argued that human existence, behaviour and body were brought into an increasingly dense and important network of medicalisation that allowed fewer and fewer things to escape (Foucault, 2008). Contemporarily, and with the upsurge of chronic conditions worldwide as health care has become more accessible and lifespans have increased (De-Graft et al., 2010), health has increasingly become more of an individual responsibility than a public issue, especially with privatisation on the back of structural adjustments. This move brings us to what Foucault called technologies of the self, in this case, extensions of medicalisation that place the biomedical governance of the body increasingly in the realm of self-care. Foucault considers medicine as a culture which has its own body of knowledge, and as a way of knowing that has evolved in conjunction with technology and in isolation with socio-political norms of affected individuals and groups (Tiefer, 1996; Foucault, 2008, Squire, 2013). Foucault's work broadens our understanding of 'subjectification' a concept that takes individuals as co-authors (with external influences) of their own identities even in the course of medicalisation. Foucault extended his ideas of medicalisation by arguing that the process of subjection is a negative force through which individuals are made subjects against their will – like taking medicine on a daily basis. This constitutes the various versions of the social and natural worlds which are fundamental to identity construction (Foucault, 2008).

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 direct as well as indirect 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 invisiblised 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 naturalisation 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 medicalised 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).

Foucault's theory of governmentality has not remained unchallenged. It is criticised for attempting to hold a discussion at once on too much and ending up with too little (Lemke, 2001). The theory seems flawed in its attempt to identify 'core characteristics' of modern medicine in a reductionist approach similar to the very health issues it seeks to interrogate (Bulley, 2014). Additionally, his approach can be criticised for being too euro and ethno-centric. However, patterns of conduct and self-regulation techniques in Foucault's theorisation of technologies of the self in relation to medicalisation can be universally applied and grasped clearly by relationally thinking of governmentality and chronicity.

Despite the noted weaknesses, Foucault's governmentality theory uncovers the subtle obligatory duty to rules that are supposed to be for the public good, rather than individual well being. For example, teachers who are on ART are required to teach even if their medical review appointments clash with their class-timetable. Thus, temporality issues in relation to the Foucauldian reconfiguration of power and time invested in governing health burdens of chronic conditions can best be described by looking at the concept of chronicity that is discussed in the section below.

Chronicity: The Time, Social and Management Factor in HIV as a Chronic Condition

The prominence of chronic health conditions in nations is a global concern because they pose serious health, economic, social, and political challenges for individuals, households, communities, and nations (Olmen, 2011). In the global south, especially Zambia, the HIV pandemic's chronic nature will continue to change the macro and micro socio-economic structures as those affected and infected by HIV cope with the conditions (Calvin, 2011). Chronic illnesses such HIV, has been so imbued in global structures and international geopolitics have gone through significant changes that are reducing bodily incapacitation and death around the world (Cooper et al., 2013; Yach et al., 2004; WHO, 2015:20).

Furthermore, Manderson and Smith-Morris (2010) argued that there are four areas of life that are affected by lifelong medicalisation. These are systemic poverty, interpersonal relationships, management of biological and epidemiological phenomena and subjective time experiences. The above aspects are interwoven within three key elements of chronicity. These are disease or health management techniques large and small scale, social phenomena and time (Colvin, 2011).

While HIV can be broadly categorised as a chronic disease, its complex prevention and treatment needs make it unique from other chronic health conditions (Colvin, 2011:4). First, to the above itemised elements, is the management of disease for a health life. The idea of chronicity expands understanding of 'disease' time verses 'illness' time and how these blurred categories of time are managed and have different effects largely due to medicalisation. Illness is more of an 'experience' than disease, which can be determined by biomedical methods, ranging from clinical observation to physiological testing and culturing. Illness depends on phenomenological examination of personally experienced distress (Curtin and Lubkin, 1995).

To manage HIV in terms of chronicity is to stabilise a person's condition that can be diseased yet not ill – as with certain types of cancer, or indeed with HIV, where the temporality of being HIV positive and becoming more and more immunologically compromised does not relate consistently to the temporality of experienced HIV illnesses.

The focus of managing chronic epidemics appear more biomedical than medico-social through such techniques as rehabilitation, prevention, palliation, risk constraint and even rights to be supported. The practices for sustaining a healthy life whilst living under medication for a chronic condition, as shown in De-Graft et al., (2010), have had special effects in modifying: (a) many chronic conditions whose management changes meanings of the ‘biological’, appear less socially contextualised and (b) HIV’s strong socio-cultural embedding foregrounds how its management over time changes ‘biological’ categories. HIV’s management is highly and increasingly biomedical – and successful – and that seems to reduce its biological determinism, as with other chronic conditions.

However, HIV is in addition highly socio-culturally contextualised because of how it is transmitted and because of its epidemiological patterns that require, reorganising and integrating health services, self-management and behavioural changes. For instance, within contemporary debates on HIV, it is often argued that the emergence of PrEP, the availability and access to ART, medicalised prevention and transmission programmes, and the creation of activist lobby groups – around treatment – is changing meanings and the scale of being HIV positive and negative (Whyte et al., 2014). With medicalisation, the number of survivors who need complex treatment and medical care increases in long term treatment successes.

The HIV – biomedicine relationship is unique from that around conventional treatment of chronic illness such as diabetes or heart disease because it requires a certain level of acquiring medical knowledge and social skills for a healthy life (Yasin, 2012). Most Zambian teachers work in social spaces thus, are subjects of policies, interventions and information that alter social behaviours in the management of schools (Kelly, 2000; Mulubale, in press). This implies that the success of being on ART for Zambian HIV positive teachers, is determined by resources and local contexts of policymaking around health which can influence how individuals are able self- manage their chronic disease effectively.

The second area of chronicity involves ‘social’ factors. Studies have shown that the social support base for people living with a chronic health condition determines the level of treatment effectiveness (Squire, 2010). Social support and the lack of it thereof for a range of chronic illnesses – such as cancer and depression – is linked to high mortality and chronic illness treatment withdraws (Yasin et al., 2012:4). Similarly, Good et al., (2010) argued that the health of patients improves when they receive functional support, like that from family. Though self-management is key, society has a bearing on the process of patients’ self-determination and commitment to wellbeing (Emson, 1987, Institute of Medicine, 1991; Curtin and Lubkin, 1995). In Zambia, it seems teachers’ access to biomedical and social technologies relies on their social status of life. Government employees, teachers included, who live ‘normal’ lives whilst on ART are those whose chronicity has been accepted by their social networks and are receiving both functional and structural social support through companionships, peer groups formation and informational links (Whyte et al., 2014). Help in the medicalisation process ranges from encouraging one to test and motivating them to get on a treatment programme. In Uganda, for instance, the sociality that kept the infected populations resilient even in sickness and long-lasting treatment was the support of kinship, friendship and partnership ties (Rabinow, 1996; Whyte, 2012). Similarly, teachers living with HIV in Zambia seek to be socially accepted and sometimes conceal their HIV status due to stigma and absence of standard social security and occupationally-related incentives of medicalization through ART (Kelly, 1999).

The third area of chronicity relates to time. Adjusting to bodily limits, disruptions and medication routines under HIV treatment is something learned over time. Time plays a significant role in shaping biomedical practices and it defines patients' everyday life experiences away from clinical encounters (Whyte, 2012). Chronic illnesses, such as HIV among teachers in Zambia, require the ability to adapt to changes of illness longevity and the passion of thriving whilst individually managing and negotiating different identities foisted by the disease and its subsequent treatment (Kelly, 2000). Within the chronicity perspective lie the idea that any disabling conditions such as alcoholism and related long-term health or even addiction illnesses can lead to living modified life-styles (Manderson and Smith-Morris, 2010).

From the discussion above, each domain of chronicity appears interrelated. This is because ripples of chronicity range from social isolation or integration, physiological or psychological limitations, independence, or dependence, enforced or forged self-images and modifications of identities, to economic pressures and the episodic fear of death among sufferers (Levy, 1979 in Curtin and Lubkin, 1995). The changes in an individual's life due to medication are shaped by means of coming to terms with one's past, present and future health conditions. How they make the links between changing life and chronic condition is facilitated by seeing life in temporality terms of adaptation and self-conduct. There is no certainty of continued health stability in living with a chronic condition. Also, a person's social clock is disrupted by the unexpected experiences of an illness (Bury and Holme, 1991) which topples life prospects at any stage. Mostly, then, chronic conditions have less to do with the past and the projected future than the present. Mead (1932) in Collyer (2015) through his theory of 'temporality' argues that time and history have no impact on long-term chronic health issues. He argues that chronic conditions are timeless bound due to focus of the 'present' on infected and affected person, because living with a chronic disease is emphasized by experiencing and embracing the 'present identity' that is either imagined or forfeited. Self-construction in chronicity is based on existing reality that is in the now – the present; this implies that *time* – past and future – are at some points irrelevant in health and illness.

Although the conceptualisation of chronicity above appears relevant in deducing the trajectories that are reshaping and normalising HIV in recent past, the concept is not devoid of problematic connotations in current scholarship. The prevailing chronicity narrative points to a panoramic view of chronic diseases as manageable, lifelong and invisibility of acute illness and body incapacitation. The above traditional view of chronicity does not help in fully describing life on ART for HIV positive individuals. The uncertainty tied to life on ART and the social expectation of invisibility of chronic conditions can be the basis for stigma in HIV medicalization. Temporality effects in biomedicine is homogeneous and linear, thus, medical narratives of chronicity appear problematic and inaccurate as social dimensions are often unaccounted. The understanding of a chronic illness such as a HIV is not only an individual account of experiences but also takes into account effects of collective actions and interpretations of living with an incurable disease and medicalised life.

The concept of chronicity can be flawed if used in low level analysis and short-term perspective of HIV medicalisation. Therefore, the theory ought to be contextualised in relation to long-term biomedical conditions that are without visible signs of being acute. New ways of understanding chronicity must be inspired by the medicalisation of invisible, non-physical disorders and life-long conditions such as HIV's contemporary phase of ART.

In the following section, an attempt is made to conceptualise 'HIV citizenship' in its new therapeutic context, in a way that also recognises the concepts discussed above.

Therapeutic Citizenship: Its Conceptualisation and Interconnections

The work of Vinh-Kim Nguyen on people living with HIV and humanitarian efforts in fighting the scourge made the concept of 'therapeutic citizenship' prominent in the HIV field (Nguyen, 2008; 2010). Through his 1990s research in West Africa, Nguyen reveals the extent to which AIDS transformed into a global industry enmeshed within the development sector leading to humanitarian projects, on effective treatment, that appear to have birthed new forms of life subjectivities such as AIDS activism, creation of support groups and subjects governed by the demands of particular regimes of treatment: therapeutic citizens. Most positive individuals in Nguyen's (2010) sample had no access to ART drugs and appealed more to donors than to the state, given that donors predominantly funded treatment at that time. Although it was not most HIV positive individuals in Nguyen's sample who sought for international assistance, their discourse appears to have had relevance to donors and such a global platform. This was done through what he calls 'confessional technologies', personal stories of disclosure and living with HIV. At the same time, it appears that his participants were regulated in their discourses and practices by the requirements of ART treatment to be regularly measurable, to adhere to treatment, and in addition, to be disclosing members of an 'out' HIV community.

The notion of therapeutic citizenship highlights notions of inclusions and exclusions of the infected and affected. Through citizenship that is medically determined, but also variably socioculturally shaped, one can gain access to resources and enjoy rights that other national citizens with other forms of chronic illness like diabetes, high blood pressure and more, may otherwise not be entitled to. In this HIV case, positive people have access to free drugs and in some instances in Zambia, they receive food stamps, and sponsorship to attain an education as well as empowerment funds (Mweemba et al. 2010; Siameja 2011). At the same time, gender, class, ethnicity and 'race' also stratify HIV citizenship itself. Access to HIV-related resources are inflected by such power relations. As before, this form of citizenship continues, too, to support a governmentality of 'solutions' by providing easily identifiable human subjects since infected people are put under medical surveillance. However, most scholarly works cited in this paper such as Nguyen, 2008, 2010; Mweemba et al., 2010 and Whyte, 2012 tend to focus on narrow conceptualisations of therapeutic citizenship, looking more at biomedical implications of medicalisation than at social dimensions within political and cultural spaces of identity and belonging – partly because, as mentioned above, they derive from earlier periods in the pandemic. They also address highly specific country contexts. The prevailing situation, perhaps best summarised through the 90-90-90 goals or more modestly, in the Zambian case, widespread ART access and efficacy, as well as country-specific histories and conditions, mean that the notion of therapeutic citizenship needs to be readdressed. For example, Nguyen's conceptualisation of relations of therapeutic citizenship was meant for a particular era and geographical area. Today, it appears minimalist as it focuses on access to medicine and difficulty of treatment access alone. However, disclosure, treatment education and adherence as technique in current discourses and practices of HIV treatment continues to create a membership base, a citizenship, at both global and national levels (Paparini and Rhodes, 2016:505). The concept of 'therapeutic citizenship' indeed involves the broader social, political, economic and cultural implications of stratifying citizens on the basis of discourses and practices of biomedicine and biopower, beyond the field of HIV.

In the present HIV field, individual biopolitical claims are recognised and respected on the basis of shared biological conditions understood through biomedicine. Under extended conceptions of 'therapeutic citizenship' applied here to HIV and AIDS and drawing on later work on therapeutic citizenship (Paparini and Rhodes, 2016; Patterson, 2015; Whytes, 2015), biological characteristics, as they are socially mapped and acted on, matter both subjectively and socially. For the relationship between therapeutic and biological citizenship is twofold: individualising and collectivising. It is individual because it focuses on the body and personal strategies of managing illness. It is collectivising because it acts as a conduit to establishing communities, group engagement with the social context, and broader civic participation and activism. For example, 'therapeutic citizenship' among HIV positive teachers in Zambia, the topic of my upcoming research, could involve such issues as support for treatment that sustains individual and collective identities through hope symbols and activism and that manifests itself in social spheres and biomedical arenas (Rose & Novas, 2005:5). The social relations of care activities undertaken on the basis of HIV diagnosis and treatment are bringing people living with HIV closer to both the state and communities (Kyakuwa, 2009 cited in Whyte, 2012). Teachers in Zambia may then come to recognise and connect with the government through its programmes of free access to testing and treatment, and with local communities defined through being HIV positive or HIV affected. 'Therapeutic citizenship' is clearly about both solidarity and the contestation of power brokering relations as seen in relations from the interpersonal to those of nation-states relationships, and it has to include attention to socioeconomic inequalities prevailing among citizens in most countries as well as between countries and regions (Ratele, 2016).

How does the picture of HIV developed earlier in this paper, and current today, fit with the concept of therapeutic citizenship? First of all, HIV is increasingly seen as a chronic condition due to the availability of and access to effective early; long-term treatment, and side effect management, although one's relations to the condition may change over time (De-Graft et al., 2010). This chronicity means that therapeutic citizenship is now framed in relation to HIV as chronic illness, as enduring, mobile – and sometimes, medically 'failing' - rather than as a response to difficult to access, rationed, life-saving treatment in the context of widespread HIV fatality, as with Ngyuen's earlier work. Second, the ongoing role of support groups both to serve and to appropriate HIV's medicalization, continues to operate as a politics that turns individual conduct into citizenly action, as in Nguyen's first work. However, HIV's increasing biomedicalisation, as treatment-driven approaches to the epidemic become more hegemonic technologies of governance, means that there is less space for such groups to articulate their own health citizenship, as happened with for instance, South Africa's Treatment Action Campaign (Robins, 2008) or indeed in Nguyen's research contexts. Third, even as a chronic health condition, HIV identities remain characterized by internal and external stigma, and HIV identities also continue to be strongly linked to cultural and social factors, for instance, race, religion, gender, and socio-economic status. Therapeutic citizenship is thus recognised now as not reducible to stigma-governed or stigma-resistant identities, as in Nguyen's typology. Stigmatisation and destigmatisation (Camphell et al., 2006) are now woven into all its identity forms, and cultural and social variabilities in identity play much more of a role in ongoing HIV lives.

Moreover, therapeutic citizenship in relation to this continuing, long-wave condition needs to be conceptualised in terms of ongoing issues of employment and of resource availability for PLWHIVs and for communities and countries addressing the pandemic – governance issues largely irrelevant to Nguyen's original conceptualisation (Squire, 2013; Whiteside, 2016). Even more widely, therapeutic citizenship in general, and for specific groups such as Zambian teachers, my research focus, is now framed by global and national political, policy and media technologies of governmentality, as well as governmental social relations at all levels, from the interpersonal to those of civil society (Whyte, 2012), all of which position HIV not as a potentially fatal emergency, as with Nguyen's first research, but as a chronic, pre-eminently medical, and largely solved problem.

The on-going practise of therapeutic citizenship, this paper, takes its shape from HIV's current chronicity; its implications with HIV identity, itself inflected by the new status of HIV as a chronic condition; and the increasingly biomedicalised governmentality of the HIV field. This complexity generates potentially disruptive and perhaps also reconstructive effects of living with HIV and antiretroviral therapy today, for those who are HIV positive or affected by HIV – effects that appear within the constraints and possibilities of contemporary HIV 'therapeutic citizenship' (Murray, 2007). Therapeutic citizenship as a concept thus allows us to think, through identity, chronicity and governmentality, about large structures of political, economic and sociocultural practice around HIV, as well as about how individuals with chronic conditions forge new forms of resilience, resistance, acceptance and belief about their illness and its subsequent treatment effectiveness (Squire, 2007).

Given the contemporary complexities just described, therapeutic citizenship can generate both benefits and limitations in citizens' public and private lives. For instance, there is increasing medical, cultural and social understanding of living with HIV. Yet, stigma isolation and bodily limitations, even fatality, are also associated with being HIV citizened. Again, discourses and practices for people living with the virus are intertwined with not only an HIV positive identity which continues frequently to involve stigmatisation, but with positive forms of self-image associated with, for instance, the professional identity of being a teacher. Moreover, claims made and privileges enjoyed based on being HIV positive seem in some circumstances to interact intersectionally with, but in other circumstances to outweigh, entitlements claimed on the basis of poverty, gender, race, ethnicity and other forms of injustices that are identity driven (Nguyen, 2008:143; Patterson, 2015); or entitlements claimed on the basis of biomedically based citizenships related to other illnesses. Such potential economic or resource conflict can create categories of 'citizens among citizens' among biopoliticised populations and populations framed in terms of identarian social justice, within the same national state and even on the global level (Squire, 2013:90 - 104). For instance, since most HIV treatment is externally funded in low-income countries like Zambia, international donors tend to shape therapeutic citizenship – for example, by focusing, contemporarily, on young women as those most needing to become 'HIV citizens', whether they are of positive or negative status (UNAIDS, 2017). Similarly, donor provisions are creating global grouping of populations which are pacifist through clinics and universal 'projectification' of HIV/AIDS (Patterson, 2015: 2). Another example: international and national patterns of manufacturing, procuring and distributing ART continue to constitute HIV positive citizens in all countries – but especially in low-income countries with least ability to fund ART - as precarious subjects of international health policy, national health departments, and brand and generic pharmaceutical company strategies.

With the above in mind, therapeutic citizenship can be linked to political citizenship. How aspects of citizenship like; national identities, responsibilities, rights, obligations and entitlements are reformed and understood among medically reliant individuals to be active citizens, exacerbates the need to extend notions of 'therapeutic citizenship' to capture political aspects of citizenship such as rights (Steenbergen, 1994:2). Human Immunodeficiency Virus patients, at least in Zambia, do not often act and mobilise on their right to health – embedded within political citizenship – hence likely not to place health related demands on the state. Teachers as therapeutic citizens in Zambia appear not to recognise the social contract they politically have with the state as the role of the state is invisible since demands are placed on non-state actors such as donors or pharmaceuticals (Whyte, 2012; Patterson 2015). Human Immunodeficiency Virus advocacy has somehow taken a much broader approach resulting to such notions as para-state: which implies an absence of full ideological state apparatus in health matters especially in non-developed nations like Zambia (Mbali, 2013). Today, in most liberal political customs, health politicking has nurtured citizenship stratification between those who are living with and without HIV (Squire, 2016). The biopolitics of HIV has allowed people to offer solidarity and to identify themselves with each other based on shared experiences (Patterson 2015:3) just like other citizenship aspects that held in commonality within and between countries.

Therapeutic citizenship here is conceived as relationally shaping understanding on the politics of HIV and perhaps other chronic conditions in this treatment era. Human Immunodeficiency Virus has transformed societies; it is a global issue with long-term health implications tied to taking medicine, every day and on time, for life – a continuity of biomedical care shared with other widespread chronic conditions (Paparini and Rhodes, 2016). How such citizenship, here, in the HIV case, affects populations that are key for development activities, such as teachers, needs a great deal more empirical investigation. Therefore, the reviewed theoretical issues above provide a diverse and modern context of therapeutic citizenship. The repurposing of therapeutic citizenship may in future require involvement of concepts of 'ubuntu' and 'decoloniality' in Zambia. Ubuntu is brought into the picture because it draws on personhood, humaneness, and morality, it is a humanistic orientation towards fellow beings in that it envelops key values of group solidarity, compassion, respect and human dignity (Ratele, 2016). Whereas decoloniality is useful in our time of framing therapeutic citizenship due to rising concerns to (de)globalise the production of knowledge and our social discourse outside western domains by utilising other disciplines (Masing, 2018), especially in this medicalisation and normalisation context.

Conclusion

This article has discussed the extent to which the medicalisation of HIV positive teachers in Zambia can possibly create forms of 'therapeutic citizenship'. The paper has also shown how HIV fits into the therapeutic citizenship picture beyond just treatment to encompass broad issues that are economic, social, political, cultural even biomedical and psychological. The preceding sections have explored how the governmentality of this disease, turned chronic, involves an identity that is bio-social and bio-political, an outward manifestation through conduct of an inward emotionality. It has been argued here that being HIV positive and on ART can change the image and role of teachers in development.

Through some of new theoretical insights highlighted in this article, it can be ascertained that use of ART is directly and indirectly changing knowledge (or understanding) of the HIV pandemic. This change in Zambia means that HIV is now a chronic illness that seem to be creating a form of 'therapeutic citizenship'. Key populations, such as teachers' well-being, sickness and, medication go beyond individuals and their families affect whole societies and their institutions and has broad national development implications (Bennell and Kwame, 2007). Thus, the role of HIV positive teachers in Zambia's development can be mediated by those who particularly may view and experience their therapeutic citizenship more positively.

Additionally, and from the foregoing discussion, it can be noted that living a life mediated by medicine can create positive, healthy, active therapeutic citizens; but the overlooked difficulties of such citizenship can also leave individuals, in positions of uncertainty, despair and periodic disruptions of self-efficacy. Human Immunodeficiency Virus is a fading tragedy due to the possibility of the effective treatment that has drastically reduced mortality in Zambia. The HIV disease has been transformed into more of a chronic condition and less of an acute illness, yet still with major implications for many aspects of human life. Going forward, social science research in this area needs to pay attention to concerns around biomedical 'objectivity', ethics and the changing role of the state in governing medicalised populations. There is also a need to further extend the biomedical conceptualisation of 'therapeutic citizenship' to capture its biopolitical and biosocial implications.

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