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"*Xilala* is only treated with a good hand": a study on the treatment of malnutrition in Mozambique

"*A xilala* só é tratada com uma boa mão": um estudo sobre o tratamento da desnutrição em Moçambique

"La *xilala* sólo puede tratarse con una buena mano": un estudio del tratamiento de la malnutrición en Mozambique

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Abstract

In Mozambique old and new evils of body and spirit intertwine, thus allowing particular contours to modern life. Traditional diseases are reconfigured along the lines of a new thinking, and what Western medicine calls malnutrition is defined as xilala *by the local traditional thinking. This study aimed to understand the point of view of both caregivers (mothers and grandmothers) of children participating in a Nutritional Rehabilitation Program and ethnomedicine experts, who find themselves entangled in a complex set of relationships through which different forms to comprehend body, health, and disease circulate. The supplement, as an object, has a life of its own and takes on new meanings when it leaves the hospital. When its use happens at home, it acquires a particularity: it becomes food. Thus, it ceases to be something inert and impersonal, which is a feature of standard medicine of the health institution. The local view centered on ethnomedicine is based on the certainty that a situation affecting a child cannot have a healing outcome if not by traditional medicine. Biomedical rationality erected from the confluence of the biological and technical sciences with their scientific postulates does not constitute the authorized discourse in this context.*

Malnutrition; Traditional Medicine; Public Policy

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Initial problem

In the complex Mozambican political and social scenario, old and new evils of body and spirit intertwine, thus allowing particular contours to modern life. Traditional diseases are reconfigured along the lines of a new thinking. What Western medicine names as malnutrition is understood in the local traditional thinking as forms of life manifestation and particularly affected personal relationships defined as *xilala*.

We propose changing the concept of malnutrition as a problem in the biomedical field for a conception that seeks a cultural perspective, since this phenomenon involves sets of corporeal, socio-relational and spiritual signs and significations. Tensions between an ancestral mythical thinking and new rationalities of Western thinking emerged due to the flooding presence of the latter in the Southern territories. In this regard, we sustain throughout the text that it is impossible to assess the movement of modernization solely under a technical perspective, as though it could be simple, unambiguous and unattached to a remote past. Not only are there many disruptions, but also resignifications and revitalizations of thought, named "traditional" in this text. Treating malnutrition and assuming it as a political problem, that is, of public health with prescriptions and institutional norms, also poses the challenge of building dialogical and intercultural processes that serve to cope with physical and mental suffering. They also serve to resist the inexorable advancement of hegemonic modernization by biomedicine in order to raise dialogical and intercultural possibilities that contemplate local epistemologies.

There are difficulties for the implementation of public policies to combat and to treat malnutrition in Mozambique. We suspect that the disregard for local epistemologies is at the root of the issue, since it also fails to acknowledge the local understanding of the world, formation of bodies and persons, and relations between the worlds of spirit and human matter. Thus, this study reflects the effort to understand the points of view of the local traditional medicine experts and the caregivers (mothers and grandmothers) of children participating in the Nutritional Rehabilitation Program managed by the Mozambican government. All of them find themselves entangled in a complex set of relationships through which different forms of understandings of body, health, and disease circulate.

Research design: context and method

Mozambique is located in the sub-Saharan Africa, where malnutrition-related health problems affected around 30% of children aged under five years in 2011. The figure corresponds to 314 million children suffering from malnutrition [1]. This issue, under the biological perspective, is defined by a range of pathological conditions that arise due to deficiency in the contribution, transport, and/or use of nutrients by the body's cells, mainly energy and protein [2].

The problem of child malnutrition and its magnitude in terms of public health in Mozambique is evidenced by its constant presence in the routine of health services and professionals. However, the complex economic and political determination of the health-disease process [3] and the hunger's social conditioning factors contribute to the maintenance and recurrence of medical states [4]. Within the scope of outpatient care for children with severe malnutrition, it is the responsibility of health professionals to ensure comprehensive care with a technical focus on clinical and nutritional aspects [5].

Acute malnutrition can be treated on inpatient or outpatient basis, depending on its severity. The protocol of the Nutritional Rehabilitation Program (NRP) adopted in 2010 by the Mozambique Ministry of Health states that children with severe acute malnutrition and medical complications must begin treatment in an inpatient setting and continue an outpatient basis until nutritional status is normalized. In Mozambique, children are treated with nutritional supplements such as the fortified blended foods (FBF), first line of treatment, or the ready-to-use therapeutic food (RUTF), known as CSB (corn-soya blend plus), or soy – which is a blend of corn and soy fortified with vitamins and minerals at the outpatient level of health care.

Therefore, the effectiveness of the treatment initiated at the hospital level should be ensured through appropriate outpatient, community and home measures with appropriate nutritional assistance and/or nutritional supplementation. It means, the implementation of this protocol depends

both on an institutional structure with trained personnel to conduct it, and on its continuation outside formal health services [5]. However, even if the protocol is properly structured, its effectiveness decreases when social and cultural aspects that may affect adherence to treatment are neglected.

Within the framework of the NRP, it is estimated that a child undergoing outpatient malnutrition treatment has a maximum of six hospital visits every two weeks, depending on the nutritional status of the child. At the end of this period, it is expected that the child will be discharged and rehabilitated with 85% of the ideal weight, thus being able to cede the vacancy to another child in the program. Regarding the treatment of malnutrition in an outpatient setting, the nutrition department of the Mozambique Ministry of Health estimates that nutritional recovery will occur between two and three months. During this period, the health service provides direct guidance to mothers and caregivers on the administration of the supplement [5].

The assessment of the NRP in home and community execution stages requires an investigation of the uses of nutritional supplements, which necessarily involves the local conceptions and representations of disease and therapy.

This paper deals with an anthropological study on the contexts and transformations of nutritional supplement use in malnourished children under 5 years old. The field study took place in Marracuene District, located in Maputo Province, territory comprising an area of 883km^2 and a population of 141,622 inhabitants [6]. This district is composed of 40 neighborhoods, but for the purpose of this research only the following seven were considered: Matimane, Macandza, Pussulane, Mapulango, Papsides, Faftine and Machubo.

The research unit was defined intentionally and for convenience by its high rates of malnutrition, estimated at over 23% by the local service, and with about 39% of households in food insecurity state [6]. The territory is characterized as a rural region, where most of the population lives on family farming and maintains their cultural identity is evidenced in their daily practices in Mozambique.

To interpret the reality of the phenomenon considering its rational matrix and complexity [7], we interviewed 23 mothers or caregivers of children. These children were under 5 years, in a state of acute malnutrition for at least 3 months and receiving the supplement during the period of the research. Other key informants of strong social reference in Mozambican culture also participated, such as elders, healers and maziones. All identified themselves by the office of healer, elder, or mazione with the distinctions by which each orientation is accepted in the local society. The interviews were conducted in the Rhonga language, took place in the health unit and continued at home. Ethical approval n. 86/CNBS/2016 obtained from National Bioethics Committee for Health.

The flesh and the spirit: disturbances in the construction of the person

A fundamental aspect to be considered regarding the set of social representations on malnutrition and its treatment refers to the diversity of ethnomedical systems in Mozambique [8]. It is noted here that, unlike malaria, whose studies in Africa report that the patient's relatives do follow the treatment "*trusting and recognizing in biomedicine the means and knowledge necessary to ensure their cure*" [8] (p. 397), the symptoms that comprise malnutrition are not configured for the local population as a "hospital disease", but as a "traditional disease". Therefore, it should be treated in a different context, with a different set of practices.

More specifically, the set of symptoms read by biomedicine as malnutrition are interpreted as constituting part of something called *xilala*, which comprises a set of physical and spiritual afflictions manifested in the child's body. *Xilala*, as heard in the field, is the result of unfulfilled rituals, spiritual debts of the child's ancestors, or causes linked to the forces of nature.

"*After all, is this baby food proper to treat* xilala*? I did not know that the hospital already knows how to treat it, but I am afraid to stop the other treatment because everyone tells me that* xilala *should not be treated in the hospital!*".

Apparently nutritional supplementation is not seen according to its purpose in Western medicine, which considers it a medicine with therapeutic value for malnourished children. The supplement has an action on the body, as observed in the interview excerpts, but does not allow the healing of *xilala*. Although physical symptoms such as thinness, depression and fine hair are significant signs of *xilala*,

it is not necessary to adequately feed the child in order to cure *xilala*. If in the western view *xilala* encompasses malnutrition, in local ethnoconception *xilala* is not restricted to signs of malnutrition.

"I don't think it treats xilala*, because the child with* xilala *needs to take traditional leaf medicine from someone with a good hand who knows how to treat it. But the baby food helps to stop children from starving, it is a good help that we all eat and feel is good".*

"I think it's good, because it feeds my children and thanks to her [malnourished child] *we have this right, but* xilala *is already being treated there in the community with someone who knows how to treat it. My mother found this person for me".*

"It is good for feeding children, but it does not treat xilala*, moon disease".*

"I think it's good! But the problem is that here at the hospital they say it treats xilala*, but it really doesn't! They just make us waste time on it* (...) *I always must come to appointments, and I live far away. Such treatment does not change! At least they give us this baby food that everyone likes".*

In native thinking, the person is made from a sociality that intertwines the worlds of nature, culture and supernatural [9]. In Mozambican society bodies are formed in these juxtapositions, *"incorporate multiple worlds, the living world, the world of the dead and the world of nonhumans"* [10] (p. 75). It is possible to understand them as ubiquitous bodies, as supported by Cossa [10]. In other words, bodies that belong to the group and whose memory and personality are accessible to everyone. These native representations of the body express other systems of knowledge about life and ontologies that diverge from the *"classic distinction between Nature and Culture* [and that] *cannot be used to describe dimensions or domains within non-Western cosmologies"* [11] (p. 115).

If the biomedical system operates from the recognition of bodily signs that conform as symptoms to then be classified as diseases, being subject to medical intervention [12], the traditional systems, in turn, also observe, classify and intervene, with the difference that each system operates based on its classificatory principals of the world. In the case analyzed here, it is noteworthy that both systems recognize and classify a similar set of signs, but the intervention process is distinct, precisely because each system has its own principles.

Thus, in the perspective of traditional thinking, this condition mobilizes a set of symptoms originated from the disturbances in the construction of the person. In a context constituted, according to Cossa [10], by ubiquitous bodies, what we verified is that, since the process of constitution of the person is relational – it involves living, dead and ancestors – when these established relationships are affected, the *xilala* is produced.

"Ancestors are vested with mystical powers and authority. They retain a functional role in the world of the living, specifically in the life of their living kinsmen; indeed, African kin-groups are often described as communities of both the living and the dead. The relation of the ancestors to their living kinsmen has been described as ambivalent, as both punitive and benevolent and sometimes even as capricious. The linkage is structured through the elders of the kin-group, and the elders' authority is related to their close link to the ancestors. In some sense the elders are the representatives of the ancestors and the mediators between them and the kin-group" [13] (p. 129).

The shared belief in the illness that afflicts the child has nothing to do with a lack of nutrients and energy in the body, it is yet of a different, nosological nature, because it is linked to the *modus vivendi in socius*, and in a specific way in which the dead affect the living [13]. To Evans-Pritchard [14], it shows a central feature of how African society approaches the world: from a holistic view of life and reality in which *"problems and solutions are presented and equated through a totality dialectically constituted, in which spirit and matter are not separated, but are confused in the composition of the lived world. There is not something that belongs to a single nature. Everything is interconnected"* [15] (p. 53).

About physicians and healers

Health in Mozambique is not dissociated from other dimensions of human life, such as religious life, hence treating *xilala* does not dispense with the intermediary between the worlds. In Mozambican society this person corresponds to the figure of the healer, and their *"functions go beyond the solutions of health problems,* (...) *reaching a holistic universe that encompasses all kinds of problems existing in this society"* [15] (p. 56).

There is a prominent position and great influence of healers in Mozambique, being such practices institutionalized in society as health practices, not religious. The healers are linked to the Association of Traditional Medics of Mozambique (Ametramo), a government-regulated body that grants them a proof of membership and ensures the legal performance of their activity. The Association brings together healers who work through herbal and oracle rituals, incorporation of guides, invocation of ancestor spirits and animal sacrifices exerting great influence on Mozambican life from birth to after death [15].

Healers practicing traditional medicine, whose social role is seen as a reference within communities, assert the inefficiency of the supplement and that *xilala* is not a disease that can be cured in the hospital: "*Yuuh!! After all that food they give children and such* xilala *treatment? I don't believe that baby food treats* xilala*. That is not medicine for* xilala", "*Hooo! I did not know that peanut djamo treats* xilala*! If you really want to know about my feelings, I think this baby food that is given to children in the hospital is more to help with food, to make them want to eat*" (Traditional medicine informants). The definitions of disease that guide healing practices obey their own coherence [16] and are based not only on manifested dysfunctions in the biological body, but also include sets of social relations between persons, ancestral spirits and nature [8].

For healers, *xilala* is the disease that arises in a child when the mother does not perform rituals soon after the baby is born, such as a curse or evil spirits. A situation conditioned by the behaviors in the community. Thus, one needs to be taken care of by someone who has a "good hand", who has a spiritual mentor that will guide the healer in the search for the origin of the disease and the best way to treat it.

The treatment of *xilala* has several lines depending on the cause. "*First, I start making* kuhlahluva [kind of diagnosis to ascertain the origin of the problem that affects the child]*, to know what the cause is, and then depending on the need, I can do the kufemba, where the spirits are the ones who guide me in the treatment. I do this to guarantee that I will administer the medicine guided by my spirits and while the child has already passed from* kubasiciwa [act of purification of the body/house]*, another aspect that I consider is the location and form of manifestation of* xilala*, it must be located in the child's head* (xahloku*) or in the spine* (xanhlana*) and* shamuzimba nindzene *which is in the whole body*" (Traditional medicine informant).

Xilala as a tumbulucu thing is related to an originary mode. The term tumbulucu indicates the origin of the affection in social, natural and supernatural relationships in the very community where the child was born and raised. The meaning of that expression is something natural and proper to the way in which one lives and which, when it comes to traditions, requires special care within one's own culture: "*I think what they give to children doesn't treat* xilala*!* Xilala *is a tumbuluco disease and is only traditionally treated with specific herbs*" (Traditional medicine informant).

That shows, as Cossa [10] argues, a non-dualistic universe in which the distinctions between nature and culture, as well as between humans and non-humans, do not apply, in such a way that *xilala* in a child's body expresses interconnections between diverse worlds (material, natural and supernatural) in the same way that the child's body also refers to plural bodies, because, as a master of initiation rites cited by Cossa [10] (p. 75) emphasizes, they are "*the nature, the spirits and the objects that circulate and exist in communities*".

From medicine to food: the trajectory and transformation of "things"

Information collected from mothers and caregivers about the actions of health service interventions aimed at children with malnutrition revealed the knowledge about a specific type of material, called by the health service as a nutritional supplement, whose functions and technical purpose were just vaguely understood. In general, the prevailing perception was that it was something appropriate for eating because of its physical characteristics, that means, its materiality.

Therefore, it had different meanings. When administered at the hospital, it was exclusively for children: "*I've never heard of the name supplement, my child receives peanut* djamo", "*I don't know about supplements, but I know that my daughter is fed with peanut puree here at the hospital*".

Outside the hospital context, which is when they have greater autonomy in the manipulation and control of the supplement, its use in daily home eating gives a different perspective from the one

established in the institutionalized space and ordered by biomedicine. A material that, upon leaving the hospital and entering the movement of family affections, assumes meanings of another semantic field: food and no longer medicine.

When children present an improvement in their nutritional status and are released to continue treatment at home, the supplement used for treatment, the "baby food" or *djamo*, is shared with the whole family: "*We all eat it, after all it's hospital help*!", "*It's very important because it satisfies hunger, it helps the family with their expenses*", "*I think it is very important that the hospital helps us to feed the children, because it also helps the whole family at home. I'm even worried because they schedule to come after 15 days and that's a lot of time!*".

RUTF is economically valued, since it serves as a support for the basic diet of families and as an alternative food to help in food crisis. The provision of nutritional supplements in hospitals is considered positive. Although the supplement is considered in the framework of general rehabilitation of children, the physical symptoms of malnutrition are not seen as a specific problem solved by the direct action of RUTF, since one does not look at the physical state as an isolated thing: "*It helps her get the nutrients that are missing from her little body*", "*It is very important because it satisfies the hunger of my children and we can see that it is good food, it must have good vitamins because the children have looked beautiful since they started eating this food*", "*It is important because it alleviates children hunger. It makes children's skin look beautiful! I saw that as soon as the other brother started eating, he began to change in a few days*".

It is widely known by women responsible for children that the presence of the family in the health unit creates bonds, establishes a relationship of reciprocity and trust, and aims to overcome some situation of abnormality regarding treatment. However, this relationship with the service is not clearly associated with the administration of the product known as a supplement, whose therapeutic purpose communicated to them would be to restore the nutritional status of children.

The medical product in Mozambican culture does not have a strictly therapeutic purpose, and almost all study participants demonstrated that they use the supplements differently from hospital indications: "*I use it on all baby food. The nurse said to give it like this: eat two packages a day. Depending on his appetite, it could be less or more than that*", "*I give it to the child twice a day; I mix it with mbila baby food. Half the sachet a day*", "*I mix it with baby food or flour and give it to the child 1-2 times a day. Regarding the quantity, it depends on the appetite of the child, but it is not a whole sachet*".

In practice, the method of administration differs from the protocol of the health service. Its use connotes the idea of an additional product to the family day meal. For many people, the supplement is considered a spice, that means, something added in a complementary way, to flavor the food.

The *New Management Scheme Protocol* [5] recommends that each child receives one sachet of RUFT per day, regardless of age and weight. It was observed in the studied communities that even in situations in which the mother or caregiver of the child has referred to use a sachet per day, all the contents of one sachet were thrown into a pot to feed the family during the day: "*Yes, I give it to the other children and I usually eat it too*", "*Yes, we all eat it, I put in the puree for the children and we adults eat with bread*".

In the case of daily hunger, the product makes it possible to restore gifts by providing a substitute for food [17] that can be shared. It also allows women to play their role in the production and distribution of food [18]. This meaning overlaps with the nutritional function of the supplement since food engenders a social process that aligns identity, belonging and affections, in addition to expressing relationships between reciprocity, commensality and kinship [14,18].

"*I discovered by myself that it is good when I tasted it, because in our tradition a mother should never give her child anything to eat without trying it, oh! When I tasted it, I noticed that it was good, and I started to give it to the other children, after that we all started to eat with it*".

The acquisition of the supplement allows the reunion and sharing of the meal in the household: "*Yes, they eat with their cousins, and they like it a lot! The owner doesn't even like it and just eats because I insist*", "*Yes, with the grandfather and brother that like it. They eat it as if it was chocolate or ice cream*". That also promotes the development of intimacy through the habit of mothers eating on the same plate as their sons and daughters and of children sharing the same recipient of food. That is, eating together is the locus of socialization of bodies [19].

Eating together with relatives expresses an act of solidarity that goes beyond the moral value and is linked to the aspects of the worldview concerning the construction of bodies and their meaning. Thus, how would it be possible to make distinctions in the distribution of food and assign different

portions of food to relatives? In this context, Cossa [10] (p. 68) continues affirming that: "*When a family member is helped, a very strong bond is created between him/her and his/her benefactor. Consanguineous relatives or allies are under the protection of the same bloodline or ethnic ancestor. By helping a family member, one respects the wishes and desires of his or her ancestors*".

The use of the supplement in daily life stimulates senses of sharing and the act of feeding the family and assumes symbols of reinforcement of social ties. The supplement, as an object in the world, has its own life and acquires new meaning when it leaves the hospital, and its use becomes domestic. At home, it acquires a particularity: becomes food, ceasing to be something inert and impersonal (the characteristic of a standardized medicine of the hospital). When it is taken out of the hospital and enters the domestic sphere, it is singularized and becomes unique. It begins to permeate the specific spheres of family interactions, relationships between relatives and all the moral responsibility that one has for his or her peers (blood relatives or not). The supplement, in its characteristic of a material object, assumes the characteristic of food substance after being offered by the government for treatment and leaving the sphere of exchange in the hospital environment, entering another circuit in which it is integrated to its own dynamics [20] – namely, the responsibility and reciprocity between relatives. Then it becomes a wrapped object in its gift paper, transforming itself symbolically and materially from a medicine to a food [21,22].

This passage from the hospital to the domestic environment – which would mark a personalization of the RUTF – refers to the discussion held by Kopytoff [21]. When the author, interested in the mercantilization and demercantilization to which the "things" would be subject, discusses the processes of homogenization and of singularization. In order to understand these processes, the author argues in favor of a biographical approach to products, goods and objects. This perspective is about being aware of the processes of change of meaning attributed to things, which would be possible due to the existence of different classification systems operating in the same culture.

Although we are not dealing with a case of mercantilization, Kopytoff's [21] argument is relevant to the extent that he indicates the necessity of not essentializing things. Furthermore, the author points out that the biography of things is a way of understanding both the drama of identities (which the author considers to be a feature of complex societies) and the social system and collective forms of knowledge (especially in small scale societies, as he argues).

In this passage from the object of an institutional space to the domestic sphere, a process of transformation is opened (considering that things are not totally stable but are culturally defined), and that the contexts of use and the networks in which these things are immersed act in the process of reconfiguration. The transition from inert substance to personality practice between domestic relationships is possibly supported by the physical characteristics that allow the supplement to assume the capacity to transform itself into food [21].

In this context, Ingold argues that the world is composed of "things" that would be in a constant process of self-formation and formation of the world itself, being essential to follow materials, since "*to follow these materials is to enter into a world that is, so to speak, continually on the boil*" [20] (p. 35). In this process, a key feature emerges: the materials are beyond our control. As the author points out [20] (p. 36): "*modern society, of course, is averse to such chaos*". As mentioned above, what we have in this case is that RUTF becomes food, due the context in which it operates and its material characteristics. However, this process of "thingification" of RUFT meets the scientific intentions of stabilizing what is understood as a therapeutic object.

Ultimately, if we consider that biomedical knowledge operates distinguishing nature and culture, the major challenge for the health team would be to interrupt this process of resignification of the RUTF so that it could be used again under the established therapeutic standards – after all, only then its effectiveness would be maintained. Then, since it is observed that there is an overlap in the signs that denote both malnutrition and *xilala* (thinness, dejection, fine hair), the hospital team tries to equalize them by saying they are taking care of *xilala*. Despite that, since it is not a mere difference in nomenclature, but rather different explanatory and organizing logics of the world, this equalization is incoherent. Consequently, the question is once again about the distinction between explanatory models for health and disease, in such a way that, in that context, a therapeutic proposal characterised by the individual consumption of a specific food is not understood to be feasible.

Further considerations: exploring perspectives

After listening to women caregivers (mothers and grandmothers) and healers, we understood that malnutrition is not classified as a disease based on the same parameters of western biomedicine. The weakened physical condition of children is not recognized as a biological affection and the physical signs of energy-protein malnutrition in children identified by the western clinic are associated with a different of problems in traditional thinking. It coincidentally seems that, at first, the physical signs are juxtaposed, but a deep divergence emerges in an unshakable manner now of designating the nature of the affection, the origin and causes that determine it.

In the discursive domain, the body as a significant material refers to malnutrition as one of the faces of the *xilala* that cannot be treated and cured with the nutritional supplements provided by the health service. The biomedical rationality built from the convergence of biological sciences (organic body) and technique, with their scientific postulates, do not constitute the authorized discourse in this context [23].

Biomedical treatment for malnutrition is based on the proposal that children affected by the disease should use appropriate therapeutic food. In this regard, RUTF is a mechanism of performance of scientific knowledge about the bodies and, as such it needs to be submitted to a constant process of purification. That means: assuming the division between nature and culture as a characteristic of modernity [24], science and its products (in this case, the RUTF) must be reduced to the natural domain, being necessary to break their relations with society. It is necessary that people recognize the therapeutic potential of the RUTF and use it according to established standards.

However, to the extent that social practices do not undergo the arbitrary distinction between nature and culture, this process of purification, which is typical of scientific knowledge, is not able to sustain itself. Thus, from the moment that hospital discharge occurs, and the families become responsible for the continuity of the treatment, the food supplement becomes part of a set of relationships that are beyond the scope of its biomedical proposal. The interviewees indicate a process of resignification of what was previously classified as therapeutic, as able to cure: RUTF becomes food, and consequently/therefore comes to be something that must be shared.

Tracing this coloniality, as a structure of political and cultural domination [25], the approach of *xilala* with the term malnutrition, the hospitalization of children and the prescription of the supplement put in disadvantage and intensify discrepancies between the traditional knowledge and practices in health and disease and the scientific practice [26]. It is a form of violence marked by the imposition of ideas that do not agree with the local knowledge and ontology from these places [10]. Prescription, the intervention forged by biomedicine – which has authority over lives and bodies – expresses very powerful intersubjective power relations, and in this context, science and its instrumentality reduce the subjects to the objectives of their action [27]. Familiarizing the biomedical term "malnutrition" and its biological meanings to traditional thinking, anchoring it in the nosological category of *xilala*, seems to cause a kind of cacophony by the disharmonious junction of classifications of orders of affections with distinct natures [26]. From the view that translates the signs into symptoms, and that causes a prescription that becomes the mechanism of action on the bodies of a monocultural thought established through biomedicine, the instrumental reasoning and the logic that configures modernity expand [28].

From this process, a questioning about African ontology and epistemology arises. An epistemology that is based on a natural knowledge and a set of social practices that are the basis of the way of seeing and acting. In the health domain, these languages of suffering are invisible to biomedicine, which operates in a unique cultural logic, retransmitting an ordering of the world that finally materializes in the bodies.

The different ends of the use of the supplement translate differences between cosmologies. *Xilala* refers to other languages of suffering that trigger particular care ecologies, and it seems that these life-management modes operate within a specific cultural logic based on the relational and daily experience between the living and the dead, which restructures personal and body agentially [8,29].

Contributors

J. I. M. Gove and R. C. F. Giordani contributed to the conception and design of the study, acquisition, analysis, and interpretation of data, drafting and revising the article and final approval of the version to be published. V. H. S. Jasper participated in the drafting and revising of the article. A. Estavela and I. Bezerra contributed in the final approval of the version to be published.

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Resumo

Em Moçambique, males velhos e novos do corpo e espírito se entrelaçam, permitindo contornos particulares na vida moderna. As doenças tradicionais são reconfiguradas em linha com um novo pensamento, e aquilo que a medicina ocidental chama de desnutrição é definida como xilala *de acordo com o pensamento tradicional local. O estudo buscou compreender o ponto de vista das cuidadoras (mães e avós) de crianças participando em um Programa de Reabilitação Nutricional e de especialistas em etnomedicina, que se encontram emaranhados em um conjunto complexo de relações através das quais circulam diferentes maneiras de compreender o corpo, a saúde e a doença. Enquanto objeto, o suplemento alimentar tem vida própria e assume novos significados quando sai do hospital. Quando seu uso ocorre no domicílio, adquire uma particularidade: torna-se alimento. Portanto, deixa de ser algo inerte e impessoal, que é uma característica da medicina convencional nas instituições de saúde. A visão local centrada na etnomedicina tem como base a certeza de que a situação que aflige uma criança não pode ter a cura como desfecho, a não ser através da medicina tradicional. A racionalidade biomédica construída pela confluência das ciências biológicas e técnicas, com seus postulados científicos, não constitui o discurso autorizado nesse contexto.*

Desnutrição; Medicina Tradicional; Política Pública

Resumen

En Mozambique los viejos y nuevos demonios del cuerpo y el espíritu se entrelazan, permitiendo así conformar las particularidades de la vida moderna. Las enfermedades tradicionales se reconfiguran a lo largo de líneas nuevas de pensamiento, y lo que la medicina occidental denomina malnutrición se define como xilala *por el pensamiento tradicional local. El objetivo de este estudio fue comprender el punto de vista de ambos proveedores de cuidados (madres y abuelas) de niños que participaban en el Programa de Rehabilitación Nutricional y expertos en etnomedicina, que se encuentran a sí mismos enmarañados en un complejo conjunto de relaciones, a través de las cuales existen diferentes formas de entender el cuerpo, la salud y la trasmisión de enfermedades. El suplemento alimenticio, como un objeto, tiene vida por sí mismo y toma nuevos significados cuando abandona el hospital. Cuando su consumo se produce en casa, adquiere una particularidad: se transforma en comida. Por ello, cesa de ser algo inerte e impersonal, que es una característica de la medicina estándar de una institución de salud. El punto de vista local centrado en la etnomedicina está basado en la certeza de que la situación que afecta al niño no puede tener un resultado curativo, si no es mediante la medicina tradicional. La racionalidad biomédica se erigió a partir de la confluencia de las ciencias biológicas y técnicas con sus postulados científicos, pero no constituye un discurso autorizado en este contexto.*

Desnutrición; Medicina Tradicional; Política Pública

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