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Depoliticising an epidemic – International AIDS control and the politics of health in Tanzania

(Dépolitisations d'une épidémie – La lutte internationale contre le sida et les politiques de santé en Tanzanie)

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List of acronyms and abbreviations

ABC: The prevention message: “abstinence, be faithful, use condoms”
AIDS: Acquired immune deficiency syndrome
AMREF: African Medical and Research Foundation
ART: Antiretroviral therapy / treatment
ARVs: Antiretrovirals
BAKWATA: The Muslim Council of Tanzania
BCC: Behaviour-change communication
CEA: Cost-effectiveness analysis
CDC: Centers for Disease Control and Prevention
CIDA: Canadian International Development Agency
CMAC: Council Multisectoral AIDS Committee
CSO: Civil society organisation
CSSC: Christian Social Services Commission
CTU: Care and Treatment Unit
DALY: Disability-adjusted life year
DFID: Department for International Development, UK
DHS: Demographic and health surveys
FAO: United Nations Food and Agriculture Organization
FBO: Faith-based organisation
FHI: Family Health International
GFATM or ‘Global Fund’: Global Fund to Fight AIDS, Tuberculosis and Malaria
GHI: Global Health Initiative
GIZ: German Agency for International Development
GoT: Government of Tanzania
GTZ: Gesellschaft für Technische Zusammenarbeit (today: “GIZ”)
HIV: Human immunodeficiency virus
HSS: Health systems strengthening
HSSP: Health Sector Strategic Plan
IDU: Injection drug user
IEC: Information, education and communication (for HIV prevention)
IMF: International Monetary Fund
JICA: Japan International Cooperation Agency
LGAs: Local Government Authorities
M&E: Monitoring and evaluation
MARP: Most-at-risk population
MDGs: Millennium Development Goals
MKUKUTA: National Strategy for Growth and Reduction of Poverty
MOEC: Ministry of Education
MoH: Ministry of Health (or: MoHSW = Ministry of Health and Social Welfare)
MOF: Ministry of Finance
MSD: Medical Stores Department
MSM: Men who have sex with men
MTEF: Medium-Term Expenditure Framework
NACP: National AIDS Control Programme

NCTP: National Care and Treatment Programme
NGO: Non-governmental organisation
NIMR: National Institute for Medical Research
NMSF: National Multi-sectoral Strategic Framework
NORAD: Norwegian agency for development cooperation
OECD: Organisation for Economic Co-operation and Development
OGAC : Office of the US Global AIDS Coordinator
OVCs: Orphans and vulnerable children
PEPFAR: President's Emergency Plan for AIDS Relief
PER: Public expenditure review
PHC: Primary healthcare
PLWH: People living with HIV (or: "PLWHA" = People Living with HIV/AIDS)
PMI: The US President's Malaria Initiative
PMO-RALG: Prime Minister's Office, Regional Administration & Local Government
PMTCT: Prevention of mother-to-child transmission
PRSP: Poverty Reduction Strategy Paper
PSI: Population Services International
RCT: Randomised controlled trial
RNA: Ribonucleic acid
RNE: Royal Netherlands Embassy
SDC: Swiss Agency for Development and Cooperation
SIDA: Swedish International Development Agency
STI / STD: Sexually transmitted infection / disease
SWAp: Sector-wide approach
TACAIDS: Tanzania Commission for AIDS
TB: Tuberculosis
TFNC: Tanzanian Food and Nutrition Centre
T-MAP: Tanzania Multi-Sectoral AIDS Project (component of the World Bank's Multi-country HIV/AIDS Program [MAP])
TOMSHA: Tanzania Output Monitoring System for HIV and AIDS
TZS: Tanzanian Shilling
UN: United Nations
UNAIDS: Joint United Nations Programme on HIV/AIDS
UNDP: United Nations Development Programme
UNFPA: United Nations Population Fund
UNICEF: United Nations Children's Fund
US: United States of America
USAID: United States Agency for International Development
VCT: Voluntary counselling and testing
WFP: World Food Programme
WHO: World Health Organization
3 by 5: Initiative launched, in 2003, by UNAIDS and WHO to provide three million people living with HIV in low- and middle-income countries with antiretroviral therapy by the end of 2005

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English abstract

AIDS-control strategies in sub-Saharan Africa involve crucial national political compromises. Yet, they are frequently formulated in heteronomous settings dominated by Western donor agencies. Drawing on a case study of Tanzania, a country whose response to the epidemic is 97% donor-funded, this thesis develops a political economy of international AIDS control. It explores some of the specifically political aspects of the struggle against HIV/AIDS in Tanzania by analysing the formulation of national HIV-prevention and -treatment policies, and confronting these policies with a critical review of their biological and epidemiological foundations. The fieldwork combines a series of 92 in-depth interviews with key policymakers at the national level with the observation of AIDS-related decision processes in donor-government meetings. In this way, this thesis analyses the unequal political attention given to different causal stories of the spread of the virus, and their impact on the use of evidence in the formulation of HIV-prevention policies. Moreover, it describes how AIDS policymakers adopt *non-decision* strategies when faced with the intricate trade-offs imposed by the inescapable prioritization of HIV-prevention and -treatment interventions in a context of insufficient resources. Finally, developing upon an analysis of the controversy among players about the effects of international AIDS control on the overall coherence of national health policies, the thesis explores the contradictions of a vertical AIDS response in a context of dysfunctional health systems and poor general population health. On this basis, it examines the possibilities to elaborate an emancipatory critique.

Résumé français

Alors que les stratégies de lutte contre le sida en Afrique sub-saharienne mettent en jeu des compromis politiques nationaux fondamentaux, elles sont souvent formulées de manière hétéronome et dans un contexte marqué par la prédominance des bailleurs occidentaux. À partir de l'étude du cas tanzanien, cette thèse analyse différents aspects proprement politiques de la lutte contre le sida, à travers une double perspective : l'étude de l'élaboration des stratégies nationales de prévention et de traitement du VIH et l'analyse critique de leurs fondements biologiques et épidémiologiques. La recherche se fonde sur une enquête de terrain combinant 92 entretiens approfondis avec les principaux acteurs institutionnels au niveau national, et l'observation des processus décisionnels lors de réunions programmatiques. Cette thèse met ainsi en évidence l'attention politique inégale accordée aux différents récits causaux de la propagation du virus, et le rôle de ces histoires causales dans la formulation des politiques de prévention. Elle donne à voir les stratégies de *non-décision* ou de « contournement du politique » qu'adoptent les acteurs face aux arbitrages difficiles qu'impose la définition de priorités dans un contexte d'insuffisance des ressources. Enfin, à partir d'une analyse des controverses au sujet des effets de la réponse internationale au VIH/sida sur la cohérence des politiques de santé en Tanzanie, la thèse explore les contradictions d'une lutte verticale contre le sida dans un contexte marqué par un système de soins défaillant et une mauvaise santé générale de la population. Elle examine, sur cette base, les conditions d'élaboration d'une critique émancipatrice.

Introduction

“The end of international funding is a nightmare for everybody.
We can only pray that it won’t happen and that, if it happens,
God...let it happen after I have died!”

The Executive Chairman of the Tanzania Commission for AIDS¹

I will start with a confession: when I began my doctoral project, I did not know that HIV/AIDS was going to become the heart of my research over the years to come. Worse still, I considered that HIV/AIDS had probably had more than its fair share of health researchers’ attention and that one needed a good excuse to conduct yet another study on the African AIDS epidemics. HIV/AIDS was but one of the issues I intended to look at within the broader enquiry into the politics of international health action I was about to start in Tanzania. I initially wanted to explore the articulation of the development of primary health care and the different international disease-control initiatives in the country. Indeed, it is only when I began fieldwork in Spring 2007 that I became fully aware of the dimensions of international AIDS-control efforts and their tremendous impact on health policymaking in Tanzania.

An international disease-control apparatus of unprecedented magnitude that had just unfolded was saving the lives of several hundred thousand Tanzanians by giving them access to antiretroviral therapy (ART) and, at the same time, it started to pose unique political challenges. The resources for AIDS control had increased about fifteen-fold in just a decade, reaching USD 520 million annually (TACAIDS 2010) – thus temporarily exceeding the country’s health budget for all non-HIV concerns combined (MoH 2010, p.32).² Over the last six years, the response to HIV/AIDS in Tanzania has been more than 97% donor-funded (Foster et al. 2008; TACAIDS 2010; TACAIDS 2012b). In 2007, AIDS expenditures represented close to 11% of total public expenditure and one third of all international aid to the country (Foster et al. 2008). The arrival of various international agencies involved in the global AIDS response entailed a significant shift in priorities within Tanzanian health policies and a rapid redefinition of different policy players’ respective roles and influence. The scale of the AIDS response had manifestly turned discussions over general health-service development into a political sideshow. Given the myriad questions of policy coherence, dependency and political autonomy this highly heteronomous policy-setting raised, it would

¹ Statement uttered at a preparatory meeting for a Global Fund proposal, Dar es Salaam, 3 Oct. 2008

² The Tanzanian health budget also significantly increased over the last decade (MoH 2010, p.32), though at a lower rate than AIDS funding. Importantly, the period of 2006-2008 is unique in that it is only during this short interval that total AIDS expenditure exceeded the rest of health expenditure. With stagnant (or even slightly decreasing) AIDS funding but continued growth of the health budget, this proportion has reversed again over the last years (Kates et al. 2012).

have seemed awkward to me *not* to study what had obviously become the most politically problematic process in the Tanzanian health field.

Beyond the intrinsic importance of HIV/AIDS, the choice to focus on the politics of international AIDS control turned out to be a particularly fruitful entry point to the study of the broader politics of health in Tanzania. As I started to analyse the complex interplay resulting from this situation, I progressively understood that the future of the Tanzanian health system itself greatly depended (and continues to depend) on the evolution both of the country's HIV epidemic and – maybe more importantly yet – on that of the international response to it. In a sense, little did I know just how appropriate the moment and how fitting a case Tanzania was to study the contemporary political economy of health in sub-Saharan Africa. Indeed, it was precisely during the three years in which I conducted fieldwork (2007, 2008, and 2009) that the tensions, contradictions and controversies prompted by the unprecedented international response to a single disease culminated in Tanzania. International AIDS-control was manifestly an exercise of power.

This work explores the politics that emerge at the interface of national and international institutional dynamics in a country whose health policies are formulated in a political configuration characterized by radical heteronomy. It analyses how AIDS players in Tanzania deal with the specifically political aspects of the epidemic and how they make the difficult choices involved in the formulation of HIV-prevention and -treatment policies. The first section of the introduction describes the Tanzanian study context. The second section discusses the main research questions, the research approach, the methodology and methods of analysis, as well as the limitations of this study. The last section outlines the structure of this work.

A) Tanzania as a showcase? From primary health care to international AIDS control

Over the last years, by far the most frequently asked question during informal discussions about my research was 'Why did you choose Tanzania?'. As most comparable decisions, my choice to conduct fieldwork in Tanzania was based on a variety of considerations. The more important factors that influenced my choice of Tanzania directly derived from my initial intention to conduct research on the politics of health in an African country that was both strongly affected by some of the major epidemics and heavily dependent on international support in the implementation of its health policies. When I started my research in 2007, Mainland Tanzania³ had an estimated adult HIV prevalence of 6.5%; i.e. approximately 1.4 million Tanzanians were living with HIV (UNAIDS & WHO 2006, p.18-19). Additionally, the country was suffering from major malaria and tuberculosis (TB) epidemics, and foreign assistance

³ This thesis concerns Mainland Tanzania. Although it is part of the United Republic of Tanzania, Zanzibar has an autonomous political system, a considerably lower HIV prevalence, and an independent institutional setting with respect to health and AIDS control.

accounted for roughly two-thirds of the country's health-related public expenditures⁴ – a proportion that has further increased since. Tanzania thus manifestly corresponded to both of these criteria.⁵

Moreover, the country's unique history of what was “[p]erhaps the most ambitious and sustained version of African socialism” (P. Lal 2012, p.212) and its former reputation as a showcase for health service development make Tanzania a country in which it is particularly interesting to study the dynamics and contradictions of international health initiatives. Soon after independence in 1961, under the leadership of its first president, Julius Nyerere, Tanzania embraced a socialist approach to development inspired by the ideals of equality and self-reliance. The *Ujamaa* (Swahili for *brotherhood* or *extended family*) doctrine resulted in a paradoxical and much commented combination of progressive social reform that genuinely aimed at creating a fairer society, and of an authoritarian one-party regime that proceeded to compulsory rural resettlement and effectively crushed any opposition from political or labour movements (e.g. Freyhold 1979; I. Shivji 1986; Gibbon 1995; Ibhawoh & Dibua 2003). Paradoxically, Tanzania's rather unique focus on proactive *endogenous* development spurred considerable interest among the donor agencies of industrialised countries. Consequently, and in total contradiction to Tanzania's explicit commitment to self-reliance, most prominently expressed in the 1967 Arusha Declaration (TANU 1967), the total inflow of international aid to Tanzania increased forty-sevenfold between 1967 and 1981.⁶ This evolution made the country one of the world's leading recipients of aid, aid which, by the early 1990s, had turned into “the blood and flesh of the national economy” (Rugumamu 1997, p.155).

“By the late 1970s”, Lal (2012, p.212) describes, “the utopian policy of *ujamaa* had unravelled, and self-reliance increasingly became a mere condition of necessity for rural people, rather than a hallmark of Tanzanian citizenship and the basis of a concerted programme of national development”. Despite their failure to prompt prosperity, the *Ujamaa* policies allowed considerable achievements in the social sectors – the most spectacular example being primary education. Similarly, the development of rural health services had become a cornerstone of the construction the Tanzanian state throughout the late 1960s and 1970s. The country became increasingly known among health scholars and, alongside the Chinese and Cuban experiences in Asia and Latin America, Tanzania was regularly quoted as a showcase for an African example of primary health care (see: Gish 1975; 1979; 1983; Van Etten 1976; Turshen

⁴ This rough estimate is based on the combination of the ‘non-HIV’ health sector budget, slightly more than one third of which was donor-funded in 2006 (DSW 2010, p.10), and the AIDS-related expenditures, 94.6% of which were donor-funded in 2006/07 (Foster et al. 2008, p.7).

⁵ While several other African countries correspond to these criteria as well, part of what tipped the balance in favour of Tanzania was that I had been to the country before and had an unexplained sympathy for its people, as well as the (admittedly less avowable) fact that its remarkable political stability made an involuntary interruption of fieldwork due to political unrest unlikely. Indeed, two senior Africanists drew to my attention this (somewhat cynical) criterion for selecting a country ‘for PhD purposes’. Political unrest and civil war had prevented several of their students from concluding their doctoral studies (or at least seriously jeopardised this conclusion). That being said, not only are political upheavals obviously at least partially unpredictable, but Tanzania's increasingly influential opposition parties, and their uneven regional distribution, suggests that the country's ‘legendary’ political stability is by no means immutable. The political situation could change rapidly, should a changeover of power – the first since independence – become a realistic perspective. For an interesting (yet slightly outdated) discussion of Tanzania's political situation and system, see (Engel et al. 2000).

⁶ Tanzania's intelligence in allowing capitalist and socialist donor countries to ‘compete’ certainly fuelled this surge of aid.

1984; Thébaud-Mony 1980, chap.III) – the watchword on the international health agenda during the 1970s and early 1980s.⁷ Since independence, the Tanzanian health system continuously suffered from structural weaknesses due to a lack of facilities, insufficient pay and training for health workers, chronic drug stock-outs and shortages of medical supplies, as well as to limited political accountability for health service performance (Hanson 2000). Nevertheless, access to essential health services did rise rapidly during the two decades following independence (Kopoka 2000).

After having generated significant scholarly interest during the 1970s and early 1980s, Tanzanian health policies fell off most analysts' radar screens. This is probably in part due to the fact that the country lost much of its initial specificity (i.e. socialist health development) as a result of the so-called 'structural adjustment programmes' (SAPs) imposed by the international financial institutions in response to the African debt crisis. SAPs, which were implemented in Tanzania from 1986 on, put a drastic stop to the development of social services and led to the implementation of neo-liberal policies radically at odds with *Ujamaa* (e.g. Benson 2001). In the social sectors, the combination of massive budget cuts and the introduction of user fees (or 'cost sharing', the technocratic euphemism *en vogue* at the time) provoked dramatic declines in school and health-service attendance and further compounded the ongoing deterioration of the population's health status due to economic contraction.⁸ As Boone and Batsell (2001, p.20) underline, the SAPs "decimated Africa's public health infrastructure just at the moment when [HIV/AIDS] was gaining momentum". While today's political context differs both from the *Ujamaa* period and from the years of structural adjustment, these periods have durably shaped the Tanzanian health system and are important to keep in mind when analysing the contemporary politics of health in Tanzania. Indeed, since the progressive backpedalling of the international financial institutions concerning SAPs and the rise of health onto the international development agenda during the early 2000s, the Tanzanian health system has entered a phase that could be described as 'post-SAP recovery'.

Yet, far from being a mere 'reconstruction' of the health system according to the past ideals of primary health care, the ongoing reforms of the Tanzanian health system take place in a political context dominated by vertical (disease-specific) international programmes – the most important ones concerning HIV/AIDS, which had been declared a "global emergency" by the United Nations (UN) General Assembly in 2001 (UNAIDS 2002a). The main vertical initiatives that contributed the lion's share of international AIDS funding in Africa over the last decade are the World Bank's Multi-Country AIDS Program (T-MAP in Tanzania), launched in 1999, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the 'Global Fund', or GFATM, established in 2002), and the US President's Emergency Plan for AIDS Relief (PEPFAR, created in 2003). As a result of this renewed political attention to HIV/AIDS, total global expenditure for AIDS control skyrocketed from an estimated USD 300 million in 1996 (UNAIDS 2006) to

⁷ It is thus no coincidence that several specialists of the Tanzanian health system (e.g. Gish 1982b; 1982a; 1984; Barker & Turshen 1986b) actively contributed to the international controversy over 'comprehensive' vs. 'selective' primary health care. For a brief summary of this debate, see the introduction to Part 3, as well as Chapter 7. For a detailed analysis of the promises, pitfalls and political undepinnings of the primary health care approach, see (Thébaud-Mony 1980).

⁸ See the introduction to Part 3

USD 15.9 billion in 2008 (Kates et al. 2009) – roughly half of which was international assistance. While the reasons for this unprecedented international response continue to be discussed, the reaction was arguably all the more important as it was tragically late.⁹

Since the same international AIDS initiatives started to operate in much of sub-Saharan Africa over this period, the Tanzanian situation shares a variety of commonalities with that of other African countries. Yet, the case analysed throughout this research is in many ways unique, because of the very specific period it covers – a period characterised by rapid and profound changes within the Tanzanian health policy landscape. Beyond the crucial political questions it raises, the international AIDS response in Tanzania opens up a field of enquiry on the political economy of health that is all the more challenging as the configuration of players to which this response gave rise is highly complex.

The Tanzanian AIDS policy arena: ‘Too many players and too much money...’?

“When he heard about my nomination to Tanzania, one of my colleagues working in another country office told me: ‘In Tanzania, you’ll be facing a damn challenge: there are too many players and too much money...’. In a sense, we have become victims of our success. When I was nominated, several other people [in the headquarters] wanted my job: Tanzania has the reputation to be a showcase. Those of my colleagues who didn’t get the job told me ‘you bastard...’ - they were jealous. Today, I’d be happy to let them do my job!” (Multilateral-6)¹⁰

The diversity of players involved in the implementation of AIDS-control programmes is neither new, nor specific to Tanzania (Gruénais et al. 1999). What does make Tanzania exceptional, however, is the sheer number of bilateral and multilateral donor agencies actively involved in the formulation of the country’s health and AIDS policies. All major international AIDS players are present in Tanzania and virtually all bilateral donor agencies with a mentionable activity in Tanzania, as well as a wide variety of international organizations, have actively participated in the formulation of Tanzania’s AIDS response over the last decade. Beyond the United States of America (US), some of the most active bilateral players in the Tanzanian AIDS field during the period of fieldwork were Canada, Denmark, Germany, Ireland, Japan, the Netherlands, Sweden, Switzerland, and the United Kingdom. The most active multilateral institutions include several UN agencies (e.g. UNAIDS, WHO, UNICEF, UNFPA, UNDP, and WFP), as well as the World Bank.

These various donor agencies play different roles in the AIDS policy process in Tanzania. Most bilateral and multilateral agencies actively contribute to the formulation of national policies. In addition, many bilateral donor agencies run HIV-related projects in specific regions or districts, while most multilateral

⁹ See the introduction to Part 3

¹⁰ Interestingly, a few moments later, the same interviewee remarks: “Some people complain, a bit stupidly, that there are too many people and too much money [in the Tanzanian AIDS sector]...that’s idiotic! Go pay for the ARVs [antiretroviral drugs], then!”. The fact that many interviewees are manifestly of two minds about the international AIDS response in Tanzania points to its profound ambiguity – a characteristic several chapters of this thesis discuss in detail.

institutions limit their work to programme-level collaboration with national administrations.¹¹ Since the year 2000, the multilateral and bilateral agencies involved in AIDS control in Tanzania meet regularly within the Development Partners Group on HIV/AIDS (DPG-AIDS), which rapidly became an important interlocutor for the Tanzanian government. Although DPG-AIDS – which, at the height of its membership, was composed of over 20 different agencies – continues to exist, the landscape of AIDS policymaking in Tanzania has significantly changed with the creation of the Global Fund and PEPFAR. While T-MAP has been phased out in 2010, Tanzania continues to host one of the largest PEPFAR country programmes and it is among the biggest recipients of the Global Fund. Today, the combined financial support provided by PEPFAR and the Global Fund accounts for roughly 90% – that of PEPFAR alone, for over two-thirds – of total AIDS funding in Tanzania (TACAIDS 2012b). Concentrating its efforts on 14 (out of 30) regions, PEPFAR has its own budgetary process and action plan for Tanzania. Beyond its completely parallel planning and budgeting process, PEPFAR has built a sometimes parallel system of service delivery either in the form of separate HIV facilities within the public health system (with staff paid by PEPFAR), or via projects directly run by non-governmental organisations (NGOs) and faith-based organisations (FBOs) from the US, or by their subcontracted Tanzanian counterparts. The Global Fund grants transit through the Tanzanian health budget, and the activities the Fund finances are generally implemented via Tanzanian public health services (and NGOs). Nevertheless, and as discussed below, the writing process of proposals to the Global Fund is largely parallel to the rest of the Tanzanian AIDS policy process, and the activities financed by the Global Fund are overseen by an *ad hoc* institution (the Tanzania National Coordinating Mechanism, TNCM) – which adds to the institutional confusion by adding another level of administrative ‘coordination’.¹² Finally, hundreds of international NGOs, FBOs, and private health foundations (e.g. the Bill & Melinda Gates Foundation or the Clinton Foundation) have decided to conduct and support HIV-related operations in Tanzania.

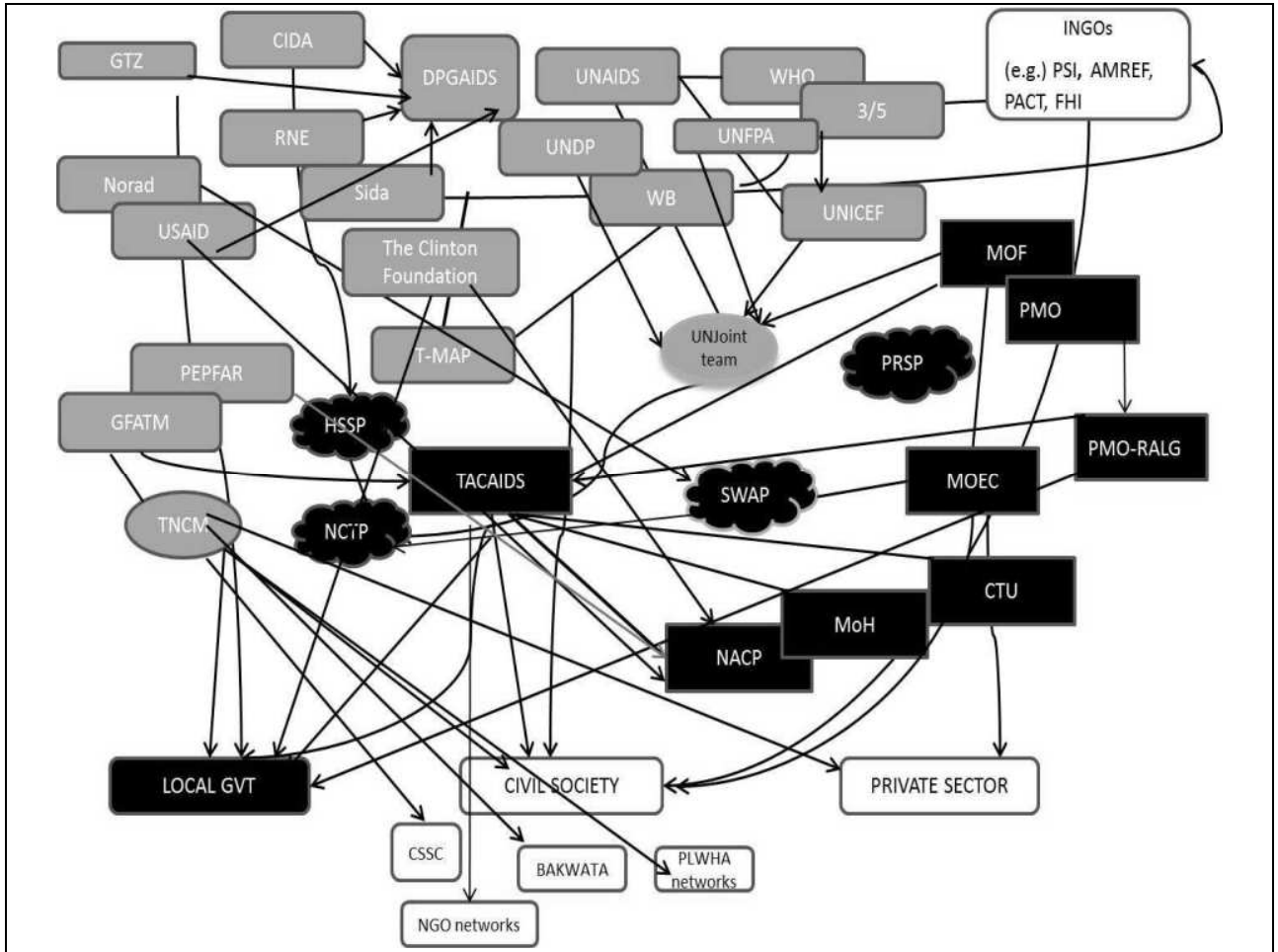
While most NGOs and FBOs concentrate on service delivery, all other institutional players mentioned above actively participate in the national AIDS-policymaking process, along with the Tanzanian AIDS administration. This administration is composed of the National AIDS Control Programme (NACP), which is within the Ministry of Health and Social Welfare (MoH), and the multisectoral Tanzania Commission for AIDS (TACAIDS), within the Prime Minister’s Office (PMO). Unsurprisingly, the resulting AIDS policy process is a complex multi-level interplay. Hellevik (2012a) has described the challenges for policy ‘coordination’ that result from the combination of the multisectoral design of the response in Tanzania and the international AIDS programmes, which “support coordination while [...] pursu[ing] their own

¹¹ A bilateral agent comments on the role of multilateral agencies as follows: “The UN and WHO are political authorities. They are close to the centres of power. The regional director of WHO, for instance, is co-opted by the ministries of health from the region. So, of course, they have open doors... [...] That makes them less critical than bilateral donors. Here in Tanzania, the WHO is the Ministry of Health! They are *very* closely related” (Bilateral-26).

¹² As a bilateral agent exclaims: “The TNCM-Mechanism is completely parallel to anything else!” (Bilateral-14). Initially conceived as a purely financial coordinating mechanism for the Round proposals to the Global Fund, the TNCM increasingly takes up broader missions of health sector governance – without any democratic mandate (see Part 3).

priorities and requirements” (ibid., p. 50). The following – simplified¹³ – diagram illustrates the multitude of players involved in AIDS control in Tanzania and the resulting complexity of the AIDS policy arena.

Figure 1: Simplified diagram of the national AIDS policy arena in Tanzania [from Hellevik (2012a, p.4), based on (UNAIDS 2005, p.19)]



Grey boxes represent bilateral and multilateral donors (and their coordinating bodies), white boxes represent non-governmental players, and the black elements represent the different ministries and public institutions involved in AIDS policymaking (boxes), as well as national policy documents or initiatives (clouds).¹⁴

¹³ A variety of players are not listed in the diagram – be they bilateral donors (e.g. IrishAid, Swiss Development Cooperation, JICA, etc.), international organizations (e.g. WFP, UNITAID), or international NGOs (e.g. Oxfam, the Elizabeth Glaser Pediatric AIDS Foundation, or the Bill & Melinda Gates Foundation). The number of national and international NGOs involved in the struggle against AIDS in Tanzania is considerable, however, and adding them to the diagram would probably have made it altogether incomprehensible.

¹⁴ Institutional acronyms not mentioned before are: AMREF=African Medical and Research Foundation, BAKWATA=The Muslim Council of Tanzania, CIDA=Canadian International Development Agency, CSSC=Christian Social Services Commission, CTU=Care and Treatment Unit, FHI=Family Health International, GTZ=Deutsche Gesellschaft für Technische Zusammenarbeit [today: GIZ], HSSP=Health Sector Strategic Plan, MOEC=Ministry of Education, MOF=Ministry of Finance, Norad=Norwegian agency for development cooperation, NCTP=National Care and Treatment Programme, PACT=an international NGO, PMO-RALG=Prime Minister’s Office Regional Administration and Local Government, PRSP=Poverty Reduction Strategy Paper, SWAp=Sector Wide Approach, PLWHA=People Living with HIV/AIDS, RNE=Royal Netherlands Embassy, Sida=Swedish International development agency, UNFPA=United Nations Population Fund, WB T-MAP=The World Bank Tanzania Multi-Sectoral AIDS Project, 3/5=The 3 by 5 campaign by WHO.

Commenting on my choice to conduct research on the formulation of AIDS-control policies in Tanzania , a multilateral agent notes:

You did well in choosing Tanzania. It's an excellent country to analyze these questions because the number of partners is at its maximum here: *everybody* is here! Why? Because many donors have the impression that, in Tanzania, they lose their money less than elsewhere – which, by the way, is not sure. Sometimes, it's just an impression... (Multilateral-6)

Many interviewees describe Tanzania as a country where global health initiatives are welcomed with open arms and can implement the programmes or projects they fund with relatively little 'resistance' from national administrations.¹⁵ A bilateral agent points to the problems this popularity raises:

Everybody *loves* spending money in Tanzania! [...] The US likes to work in Tanzania. They have a stable government and...'democracy'. But there are so many organizations, there is a lot of private support, so *many* FBOs, including from the US...it's almost impossible to capture! (Bilateral-24)¹⁶

The scale and multifaceted nature of the international response overstrained Tanzania's AIDS administrations, which have proven unable to coordinate the national response effectively. One interviewee underlines:

In Tanzania, people focus very much on individual diseases. Most proposals come from vertical initiatives. There is no planning department! You would think that there would be a coordinating institution in the receiving country...that the director of Policy and Planning would have an overview and make sure the vertical programmes stay in line! That hasn't happened in Tanzania. (Bilateral-20)

The combination of strong international initiatives and the Tanzanian administration's weak coordination ability exacerbates a number of problems frequently identified by health-policy analysts in resource-poor settings. The resulting situation poses serious challenges concerning both the political accountability for the trade-offs involved in AIDS policymaking and the overall coherence of Tanzanian health policies. In many ways, the policy process analysed throughout this research suggests that Thébaud's analysis of international health aid in the 1980s is still disconcertingly topical today. Back then, she asked:

[H]ow can a country construct a coherent health policy on the basis of a national strategy, as WHO recommends, when international experts are placed in ministries, when medical volunteers of more than fifty nationalities are working individually or in organised missions and when the workers of multiple microprojects developed by hundreds of NGOs of different nationalities and different professional, political, and ideological perspectives are all operating in one and the same country? (1986, p.46)

Beyond being an especially appropriate case for conducting research on international AIDS-control efforts, Tanzania illustrates the more general dynamics and contradictions of international health action in particularly striking ways. Yet, surprisingly few political analysts have explored the country's AIDS policy process in detail over the last years. Two notable exceptions are Hartwig (2001)¹⁷ and Hellevik

¹⁵ Several interviewees underline that the attitude of the Tanzanian government differs from what they experienced in other African countries in which they previously worked.

¹⁶ Underlining that "there are so many stakeholders...we really need some de-clustering", another bilateral agent wonders: "How do we manage to get everybody around the table?" (Bilateral-14).

¹⁷ See also (Hartwig et al. 2005).

(2012a), who studied the institutional structure of the response to the epidemic, with a focus on the administrative framework, donor coordination, and country ownership.¹⁸ Although I have adopted a different analytical and thematic approach – focusing, for instance, less on official institutional mechanisms and more on the direct interaction of players – Hellevik’s study echoes several of the issues addressed throughout this work. Given her analysis of multisectoral coordination, for instance, I decided not to explore this important aspect of AIDS control much further, but to refer to her work.

B) An eclectic political economy of AIDS control

The substantial research efforts deployed over the last three decades have undoubtedly turned HIV/AIDS into the most-studied epidemic of all times¹⁹, transforming it into what Olivier de Sardan (2013) would call an “overgrazed field of investigation”. This has at least two immediate implications: One is that it is easy to become “terrorized by the literature”, as Becker (1986, chap. 8) puts it, since one could spend one’s whole life reading the latest studies on AIDS in Africa, trying to catch up with the perpetual flow of scholarly works. The second implication, alluded to above, is that one needs good reasons to conduct yet another study on AIDS in Africa, given the considerable risk to confirm involuntarily Louis Wirth’s claim that “originality is the product of a faulty memory”²⁰. Consequently, I conceived my research in a spirit of complementarity with existing analyses of the political aspects of AIDS control in sub-Saharan Africa. More generally, this study is built on the principle of eclecticism – a guiding idea of which is *non-contradiction*, not *coherence* in the strongest sense. Despite my attempts to produce more general intelligibilities, I conceive this work as proposing, not *the* political economy of AIDS control in Tanzania, but ‘interrelated fragments’ of such a political economy. The grounded theory approach that allowed me to focus consistently on what I considered to be less explored aspects is described below.

That being said, the ambition of originality is made more achievable by the fact that the mere number of researchers working on the epidemic does not, by itself, ensure a satisfactory level of thematic, disciplinary, geographic, and theoretical pluralism. Indeed, the bulk of social science research on the African AIDS epidemics focuses on issues such as sexuality, stigma and the everyday experiences of people living with HIV (PLWH), on social or behavioural aspects of vulnerability and risk, or on the evaluation of the (cost-)effectiveness of specific interventions or projects. While medical anthropologists and health economists have successfully ‘claimed ground’ in studying the African epidemics during their early years, the specifically *political* dimensions of AIDS control initially received little attention. Political

¹⁸ Dealing with successive periods of the institutional response to HIV/AIDS in Tanzania (the 1990s and the 2000s respectively), their analyses are complementary. Yet, given the major changes in the international AIDS response over the last decade, only Hellevik’s analysis concerns today’s institutional setting.

¹⁹ To give an order of magnitude, the biennial International AIDS Conference organized by the International AIDS Society is one of the world’s largest scientific conferences and gathers between 25,000 and 30,000 delegates.

²⁰ In: (H. S. Becker 1986, p.136)

science and political economy²¹ are relatively side-lined ‘disciplines’ within HIV-related social science research, which itself occupies a subordinate position in the broader field of AIDS research – dominated by the biomedical disciplines and epidemiology.

Research on the politics of AIDS in Africa: ‘unploughed territories’ in an ‘overgrazed field of investigation’

The assessments by several political scientists of their colleagues’ interest in HIV/AIDS illustrate the hesitant uptake of the epidemic on the research agenda of political analysts.²² One decade after the recognition of the first African AIDS cases, Lanegran and Hydén (1993, p.247) lamented: “Here is a major global issue with potential ramifications as great as any war, yet hardly any political scientist shows scientific interest in it!”. This initial neglect is all the more surprising as, from the 1980s on, HIV/AIDS was clearly perceptible as a serious challenge for African governments (Dozon & Fassin 1989). By the mid-1990s, it became glaringly obvious that AIDS was turning not only into one of the continent’s principal political problems, but also into a resource for many African governments – be it through ostentatious action in Uganda (Tumushabe 2006), through politically motivated denial in South Africa (e.g. Fassin 2007), or through a more subtle demonstration of the ability of the state to ‘take care of its population’ in Botswana (Chabrol 2012).²³ In 2001, Boone and Batsell still consider that “AIDS politics is largely unploughed territory” (2001, p.27), and that “[n]early two decades into a pandemic that poses one of the gravest threats to public health and development that sub-Saharan Africa has ever faced, political science can no longer afford to ignore the political implications of AIDS in Africa” (*ibid.*, p. 26). Yet, a few years later, Nguyen and Stovel still (2004, p.39) consider that “more than any other social science, political science has been largely silent on the issue of HIV outside of the developed world”. While Densham (2006) re-utters a similar assessment two years later, Dickinson (2006, p.1) underlines that “recently, literature on the political economy of HIV/AIDS has grown, with the *economics* of HIV/AIDS receiving more attention than the *politics* of HIV/AIDS”. In 2012, Paxton underlines: “the number of works that address the politics of the epidemic in a social scientific fashion [...] is substantial. Political science on HIV/AIDS exists, and it has grown over time” (2012b, p.3). Concerning the African epidemics, the surge in international AIDS funding over the last decade probably contributed to awakening the curiosity of policy analysts – who prefer to study action, rather than inaction.

²¹ In the 19th century, ‘political economy’ designated what is referred to as ‘economics’ today. John Stuart Mill (1844, chap. 5), for instance, defined political economy as “a science which teaches [...] in what manner a nation may be made rich”, and which “informs us of the laws which regulate the production, distribution, and consumption of wealth”. In its more recent usage, political economy designates “the theory or study of the role of public policy in influencing the economic and social welfare of a political unit” (Merriam Webster’s Encyclopaedia) – a definition that implicitly points to the often interdisciplinary enquiry it involves (see below).

²² Several authors successively reviewed the literature on the political aspects of HIV/AIDS (Boone & Batsell 2001; Nguyen & Stovel 2004; Dickinson 2006; Paxton 2012b). While each of these compilations takes a different approach (due, in part, to differing geographic focus and diverging definitions of ‘political science’), they collectively provide a balanced overview of existing research on the politics of AIDS and AIDS control. For a more detailed view of this sub-field, see also (Singer 1998; Barnett & Whiteside 2002; Poku & Whiteside 2004; Patterson 2005; Poku et al. 2007).

²³ As Comaroff (2007, p.214) puts it, “biomedical discourse becomes a critical affair of state – and not merely state but also nation”.

Political analysts have undoubtedly contributed to today's understanding of the dynamics of international AIDS control and of the policy responses in a variety of African countries. In the aftermath of the 9/11 attacks, the potential of HIV/AIDS as a threat to US and global security – a political question *par excellence* – has, for instance, prompted various studies (and data-free speculation) about the interrelations between HIV/AIDS, armed conflict, and/or state stability (e.g. Ostergard 2002; Elbe 2002; Ostergard & Tubin 2004; Poku & Sandkjaer 2007). Despite being based on “crude and unsupported analysis” (Barnett 2006, p.308), and irrespective of its harmful side effects (Elbe 2006; Feldbaum et al. 2006), the apocalyptic framing of AIDS as a threat to the stability of African states²⁴ – and thus to the interests of the industrialised world – was instrumental in turning the epidemic into a top international agenda item.²⁵

Rather than speculating about the epidemic's impact on state breakdown or global security, several studies have analysed its effects on African political institutions and regimes (e.g. de Waal 2003a; Strand 2005; Patterson 2005). Inversely, other scholars analysed how the *response* to the epidemic was influenced by different countries' political characteristics (e.g. Whiteside 1999; Aggleton 2001; Allen & Heald 2004; Parkhurst & Lush 2004; Putzel et al. 2006; Bor 2007; Justesen 2012) or by the administrative organisation of the state (e.g. Putzel 2004b; Patterson 2005; Eboko et al. 2010; Paxton 2012a).²⁶ Despite the similarities due to the common international framework, these studies yield few results of a more general validity. Not only are competitive electoral processes alone not enough to ensure a sustained response against the epidemic, but different components of 'democracy' can have contradictory effects on the effectiveness of AIDS-control efforts (Allen 2004; Strand 2007; Strand 2011; Parkhurst 2012b). While AIDS control is a key element in the legitimization (and at times the construction) of many African states, the role of AIDS activists and other non-state actors in shaping national and international responses to the African epidemics has received considerable scholarly attention as well (e.g. Eboko et al. 2011; Jönsson & Söderholm 2005; J. White & Morton 2005; Batsell 2005; Seckinelgin 2005; S. Epstein 1996; Rau 2007).²⁷ As in other 'development' fields, an underlying concern relates to the weakness of

²⁴ US government services, as well as UNAIDS (e.g. 2002b, p.57-59), have actively contributed to this framing. Poku and Sandkjaer, for instance, warn against “the real possibility that with HIV/AIDS the very survival of the African state may well be at stake” (2007, p.9). For a more critical, less alarming, analysis, see: (de Waal 2010a; de Waal 2010b; Barnett 2006; Barnett & Prins 2006; Barnett 2007; Chirambo 2007)

²⁵ This agenda-setting process itself is, of course, a field of enquiry for political analysis (e.g. Shiffman 2008; 2009).

²⁶ Uganda is obviously overrepresented in these studies, as many of them use the country as a showcase, or at least a comparative basis. Indeed, the case of Uganda has been constructed and widely quoted as a 'best practice' concerning behaviour-change prevention policies and its 'ABC' – abstain, be faithful, use condoms – approach is a classical case of “policy branding” (Ogden et al. 2003). That being said, while several studies underline that the Ugandan 'success story' is less straightforward than frequently suggested (Parkhurst 2002; 2012a; Tumushabe 2006), the evidence concerning concurrent sexual partnerships presented in Chapters 1 and 2 puts into question the contribution of the famous “zero grazing” message (i.e. 'be faithful') in the Ugandan 'success'.

²⁷ Again, AIDS activism and its impact on national responses differ widely between countries, depending, among other things, on each country's epidemic profiles, the politicization of the populations hit hardest by the epidemic (Ellison et al. 2003), as well as on the more general national political context. In some countries, such as South Africa, AIDS-related social movements, for instance, politically challenge the government in a confrontational manner (Heywood 2009). In others, such as Tanzania, HIV-related NGOs contribute very little to the policy process and often simply play a role of service providers, if not as sub-contracted agents of triage in the access to treatment (Pearce 2009; Beckmann & Bujra 2010; see also: Haven & Patterson 2007).

African states and the detrimental effects in terms of political accountability of international NGOs becoming key players of social policy (de Waal 2003b; D. Webb 2004; Putzel 2004a; Nguyen 2009; 2010). Finally, another important aspect of the politics of AIDS control concerns the political economy of the manufacturing and procurement of antiretroviral drugs and the struggle over intellectual property rights (e.g. Cleary & Ross 2002; Sell & Prakash 2004; Shadlen 2007; Coriat 2008; Beigbeder 2007).

If anything, this very brief glance at the literature on the politics of AIDS confirms Paxton's (2012b, p.14) conclusion that "we know exponentially more now than we did 10 years ago". That being said, some aspects of the politics of AIDS still remain strikingly underresearched. Accusing the literature in the field of being overly descriptive, Dickinson underlines: "Country studies that provide a simplistic analysis of national success stories and/or studies that describe a country's response and the challenges facing governments are numerous, but there are very few which take politics either as the starting point of their analysis or consider in any depth, the political dimensions of the response" (2006, p.1). At least concerning the national level, her assessment remains true today. There is still little empirical research into some of the specifically political aspects of AIDS control in Africa.²⁸ The research on the political economy of AIDS in Africa has been particularly incomplete in two domains. One concerns the politics that underlie the causal narratives of the African epidemics, the other domain concerns the formulation of national AIDS-control strategies and of the fundamentally political compromises and trade-offs they involve.

Concerning the first domain, it is striking how incompletely the political dimensions of the causal narratives of the inordinate spread of HIV in sub-Saharan Africa are reflected in the existing analyses.²⁹ Indeed, most political scientists and political economists who work on AIDS in Africa implicitly accept the dominant aetiological framing, which stipulates that the particular magnitude of the African epidemics is due to specificities of 'African' sexual behaviour – which is incorrect (see Chapter 1). To be sure, many studies have linked the uniquely efficient spread of HIV in sub-Saharan Africa to the African debt crisis and the so-called 'structural adjustment programmes' (SAPs) imposed by the international financial institutions in response to it (e.g. D. Sanders & Sambo 1991; P. Lurie et al. 1995; Collins & Rau 2000; Barnett & Blackwell 2003; Poku 2004). By impoverishing societies and systematically dismantling African public health systems, SAPs have been rightly accused of creating conditions that allowed HIV to spread more efficiently while at the same time jeopardising the ability of African states to formulate and implement effective HIV-prevention programmes.³⁰ Those studies that relate the African AIDS epidemics to their broader socio-economic and (geo)political context importantly point to the fact that societies' susceptibility to HIV is conditioned by political decisions. Yet, most of their authors maintain a

²⁸ For three (recent) exceptions, see (Hellevik 2012a; Class 2012; Chabrol 2012).

²⁹ The few in-depth analyses of the framing of AIDS (e.g. G. Oppenheimer 1988; Rosenberg 1988; Fee & D. Fox 1988; Rosenberg & Golden 1992) date back to the early years of HIV/AIDS and primarily concern the epidemics in the industrialized world. The exceptions to this rule are discussed in Chapter 1.

³⁰ Interestingly, as the 'conditionalities' imposed by structural adjustment programmes were progressively loosened and as the painful memories of the catastrophic impact of SAPs on African health systems fade, these broadly framed, critical political economy analyses of AIDS in Africa have become rare.

behaviour-mediated narrative.³¹ Biological and epidemiological evidence concerning the decisive importance of co-infections in the uneven spread of HIV has, for instance, accumulated since the 1990s. Nevertheless, political economists have hardly taken up these insights on the importance of the political ecology of disease in their analyses of AIDS in Africa. By uncritically accepting the claim that variations in sexual behaviour explain the differences in HIV incidence between sub-Saharan Africa and the rest of the world, these policy scholars have created a self-made analytical blind spot and deprived themselves of a powerful heuristic tool. The lack of awareness that the behaviour-centred explanation of the disproportionate spread of HIV in Africa is politically mediated has translated into a lack of analysis concerning the politics of disease framing and the political determinants of the strikingly uneven resonance of different causal narratives of the spread of the virus.³²

A second 'blind spot' in the existing political economy analyses of AIDS in Africa paradoxically concerns the specifically political aspects of the formulation of HIV-prevention and -treatment policies. While much has been written about the complex 'multi-level governance' in the field of AIDS, the formulation of national AIDS-control strategies is rarely analysed in detail as an immediate exercise of power over life and death. In defining who gets access to HIV-related services, the allocative trade-offs that underlie national responses to HIV/AIDS are at the very heart of the political. Surprisingly, most authors who explicitly point to AIDS control as a core element of 'biopolitics'³³ that directly puts at stake the exercise of citizenship and sovereignty are (medical) anthropologists (e.g. Dozon & Fassin 1989; Comaroff 2007; Kalofonos 2008; Nguyen 2008; 2010), not political scientists. Yet, as Nguyen underlines, "[t]he informal and formal procedures, protocols, and policies that decide who should live [...] are not technical, medical, or humanitarian issues", but "they constitute an exercise of sovereignty" and "point to how and by whom power over life is exercised" (2010, p.6□7). This predominance of anthropologists might help explain why the analysis of AIDS control as an element of biopolitics has primarily consisted in the empirical study of its local – and often individual – aspects (generally combined with a theoretical exploration of international health initiatives as instruments of power), and why the 'intermediate' level of *national* policymaking processes has somewhat fallen by the wayside. Indeed, few empirical studies on AIDS in Africa analyse in any significant depth the fundamentally *political* trade-offs involved in the formulation of national HIV-prevention and -treatment strategies. In this sense, many political economy studies abstract from the very subject matter of political economy, i.e. the formulation of compromises over conflicting interests and values.³⁴ Other than that, most analyses of AIDS control as an exercise of biopolitical sovereignty have focused on the politics that underlie the provision of antiretroviral therapy.

³¹ See Chapter 1.

³² This relative lack of analysis is all the more surprising since, far from being purely 'natural' phenomena, public health 'problems' are invariably 'socially constructed' (e.g. Brandt 1987; Rosenberg & Golden 1992; Rosenberg 1992; Gilbert & Henry 2009; Fassin et al. 2010). The 'denaturalisation' (Fassin 2008, p.6) of a health problem is thus a prerequisite to the political analysis of the way this problem is framed and responded to. See the sub-section "Caught between the lines?".

³³ See (Foucault 2004)

³⁴ Rare are those who, like Parkhurst (2012b), acknowledge the irreducible conflict that underlies HIV-related policymaking and underline "the need for an explicit normative approach".

The political stakes of AIDS control, however, go well beyond the sole issue of treatment-related allocative decisions and directly concern HIV-prevention policies as well.

Interestingly, both of these ‘blind spots’ of today’s political economy analyses of AIDS in Africa in part result from a lack of interdisciplinarity. Concerning the neglect of the fundamentally political trade-offs involved in the formulation of AIDS-control policies, many political scientists’ disciplinary blinders probably led them to abdicate in the face of the apparently ‘technical’ issue of identifying the most appropriate interventions. The analytical blind spot seems to stem from their *a priori* acceptance of technocratic definitions of allegedly ‘optimal’ solutions and of the positivist conception of health on which it draws (see Chapters 3, 7 + 8). As for most political economists’ implicit subscription to the behavioural narrative of the spread of HIV in Africa, this adherence might, of course, be the result of genuine conviction in some cases. For others, however, the acceptance on face value of the dominant causal narrative also appears to be due to the fact that they have tacitly declared themselves incompetent on the bio-epidemiological aspects of the epidemic.

This uncritical acceptance of the dominant aetiological framing of AIDS in Africa has not only introduced a durable bias into research on the politics of AIDS control on the continent, it might actually help explain why the discipline of political science has been so slow to grapple with the African epidemics in the first place. While Gruénais et al. (1999) suggest that political analysts’ lack of attention to AIDS in Africa might be due to the low politicization of the epidemic in many African countries, Boone and Batsell argue that HIV/AIDS “has been conceived of as too private, too biological, too micro-level and sociological, too behavioral and too cultural to attract the attention of many political scientists” (2001, p.4).³⁵ Both explanations are related: the low politicization of HIV/AIDS in most African countries, as well as political scientists’ low interest in the epidemic, can be traced back to the behavioural explanation of the spread of HIV (Chapters 1+ 2). The framing of AIDS as being principally a matter of sexual behaviour influenced its general perception as a ‘private’ or ‘cultural’, not a political problem. This led political scientists to consider the epidemic as an issue to the understanding of which they could only make a limited contribution.

‘Repoliticising’ the political economy of AIDS

As discussed below, an important part of my fieldwork consisted in listening to the narratives of AIDS and health players, many of whom point to the ambiguities of international AIDS-control initiatives and to the contradictions to which they give rise in Tanzania. When confronting these narratives with the existing analyses of the political economy of the African AIDS epidemics, I increasingly had the impression that something was missing from the picture. Bluntly speaking, most ‘political economy’

³⁵ As a result, they contend, “[m]ost of the literature has concentrated on microsociological issues that speak directly to the interpersonal dynamics of the spread and prevention (education, behavior changes) of the disease”, while the literature on “the more political, institutional, and macro causes and effects of HIV-AIDS [...] is very sparse indeed” (Boone & Batsell 2001, p.4).

studies that analyse the production of HIV-prevention and -treatment policies focus on the description of the complex multi-level interactions between institutional players, or limit the bulk of their analysis to identifying why these players did not adopt so-called international 'best practices' and what could be done to improve their compliance. The management of irreducible conflict that is inherent in AIDS policymaking receives little or no attention.

Based on this general impression, a variety of questions arose about the politics that emerge at the nexus of global health initiatives and national policymaking processes. These questions can be roughly grouped into three domains. A first group of questions grew out of the awareness that the aspiration expressed by Stillwaggon, that "[t]he physiological complexity of HIV transmission in varied social and economic contexts should be the basis of policy" (2006, p.31), was strikingly remote from the realities of AIDS policymaking in Tanzania. How could one explain that, although a variety of analysts had pointed to the excessively behaviour-centred explanation of the African epidemics (e.g. Turshen 1989; Packard & P. Epstein 1991a; Farmer 1999; Stillwaggon 2002; 2003; 2006), these studies had had so little impact on policy? More generally, how is the 'problem' of HIV/AIDS framed in Tanzania, how can the political stakes that underlie the framing of the African AIDS epidemics as 'behaviour-driven' be observed and described, and what are the political determinants of the uneven resonance of competing causal narratives? What effect does this struggle over the framing of HIV/AIDS have on the formulation of the country's HIV-prevention strategy? Given the manifestly mediated use of biological, epidemiological, and economic evidence in prevention policymaking, what makes knowledge politically relevant and which considerations have an impact on evidence uptake in the formulation of AIDS-control policies?

A second group of questions relates to a particular aspect of the formulation of national AIDS policies. The complexity of the heterogeneous network of national and international institutional players who formulate these policies in many African countries has been repeatedly underlined. Yet, the question of how national strategies (or prioritised action plans) are actually formulated via the day-to-day interaction of different policy players – particularly of international donor agencies and national AIDS administrations – has received little attention. How are priorities set and which controversies shape debates among players? More specifically, how do AIDS players collectively formulate the highly sensitive trade-offs over life and death that these strategies imply? How are the fundamentally political aspects of AIDS control dealt with politically and to what extent is their irreducibly political (or conflictual) nature explicitly acknowledged or, on the contrary, passed over in silence or obscured?

A last group of questions revolves around Tanzania's ability of self-determination, or biopolitical sovereignty – an issue to which many interviewees allude, often with a palpable sense of resignation. Indeed, the massive presence of international players and their involvement in the formulation and implementation of the response to AIDS in Tanzania raises a number of sensitive political questions. These go well beyond the sole content of AIDS-control policies and include decisions concerning the broader balance between the country's various health priorities. It is rare, however, that these questions

of political autonomy are analysed directly, based on empirical enquiry and specific examples. To use the language of development agencies, what are the realities of 'country ownership' in the formulation of the national AIDS response? What concrete effects has aid dependency on the country's AIDS and health policies and to which contradictions does the heteronomous character of AIDS control give rise within the Tanzanian health system? Responding to these three groups of questions requires a transdisciplinary approach.

Caught between the lines? The transdisciplinary imperative and its epistemological consequences

“Disciplinary boundaries are meaningless in HIV/AIDS research, as HIV transmission, as an objective phenomenon, lies at the junction of various overlapping disciplinary systems: historical, sociological, economic, cultural, political, anthropological and virological. Providing a methodological framework for the study of such a diversity of variables, as well as their interaction, is a problem not yet resolved by epidemiologists and social scientists.” (D. Webb 1997, p.61)

The analytical challenges posed by HIV/AIDS do not stop at disciplinary boundaries. The socio-biological complexities that underlie the African epidemics have an important implication for political analysis. Policy scholars must familiarize themselves with the biological and epidemiological underpinnings of the pathology of which they propose to study the political economy. As Turshen warned during the early years of the African epidemics,

Social scientists should not accept uncritically medical reports and epidemiological research findings of AIDS in Africa. They should read the clinical literature and question and interpret medical and epidemiological studies from the vantage point of their knowledge of the economics and politics of African societies. (1989, p.225)³⁶

Uttering a similar claim a decade later, Farmer (1999, p.33) regrets that although “AIDS in all its dimensions seems to demand broad, *biosocial* approaches, [...] work to date is fettered by disciplinary boundaries” – an assessment that still holds today. Far from substituting themselves for biologists or epidemiologists, social scientists can – and *should* – contribute to AIDS research both by analysing the bio-social dynamics that underlie the spread of the virus and the response to it, as well as by studying how widely accepted conceptions about disease are socially and politically constructed or 'framed'. Rather than merely accepting the dominant bio-epidemiological paradigms as their given framework of analysis, social science researchers (and particularly political analysts) working on HIV/AIDS need to question these very frames.³⁷ As Reid (1999, p.99) puts it, “[a] critical approach to the HIV epidemic requires that the production of health and the production of knowledge become sites of contestation

³⁶ Stillwaggon (2006, p.31) also underlines the need for social scientists to “become more scientifically literate” – a call that can also be found in (Packard & P. Epstein 1991a).

³⁷ This approach echoes Maier's (1988, p.4+6) definition of 'political economy'. He suggests that a political economy approach "interrogates economic doctrines to disclose their sociological and political premises", it "regards economic ideas and behavior not as frameworks for analysis, but as beliefs and actions that must themselves be explained. They are contingent and problematic; that is, they might have been different and they must be explained within particular political and social contexts". If one abstracts from the economics-centred character of this definition and replaces 'economic' by 'health-related', one obtains a fruitful element of definition of what a political economy of health could – and should – strive for.

and re-articulation". Since "disease prevention policies are always based on assumptions about disease causality" (Tesh 1988, p.3), analysing the former without scrutinising the latter is bound to produce irrelevant scholarship. More generally, any detailed analysis of the political economy of HIV-prevention and -treatment policies must be biologically and epidemiologically informed.

In light of the blind spots of today's analyses of the politics of AIDS, these observations suggest that the history of political economy research on AIDS control in Africa is, in many respects, that of a missed *rendez-vous* between political analysts and public health scholars. On the one hand, the bio-epidemiological literacy these authors call for has remained the exception among policy scholars concerned with AIDS in Africa, many of whom keep wearing their disciplinary blinders. On the other hand, most epidemiologists and public health researchers have little literacy in political theory or public policy analysis, and thus draw on purely technical conceptions of health policymaking and continue to reason within a political vacuum that is not of this world.

By proposing a political economy³⁸ of AIDS control in Tanzania this study endeavours to contribute to bridging this gap. The eclectic approach this study adopts thus both concerns the selection for detailed enquiry of some of the problematic aspects that emerged from fieldwork according to the blind spots described above, as well as the literature and theoretical tools on which it draws to grasp and interpret the observed reality. Although some theoretical elements shaped the analysis as a whole, each part or chapter refers to significantly differing bodies of literature in order to build an improved understanding of the policy processes I observed. The resulting analysis is thus situated at the crossroads of different fields, including public policy analysis, epidemiology, the social study of sciences, political theory, as well as health economics and the sociology of health. This approach, I believe, allowed me to articulate an in-depth analysis of specific aspects of the formulation of HIV-prevention and -treatment policies with a study of the broader political economy of health in Tanzania and AIDS control in sub-Saharan Africa.

The necessarily transdisciplinary nature of political economy research on AIDS poses an epistemological question concerning the status that social scientists assign in their work to biological and epidemiological research findings. No doubt, it is possible to propose insightful analyses of AIDS-related controversies without taking sides explicitly or *a priori* (cf. S. Epstein 1996; Fassin 2007). Rather than conserving a façade of neutrality, however, I have chosen to draw explicitly on my personal assessment concerning the content of the controversies I observed as the basis of the political analysis I propose. In this sense, Part 1 is, for instance, grounded in the epidemiologically informed conviction that the magnitude of the African HIV epidemics cannot be explained by differences in sexual behaviour. The analysis presented in

³⁸ While Scott rightly underlines that "the bulk of writing in political economy is devoted to narrating how [...] the competitive 'rent seeking' behaviour of non-commercial individuals or institutions results in the seriously inefficient distribution of resources" (2000, p.577), the political economy analysis proposed in this research is not limited to elements of rational choice alone. It explores the (power) relations between the players involved in and/or affected by the response to HIV/AIDS in Tanzania and analyses the role played by "interests, institutions, and ideas" (Paxton 2012b, p.3) in the formulation of AIDS-control policies. The term 'resources' is thus defined in a very general meaning, including economic (aid, funding, access to employment, etc), medical (e.g. access to antiretroviral treatment), and symbolic resources (e.g. political legitimacy).

Part 2 draws on the idea that the scarcity of resources imposes inescapable trade-offs over life and death and that it is the responsibility of AIDS policymakers to acknowledge the need to choose in order to allow the formulation of the difficult compromises this situation imposes via an inclusive political process. Similarly, Part 3 takes comprehensive primary health care as a starting point of the analysis of vertical AIDS-control in Tanzania.³⁹

Although I retrospectively consider it as heuristically valuable, this approach put me in the position of a policy analyst who studies and interprets the players' controversies, struggles and strategies, but who, at the same time, has an increasingly precise opinion about the different players' statements and claims. The discomfort that sometimes resulted from this approach is due to the 'intermediate' position between the inherently and openly value-driven field of public health and the at times ostentatiously 'non-evaluative' tradition of public policy analysis. More generally, this 'involved' position stems from my willingness to contribute both to academic discussions about the political economy of health *and* to a broader public debate over the most adequate responses to the African AIDS epidemics. As Siplon (1999) puts it somewhat bluntly, "the disciplinary pressures often are to be either a 'researcher' (who is dispassionate and objective) or an 'activist' (who is prejudiced but doing something)". The tension between researchers' involvement in the social world we are studying (and are thus sensible to), and the necessary preservation of an intellectual and emotional distance vis-à-vis the phenomena we are researching is common to all social sciences. Yet, it might be particularly palpable in a domain such as HIV/AIDS that immediately concerns human survival (Fassin 1999; Chabrol & Girard 2010; Delfraissy & Fassin 2010). As Becker argues, however, the widespread perception of this tension as a 'dilemma' is due to a false alternative:

When sociologists undertake to study problems that have relevance to the world we live in, they find themselves caught in a crossfire. Some urge them not to take sides, to be neutral and do research that is technically correct and value free. Others tell them their work is shallow and useless if it does not express a deep commitment to a value position. This dilemma, which seems so painful to so many, actually does not exist, for one of its horns is imaginary. For it to exist, one would have to assume, as some apparently do, that it is indeed possible to do research that is uncontaminated by personal and political sympathies. I propose to argue that it is not possible and, therefore, that the question is not whether we should take sides, since we inevitably will, but rather whose side we are on. (1967, p.239)

Becker's acknowledgment that "we cannot avoid taking sides, for reasons firmly based in social structure" (ibid.)⁴⁰ rejoins Strauss' more general critique of (a certain interpretation of) Max Weber's conception of a non-evaluating social science. Strauss provocatively wrote:

³⁹ While the first position primarily stems from my review of the literature, the other two are the result of a confrontation of the literature with the empirically observed realities of health and AIDS policymaking in Tanzania.

⁴⁰ As Becker underlines, "We must always look at the matter from someone's point of view. The scientist who proposes to understand society must [...] get into the situation enough to have a perspective on it. And it is likely that his perspective will be greatly affected by whatever positions are taken by any or all of the other participants in that varied situation. [...] Almost all the topics that sociologists study, at least those that have some relation to the real world around us, are seen by society as morality plays and we shall find ourselves, willy-nilly, taking part in those plays on one side or the other." (H. S. Becker 1967, p.245)

The prohibition against value judgements in social science would lead to the consequence that we are permitted to give a strictly factual description of the overt acts that can be observed in concentration camps and perhaps an equally factual analysis of the motivation of the actors concerned: we would not be permitted to speak of cruelty. Every reader of such a description who is not completely stupid would, of course, see that the actions described are cruel. The factual description would, in truth, be a bitter satire. [...] The writer would deliberately suppress his better knowledge, or, to use Weber's favourite term, he would commit an act of intellectual dishonesty. Or, not to waste any moral ammunition on things that are not worthy of it, the whole procedure reminds one of a childish game in which you lose if you pronounce certain words, to the use of which you are constantly incited by your playmates. Weber, like every other man who ever discussed social matters in a relevant manner, could not avoid [...] making value judgements." (1953, p.52)⁴¹

Far from being a call to emotionalise the social sciences, this position is about ensuring that social science research is actually able to grasp in a meaningful manner the realities it attempts to analyse. Indeed, not only would posing as a radically external observer imply adopting a cynical position in many matters concerning HIV/AIDS, but pretending that it is possible *not* to take sides either amounts to self-delusion or implies adopting a radically constructivist – and thus ethically nihilist – epistemological position (e.g. Tesh 1988, p.173–6).⁴² Neither positivism nor radical constructivism are, however, viable options in social science research on HIV/AIDS (and health in general). As Rosenberg (1988, p.14) puts it:

[T]he biomedical aspects of AIDS can hardly be ignored; it is difficult to ignore a disease with a fatality rate approaching 100 percent. AIDS has, in fact, helped create a new consensus in regard to disease, one that finds a place for both biological and social factors and emphasizes their interaction. Students of the relationships between medicine and society live in a necessarily postrelativist decade. [...] It is [...] hard to embrace the clarifying simplicity of either extreme: the reductionist view that concerns itself with verifiable pathological process alone, or the uncompromising relativist position that chooses to ignore that same pathological process in shaping specific social responses.⁴³

In the social sciences of HIV/AIDS, adopting a moderately constructivist position is thus arguably the only viable epistemological option. This position consists not only in acknowledging “the presence of differing and co-existing interpretations” (Schurmans & Charmillot 2007), but in considering that ‘health’ itself is the result of the continual dialectical interaction of the biological and the social, of the individual and society.⁴⁴ As Tesh (1988, p.175) insightfully writes,

⁴¹ “As for the question *whether* the inevitable and unobjectionable value judgements should be expressed”, Strauss adds, “it is really the question of *how* they should be expressed, ‘where, when, by whom and towards whom’; it belongs, therefore, before another tribunal than that of the methodology of the social sciences” (1953, p.54).

⁴² Delaporte (1986, p.6), for instance, adopted a radically constructivist position in writing: “I assert that ‘disease’ does not exist. It is therefore illusory to think that one can ‘develop beliefs’ about it or ‘respond’ to it. What does exist is not disease but practices.”

⁴³ He insightfully concludes: “Ironically, [AIDS] reflects both elements – the biological and cultural – in particularly stark form. [...] If diseases can be seen as occupying points along a spectrum, ranging from those most firmly based in a verifiable pathological mechanism, to those, like hysteria and alcoholism, with no well-understood mechanism but with a highly charged social profile – then AIDS occupies a place at both ends of that spectrum. [...] AIDS underlines the inadequacy of an approach to understanding and controlling disease that ends at the laboratory’s door. But it also emphasizes the parallel inadequacy of disregarding the specific biological character of an ailment – and the status of our understanding of that character” (1988, p.28–9).

⁴⁴ As Lewontin et al. (1984, p.75 in Tesh 1988) put it, “a full understanding of the human condition demands an integration of the biological and the social in which neither is given primacy or ontological priority over the other but in which they are seen as being related in a dialectical manner, a manner that distinguishes epistemologically between levels of explanation relating to the social without collapsing one into the other or denying the existence of either”. For an interesting update of the recent insights concerning health as the result of socio-biological interactions, see (Janssen 2006; Ganten et al. 2009).

A dialectical view [...] holds that mind and body [...] create one another; they are never entirely one thing or the other. In the same way, the individual and society are not reducible to one antipode or the other. Rather than being distinct parts, they are wholes in process. Being and becoming simultaneously. At every level of explanation, down to the molecular, all we have is interaction. We never arrive at a static, fixed base.

There is thus an elective affinity between the epistemological position of moderate constructivism and a holistic approach that pays particular attention to the social determinants of health. Such an approach is 'naturally' compatible with the idea that health itself is co-determined by historical processes of social construction (e.g. Canguilhem 1966; Rosenberg 1988; Rosenberg & Golden 1992; Turshen 1989; Tesh 1988). This approach, for instance, implies that a purely technocratic definition of health needs is a fallacy (Thébaud-Mony 1980), and that, therefore, a heteronomous *a priori* definition of AIDS-control policies that abstracts from collectively and endogenously formulated responses to disease is problematic and insufficient (see Part 3).

The constructivist position renders it necessary to make explicit certain elements of the research approach and process. The approach that guided my work, and thus underlies its results, could be described as the sum of implicit and explicit decisions taken at three interrelated levels: 1) the broader theoretical, ethical and epistemological considerations I just mentioned, 2) the choice of methods and explicit decisions to look at certain issues rather than others, to talk to some people rather than others (see the next sub-section), and 3) the myriad often implicit adjustments and day-to-day micro-strategies deployed all along the research process – from the collection and analysis of data to the writing of the manuscript. Providing a detailed *ex post* description of this third aspect would hardly add anything to the intelligibility of the overall research process but rather “present a far more coherent image of the research process than what was generally the case” (Olivier de Sardan 2008, p.205). I tried not to fall victim to excessive self-referential introspection and attempted to limit my methodological reflections to those elements which effectively allow the reader to understand my motivations for the choice and framing of the subject, and to assess the plausibility of the presented results (cf. Olivier de Sardan 2008, chap. V). In this sense, I hope to have managed, in writing this thesis, to find a compromise between what Geertz (1988, p.9) calls an “author-evacuated” and an “author-saturated” text.

The next sub-section briefly describes the methodological approach I adopted in order to explore the questions discussed above and to ensure the validity of my findings – or their “plausibility”, as Olivier de Sardan (2008, p.7) more modestly defines the legitimate scientific ambition of qualitative research. Indeed, far from being a methodological *carte blanche*, the acknowledgement of the impossibility not to take sides comes with the responsibility to ensure that, as Becker underlines, “whatever point of view we take, our research meets the standards of good scientific work, that our unavoidable sympathies do not render our results invalid” (1967, p.246).

Data collection and analysis: a constructivist grounded theory approach

“It’s a capital mistake to theorize before one has data. Insensibly one begins to twist facts to suit theories, instead of theories to suit facts.”
(Sherlock Holmes⁴⁵)

There is, of course, no research that is entirely ‘untainted by theory’. When I arrived in Tanzania, I obviously already had in mind several elements of what was to become the multifaceted theoretical framework of this study. If the two ‘blind spots’ of political economy analysis of AIDS in Africa described above struck me, this was clearly because I had been inspired by definitions of the political as the formulation of compromises over irreducibly conflicting interests and values (cf. Schmitt 1932b; Mouffe 1993; 2005)⁴⁶ and because, having read Stillwaggon’s analyses, among others, I was convinced of the importance of linking the African AIDS epidemics to the continent’s broader political ecology of disease. That being said, my research approach was not *primarily* theory-driven.

As discussed, a guiding idea of my research was to allow the development of new intelligibilities in the spirit of complementarity with existing political economy analyses of AIDS in Africa. To do so, I adopted a grounded theory approach (Corbin & A. Strauss 2008; B. Glaser & A. L. Strauss 1967; Charmaz 1983; Bryant & Charmaz 2010), which is particularly suited to this end.⁴⁷ It allowed me to focus on the less explored questions among the problematic issues that emerged from fieldwork, while ensuring the empirical solidity of the findings. The grounded theory approach itself aims at ensuring the relevance of results as its core methodological principle is based on the progressive refocusing of the empirical enquiry via the exclusion of issues considered as less relevant by the researcher.⁴⁸ Starting out with “general research questions rather than tightly framed pre-conceived hypotheses” (Charmaz 1990, p.1162), grounded theory allows the progressive building of categories and construction of theory based on what is actually observed during fieldwork.

Fieldwork took place in Tanzania during three successive periods between spring 2007 and autumn 2009. It included the conduct of key informant interviews with people involved in AIDS and health policymaking in Tanzania. Of the 92 interviews conducted, 15 were conducted with Tanzanian officials,

⁴⁵ In *Scandal in Bohemia* by Arthur Conan Doyle, quoted in (Valade 2001, p.401).

⁴⁶ See the last section of the introduction, as well as Chapter 2.

⁴⁷ The general principles and methods of grounded theory research are particularly well-documented in health-related fields (e.g. Charmaz 1990; Kearney et al. 1994; Clare et al. 2008). Indeed, grounded theory itself emerged as an effort to legitimize qualitative research in the field of public health, which is dominated by the biomedical and epidemiological disciplines and their positivist epistemologies. While the grounded theory approach is sometimes fiercely debated (B. Glaser 1998; B. G. Glaser 1992; Heath & Cowley 2004) or fundamentally challenged (Thomas & James 2006), Olivier de Sardan (2008) proposes a realistic account both of the requirements for accuracy that underlie any grounded theory approach and of the new insights it can yield.

⁴⁸ Howard Becker (1998, p.194–212) proposes a less formalized but comparable approach in which what he calls “analytic induction” plays a key role. As he puts it: “You have the data you have, because you decided many times to talk to this person rather than that one, to investigate that source rather than some other one, ignore that path that seemed so inviting in favor of another one that looked even better, concentrate on this idea rather than that one. [...] [A]ll the choices you have made [...] have given you this particular thing to say and made it difficult, maybe impossible to say some other thing” (preface to Hunsmann & Kapp 2013).

31 with employees of Tanzania-based bilateral donor agencies, 18 with employees of Tanzania-based multilateral donor agencies (hereafter: “bilateral” and “multilateral agents”), 11 with academic researchers or independent consultants, as well as 6 with employees of Tanzanian NGOs and 11 with employees of international NGOs. The interview data were controlled and contextualized through the observation of 8 national-level policy discussions involving the Tanzanian government and the principal donor agencies as well as, in most cases, representatives of Tanzanian (and sometimes international) NGOs.

The research strategies I used for data collection and analysis are in line with – and in some instances inspired by – the constructivist interpretations of grounded theory proposed by Charmaz (2000), Olivier de Sardan (2008), or Bryant and Charmaz (2010). This approach openly acknowledges the active role of the researcher in the construction of knowledge. As Charmaz (2000, p.523) puts it, “the viewer creates the data and ensuing analysis through interaction with the viewed”. Charmaz (1983, p.125) summarizes the defining features of grounded theory as follows: 1) “discovering and analyzing social [...] processes structures inquiry”; 2) “data collection and analysis phases of research proceed simultaneously”; 3) “analytic processes prompt discovery and theory development rather than verification of existing theories”; 4) “theoretical sampling refines, elaborates, and exhausts conceptual categories”; 5) “systematic application of grounded theory analytic methods progressively leads to more abstract analytic levels”. While the adoption of a grounded theory approach itself by no means guarantees scientific rigour, it does provide methodological crutches (or ‘safeguards’) that help avoid some of the common pitfalls of qualitative research.⁴⁹ It allows an open empirical enquiry, while at the same time helping to ensure the “empirical adequateness of sociological interpretations” (Olivier de Sardan 2008, p.19). The research methodology and methods of analysis, as well as the practical aspects of data collection (interview conduct, observations, and bibliographic research) are discussed in more detail in Appendix 1.

Limitations deriving from the research approach

The intentionally eclectic nature of this research brings with it several inconveniences. Many relevant issues necessarily fall by the wayside. Some issues are passed over because they have been extensively analysed elsewhere⁵⁰, others are simply omitted because any research project must have boundaries.⁵¹

⁴⁹ As Becker (1967, p.246) puts it, “[o]ur textbooks in methodology [...] tell us how to guard against error, but they do not tell us how to make sure that we will use all the safeguards available to us”. An important aspect is to avoid ‘sentimentality’: “We are sentimental when we refuse, for whatever reason, to investigate some matter that should properly be regarded as problematic. We are sentimental, especially, when our reason is that we would prefer not to know what is going on, if to know would be to violate some sympathy whose existence we may not even be aware of” (*ibid.*). In sum, “we must use our techniques impartially enough that a belief to which we are especially sympathetic could be proved untrue” and “inspect our work carefully enough to know whether our techniques and theories are open enough to allow that possibility” (*ibid.*). I did my very best.

⁵⁰ Looking at the epidemic from a political vantage point, this study, for instance, does not attempt to give full account of the complexity of individual experiences of HIV infection, AIDS, stigma and death. In a sense, it thus voluntarily abstracts from the anthropological dimensions of HIV/AIDS.

Another related limitation, due to obvious reasons of scope and feasibility, stems from the fact that this thesis focuses primarily on policy *formulation* processes at the interface of the national and the international AIDS policy arenas. I therefore do not address sub-national policy processes and sometimes abstract from the wide array of implementation issues.⁵² This focus does not mean to suggest that implementation is not important or not problematic. Implementation is vital and often a genuine challenge. Although different⁵³, policy formulation and implementation are related – be it only because of the key importance of policymakers' anticipations about the potential of different measures to be implemented effectively (or not). Inversely, the more or less inclusive nature of the decision processes that lead to the formulation of policies is a key determinant of their implementation. It therefore makes sense to study policy processes *as such*, yet obviously not in complete isolation.

More generally, both the aspects analysed and the results presented are inevitably influenced by the contingencies inherent in qualitative fieldwork and the formulation of concepts (Charmaz 1990; Olivier de Sardan 2008). As a result of the grounded theory approach and the research design, the framing of the study itself, for instance, draws significantly on the experiences and views expressed by the interviewees. While giving a voice to those players who deal with the challenges and contradictions of AIDS control on an everyday basis is an explicit goal of this research, inviting the players' own reading of the situation at the heart of the analysis necessarily influences the choice of the issues I decide to address and the interpretations I propose. That being said, I consistently sought to derive my analysis from the *confrontation* of my fieldwork findings with the relevant scientific literature and policy documents (see Appendix 1).

Another potential bias could result from the fact that, during fieldwork, I was physically located at the health coordination office of the German Agency for Technical Cooperation (GTZ)⁵⁴. Not only did this make my fieldwork manageable by providing me with a desk, a roof, and electricity, but it opened many doors, gave me valuable insights into the everyday work of a donor agency, and provided me with the opportunity to attend a variety of non public meetings. In this respect, the support of the head of the office – an old hand in the global health business and an insider of the politics of AIDS and health in Tanzania – was invaluable. He took me along to meetings or told his colleagues to take me with them; he opened up his address book and let me contact a variety of senior policymakers on his behalf. In some cases, this was probably the only way to obtain an interview appointment. Instead of the circumspection

⁵¹ Howard Becker admirably describes how the decision to finish a PhD comes about: "You finish by saying to yourself 'Stop!' the way a mother would say it to a child who is banging on a drum, or crying uncontrollably over a spilled ice cream cone, or pulling the cat's tail. [...] [T]here is no really good, logical place to stop. There are always new and interesting problems just ahead, beckoning to us, enticing to spend just a little more time, and to think how much better our work would be if we did that. The corpses of wonderful studies that might have been, had the authors avoided such lures, litter the history of our fields. Since there's no logical end point, it's only sensible to let circumstances tell you when it's time to quit. External signals abound. [...] The world you work and live in is telling you something. Pay attention." (preface to: Hunsmann & Kapp 2013).

⁵² I also only very incompletely address the political dynamics *within* international agencies themselves.

⁵³ As a Tanzanian official puts it, "policies and actual programmes are different stories, and programmes and implementation is yet another story..." (GovSector-3).

⁵⁴ Since that time, the GTZ became part of the German Society for International Cooperation (GIZ). At the time, the office was situated on the Muhimbili campus – Tanzania's biggest hospital and medical training institution.

I confronted in a variety of other interviews, many of the people I contacted through his intercession received me with open arms and were immediately talkative and ready to engage in an unrestrained conversation. The 'price to pay' for this privileged access to interviews and observational data was that several of my interlocutors spontaneously considered me as being affiliated with the German development cooperation.⁵⁵ While this did probably affect the conversations to a certain extent, the bias it induced both in the choice of the interviewees and during the interviews themselves was probably rather limited. In any case, such a bias is inescapable in social science research, given the impossibility of pure observation it brings with it. Although human beings differ from sub-atomic particles, this dilemma is closely akin to the 'observer effect' in quantum mechanics. In the social sciences, just as in quantum mechanics, the presence of the observer modifies the phenomenon to be observed (in my case, the players' discourses and interactions). That being said, especially in the qualitative social sciences, one can certainly not hope for more, and such 'biased' data are better than no data at all. The key to reducing bias is being aware of these limitations.⁵⁶

Finally, a fundamental charm and important limitation of social science research on HIV/AIDS is the challenge to grasp what is an extremely fast-moving target. While this is true for all social sciences, the fact that the world resolutely (and fortunately) refuses to stop moving as we look at it is particularly striking in the field of HIV/AIDS. The very issue one is looking at changes its shape, aspect and context right before one's eyes. Despite being a "long wave event" (Barnett 2007) the consequences of which unfold over decades, the African epidemics and the responses to them have evolved very rapidly over the last ten years. Both the mix of interventions and the overall scale of the response have profoundly changed since the turn of the century.⁵⁷ Given the unprecedented inflow of international funding during the years of fieldwork and the rapid increase of activities resulting from the roll-out of antiretroviral therapy, domestic policy processes hardly had the time to keep up with the swiftness of the international mobilisation.⁵⁸ National institutions were manifestly overstrained and some national policies had already lost their relevance by the time they had reached the implementation phase. As a Tanzanian official puts it: "There are so many new emerging issues coming up...so if you go back to policies, maybe you cannot link what we are doing right now to the policy on the paper" (GovSector-14).

⁵⁵ Several of my interviewees, for instance, asked me: "So, you're doing your PhD at GTZ?". Similarly, the former head of a national agency introduced me to one of his former collaborators by saying "Please meet Moritz, he's Bergis' boy" – Bergis being the head of the German health coordination office through whose help I had contacted him.

⁵⁶ A comparable bias of my data stems from the fact that I am a white, young, male European, who is unable to conduct interviews in Swahili. This certainly led many of my interlocutors at least implicitly to put me in the group of 'donor agents'. Yet, the biases related to the colour of skin can work both ways. Mbaye (2010), for instance, describes how, during his fieldwork on AIDS and immigration policies in France, his African origins repeatedly caused him to be considered as HIV-positive and/or as an (undocumented) immigrant.

⁵⁷ The history of AIDS control in Africa over the last decade has been decisively influenced by a series of breakthrough innovations referred to as 'game changers' (cf. De Cock et al. 2011). While these are generally considered to emerge from the biomedical field (e.g. the invention of antiretroviral therapy, the effectiveness of treatment as prevention, or the hypothetical discovery of an HIV vaccine), political and financial changes (such as the decision to roll-out ARV therapy in Africa, or, more recently, the sudden halt to over a decade of rapidly increasing international AIDS funding) can certainly also be considered as 'game changers' – i.e. as evolutions that radically modify the challenges policymakers and researchers confront.

⁵⁸ The limitations concerning the generalisability of the findings that derive from the specificities of this study's place (Tanzania) and time (period of relative AIDS-funding abundance and rapid ART roll-out) are discussed in the conclusion.

While the massive international response was excellent news for millions of Africans living with HIV, it also poses serious problems in terms of political control and democratic accountability. The rapid evolution of the epidemic and of the responses to it thus opens up exciting fields of enquiry. At the same time, it constitutes a serious challenge for research on AIDS in Africa and reduces its 'duration of relevance'.⁵⁹

C) Exploring the multifaceted depoliticisation of an epidemic at the heart of the political

“The point is not that values contaminate policy, not even that values contaminate science. Instead there is an inextricable interrelationship between facts and values, both in the search for the causes of disease and in the process of developing the best preventive policy. I argue not that values be excised from science and from policy but that their inevitable presence be revealed and their worth be publicly discussed.”
(Tesh 1988, p.3)

As mentioned, the formulation of AIDS-control policies involves decisions about who will have access to life-saving treatment and who will not, about which interventions and populations groups should be prioritised in HIV-prevention programmes, and about striking the right balance in the allocation of resources between HIV/AIDS and other health problems. Each domain implies fundamentally political compromises that constitute core elements of the exercise of biopolitical sovereignty. While technical advice on the effectiveness, efficiency, and equity effects of different options can help inform decisions, such advice cannot eliminate the inescapably political trade-offs AIDS policymaking implies. In line with the emancipatory interpretation Mouffe proposes of the works of Carl Schmitt on the nature of the political (Schmitt 1932b; Mouffe 1993; 2005), I adopt what could be termed an 'essentialist' conception of the political. In this sense, I consider that certain questions inescapably involve the formulation of trade-offs between irreducibly conflicting interests and values. These questions are therefore *intrinsically* political in nature, irrespective of the way they are predominantly framed and perceived in the public sphere (i.e. as 'private', 'cultural', 'technical', 'ethical', etc.). The conflict between differing interests and values that underlie these questions cannot be *solved*; it can merely be *managed* via the collective formulation of temporarily acceptable compromises via the political process. The formulation of these compromises thus lies at the heart of the political and is one of the core functions of politics (see Chapter 2).

During fieldwork, I progressively realised that the inherently political nature of the wide variety of trade-offs involved in HIV-related policymaking was consistently omitted in the management of AIDS control in Tanzania. I was increasingly struck by the lack of public debate on the epidemic itself and by the absence

⁵⁹ Indeed, many studies from the 1990s read like testimonies from another era – that preceding the roll-out of antiretroviral treatment. The times when Turshen underlined that “AIDS is interesting to public health because it exposes the limits of clinical medicine, which has little to offer patients dying of AIDS.” (1989, p.219), and included her chapter on AIDS in Africa in a book section on “Non-Medical Approaches in Public Health”, are over...at least for those HIV-infected Africans who have access to medical care. Another 'positive' consequence of the short 'life span' of studies on HIV/AIDS is that it limits the negative effects of the scientific 'overgrazing' described above.

of confrontational politics concerning the formulation of AIDS-control policies. In a sense, the political management of HIV/AIDS had been extremely 'successful' in that the deeply problematic and conflict-laden questions the epidemic raises had been politically domesticated in a surprisingly effective manner. At every step of the way, from the causal explanations of the epidemic to the elaboration of the strategies put in place to control it, HIV/AIDS was – and still is – subject to protean depoliticisation processes. The irreducibly political aspects of the epidemic and of the response to it are frequently not acknowledged as such, and political debates and decisions over the content and design of AIDS policies are confined to non-public spheres with limited democratic legitimacy.

This thesis argues that this depoliticisation of AIDS control in Tanzania results from a political configuration in which governments attempt to avoid blame for the spread of the virus and escape responsibility for the unpopular rationing choices the response to HIV/AIDS necessarily involves; from a configuration in which the incentive structures of in-country donor agents, Tanzanian health and AIDS officials, and various implementing organisations hinder the tackling of more structural causes of ill health and population susceptibility to HIV infection, and in which international agencies and Tanzanian officials draw on a positivist, technical vision of health and a technocratic conception of public health action. As a result of this multifaceted process, the Tanzanian AIDS epidemic and the responses to it are quite consistently 'organised out of politics'. The negation of the political nature of the trade-offs involved in AIDS policymaking leads to the avoidance of public debate and collective decision processes. This circumvention of the political is itself a key modality of politics. It not only contributes to the invisibilisation of the inequalities that result from the non-public and implicit decisions concerning HIV/AIDS, it also hinders the design of adequate AIDS-control policies via a necessarily collective formulation of temporarily acceptable compromises.

This thesis is sub-divided into three parts, each of which explores distinct but interrelated parallel processes that contribute to this multifaceted depoliticization of the Tanzanian AIDS epidemic and of the responses to it. Part 1 analyses the role of causal narratives and bio-epidemiological evidence in HIV-related agenda-setting processes. Based on a review of the biological and epidemiological evidence on the determinants of population susceptibility to HIV, it explores the political economy of the causal narratives of the African AIDS epidemics and their uptake in the formulation of HIV-prevention policies. By drawing on a critical scrutiny of the dominant behaviour-centred explanations of the spread of HIV in Africa (Chapter 1), it argues that the uneven political resonance of different causal stories results from struggles over the ascription of blame and responsibility to act (Chapter 2). More generally, and far from being random, the translation of available bio-medical and epidemiological evidence into prevention measures is politically mediated. While the behaviour-centred narratives of the spread of HIV contribute to the political domestication of the epidemic, the policy uptake of evidence concerning the structural (i.e. non-behavioural) drivers of the epidemic is also hampered by a variety of obstacles to evidence-informed policymaking that are due to the nature of the policy process itself (Chapter 3).

Part 2 shifts the focus from agenda setting to the analysis of the political processes that lead to the prioritization of those interventions that have successfully reached the national AIDS policy agenda. Since the available resources are insufficient to implement HIV-prevention and -treatment strategies fully, any effective implementation necessarily involves a prioritization in terms of the types of interventions, their beneficiaries and geographic coverage. Against this backdrop, this part analyses the priority-setting processes this situation imposes. Each of the two chapters proposes a case study of how AIDS policymakers in Tanzania deal with the vital trade-offs involved in the formulation of HIV-prevention (Chapter 4) and -treatment (Chapter 5) programmes. Taken together, they explore different aspects of what could be described as a political economy of *non-decision*. In each case, the policymakers' refusal to choose, motivated by the willingness to maximize aid flows and/or to escape political responsibility for unpopular rationing decisions, entails a depoliticisation of fundamentally political decisions via the *a priori* non-hierarchical juxtaposition of interventions. Thereby they shift the locus of decision from explicit prioritisation via the formulation of national strategies to implicit prioritisation via their inevitably incomplete implementation. Both non-decision and depoliticisation are analysed as fundamentally political processes.

Part 3 puts the response to AIDS in Tanzania in the broader context of international health action and national health planning. It explores an overarching depoliticisation that results from the fundamentally heteronomous character of the international AIDS response – i.e. the dispossession of the Tanzanian people with respect to their more general health-related decisions. Based on the players' controversies concerning the ambiguous effects of vertical AIDS-control on the national health system and the coherence of Tanzanian health policies (Chapter 6), this last part explores the limits to vertical disease control in a context of widespread poverty and dysfunctional health systems. Based on a case study of the articulation of AIDS and nutrition-security policies, it analyses how policymakers grapple with the challenges that arise from the disconnect between the massive arrival of earmarked AIDS funding and the diversity of the population's health needs (Chapter 7). Developing upon this empirical assessment of the tensions and contradictions to which the heteronomous character of AIDS control in Tanzania gives rise, the last part concludes by reflecting upon the concomitant necessity and intellectual challenge of formulating radical criticism of international AIDS control in a context of acute dependency (Chapter 8).

Part 1: The politics of causation and HIV prevention

“At present levels of infection, about one sixth of all the people in sub-Saharan Africa will contract HIV in their lifetimes. But the epidemic does not threaten the continent’s rulers – democratic or otherwise. [...] African rulers, with a sound appreciation of how power functions, know that they won’t be removed from office or even face political threats on account of AIDS.”
(de Waal 2006, p.2)

In his stimulating book *AIDS and Power*, Alex de Waal attempts to explain why this epidemic of unprecedented dimensions has not caused major political upheavals in sub-Saharan Africa. An epidemic of only a fraction of the magnitude of many African epidemics would certainly have caused major political crises in most European countries. Yet, even in the hardest-hit countries in Africa, HIV/AIDS is conceived as politically uncontroversial, if not as an altogether apolitical issue. The 2002-2003 Afrobarometer – a comparative series of national public attitude surveys – shows that when asked “In your opinion, what are the most important problems facing this country that government should address?”, only 11% of the people surveyed across fifteen sub-Saharan countries mentioned AIDS as one of the top three priorities. In Tanzania, this proportion even declined from 14% in 2002 to 6% in 2008 (REPOA 2008). HIV/AIDS is obviously not considered as an important issue the government should tackle.⁶⁰ Several analysts suggest that the surprisingly low politicisation of HIV/AIDS is due to the fact that the epidemic is but one among many serious problems African people face (e.g. Fredland 1998; Gruénais et al. 1999; Whiteside et al. 2002). This explanation echoes the statement of a Tanzanian AIDS official, who underlines:

A normal person will not say that HIV/AIDS is a disaster...maybe his or her priority will be how to get water or grass to feed the cattle, how to send his or her kids to school...but not HIV. People here don’t see themselves, *individually*, as being vulnerable or at risk of HIV infection [...]. Because life continues! (GovSector-3).⁶¹

Similarly, Whiteside et al. (2002, p.v) consider that people simply engage in rational prioritisation:

Faced with grinding poverty and widespread unemployment, people may be more concerned with getting a chance to earn an income, feed their families, protect themselves from crime and insecurity, and obtain basic health care, than with being saved from a largely invisible killer.

Although plausible, this reasoning overlooks – as most political science research on the subject⁶² – a decisive point in the analysis of the African epidemics and their underlying power relationships: the telling of causal stories.

⁶⁰ The broader category of ‘health’, in turn, is considered a higher priority.

⁶¹ In her work on the Bahaya people in north-western Tanzania, Githinji (2009) shows how AIDS is perceived as “yet another ecological challenge that coincides with a decline in soil fertility, diminishing access to land, increased poverty, food and nutrition insecurity, and a lower production of their long-standing cultural and staple food”. Similarly, Rugalema (1999, p.69) describes how people in this region perceive AIDS as just another serious problem in a long series of uninterrupted crises such as famine and war, and consequently do not consider the epidemic as “something terribly new”.

⁶² See the introduction.

Political scientists know well that difficult conditions become political ‘problems’ only when people come to see them as amenable to human action (e.g. Blumer 1971). In studying this process, Stone points to the role of “causal stories”. Causal stories are public narratives that, by establishing causal relationships, identify generally problematic situations as being the result of human action or inaction. They serve as conceptual devices to “move situations intellectually from the realm of fate to the realm of human agency” (1989, p.283).⁶³ Being sexually transmissible, HIV/AIDS is widely considered as being amenable to human action.⁶⁴ The struggle over causal stories, however, does not stop once an issue has been successfully pushed into the realm of human agency. Causal stories not only explain, they inevitably put the blame on certain players, while dismissing other players. “Causal stories continue to be important in the formulation and selection of alternative policy responses”, Stone argues, “because they locate the burdens of reform very differently” (1989, p.283). Beyond the political struggle over who is to be blamed for the epidemic, lies the question of who should act and how – and thus the struggle over the distribution of resources for AIDS control.

Since its very beginning, HIV/AIDS has been subject to uniquely intense scientific controversy and political struggles over various ‘contested truths’ concerning the origin of the disease (S. Epstein 1996; Root-Bernstein 1993),⁶⁵ the causes of its epidemic spread in sub-Saharan Africa (e.g. Iliffe 2006; Stillwaggon 2006; H. Epstein 2007; Thornton 2008; Pepin 2011), and the most appropriate strategies to prevent transmission. In Tanzania, the preparatory debates over the Global Fund proposal concerning HIV are, for instance, considerably more controversial than those concerning malaria or TB. The different modes of transmission and the variety and heterogeneity of contributing factors (or ‘drivers’) of HIV transmission make allocative decisions in the field of AIDS control particularly complex. As a multilateral agent puts it, “It’s more complicated than, say malaria...not that fighting malaria is easy, but fighting HIV/AIDS is not like distributing mosquito nets and telling people to sleep under them...” (Multilateral-8).

In sub-Saharan Africa, the lack of consensus concerning the causes of the spread of the epidemic leaves ample room for competing narratives about the content and design of HIV-prevention policies. Today’s dominant causal story considers sexual behaviour as the key explanatory variable of the African AIDS epidemics and most competing narratives are situated *within* this behavioural paradigm. Consequently, behaviour-change programs have been the centrepiece of HIV-prevention strategies on the continent over the last decades and a significant proportion of prevention funding is channelled into policies that aim at individual behaviour change. Over the last fifteen years, a growing body of biomedical and epidemiological evidence, however, indicates that a population’s general health and immune status

⁶³ Causal stories can, of course, also move situations the other way around – from agency to fate. The concept of ‘causal stories’ is discussed in more detail in Chapter 2.

⁶⁴ Even those who declare AIDS as god’s punishment for people’s sins acknowledge the role of human agency (‘sin’).

⁶⁵ Steven Epstein’s description of the permeability of the boundaries between science and politics in AIDS research is particularly telling.

codetermine its susceptibility to HIV infection. In parallel, a variety of studies on unsafe medical practices in sub-Saharan Africa suggest that iatrogenic transmission of HIV has been underestimated.

Taking the strikingly unequal resonance of different causal stories of the African AIDS epidemics and the predominantly technical framing of debates over the most adequate prevention strategies as a starting point, the first part of this thesis shows that debates over the causes of the African epidemics and the best way to respond to them are inherently political struggles. As Rosenberg and Golden (1992, p.xxii) put it, the framing of disease has long “served to project and rationalize widely held values and attitudes”. Yet, the following chapters suggest that, beyond difference in values, these struggles over the selective mobilisation of aetiologies also concern the ascription of blame and of the responsibility to act, as well as the distribution of resources and a series of trade-offs between incompatible interests.

Based on the policymakers’ explanations of the Tanzania AIDS epidemic, Chapter 1 confronts their overwhelmingly behaviour-based causal narratives with the largely omitted body of evidence concerning both non-behavioural drivers of sexual transmission, and iatrogenic HIV transmission through unsafe medical practices. The nearly complete absence of these findings from the policymakers’ narratives raises the question why entire segments of evidence have not made their way into public discourses and HIV-prevention policies. In this context, Stone’s concept of “causal stories” appears to be a valuable heuristic tool for the analysis of the political response to AIDS in Tanzania, and in sub-Saharan Africa more generally.⁶⁶

Developing upon Stone’s analytical framework, Chapter 2 addresses the unequal resonance and policy uptake of different causal stories by looking at their respective political ‘side effects’. Indeed, by pointing to non behaviour-related drivers of HIV transmission, the omitted explanatory approaches indirectly highlight the failure of governments to satisfy even the most essential health-related needs of their population (such as nutrition security, safe primary health care, clean water and sanitation). By shifting responsibility – and thus the obligation to act – from the individual to the political level, these approaches challenge fundamental socio-economic trade-offs and shed a different light on the political management of AIDS in Africa. Contrary to what Gruénais et al. (1999) or Whiteside et al. (2002, p.v) suggest, the low politicisation of HIV/AIDS in most African countries might thus not be primarily due to the fact that Africans have other things to worry about. The low politicisation is also due to the dominant framing of the African epidemics as being the result of Africans’ alleged sexual promiscuity. While a problem has to be seen as being the result of government failure (be it through inaction or inappropriate action) to become a potential challenge to its legitimacy, the dominant aetiological framing leaves the population with the impression that those who are infected have no one to blame but themselves.

⁶⁶ Surprisingly, although the relevance of the causal stories framework to the analysis of AIDS in Africa is obvious, I have found no AIDS-related analysis paying specific attention to it. Given their semantic proximity, the terms ‘aetiology’ and ‘causal story’ could be distinguished as follows: aetiologies are statements about causes of diseases while causal stories of epidemics consist in the politically mediated selection of these aetiologies in public and expert narratives.

Despite its apparent simplicity, such an analysis of the political economy of the framing of the African AIDS epidemics requires justification. I therefore conclude the chapter with a series of considerations on the concept of 'depoliticisation', its theoretical underpinnings and the difficulties it entails with respect to agency and intentionality.

The analysis of causal stories helps one to understand the uneven resonance of different aetiologies in public narratives. Yet, the governments' struggle to avoid political sanction and preserve the socio-economic status quo is probably not sufficient to explain why certain elements of biological and epidemiological knowledge have received so little attention in the actual formulation of HIV-prevention policies. Based on a case study of the process of prevention policymaking in Tanzania, Chapter 3 argues that, beyond the self-serving preservation of interests, a variety of *process-related* factors (situated at the *policy-* rather than the *politics-*level) help explain the limited use of scientific evidence in Tanzanian prevention policies and particularly the low uptake of knowledge concerning structural drivers of HIV. More generally, this chapter questions the real-world relevance of allegedly apolitical, technocratic conceptions of purely 'evidence-based' health policymaking.

Chapter 1) Why Africa? Controversies over the uneven global spread of HIV

“We are in fact much further from understanding the epidemiology of AIDS in Africa than some medical researchers, development officers, and social scientists would have us believe.”
(Packard & P. Epstein 1991a, p.781)

In 2011, approximately 68% of all HIV-infected people lived in sub-Saharan Africa, a region which represents only 12% of the world’s population (UNAIDS 2011b, p.7). Globally, HIV prevalence ranges anywhere from below 0.01% to over 30%. HIV prevalence in some sub-Saharan countries is several hundred times higher than the rates in many Western countries. Since the origin of the epidemic, most epidemiological studies about the spread of HIV in Africa have focused on sexual behaviours. While differences in these behaviours can help explain differences in individuals’ risk of infection and specific patterns of viral spread within a given population or sub-population, they do not, in any way, explain why HIV has turned into generalised epidemics in some countries or regions and not in others. Behavioural factors do not explain why sub-Saharan Africa is the only world region where HIV/AIDS has reached such overwhelming proportions. More than 20 years down the road, Packard and Epstein’s assertion thus lost its appropriateness only quite incompletely. As Stillwaggon (2006) argues, AIDS researchers have been misled by preconceptions about African sexuality and by a fundamentally individualistic bias in their methodologies. Consequently, she suggests, they have been asking the wrong question for decades:

The question, Why does a person contract HIV? gives rise to an answer about an individual and to policies that address individual-level, generally behavioral variables. It is a very different question to ask, Why do nearly 40 percent of the adult population in one country and only 1 percent in another country contract HIV? Widely divergent rates of infection suggest different underlying causes of epidemics among populations and even different contributing causes of individual infection. (2006, p.158)

In a seminal paper on the fundamental difference between the causes of illness at the individual and the population level, Rose (1985, p.34) compares two populations with significantly differing levels of blood pressure and comments:

We might achieve a complete understanding of why individuals vary, and yet quite miss the most important public health question, namely, 'Why is hypertension absent in the Kenyans and common in London?'. The answer to that question has to do with the determinants of the population mean; for what distinguishes the two groups is nothing to do with the characteristics of individuals, it is rather a shift of the whole distribution – a mass influence acting on the population as a whole. To find the determinants of prevalence and incidence rates, we need to study characteristics of populations, not characteristics of individuals.

While individual risk factors can be of interest, understanding why HIV has spread with such unique effectiveness in sub-Saharan Africa is the central question to be answered in order to design effective prevention programmes.

This chapter describes the answers to that question, by contrasting the AIDS players’ narratives with evidence on some oft-omitted drivers of HIV transmission. Section A describes the causal narratives AIDS

policymakers in Tanzania give of the spread of HIV in the country. While these narratives differ sometimes substantially, nearly all are based on the idea that differences in sexual behaviour explain the differences in HIV prevalence between sub-Saharan Africa and other world regions. Section B shows that this central claim of the behavioural paradigm does not withstand empirical or theoretical scrutiny. In response to the lack of explanatory power of the behavioural causal story, Section C presents evidence on the impact of various infectious diseases and other conditions on people's susceptibility to HIV infection. Section D discusses the role of unsafe medical practices in HIV transmission. These two causative pathways help explain the differences in the epidemic spread of HIV between sub-Saharan Africa and the rest of the world.

A) Causal narratives of the spread of HIV in Tanzania

“Prevention efforts in Tanzania currently face several barriers: socio-cultural ones, religious ones... There are a lot of barriers to break. [...] HIV is different from other diseases in the sense that it is so behaviour related. [...] The question for HIV prevention is: How do you make the whole society part of the prevention efforts? It all starts from the individual level, that's where the important barriers are...they have to be overcome first. Then you can address the issue from a society level”
(Multilateral-8)

The homepage of the Tanzania Commission for AIDS (TACAIDS 2012a) contains a brief explanation of what TACAIDS believes drives the country's epidemic. This presentation gives an idea of the official causal narrative of the spread of HIV in Tanzania. It identifies the following five “drivers of the epidemic”:

- 1) Promiscuous sexual behaviour
- 2) Intergenerational sex
- 3) Concurrent sexual partners
- 4) Presence of other sexually transmitted infections such as herpes simplex 2 virus
- 5) Lack of knowledge of HIV transmission

It also points to seven “[c]ontextual factors shaping the epidemic in the country”, namely:

- 1) Poverty and transactional sex with increasing numbers of commercial sex workers
- 2) Men's irresponsible sexual behaviour due to cultural patterns of virility
- 3) Social, economic and political gender inequalities including violence against women
- 4) Substance abuse such as alcohol consumption
- 5) Local cultural practices e.g. widow cleansing
- 6) Mobility in all its forms which leads to separation of spouses and increased establishment of temporary sexual relationships
- 7) Lack of male circumcision

The official causal story is thus rather clear: individual behaviour in general, and sexual behaviour in particular, is considered as the main cause of HIV transmission.⁶⁷ This causal story is representative of the dominant narrative about HIV/AIDS in sub-Saharan Africa, which attributes the differences in HIV

⁶⁷ All these “drivers” and “contextual factors” can, of course, increase a person's risk of exposure to HIV. Nevertheless, *comparative* empirical evidence on their prevalence in other world regions shows that differences in any of these factors (the case of STIs excepted) in no way explain the incommensurably higher HIV rates in sub-Saharan Africa (see Sections 2 and 3).

prevalence between Africa and other world regions to differences in sexual behaviour – such as rates of unprotected sex or the configuration of sexual networks (e.g. prevalence of concurrent sexual partnerships, interrelations between commercial sex networks and the ‘general population’, cross-generational sex, etc.). Before going into detail on the critique of the behavioural paradigm, this section looks at how AIDS policymakers in Tanzania talk about HIV prevention. Doing so helps explain the oft-implicit causal narratives that underlie their conception of the Tanzanian epidemic.

A-1) ‘Making everyone feel they are at risk’: information, persuasion and individual choice

“We have to really make everyone feel they are at risk. The problem is how do we make people change their behaviour and to actually protect themselves.”
(Multilateral-17)

Strikingly, virtually all players – donor representatives, Tanzanian officials, as well as local and international NGO workers – accept the behaviour-based causal story of the spread of HIV in Africa. “When one regards the main causes of the infection, one sees that it’s about sexuality”, says a multilateral agent (Multilateral-8). Many interviewees see a lack of information as the cause of what they consider widespread risky sexual practices. A Tanzanian official, for instance, notes:

People have to be put in a situation where they are able to understand the risk of HIV infection and they have to be enabled to balance it against the pleasures of sex. We have to put people in a better position to decide. People tend to be reckless...they don’t know. We really need to let the people know what it’s all about! To make them understand so that they won’t sacrifice their lives for pleasure! As far as prevention is concerned, we have to tell them: ‘You are responsible!’ (GovSector-4)

The appeal to individual responsibility and the call for HIV-prevention policies that primarily educate people about risky sexual behaviours is a logical consequence of this narrative. As another Tanzanian official underlines:

The prevention of new infections needs serious individual behaviour-change commitment. This will be possible if individuals become more aware of their vulnerability to HIV infection...and that takes time! We have to start working with youth, early in life to create awareness and get individual commitment from people that they will not infect themselves. (GovSector-3)

The complete narrative of this former high-level Tanzanian AIDS official is telling as far as the adherence of Tanzanian policymakers to the behavioural causal story is concerned. He continues:

I haven’t read the epidemiologic literature at all. All I know is that here, sexual activity is different from Europe. It can get so violent...you’ll get more scratched than if when you do it in a civilised manner. Here, sex is a blood-shedding activity! There is higher exposure of raw flesh, if I can put it this way. So condoms will just tear off! Women will attach you in their kanga⁶⁸ to make sure you don’t run off! [...] As a Russian colleague told me once: ‘You Africans are lucky, because your way of infection is so much more pleasant than needle stitches⁶⁹!’ (GovSector-3)

Not only have most Tanzanian interviewees made the behavioural paradigm their own, but some have apparently interiorised conceptions of ‘wild’ African sexuality and ‘civilised’ sexuality in the West. This

⁶⁸ A ‘kanga’, in Swahili, is a piece of decorated, thin cotton cloth, worn as a skirt, shawl, or baby carrier.

⁶⁹ The “needle stitches” refer to injection drug use – an important driver of HIV transmission in Russia.

interviewee is visibly proud of what he feels are distinctive features of African sexuality, a feeling which facilitates the acceptance of the behavioural causal story – which is all the more plausible as it is considered as flattering by people who engage in sexual bravado.

Few interviewees – all of them Tanzanians – openly blame what they consider irresponsible individual behaviour. While one Tanzanian official passionately declares that “there are people out there who want to transmit the virus” (GovSector-7), another one suggests,

In Tanzania, there is a problem with the attitude of people. [...] First, we thought we could control HIV through public education alone...that has not worked because of socio-cultural oppositions and an aversion to condoms. [...] In *your* country, everybody knows about HIV and when it comes to sex, it is sure that everybody will protect themselves. (GovSector-3).

Similarly, a Tanzanian national who works for a bilateral donor agency suggests:

There are some taboos in Tanzania that are not addressed. Even people who are already sick won't believe it's HIV/AIDS...people in Tanzania don't want to accept that this is real! Don't look at Dar! Go to a local place...even a village only 50km from Dar... Go there and ask yourself: What does 'awareness' mean? They are aware of *what*? They know that the virus exists. They know the information just like the lyrics of a song...but do they realise: 'When I have it in my body I will die with a very high probability'?! At this level, the awareness is very low. *That* is the reason why the prevalence is not going down in sub-Saharan Africa. I'm Tanzanian, so I know! I see it from my family: in Makete, Iringa, the prevalence is so high! When you're asking people about HIV, they'll tell you: 'Even that tree, that tea plant is infected...don't touch anything!'. If one person is HIV positive, they'll tell you: 'The whole family is infected, they're all ill!'. The stats say that 98% of Tanzanians are 'aware' of HIV/AIDS...but people feel like this is an entertainment! (Bilateral-10)

This causal narrative, which stresses the role of relatively unconstrained individual decisions, underlies a centrepiece of African HIV-prevention programmes: behaviour-change communication (BCC) interventions. In a remarkable exercise of policy branding, these interventions have come to be defined as the 'ABC' approach – where A stands for 'abstinence', B for 'be faithful', and C for 'condoms'.⁷⁰ The Tanzania National Policy on HIV/AIDS is instructive in this respect. It states:

[A]ppropriate approaches in prevention of HIV transmission [...] include being faithful to the same partner, practicing abstinence, correct and consistent use of condoms, voluntary counseling and testing, delaying engagement in sexual practices according to well informed individual decision (URT 2001, p.6).

Information about risks of transmission and one's own serological status is assumed to induce more protective behaviours. As PEPFAR's fourth annual report puts it, “[w]herever people are, prevention programs must be there to meet and empower them at every turn with appropriate knowledge and skills” (PEPFAR 2007). This information-based approach is amended by some interviewees who stress that, although important, information and persuasion alone might not be enough to result in effective behaviour change. As the head of a local NGO of PLWH puts it, “[i]t's not easy to change people's behaviour. So many urban people know all about HIV/AIDS and still...they get infected!” (NGO-2). The acknowledgement that information about HIV transmission does not automatically translate into protective behaviours is at the origin of 'structural' explanations of the spread of HIV in Africa.

⁷⁰ For an interesting analysis of the role of 'policy branding' in the international transfer of health policies, see: Ogden et al. (2003) as well as Parkhurst (2012a).

A-2) 'If we were sex workers, we would do the same': structural explanations of risk behaviours

“Why do people become positive in the first place? It’s the result of rational decisions according to particular circumstances... If you are 32 years old and your life expectancy is 39 years, it is perfectly rational to take the risk of getting infected with HIV! If we were sex workers, we would do the same. We have to change people’s living conditions for them to change their decisions.”
(Multilateral-5)⁷¹

A variety of studies on ‘structural’ HIV prevention discuss the constrained nature of individual choice in preventive behaviours and the ensuing need to address the broader legal, socio-economic, and cultural contexts in which people make behavioural decisions (Gupta et al. 2008; R. G. Parker et al. 2000; Sumartojo 2000; Padian et al. 2011). Similarly, rather than stressing the role of free individual choice, many interviewees point to a context of social inequality and economic deprivation, and to what they consider archaic cultural norms – all of which they designate as structural obstacles to behaviour change. Referring to those structural constraints, which he considers particularly strong in Africa, a bilateral agent suggests: “in Europe, it is relatively simple to change behaviours” (Bilateral-17). While one multilateral agent points to “internal migration due to tea and sugar plantations” (Multilateral-16) as a driver of HIV transmission,⁷² an international NGO worker notes:

The biggest challenge is the cultural environment and norms: gender, transactional sex, poverty issues, gender inequalities...they limit people’s ability to practice HIV prevention. There is not much you can do about that...especially in a narrowly focused project like ours. We just got our donors to accept a pilot project with an integration of HIV prevention, economic support and capacity building. That would help them generate income, which would allow them not to sell their body. (INGO-8)

Interestingly, those interviewees who mention a relation between poverty-related conditions and HIV generally end up reducing it to the role of poverty-induced transactional sex. A Tanzanian consultant, for instance, stresses that “poverty is impeding a lot of prevention actions, both at the household and at the individual levels: OVCs [orphans and vulnerable children], ladies selling their bodies in the streets...” (Research-11). A multilateral agent expresses this causal narrative in a rather straightforward manner:

If people have food, they will not transact for sex. The reason for HIV is poverty. If you ask commercial sex workers, they will tell you ‘We have nothing to eat!’. So they sell what they have: their bodies. (Multilateral-10)

Frequently, gender issues form an important thread of the causal story. A bilateral agent (and Tanzanian national), for instance underlines,

There are power relations inside the house, which lead to HIV risk. I’m so sorry for uneducated women...they are barely surviving. [...] Don’t even try to talk about marital rape with an African guy,

⁷¹ This calculation is biased as it implicitly confounds a country’s average life expectancy *at birth* and the *remaining* life expectancy of a 32-year-old person – which, especially in countries with high infant- and child-mortality rates, is considerably higher than the difference between average life expectancy and current age.

⁷² Male circular migration induced by mining and plantation activities, as well as by long-distance transport has been repeatedly described as fuelling the spread of HIV, generally due to men seeking female companionship during their long periods of absence from home (and, which is less frequently mentioned, women seeking male companionship during their husbands’ absence).

especially a married guy! He will never understand... [...] When it comes to gender and women's rights, no one understands... In order for a Tanzanian guy to understand, you have to say: 'Let's not talk about your wives, let's talk about your daughters and your sisters!' If you talk about marital rape like this, they'll say: 'I'll kill that guy!' – There's the issue! In sub-Saharan Africa, there is no domestic violence act that addresses marital rape. In Tanzania, the Sexual Offence Special Provisions Act from 1998 talks about all this. But when it came to definitions, the activists put 'marital rape' [in their proposition]...but the MPs said: 'No way, we can't put that!' So if you are a victim of marital rape, where are you going to report that? That's a really big problem! (Bilateral-10)⁷³

These variants of the behavioural narrative prompt a call for somewhat different prevention strategies, referred to as 'structural' approaches. As the former head of UNAIDS puts it:

We know very well what needs to be done on prevention – we know what works. [...]. Crucially, HIV-prevention efforts have to fit the realities of women's lives. We must promote real access to the female condom. We must speed up the development of microbicides [another means of prevention that can be autonomously used by women]. Girls need to be assured of an education. Governments must enforce laws to make domestic abuse illegal, and to treat rape as a real crime that is punished harshly. (Piot 2005, p.8)⁷⁴

These more structural approaches focus on providing what has come to be called an 'enabling environment' – i.e. a legal, economic and socio-cultural environment that enables individuals to change their sexual behaviours.⁷⁵ The underlying causal narrative thus remains essentially the same: Africans' alleged sexual practices are considered to be, at least in part, due to factors that go beyond the individual, but specificities of sexual behaviour in Africa continue to be considered as the explanation of the African HIV epidemics. Consequently, even though the advocates of 'structural' approaches – in both the interviews and the scientific literature – have overcome naively individualistic notions of sexual behaviour, they continue to adopt a reductionist conception of HIV transmission. At one point or another, their causal narrative is behaviour-mediated.⁷⁶ This one-sided emphasis on behaviour change – be it through information and persuasion, or thanks to an improved 'enabling environment' – has led many policymakers to confound behaviour change and HIV prevention, mistaking the one for the other.

⁷³ This interviewee adds the following example: "My friend's husband has been unfaithful with an HIV-positive woman and my friend knew about it. So she asked him for condom use hiding it as a 'family planning' issue. That worked for two weeks. Then the husband objected and she didn't dare to refuse. He said: 'Even if I'm going out, you are my wife, so we have to mate!' She was infected! Later on, he apologised... Using a condom within a married couple, for an African guy, you don't need the marriage anymore!" (Bilateral-10)

⁷⁴ This 'we-know-what-works' discourse is all the more surprising as the evidence base for the HIV-specific effectiveness of such human-rights-inspired measures is at best slim. Concerning some of the contradictions of the 'human rights are good for HIV prevention' discourse, see (Parkhurst 2012b).

⁷⁵ As an international NGO worker underlines: "There are three studies on behaviour-change interventions with youth. None of them shows a difference – either in incident HIV or in other reproductive health issues – between the youth who had access to behaviour-change interventions and young people who did not have access. There is increasing recognition of the need to address these issues that go beyond...that behaviour has to do with the environment of young people" (INGO-8).

⁷⁶ STRIVE, a recently launched research consortium at the London School of Hygiene and Tropical Medicine on the structural drivers of HIV, illustrates this essentially behaviour-mediated understanding of 'structural' HIV prevention (<http://strive.lshtm.ac.uk>).

A-3) A common conclusion: confounding HIV prevention and sexual behaviour change

“The vast majority of people with AIDS have been infected during sexual activity with another HIV-carrier. The most important weapon we have against AIDS, *therefore*, is to reduce further sexual transmission of the virus; this is done either through safer sex or through reducing the number of sexual partners per person. [...] [T]he best way to slow the momentum of the virus in the community is sex education: persuading people to change the sexual habits which place them at risk.”
(Sabatier 1988, p.1, my italics)

It is striking how little has changed in the conventional wisdom about HIV prevention over the last 25 years. As a result of the role they assign to individual behaviour in the spread of the epidemic, most proponents of the behavioural paradigm still tend to equate HIV prevention with sexual behaviour change. Countless interviewees consistently confound the two issues, reducing HIV prevention to what is but one of its many possible components. “I need someone to change behaviour, because HIV [prevention] is mainly about changing individual behaviour”, says a Tanzanian official (GovSector-2). A multilateral agent underlines that “prevention is a tough job, you need to convince people to change their behaviour” (Multilateral-6). Similarly, having talked about care and treatment, a Tanzanian AIDS official defines HIV prevention in passing, by saying: “the other [issue] is prevention activities, that is telling them [people] about what they risk” (GovSector-4).

In the same way, when talking about the costing exercise of the National Prevention Strategy (see Chapter 4), a bilateral agent suggests: “Prevention is very hard to cost. We would have to measure the cost of talking...now, how do you do that?!” (Bilateral-24). PEPFAR, the world’s biggest AIDS initiative, long considered sexual behaviour change as virtually equivalent to HIV prevention.⁷⁷ In its fourth annual report (PEPFAR 2007), it writes:

Just as combination therapy revolutionized treatment, combination prevention is needed to revolutionize behavior change programs. Combination prevention includes using many different modalities to affect behavior [...]. Prevention programs need to blanket geographic areas with varied prevention modalities, so that all the youth hear the messages and can change their behavior accordingly.

What the authors of the PEPFAR report call ‘combination prevention’ essentially consists in a combination of different types of behaviour-change interventions (see also table 6 in: *ibid.*). The Tanzania National Policy for HIV/AIDS summarises today’s dominant framing of the epidemic:

As over 80% of HIV infection is through sexual intercourse, prevention of sexual transmission is the key in the control of the HIV/AIDS epidemic. *Therefore* the main objective is to raise public awareness of the risk and change of behaviours that put individuals at the risk of contracting or transmission of HIV and other sexually transmitted diseases in order to reduce the spread of the epidemic. (URT 2001, p.18, my italics)

⁷⁷ PEPFAR does, of course, acknowledge mother-to-child and health-care transmission, and it now encourages male circumcision – a non immediately behaviour-based prevention intervention.

The reductionist nature of the conventional wisdom on HIV/AIDS is illustrated by the transition from what is presented as a statement of fact – “over 80% of HIV infection is through sexual intercourse”⁷⁸ – to the allegedly logical conclusion in terms of prevention priorities: “therefore” the main objective is to change behaviours. The question of transmission efficiency (i.e. the risk of infection per sexual contact) is simply ignored (see Section B). This leads to an exclusive fixation on behaviour as the determinant of sexual transmission.⁷⁹ Consequently, changing people’s behaviour is erroneously considered as being the only way to reduce sexual HIV transmission. This reductionist vision is also widespread at the international level – where it has immediate allocative consequences. UNAIDS (2008), for instance, suggested that, in 2010, 73% of the funds for HIV prevention in sub-Saharan Africa should be spent on interventions related to behaviour change.⁸⁰ Most of these interventions fall within the ‘ABC’ approach, all focus on reducing the number of (unprotected) sexual contacts.

While behaviour-based narratives of the spread of HIV are dominant among AIDS policymakers in Tanzania, some rare interviewees do have a less individualised and considerably more political vision of the Tanzanian epidemic. Well aware of the impact of various neglected tropical diseases (NTDs) on susceptibility to HIV infection (see Section C), one Tanzanian official, for instance, declares: “It’s also a social issue! All these infections are skewed in that they over-proportionally hit the poorest of the poor. Now, that is not a specifically scientific criteria...it’s more of a social reason to combat these diseases” (GovSector-13). Similarly, having underlined the role of socio-economic inequalities and ill-conceived economic policies in making African populations vulnerable to infectious diseases, a senior researcher and activist at a Tanzanian NGO concludes: “We have to get out of victimology! [...] What are people’s livelihoods? What about user fees, maternal mortality, access to clean water, etc...?!”, adding, with reference to one of my previous remarks about co-infections, “the main problem is the very thing you are working on!” (NGO-1). While these critical, politicised voices exist in Tanzania, they remain rare exceptions to the rule. Interestingly, the few interviewees who clearly distance themselves from the dominant behavioral narrative of the African HIV epidemics appear to either have a specific technical expertise in the field of transmission-facilitating cofactors, or a background of social justice activism, and thus a political worldview that facilitates the adoption of non-individualistic narratives of disease.

⁷⁸ The remaining infections being due to mother-to-child transmission, injection drug use, blood transfusions, and other unsafe medical, paramedical and esthetical practices. As discussed below, this statement is, at best, a vague approximation.

⁷⁹ A multilateral agent’s reaction to the costing of the National Prevention Strategy reflects the idea that sexual behaviour is the only variable that affects sexual HIV transmission: “I was very shocked to see the 8% for youth and behaviour-change interventions. If you look at the document, it says that heterosexual intercourse accounts for 80% of the transmissions – so *that’s* the main driver!” (Multilateral-9).

⁸⁰ The actual effect of such UNAIDS guidance on the budgetary allocation within PEPFAR or the Global Fund, however, is at best indirect. It should also be noted that the UNAIDS’ “investment framework allocation” for 2015 suggests that the proportion of behaviour-related programme activities be reduced, mainly to the benefit of PMTCT and male circumcision programmes (UNAIDS 2011b, p.32). Yet, although quite vague, the expenditure for what UNAIDS calls “critical enablers” seems to include a significant proportion of structural behaviour-change interventions.

B) Paradigm maintenance and public health obscurantism

“In an age when lifestyle is causally linked to disease, it is not surprising that researchers associate distinct patterns of human behaviour with AIDS or that AIDS is categorized primarily as a sexually transmitted, rather than blood-borne, disease. The emphasis on sexual behaviour has led some observers wrongly to characterize Africans as highly promiscuous. Without a global survey of sexuality, no norm for sexual behaviour exists to measure this assertion.”
(Turshen 1989, p.229)

Historically speaking, the behavioural paradigm (i.e. the claim that differences in sexual behaviour explain Africa’s disproportionate HIV epidemics) was directly derived from studies of Western AIDS epidemics.⁸¹ Sexual behaviour being the main explanatory variable in their causal model, Western AIDS scholars, when confronted with the extremely high African prevalence rates, deduced that ‘African’ sexual behaviour must fundamentally differ from that of the rest of the world. During the early years of the epidemic, when describing the reasoning of Western lifestyle advocates of disease causation when they were faced with the African AIDS epidemics, Turshen wrote: “they level charges of widespread promiscuity and prostitution, distorting the reality of African life to fit their preconceptions” (1989, p.220). Packard and Epstein (1991a, p.774) also argue that “the association of AIDS in the west with the alleged sexual promiscuity of homosexuals” led researchers to conclude that the heterosexual spread of HIV in Africa “implied similar levels of promiscuity”. “[W]estern research on AIDS had already defined AIDS as a behavioral problem associated with aberrant lifestyles”, they underline, “[t]here was thus a predisposition to look for ‘deviance’ in an African setting” (*ibid.*). It is deductive reasoning, not empirical observation, that led to the uncontrolled transfer of the dominant causal story from Western countries to Africa.⁸² Consequently, various researchers have successively put forward a wide variety of hypotheses about specificities of sexual behaviour in Africa. Among their favourite examples were ‘exotic’ sexual practices (e.g. ‘dry sex’) or cultural customs (e.g. widow cleansing or initiation rites)⁸³. Admittedly, anthropologists did not have to search very hard, as many of these very same ‘customs’ were already at the heart of the causal stories of widespread syphilis in East Africa during the late 19th

⁸¹ Caldwell et al. (1989; 1992), Rushing (1995), Morris and Kretzschmar (1997), Thornton (2008), as well as Halperin and Helen Epstein (Halperin & H. Epstein 2004; Halperin et al. 2011; H. Epstein 2007) – to name only a few – are among those who most explicitly and most successfully levelled this claim. The essentially sexuality-based nature of Western AIDS activism during the 1980s described by Steven Epstein (1996) certainly played an important role in the over-sexualisation of notions of the African epidemics.

⁸² de Waal interestingly argues that the transfer of the Western responses to HIV/AIDS not only affected the (behaviour-centred) content of HIV-prevention policies, but also their shape, i.e. the individualistic, NGO and human rights-based model of political action to which AIDS activism in the West gave rise. As de Waal puts it, “[t]he AIDS industry is a prisoner of political circumstance [...]. In fact, the un-theorized consensus on AIDS programmes and policies has been dictated by the political and ideological environment in which AIDS first developed in the United States, and then became a subject of concern in Africa” (2003, p.255). This analysis directly echoes the statement of one interviewee about how the risk of HIV transmission through breastfeeding was dealt with in Africa: “The Abidjan study on the risk of breastfeeding showed that 2 years of breastfeeding cancels the benefit of [a single dose antiretroviral treatment] at birth. So we needed to give clear messages on breastfeeding! But they decided to do so-called ‘informed consent workshops’ for counsellors all over Africa! And 7 years down the road, they come up with [the guideline of] ‘exclusive breastfeeding’... We lost 7 years! We adopted the human rights approach from the gay community without critical reflection!” (Multilateral-13)

⁸³ These narratives are taken up by AIDS policymakers. Several interviewees point to traditional practices as drivers of HIV transmission. One multilateral agent (and Tanzanian national), for instance, underlines: “Another issue are traditional medical practices. And then there are areas of cultures and taboos...you know, there are so many tribes in Tanzania...some have practices that might drive HIV infection...like the marrying of widows, etc.” (Multilateral-15)

and early 20th centuries – a variant that turned out to be *non-venereal* endemic syphilis.⁸⁴ The less immediately culturalist behavioural variables that were regularly mentioned as being of relevance to the spread of HIV include the age at first sex, the frequency of sexual intercourse, the number of life-time partners, the rates of condom use, the prevalence of cross-generational, commercial or transactional sex, and – more recently – the prevalence of concurrent sexual partnerships (see below).

Differences in sexual behaviour can, of course, influence differences in individual risk⁸⁵ and they can, in certain cases, help explain the distribution of HIV *within* a population. Consequently, behaviour change can play a role in preventing the spread of the virus – as it certainly did in many Western countries.⁸⁶ Empirical evidence, however, has made it increasingly clear that there is no such thing as ‘African’ sexual behaviour. Differences in sexual behaviour or sexual mixing patterns do not explain the variations in HIV-infection rates *between* countries and world regions, and they certainly do not explain sub-Saharan Africa’s run-away epidemics – some of which reach prevalence rates several hundred times higher than those in many Western countries (Stillwaggon 2006, chap.1+7; A. Katz 2002; A. Katz 2009; Sawers & Stillwaggon 2010a; Gisselquist et al. 2003). Indeed, not only is there no evidence of a higher frequency of sexual contacts or number of sexual partners in sub-Saharan Africa as compared to the rest of the world (Wellings et al. 2006), but *at the population level*, “there is no empirical basis for the presumption that high rates of sexual activity correlate with high HIV prevalence” (Stillwaggon 2006, p.18; See also: Buvé et al. 2001; Boerma et al. 2003; and Pettifor et al. 2011). The behavioural paradigm does not withstand empirical scrutiny.

The case of concurrent sexual partnerships merits special attention as one of the most successful behavioural causal stories of the African epidemics. Its emergence is an instructive example of the production of knowledge concerning AIDS in Africa.

⁸⁴ “Following this behavioral explanation”, Packard and Epstein write, [...] “authorities advocated public health policies which centered largely on the development of measures, often draconian in nature, to control the behavior of prostitutes. At the same time, problems associated with living conditions and sanitation, which were in fact centrally important to the spread of endemic syphilis, were ignored.” (1991a, p.773) As Packard and Epstein argue, and as discussed below, the parallel with HIV-prevention policies is striking.

⁸⁵ An abstinent person or one who consistently uses condoms is, of course, at considerably lower risk of infection than one who has frequent, unprotected sexual relations with different partners.

⁸⁶ It is, however, becoming increasingly clear that past and present behaviour-change policies have been fundamentally wrongheaded. Not only have individual-based behaviour-change measures shown little effect, but by implementing blanket prevention interventions addressed at the ‘general population’, these policies have failed to focus on key populations (Potts et al. 2008).

B-1) The concurrency hypothesis as paradigm maintenance

“And then, there is the issue of multiple concurrent sexual partnerships. They have been identified as being probably the main driver of the epidemic in Tanzania.”
(Multilateral-17)

“We have an idea that multiple concurrent sexual relations and unprotected sex play an important role [...]. Policy should really target multiple concurrent partnerships.”
(Multilateral-4)

Within a few years' time, the idea that a specific structure of sexual relations (concurrent sexual partnerships) is a key driver of HIV transmission has become a widely accepted explanation for the unique magnitude of the African AIDS epidemics. Most AIDS players in Tanzania have swiftly adopted this new causal story on the international policy agenda, without the necessary critical scrutiny. Often based on anecdotal or non-comparative 'evidence', past behaviour-based explanatory attempts have failed as comparative behavioural surveys show that the very 'risk behaviours' thought to explain the exceptional spread of HIV (e.g. early sexual debut, life-time number of sexual partners, frequency of sexual intercourse, sexual relations before and/or outside marriage) were not more – and often less – prevalent in sub-Saharan Africa than in other world regions (e.g. Wellings et al. 2006). Being considered by many as the last plausible behavioural explanation, the claim that concurrent sexual partnerships drive the disproportionate spread of HIV in sub-Saharan Africa has become a key message over the last decade.

The basic idea behind the claim is that the spread of HIV depends on the *configuration* of these sexual relations rather than on the number of sexual contacts. Indeed, at equal numbers of sexual contacts, two networks can have different densities, i.e. degrees of interrelatedness between components or sub-groups (people *indirectly* linked to one another because of their partners' sexual relations). The concurrency hypothesis consists in the double claim that HIV spreads faster in 'nets' (networks with *regular* concurrent sexual partnerships) than in 'chains' of serial monogamy (people having sex with different partners over time, but only with one partner over a given time period) *and* that concurrent sexual partnerships are more prevalent in sub-Saharan Africa than in other parts of the world.⁸⁷ The existence of a short period (of approximately six weeks) of high viral load soon after initial infection (see Appendix 2) is a key element of the concurrency hypothesis. Indeed, concurrency-based structures of sexual relations increase the chances that newly-infected individuals have sexual contact with one or several other partners during this short period of high infectiousness.

⁸⁷ Neither sexually inactive people, nor those in life-long exclusively monogamous relations are part of a sexual network. Such networks are formed by 1) serial monogamy (people change partners over time, but have no sexual relation outside the couple), 2) predominantly monogamous relations (whether serial or life-long), with *occasional* relations outside this long-term partnership, and 3) 'concurrent sexual partnerships', which consist in having more than one *regular* sexual partner over a given time period.

While the logical argument seems compelling at first, several authors have voiced concerns about lacking empirical evidence (M. Lurie & Rosenthal 2010; M. Lurie et al. 2009). Sawers and Stillwaggon (2010a) have conducted a systematic analysis of the theoretical and empirical foundations of the concurrency hypothesis. For the hypothesis to hold, they argue, epidemiologic modelling would need to show that HIV spreads more effectively in populations with concurrent sexual partnerships than in populations without, and behavioural surveys would have to establish that concurrent sexual relations are significantly more prevalent in sub-Saharan Africa than elsewhere. Sawers and Stillwaggon show that neither of these two conditions is met.⁸⁸ Since their study underpins and illustrates several key points of this Chapter, this sub-section briefly presents some of their core findings.

Morris and Kretzschmar (1996; 1997) created a model of the effect of concurrency on the spread of HIV that has been – and continues to be – widely referred to. The success of the concurrency hypothesis is based on the model's finding that, over a period of only five years, the number of infections is multiplied by ten in a population where half of all sexual relations are concurrent, as compared to a population without concurrent relations. Yet, the relevance of any model depends on the realism of its assumptions – which, in this case, are extremely remote from reality. The model's key variables are 1) the frequency of sexual contact in each relation, 2) the risk of transmission per unprotected sexual intercourse, and 3) the proportion of sexual relations that are concurrent – the total number of sexual relations being constant.

Concerning the first variable, Morris and Kretzschmar arbitrarily suppose that *every* person has sex with *every* partner, *every* day – a manifestly unreal assumption that is consistently contradicted by behavioural surveys. Using empirically observed data concerning the frequency of sex reduces the effect of concurrency up to thirtyfold (Sawers & Stillwaggon 2010a). Adding the fact that non-primary partnerships have lower rates of coital frequency than primary partnerships reduces the effect of concurrency even further, even if this “coital dilution” is low (Sawers et al. 2011).⁸⁹

Concerning the second variable, Morris and Kretzschmar assume that the risk of HIV transmission per unprotected coital act is 5% – which is about fifty times the estimated average risk (see below) and still considerably higher than the empirically observed risk of transmission during the most risky, early phase of infection among people with no co-infections (1%-2%). This combination of unrealistic hypotheses concerning the risk of transmission and coital frequency implies that the transmission of the virus to all partners is nearly certain during the six-week period of acute viremia. As Sawers and Stillwaggon (2010a) show, assuming a 1% (or 2%) risk of transmission and a more realistic coital frequency (i.e. one sexual act per partner every ten days), the probability of transmission during this six-week period drops from

⁸⁸ Most studies that invoke the concurrency hypothesis refer to the works of Martina Morris, Timothy Mah, Daniel Halperin and Helen Epstein. Sawers and Stillwaggon have therefore conducted an exhaustive analysis of these authors' works on the subject, and of all studies to which they refer.

⁸⁹ This finding is based on an amended version of a more recent concurrency model by Eaton et al. (2011).

88,4% to 4% (or 8%), then to below 4% per year, assuming a per-act transmission risk of 0.1% after acute viremia.

As for the third variable, the percentage of partnerships that are concurrent, Morris and Kretzschmar's initial model (which continues to be widely referred to) assumes this proportion to be 50% – again, an unrealistic figure. In a more recent model, Morris and Kretzschmar (2000) used the proportion (and average duration) of concurrent sexual partnerships observed in Rakai (20,2%), a Ugandan region where this proportion is certainly higher than the African average (if compared to the data from the Demographic and Health Surveys (DHS) mentioned below). They also abandoned the initial assumption (which is consistently contradicted by behavioural surveys) that women were as likely to have concurrent sexual partners as men.⁹⁰ Dropping this assumption, alone, provokes a fourfold decrease of the effect of concurrency on the spread of HIV. When taking into account the 20% (rather than 50%) prevalence of concurrent partnerships, the model suggests that concurrency increases the number of HIV infections by only 26% over five years (and not by 1000% as in the initial model) – still assuming the manifestly absurd rates of coital frequency and transmission efficiency described above. Once the model adopts empirically informed assumptions, the effect of concurrency on the spread of HIV thus collapses and, as Sawers and Stillwaggon argue, the negligible residual effect is probably due to the fact that the model compares a situation with concurrent sexual partnerships to one with perfect serial monogamy (without any occasional sexual contacts outside stable partnerships) – an unrealistic basis for comparison (see also: Sawers 2013).

As for the empirical foundation of the hypothesis, existing data show that the average prevalence of concurrency is slightly lower in sub-Saharan Africa (3.4%) than in the United States (3.6%) (Sawers 2013).⁹¹ Moreover, Sawers and Stillwaggon (2010a) point to a disconcerting list of omissions, inaccuracies and mistakes in the use of data by the proponents of the concurrency hypothesis. These authors repeatedly quote anecdotal rather than representative data, report inaccessible studies, and misreport existing but irrelevant data (e.g. invoking studies that have not measured concurrency as the authors themselves define it). More strikingly, by omitting to mention the prevalence of concurrent sexual partnerships outside Africa, their studies generally abstract from the necessarily comparative nature of evidence concerning this essentially comparative question. Last but not least, the proponents of the concurrency hypothesis generally ignore or disregard without reason the detailed and representative data from the Demographic and Health Surveys. These surveys contradict previous studies by the WHO in 1989-90, which exaggerated the prevalence of concurrency by including the mere intention of having a sexual relation and by adopting a definition of 'regular partner' that includes partners with whom the respondents have not had any sexual relation for several months, if not years.

⁹⁰ In all behavioural surveys, fewer women than men declare having concurrent sexual partnerships. Since the data are based on self-reported behaviour, there certainly is a bias due to the lower social acceptability for women to have multiple partners. Yet, the difference between men and women is consistent and important (Sawers 2013).

⁹¹ The figures for Europe are very close to those from the United States (Sawers 2013).

Unsurprisingly, no national representative survey has confirmed these figures since (see: Sawers & Stillwaggon 2010a; Sawers 2013).

In sum, one of the theoretical pivots of the dominant explanatory paradigm of the African AIDS epidemics is built upon ill-documented assumptions about African sexual behaviour and its alleged epidemiological consequences, not upon rigorous scientific research. As mentioned, each of the two elements of the reasoning – the theoretical plausibility that concurrency significantly increases the spread of HIV, and the empirical proof that concurrent sexual partnerships are exceptionally prevalent in sub-Saharan Africa – is a necessary condition for the credibility of the concurrency hypothesis. Having shown that even this last behaviour-based explanatory attempt of the African AIDS epidemics is theoretically implausible and empirically unfounded, Sawers and Stillwaggon (2010a; Sawers 2013) call for future research to concentrate on factors other than sexual behaviour.

Notwithstanding the meticulous rigour of their work, the unabated research and prolific publications on the issue suggest that their wish is not being fulfilled. On the contrary, many behavioural researchers are manifestly engaged in what Wade (1996), in a different context, fittingly termed “paradigm maintenance”. This reinforcement of beliefs following empirical invalidation falls within what Festinger (1957) described as the reduction of “cognitive dissonance”, i.e. a situation that induces denial due to people’s inability to face a reality that is radically incompatible with their mindset (see Chapter 5).⁹² One consequence of the effort to maintain cognitive harmony is a blinkered perception of available evidence. Interestingly, although *variations in HIV infectiousness* are at the very origin of the concurrency hypothesis, its proponents have exclusively focused on the interactions of the natural viral-load fluctuation (due to the delayed initial immune response) with the structure of sexual relations they posit. They have not looked at which other biological factors temporarily or durably affect the transmission efficiency of HIV.

⁹² A now famous case of denial due to cognitive dissonance is the US military’s reaction in Pearl Harbor. The US army decided to ignore the radar alarm system signalling enemy planes coming right at them because they firmly believed a Japanese attack so far off-coast to be impossible. Festinger, as for him, observed the counterintuitive belief persistence of members of a UFO doomsday cult. The failed message of earth’s destruction, sent by aliens to a suburban housewife in 1956 became a disconfirmed expectancy that increased dissonance between cognitions and led to increased proselytism, rather than to the abandonment of their belief. As the Spanish philosopher George Santayana said, fanaticism calls for a doubling of effort in the face of failure (quoted in: Ricupero 2003, p.1).

B-2) Practicing public health by scaring the public: The inefficiency of coital HIV transmission and the spectre of a 'global AIDS pandemic'

“And why UNAIDS? Why is there no UN-malaria?! AIDS has a fear factor. International experts said: ‘Everybody is at risk of HIV...it’s like a time bomb!’ That hit it right to the politicians! Look at the photos used at the start of the epidemic... And epidemiologically speaking it is *not* true that everybody is at risk. They used the fear factor!”
(INGO-3)

A person’s risk of HIV infection depends on two variables: the number of times he or she is exposed to the virus, and the risk of infection per exposure (which depends on the infectivity of the virus and the efficiency of the mode of transmission). While the first variable depends to a great extent on individual behaviour, the second one is essentially non-behaviour determined. By focusing on sexual behaviour change, today’s HIV-prevention policies predominantly attempt to act upon on the number of exposures to the virus.⁹³ Generally speaking, however, penile-vaginal contact is a very inefficient way to transmit HIV, which clearly distinguishes it from other sexually transmitted diseases. Indeed, within otherwise healthy sero-discordant couples, the average male-to-female risk of HIV transmission is approximately 1 per 1000 unprotected coital intercourses, and about 1 per 2000 for female-to-male transmission (Boily et al. 2009).⁹⁴

By omitting the risk-per-exposure variable, most studies based on the behavioural paradigm implicitly assume this average risk to be identical all over the world. This average probability, however, varies not only according to the phase of HIV infection of the HIV-positive partner (see above)⁹⁵, but also according to people’s general and genital health status. Indeed, the estimates of per-coital-act transmission risk mentioned above concern industrialised countries with generally well nourished, healthy populations that have access to clean water, sanitation and quality health care. It is the inefficiency of heterosexual transmission of HIV in *healthy* populations that explains why “[t]o the surprise of epidemiologists, HIV has made few inroads in the [general] population in affluent countries, in spite of heterosexual epidemics of other sexually transmitted diseases” (Stillwaggon 2006, p.4). Indeed, no Western country has known a generalised epidemic and, outside sub-Saharan Africa, HIV has generally remained confined to groups in which the dominant mode of transmission is not coital intercourse (e.g. men having sex with

⁹³ As discussed below, there are two exceptions to this rule: male circumcision and the treatment of sexually transmitted infections.

⁹⁴ Referring to a Zambian cohort study (Trask et al. 2002), Brewer et al. (2007) rightly underline that estimates of transmission probability are biased upwards if based on seroconversion in serodiscordant couples alone. Indeed, in the Zambian study, 13% of the couples thought to have transmitted the virus within their couple were infected with genetically unrelated viruses.

⁹⁵ According to Boily et al. (2009), the risk of transmission is approximately 9 and 7 times higher if the HIV-positive partner is in the early or late phase of HIV infection respectively (as compared to the long, asymptomatic phase in between). Although this is a significant increase in risk, HIV transmission is still far below 100%. The French ‘tainted blood scandal’ in the 1980s provided an unfortunate but instructive experience in this respect : After three years of conjugal life, 10% of the partners of the previously transfused haemophiliacs got infected with HIV (personal communication). The fact that 90% of the partners were not infected despite regular unprotected sexual contact, even during the most dangerous early phase of HIV infection, illustrates the low coital transmission efficiency of HIV. Some cases of transmitted HIV could, of course, also be due to anal intercourse.

men (MSM) and injecting drug users) or who had a very high coital frequency (e.g. commercial sex workers).⁹⁶

The strategic use of the term 'pandemic' by many international AIDS players is revealing of their negation of the low coital infectivity of HIV. Indeed, the use of the term pandemic (from the Greek 'pan-' = 'all' and 'demos' = 'people or population') is misleading, as it suggests an *equally distributed* risk of infection over the whole population – which is obviously not the case. Not only do HIV epidemics significantly differ from one region to another, but many countries (and cities) have *multiple* parallel HIV epidemics. While these epidemics are interrelated through a complex interplay (which is why the use of 'epidemic' in the singular can make sense), each of them evolves in parallel, according to different dynamics, with different drivers and 'key populations' (IDUs, MSM, CSW, users of unsafe medical care, etc.).⁹⁷ Concerning HIV/AIDS, the use of the term 'global pandemic' is thus not only epidemiologically inappropriate and politically questionable, it hampers a realistic understanding of epidemic dynamics and a definition of adequate responses.⁹⁸ It makes it impossible to understand why HIV has reached massive proportions only in relatively few countries, where HIV has spread in the 'general population'⁹⁹. As one interviewee, a French doctor working with HIV patients since the beginning of the epidemic, puts it :

Montagnier said 'AIDS is invading the world and it will soon arrive in Asia...'. As if there was a sculler, rowing to gently move forward the boat of HIV...it doesn't work that way! It's not like the flu: there is no clear geographical propagation. HIV, that's mini-epidemics...AIDS is not a pandemic! People should stop saying this kind of nonsense. It does not affect *everybody*, it's an endemic, or more precisely, an endemo-epidemic disease. It's [composed of] lots of small, localised epidemics. (Research-12)

Although UNAIDS and other international organisations have stopped speaking of HIV/AIDS as a 'pandemic' over recent years, they have intentionally kept alive the fear of a global spread of the virus. In 2005, the head of UNAIDS (Piot 2005, p.2), for instance, still claimed:

[T]he epidemic is globalizing increasingly rapidly, from West Africa to Eastern Europe, from China and India to the Caribbean and Central America. And in country after country, the tipping point is being reached – that ominous point, which varies between countries, after which AIDS no longer remains concentrated in so-called 'hot spots' but becomes a generalized explosion across the entire population. [...] Within the next decade, the Asia-Pacific region, with a population five times that of sub-Saharan Africa, could easily become the next epicentre of the epidemic.

Pisani (2008, chap.1) insightfully describes how this fear of generalised AIDS epidemics outside Africa was entertained against better knowledge by UNAIDS. This claim is indirectly confirmed by a multilateral agent in Tanzania: "We did good advocacy work on the global level", he says, adding "maybe we exaggerated sometimes, but had we done less, we wouldn't have had as many results!" (Multilateral-6).

⁹⁶ Interestingly, Turshen (1989, chap.12) and Vachon (2010, p.42-44) underline that, in several studies, most of the commercial sex workers who were found to be HIV infected were also injection drug users – an important detail.

⁹⁷ For this reason, and contrary to many political scientists and AIDS activists who freely refer to 'the global AIDS pandemic' in the singular, I use the term 'epidemic' or 'epidemics'.

⁹⁸ See also (Vachon 2010, p.56-65).

⁹⁹ The 'general population' is an unfortunate expression that designates people who do not belong to a 'risk group' that is easily identified *a priori*. It thereby quite arbitrarily stigmatises and isolates people as not being part of the 'general population'.

In June 2008, Kevin de Cock, the then director of the WHO department of HIV/AIDS actually declared that "[i]t is very unlikely there will be a heterosexual epidemic in other countries" – "other" meaning outside Africa (The Independent 2008). He thereby acknowledged that HIV is not infectious enough to provoke generalised 'heterosexual' epidemics in healthy populations. Despite its epidemiologic foundation, de Cock's statement provoked a surge of indignation among AIDS players all over the world and vested interests in UNAIDS and other international agencies forced him to qualify his statement considerably. This reaction illustrates the still deep-seated adherence to the behavioural paradigm, which not only assumes that largely diverging epidemic dynamics are due to differences in sexual behaviour, but which implicitly suggests that HIV prevention and resource mobilisation are facilitated by fear, rather than transparent information.

While the low coital infectiousness of HIV might not be the kind of information public health officials would want to shout from the rooftops¹⁰⁰, the obscurantism of most HIV-prevention programmes in this respect has serious implications. Talking about PMTCT programmes, an INGO project manager reports:

95% of the women chose to get tested. But there is a dramatic difference between men and women. Most men wait for their partner's test result and then deduce their own serostatus. People don't believe in discordance! (INGO-11).

Similarly, a multilateral agent notes:

Many people don't believe in discordance in Tanzania. And they won't believe you when you talk about discordance. They think that if you have unprotected sex with an HIV-positive person, you are 100% sure to be HIV positive, too. So they think, if my partner is positive, I'm positive too, and if I'm positive, my partner is too. They take their partner's HIV status as their own! So when you come and talk about discordant couples, they say: 'you must be lying!'. But I guess that's also because of the more general messages on HIV that have been spread... (Multilateral-12)

In Uganda, for instance, it is estimated that half of the new infections that occurred within married couples in 2007 happened within HIV-discordant couples – i.e. from one partner to the other, rather than due to outside partners (PEPFAR 2007). It becomes extremely difficult to protect the uninfected partner if people do not believe in sero-discordance because of obscurantist prevention messages that implicitly suggest that the risk of HIV transmission via unprotected sex is close to 100%. The omission of transmission efficiency not only has negative side effects on prevention messages, it also hampers a realistic and transparent evaluation of transmission risks, biasing HIV-prevention strategies towards behaviour-change interventions.

¹⁰⁰ Another oft-omitted fact underlined by one interviewee confirms that statistical regularities might not be such good advice for individual conduct: "For young women, at defloration, the risk of transmission is huge! In my service, I had at least ten [HIV-positive] girls telling me: 'Doctor, it was my first sexual relation!'. [...] It's a wound, it bleeds! It's a 100% [of transmission risk]...or nearly" (Research-12).

The selective acknowledgement of transmission efficiency: two exceptions

The promotion of medical male circumcision and STI control constitute two noteworthy exceptions to the neglect of HIV transmission efficiency.¹⁰¹ Both male circumcision (if practised safely and if patients comply with the post-surgery obligation of abstinence) and the treatment of STIs lower the risk of HIV transmission per exposure. Yet, why did precisely these two interventions – male circumcision and STI control – ‘make it through’ the long process into national prevention strategies and not others? The existence of randomised controlled trials showing the protective effect of male circumcision certainly contributed to its resonance. Two elements might help explain the uptake of these two interventions based on lowering HIV-transmission efficiency: both consist in closely circumscribed ‘technical’ measures that can be implemented without raising questions of social justice, and both are related to sex and compatible with the behavioural paradigm. The rationale for limiting interventions to *sexually* transmitted infections only (excluding vector-borne diseases such as genital schistosomiasis), however, is never stated. That being said, while these measures have become standard elements of most African HIV-prevention strategies and discourses, their actual implementation remains haphazard. As a Tanzanian health official stresses:

The response is not evidence-guided! Look at STIs: the evidence is there since 1995¹⁰² that STI control prevents HIV transmission, but hardly any money was spent on it! I still don’t know of any national AIDS control programme where the whole country is covered with STI management. The same is true for male circumcision...it’s been three years since we found out that male circumcision could prevent HIV infections. But there is not that much interest in male circumcision as there is on ART [antiretroviral treatment]! [...] Male circumcision came up very strongly and everybody was convinced it would be a major element of future prevention. Now, three years down the line, they are pushing us to adopt it as an intervention, but nobody is giving us money to do it. Donors don’t want to paralyse our health system. We told them that most health centres in the country only have one theatre, which is already booked solid for other surgeries. So they would need another, smaller theatre to perform male circumcisions. And these would need the equipment and the gloves, etc. ... and donors don’t want to pay for that! With STI control, it’s the same thing! (GovSector-12)

Although the implementation of male circumcision has recently increased in several regions of Tanzania, the major obstacles these two medical interventions face in their implementation illustrate the crucial importance of a functioning health infrastructure in the response to HIV/AIDS (see Chapters 6 + 7).

¹⁰¹ As early as 1997, the World Bank (1997, sect.2.2) acknowledged that “[t]he risk of infection per contact is not a constant; it can be influenced by a variety of factors, some of which may tend to exacerbate the epidemic”. The only two factors the report mentions are STIs and male circumcision: the crucial insight that the risk per contact is not uniform, did not affect the policy priorities – nearly exclusively based on the behavioural paradigm.

¹⁰² This interviewee refers to the first randomised controlled trial conducted on STI control on HIV transmission was conducted in Tanzania (Grosskurth et al. 1995).

C) An epidemic waiting to happen?¹⁰³ Cofactors and population susceptibility to HIV infection

“HIV sexual transmission is very inefficient, and a number of biological factors are critical in determining whether an unprotected sexual exposure to HIV results in productive infection.”
(Kaul et al. 2011, p.317)

“Béchamp avait raison, le microbe n'est rien, le terrain est tout.”
(Louis Pasteur¹⁰⁴)

No doubt, the behavioural narrative of the African AIDS epidemics has been influenced by Western stereotypes of African sexuality (Sabatier 1988; Turshen 1989, chap.12; Farmer 1992; Stillwaggon 2003). The mere argument that its proponents were guided by culturalist (or racist) prejudices about Africans' alleged sexual promiscuity, however, is insufficient to dismiss behavioural explanations of the spread of HIV. As Sabatier (1988, p.5) puts it, the charge of racial prejudice can be “a convenient tool to avoid discussing the real dangers of AIDS”. Contesting the behavioural explanations of the African epidemics thus requires more of an argument than the mere assertion that they are ideologically biased or politically convenient (which they are, as discussed in Chapter 2). In order to develop a political analysis of the causal stories of AIDS in Africa, it is thus important to scrutinise the evidence that helps explain the disproportionate spread of HIV in sub-Saharan Africa. Since differences in sexual behaviour cannot explain the magnitude of the African HIV epidemics, one has to look at which other differences potentially relevant to the spread of HIV exist between sub-Saharan Africa and the rest of the world. One of these differences is the high prevalence of parasitic diseases and co-infections known to facilitate HIV transmission.

The risk of transmission per coital act depends on two factors: 1) the susceptibility to infection of the HIV-negative person and 2) the infectiousness of the HIV-positive partner, which greatly depends on his or her viral load, i.e. the concentration of HIV RNA in the blood and other body fluids (Quinn et al. 2000; Hughes et al. 2012). Apart from the use of antiretroviral treatment, a person's viral load depends to a great extent on his or her general health status. The healthier a person, the better his or her immune system can keep the virus from entering and replicating in the body.¹⁰⁵ In the same way, an HIV-negative person's ability to avoid infection in case of exposure depends on his or her general health status. Another important factor in determining the risk of transmission is the health of the mucous membranes of both partners' genitals. Any infection, even asymptomatic, increases their permeability to the virus and greatly adds to the risk of HIV transmission in either direction. The risk of transmission per coital act varies depending on the two partners' immunological and general health status as well as on the health

¹⁰³ Expression taken from Marks' homonymous paper (2002), which, however, does not address cofactors.

¹⁰⁴ It is difficult to trace back to its original version this legendary sentence, supposedly pronounced by Pasteur shortly before dying...let alone to verify if it has actually been pronounced. Alternatively, some quote Pasteur as referring to Claude Bernard, not Antoine Béchamp.

¹⁰⁵ One illustration is the fact that malnourished HIV-infected people show a quicker progression to AIDS (see Chapter 7).

of their genital mucous membranes. The same is true for mothers, whose health and nutritional status influences the risk of vertical (mother-to-child) HIV transmission. This basic epidemiologic fact sheds a different light on the unequal global distribution of HIV.

A wide range of biomedical and epidemiological evidence points to the fact that the virus spreads more easily in populations with poor nutritional and general health status. While many forms of ill health affect individual and population susceptibility to infection, a great number of studies underline the role of certain biological cofactors in increasing the probability of sexual and vertical HIV transmission. Sexually transmitted diseases (such as HSV-2, syphilis, gonorrhoea, trichomoniasis, chlamydia, and bacterial vaginosis¹⁰⁶) were among the first cofactors whose effect on HIV transmission was pointed to by epidemiologic studies (e.g. Auvert et al. 2001; Kaul et al. 2011; McClelland et al. 2007). Similarly, genital ulcers – which are particularly widespread in sub-Saharan Africa and can be sexually transmitted or due to non communicable diseases – considerably increase coital infectivity of HIV by disrupting genital epithelia (Powers et al. 2008). Although recently debated, these insights have been reasonably well integrated into UNAIDS prevention guidelines (UNAIDS 2007). Yet, the geographic coverage of STI management remains haphazard in most of sub-Saharan Africa. The prevalence of STIs greatly depends on a population's access to health care, and particularly to antibiotics – which are all too often unavailable in African health centres. Nevertheless, because the spread of STIs *also* depends, by definition, on sexual behaviour, the high prevalence of STIs in sub-Saharan Africa is compatible with – and at times abusively invoked as a confirmation of – the behavioural paradigm. Stressing the role of STIs as cofactors in the spread of HIV thus only partially contributes to a less behaviour-centred causal narrative of the African HIV epidemics.

That being said, the effectiveness of STI treatment for HIV prevention has been put into question by several randomised controlled trials (RCT) showing no significant difference between the intervention arm and the control group (only one RCT showing a positive effect). As a result, several bilateral donors (among which Germany) have taken STI treatment off their list of HIV-prevention interventions. These results, however, are biased for several reasons (see Stillwaggon 2006, p.65–6; Stillwaggon & Sawers 2012). One of them being that, in order to comply with minimal ethical standards, control groups of RCTs need to benefit from basic medical care (e.g. deworming, vitamin supplementation, etc.). As a result, there is no control group of completely untreated individuals. The RCTs thus measure the difference in HIV incidence between people treated for STIs and people treated for helminths and receiving vitamin supplements. The absence of a significant difference might therefore simply indicate that both interventions are equally effective (if the intervention group did not receive deworming and vitamin supplementation), or that treating STIs does not procure a significant *additional* protection as compared to the other interventions alone. More generally, and as discussed in Part 3, the synergistic interactions

¹⁰⁶ Bacterial vaginosis can also occur in individuals who are not sexually active.

between cofactors suggest that isolating single conditions in multi-burdened populations amounts to adopting a reductionist vision of linear causality that is of limited value (Stillwaggon 2006, chap.8; 2012).

Several other common parasitic or infectious diseases such as malaria, tuberculosis, lymphatic filariasis, soil-transmitted helminths, leishmaniasis, genital schistosomiasis, or other reproductive tract infections, as well as certain micronutrient deficiencies have been shown to fuel HIV transmission by increasing their carriers' infectiousness and by impairing HIV negative people's mucosal and systemic immune response in case of exposure to the virus (cf. Stillwaggon 2006, chap.1□4; 2012; Kaul et al. 2011).¹⁰⁷ The (chronic) immune activation some of these conditions can entail leads to both local (genital) and general increases in CD4 + lymphocytes and macrophages, the target cells of HIV. This facilitates initial viral replication in case of exposure.

Malaria and tuberculosis, for instance, clearly fuel the spread of HIV. In vitro, malaria antigens have been shown to multiply HIV replication in blood cells by up to 100 times (Xiao et al. 1998), and a study in Malawi showed that HIV-positive men with malaria had seven times the median viral load of HIV-positive men without malaria (I. Hoffman et al. 1999).¹⁰⁸ Similarly, malaria increases HIV viral load up to tenfold and for a duration up to six weeks after malarial episodes (Abu-Raddad et al. 2006; I. Hoffman et al. 1999; Reithinger et al. 2009), increasing both sexual and vertical HIV transmission.¹⁰⁹ In a model of the interaction of HIV and malaria in a hypothetical (but realistic) Kenyan setting with a population of 200,000 adults, Abu-Raddad et al. (2006) estimate that the disease interaction was responsible for 8,500 excess HIV infections and 980,000 excess malaria episodes since 1980. With over 300 million people suffering from acute malaria each year in sub-Saharan Africa, malaria clearly affects population susceptibility to HIV/AIDS. A recent study using nationally representative samples from Kenya, Malawi and Tanzania confirms these findings at the population level: living in areas with high malaria parasite (*plasmodium falciparum*) rates more than doubles people's risk of being HIV-infected compared with individuals who live in low malaria prevalence areas (Cuadros, Branscum, et al. 2011). The interaction between HIV/AIDS and malaria is mutually reinforcing. This leads to a vicious cycle: not only does malaria increase the spread of HIV, but being HIV positive increases people's risk of infection with malaria, their malaria parasite density, and the risk of antimalarial treatment failure (WHO 2004).

A comparable vicious cycle exists between HIV and tuberculosis, which also promote and reinforce one another. HIV infection makes the immune system particularly susceptible to TB infection and activates dormant TB, and untreated tuberculosis drastically increases HIV viral load.¹¹⁰ The mutual acceleration of

¹⁰⁷ I thank Eileen Stillwaggon for making me discover this widely omitted body of evidence, which I only very briefly review here.

¹⁰⁸ As Stillwaggon notes, the reduction in viral load resulting after malaria treatment indicates that causation goes from malaria to higher viral load, not vice versa.

¹⁰⁹ Interestingly, the WHO (2004) notes that some of the increase of HIV transmission to children is due to the transfusion of unscreened blood to treat malaria-induced anaemia. The same risk, of course, exists for adults.

¹¹⁰ The incidence of active TB is significantly higher in people with weakened immune systems and/or who live in overcrowded housing (cf. Clark et al. 2002).

the two pathogens creates a highly deadly mixture. Treating tuberculosis in HIV-positive TB patients, in turn, reduces their viral load by up to 3.47 log₁₀ copies per mL (Modjarrad & Vermund 2010), slowing disease progression and lowering the per-coital-act HIV infectivity considerably (Hughes et al. 2012; Modjarrad et al. 2008). In Tanzania, the number of TB cases surged rapidly as HIV prevalence rose, increasing six fold between 1983 (11,753 notified cases) and 2004 (65,665 cases), which approximately represents an incidence of 230 per 100,000 people. Today, this incidence has dropped to 177/100,000¹¹¹, while close to half of all Tanzanians newly diagnosed with TB are also infected with HIV (PATH 2011). Controlling malaria and TB is thus essential in reducing the spread of HIV.

A wide variety of less known but highly prevalent parasites have also been shown to facilitate HIV transmission. Genital schistosomiasis, a lifetime infection of the reproductive tract due to flatworms whose larval stages live in freshwater (P. J. Hotez 2008, p.29), for instance, causes irreversible lesions in the vulva, vagina, cervix and uterus, providing direct access to the blood stream for the virus (Feldmeier et al. 1995). Male genital schistosomiasis also causes inflammation and bleeding, as well as increased viral shedding in HIV positive people. An observational study on HIV and schistosomiasis in Zimbabwe has shown that HIV prevalence was three times higher in women with genital lesions and inflammation due to schistosomiasis than in women without these lesions (Kjetland et al. 2006). In Tanzania, genital schistosomiasis is highly prevalent in several regions, among which districts around Lake Victoria, which were hardest hit during the early years of the epidemic (Clements et al. 2006). A recent study of the relation between schistosomiasis and HIV (conducted in the Lake Victoria region) confirms the findings from Zimbabwe: HIV prevalence was more than three times higher among women with genital schistosomiasis than among women without this parasitic disease (J. Downs et al. 2011; see also: J. Downs et al. 2012). The pathology caused by schistosomiasis in adults can be prevented effectively by a once-per-year, single-dose praziquantel treatment, which costs 0,15 € and can be administered by non-specialised people (P. J. Hotez 2008, chap.3). WHO underlines that “even a single treatment given in childhood prevents half of the cases of female genital schistosomiasis” (WHO 2009b). Yet, in his analysis of schistosomiasis control in Brazil, Katz (1998) underlines that even though chemotherapy has been shown to be “a very important tool”, “in medium and long term, sanitation, water supply, sewage draining and health education seem to be the real tools when the aim is persistent and definitive schistosomiasis control”.

In the same way, lymphatic filariasis (LF) fuels the spread of HIV. LF is a mosquito-borne parasitic disease, oft referred to as elephantiasis, that is caused by thread-like worms (filariae). LF causes inflammation in genitals and increases the viral load of HIV-infected people – both of which increase the risk of HIV transmission. Treatment against LF, in turn, significantly decreases people’s viral load (Nielsen et al. 2007). In Tanzania, approximately 6 million people have clinical manifestations of the disease

¹¹¹ Numbers from a 2011 World Bank report and a 2006 National Tuberculosis and Leprosy Programme report, quoted on <http://www.tradingeconomics.com/tanzania/incidence-of-tuberculosis-per-100-000-people-wb-data.html>, and <http://www.thisday.co.tz/?l=10629> respectively.

(Malecela et al. 2009), most of whom live along the coast of the Indian Ocean and close to the great lakes. In Africa, an estimated 40 million people are living with LF and the prevalence continues to increase, in part, due to rapid and unplanned urbanisation which creates numerous breeding sites for mosquitoes (GAELF 2012). Depending on programme design, the per-person cost of a once-a-year distribution of medicines can be as low as 0.05€ (GAELF 2012). While just two rounds of mass drug administration can lead to a 90% decrease in transmission, the Tanzanian experience indicates that effective *elimination* of LF might require a combination of sustained treatment efforts and vector control (P. Simonsen et al. 2010).

Other parasites, such as various soil-transmitted intestinal worms (helminths), significantly increase HIV viral load, and thus the infectiousness of HIV-infected people (Wolday et al. 2002; Walson, Otieno, et al. 2008; Walson, Singa, et al. 2008).¹¹² Maternal helminth infection, for instance, increases mother-to-child HIV transmission up to sevenfold (M. Gallagher et al. 2005). Close to 2 billion people in Africa, Asia and the Americas live with at least one – and frequently several – of three intestinal worms (ascaris, trichuris, and hookworm). In many shantytowns and rural areas in sub-Saharan Africa helminthic infections are omnipresent. The chronic immune activation they bring about also increases people’s susceptibility to HIV infection in case of contact with the virus (Harms & Feldmeier 2002; Wolday et al. 2002). Fincham et al. (2003) even warn that “the efficacy of some vaccines against HIV is likely to be impaired by chronic helminthiasis”. Mass deworming with albendazole or mebendazole is highly effective, safe, significantly reduces viral load, and costs about 0.02€ per pill. Yet, Fincham et al. underline that “prevention of faecal pollution, as a public health measure, can control and possibly even eradicate [soil-transmitted helminth] infection” (2003, p.322), stressing that “mass antihelminthic treatment is a short-term measure, not a panacea” and that “[r]eal prevention depends on reducing environmental contamination by human faeces to a level where [soil-transmitted helminth] lifecycles break down” (2003, p.328). They conclude their review of 109 studies on the subject by affirming that “[t]he scientific evidence that the pandemic of HIV/AIDS has added new urgency to the need for control and prevention of helminthiasis is substantial” (2003, p.329).

Malnutrition, which is frequently exacerbated by worm infections, causes immune suppression and increased susceptibility to infections (see: Stillwaggon 2006, chap.2). More specifically, even asymptomatic nutritional deficiencies lead to an increase in viral replication in HIV-infected people and to a weaker immune response in case of viral challenge in HIV-negative people. Beyond increasing viral load, poor nutrition also impairs mucosal and systemic immune responses in HIV-negative persons. Certain highly endemic forms of micronutrient deficiency such as anaemia or vitamin deficiencies are associated with an increased risk of sexual and mother-to-child HIV transmission (e.g. Friis & Michaelsen 1998; Fawzi et al. 2002). Anaemia is associated with higher viral shedding, causing a locally higher viral

¹¹² In Tanzania, for instance, 73.1% of the population live in houses with an earth, sand or dung floor (85.6% in rural areas) (TACAIDS 2008, p.17).

burden in semen and in the vagina, which increases the risk of transmission, both vertically and sexually (G. John et al. 1997). Vitamin A deficiency – a condition that reaches a prevalence of up to 60% in HIV-positive pregnant women in developing countries – alters the integrity of both the vaginal mucous membrane and the placenta, leading to an up to fourfold increase in mother-to-child HIV transmission (Semba et al. 1994; Nimmagadda et al. 1998). Micronutrient and vitamin supplementation can, of course, be useful in many cases. Both very low and very high (as compared to intermediate) intake of vitamin A, however, lead to *accelerated* disease progression in HIV patients and possibly to increased HIV transmission (Nimmagadda et al. 1998).¹¹³

This list is not exhaustive. Not only are these conditions highly coendemic in sub-Saharan Africa, but most of them show significant overlap with HIV prevalence in their geographical distribution.¹¹⁴ For example, over 25% of the population in 27 African countries had at least one malarial episode in 2006, and in 22 African countries the prevalence of genital schistosomiasis exceeded 25% (source: WHO, from Sawers & Stillwaggon 2010b). The latter afflicts approximately 200 million people in sub-Saharan Africa – which accounts for 97% of cases worldwide (P. J. Hotez 2008, p.29). Similarly, about half of all Africans are infected with at least one species of intestinal helminth (Walson, Singa, et al. 2008). As Stillwaggon (2006, p.66) puts it, “[i]f we look at all the factors that affect transmission of HIV and map where those cofactors are most prevalent, the global distribution of HIV and AIDS becomes considerably more logical”. Not surprisingly, the prevalence of most of these co-infections is consistently, and sometimes strongly, correlated with HIV prevalence (Sawers et al. 2008; Sawers & Stillwaggon 2010b; WHO 2004; Feldmeier et al. 1995). In a multiple regression analysis based on country-level data Sawers and Stillwaggon (2010b) show that adding cofactor infection variables to more standard socio-economic variables statistically ‘explains’ two-thirds of the difference in HIV prevalence between southern Africa and other low- and middle-income countries (compared to one-fourth of the difference, using socio-economic variables alone).

All these findings are further corroborated by a variety of studies reporting between 3 and 5 times higher steady state HIV-1 viral loads¹¹⁵ in Africans as compared to people from high-income countries (e.g. Dyer et al. 1998; Modjarrad & Vermund 2010), as well as by the great variation in per-act HIV transmission efficiency between world regions. A meta-analysis by Boily et al. (2009), for instance, indicates that the heterosexual per-act transmission risk within sero-discordant couples is, on average, five times higher in low-income countries than in high-income countries.¹¹⁶ As Sawers et al. (2008, p.492)

¹¹³ Chapter 7 provides a more detailed account of the complex interrelations between HIV/AIDS and nutritional issues.

¹¹⁴ Malnutrition and TB are, to a certain extent, an exception. While both are highly prevalent in sub-Saharan Africa, they are by no means specifically African problems.

¹¹⁵ The steady state viral load (or ‘HIV set point’) is the relatively stabilised level of the viral load after the period of acute HIV infection, i.e. once the immune system has developed HIV antibodies and started to fight the virus (cf. Appendix 2). The higher the steady state viral load, the more infectious is the person and the faster is the progression to AIDS.

¹¹⁶ Paradoxically, this figure could be both an underestimation of actual HIV infectivity (because most people enrolled in observational studies receive at least basic medical care (e.g. deworming) and are thus likely to be healthier than average) and an overestimation. Indeed, as discussed below, many studies do not control for non-sexual transmissions.

put it, “[e]ndemic parasitic and infectious diseases are not just background noise. They increase the likelihood of HIV infection and alter the dynamics of epidemic spread”. Recently, several models of transmission have confirmed that cofactors can have a considerable impact on the epidemic dynamics of HIV. A model proposed by Cuadros et al., for instance, suggests “that without the amplification effect caused by co-infection, no epidemic is generated, and HIV prevalence decreases to extinction” and that, in their model, “an epidemic can be generated by the amplification effect on HIV transmission caused by co-infection” (Cuadros, Crowley, et al. 2011). Consequently, they conclude that “transient increases in HIV viral loads associated with co-infections may provide a biological basis for the accelerated spread of HIV in sub-Saharan Africa”.¹¹⁷

Today, notwithstanding their HIV-independent public health effects and the evidence of their contribution to HIV epidemics, most of these endemic parasitic and infectious diseases and nutritional deficiencies are not adequately addressed in most of sub-Saharan Africa. To be sure, malaria control has benefited from the significant increase in funds and public attention prompted by the Global Fund and the US President’s Malaria Initiative (PMI) over the last years, and TB control is increasingly integrated with HIV-treatment programmes. Yet, most of the other cofactors mentioned above have not become part of HIV-prevention programming. Indeed, it is striking how loose the link between bio-epidemiologic knowledge and the existing preventive interventions actually is. While AIDS scholars and governments have framed the epidemic as ‘exceptional’¹¹⁸, one of the main characteristics of HIV/AIDS has sunk into oblivion: it is first and foremost an *infectious disease*. As Stillwaggon underlines, it “is not mere coincidence” that “AIDS flourishes where people are dying of other diseases” (2006, p.10). She continues:

[T]he epidemic spread of HIV derives from the same context as the propagation of so many other afflictions. AIDS policy has asked very little about that context and so has generated strategies that cannot solve the problem of poor health, of which HIV is only a part. (2006, p.13-14)

Importantly, this context should not merely be understood as a biological one. Although I qualify the cofactors mentioned above as ‘biological’ drivers or determinants of HIV transmission, the distribution of and response to these conditions are, of course, socially and politically co-determined. Far from merely calling for a ‘technical fix’, biological aspects of susceptibility to HIV infection are intricately interrelated with individuals’ and populations’ social and socio-economic characteristics. Disentangling these bio-social complexities should be one of the main tasks of epidemiologists interested in the African AIDS epidemics.

¹¹⁷ Orroth et al. (2011) propose a different but similar model, which aims to explain differences in HIV prevalence between different African regions. They conclude that, “[w]ithout biological cofactors, even implausibly high historical levels of risk behaviour in East Africa could not reproduce the observed heterogeneity in the late 1990s”.

¹¹⁸ See the introduction to Part 3.

Interestingly, when prompted, several interviewees acknowledge the role of cofactors but look at them from their behaviour-centred standpoint. Approving of the idea to include the control of neglected tropical diseases in HIV-prevention policies, a Tanzanian official suggests:

Many of these issues – such as helminths, for instance – are issues of lifestyle, just like HIV. So in our education messages, we could be more comprehensive and include these issues. We should try to package the communication messages. (GovSector-12).

While this interviewee's stance in favour of policy integration is commendable (see Chapters 6 and 7), the behavioural conception of parasitic disease illustrates the depoliticisation of ill health described below. Indeed, teaching people who live in multi-parasitic environments without access to clean water, sanitation, adequate housing, and quality primary health care, to change their behaviours to 'avoid worms' is at best ignorant and at worst cynical.

In sum, sexual behaviour is only part of the story, and definitely an insufficient explanation for the epidemic spread of HIV in sub-Saharan Africa. The impossibility to explain the exceptional spread of HIV in sub-Saharan Africa by behavioural variables does not disqualify behaviour-change interventions *per se*. Nevertheless, given the fact that sexual behaviours cannot explain the overall prevalence of HIV in sub-Saharan Africa, the relative importance of behaviour-change interventions for HIV prevention in the region must be reconsidered. Sexual transmission of HIV is driven, in part, by factors independent of sexual behaviour and a wealth of evidence indicates that these factors are much more prevalent in sub-Saharan Africa than elsewhere. Addressing these factors can effectively contribute to limiting the spread of the virus.

The difference in the risk of HIV transmission per coital act that is induced by these (and possibly other) cofactors is an important part of the explanation for the disproportionate spread of HIV in sub-Saharan Africa. Yet, part of this difference could also be due to non-sexual HIV transmission via unsafe medical (or cosmetic) interventions. Most models of HIV transmission in Africa do not even consider this mode of transmission. As the following section argues, the exclusive fixation on sexual transmission has contributed to dismissing evidence concerning the non-sexual transmission of HIV in sub-Saharan Africa.

D) HIV transmission through unsafe medical practices

“Blood transfusion plays a role in HIV transmission, but we have no data. We only have the number of units tested [...]. We don’t know about transmission rates. [...] In Tanzania, many people don’t realise the connection between blood safety and HIV prevention [...]. Blood is seen as a medicine, a medical service...it is seen as life-saving.”
(Bilateral-21)

While most official figures claim that about 90% of adult HIV infections in sub-Saharan Africa are due to sexual transmission, some authors have voiced concern about a possible, potentially dramatic underestimation of iatrogenic transmission of HIV (e.g. Brewer et al. 2003). While the WHO estimates that between 2.5 and 5% of new HIV infections in Africa are due to unsafe medical care, Gisselquist et al. (2003, p.148) argue, with respect to the early years of the epidemic, that “[e]vidence permits the interpretation that health care exposures caused more HIV than sexual transmission”. Such an extremely high rate of iatrogenic HIV transmission seems questionable in today’s HIV epidemic in Tanzania.¹¹⁹ Yet, a variety of studies (e.g. Gisselquist et al. 2002; Gisselquist et al. 2009; Hauri, Armstrong, et al. 2004; Reid 2009b) suggest that most national and international AIDS players still considerably underestimate the phenomenon – which is difficult to identify because of the long time laps between infection and illness.¹²⁰

Studies reporting HIV-positive children of HIV-negative mothers are an interesting indicator, as sexual transmission can be ruled out.¹²¹ Between 1991 and 1993, the WHO, for instance, tested 5,593 children (aged 6 months to 5 years) admitted to paediatric care and their mothers in Kigali, Dar es Salaam, Kampala, and Lusaka. Strikingly, 61 (1.1%) children who were HIV-positive had HIV-negative mothers (Hitimana et al. 1993).¹²² In a meta analysis of 32 studies that match HIV-positive children to HIV-negative mothers, Reid (2009c) reports a total of 406 documented sero-discordant mother-child pairs. In those of the studies that identify five or more cases of such non-vertical infections, the HIV-infected children who have HIV-negative mothers represent on average 17.5% of all HIV-positive children identified (Reid 2009c, p.820). This indicates significant iatrogenic outbreaks of HIV. Similarly,

¹¹⁹ The 2007-08 Tanzania HIV and Malaria Indicator Survey, for instance, indicates that HIV prevalence in Tanzanian youth – a (rough) indicator for incidence – evolves as follows: 15-17y: 0.6%, 18-19y: 2.7%, 20-22y: 5.7%, 23-24y: 7.2% (TACAIDS 2008). There appears to be no apparent reason why the Tanzanian youth would be suddenly and massively exposed to unsafe medical practices at that age. Young women who reported having never had sex (= one third) had an average HIV prevalence of 0.7%, compared to 3.6% for all young women. Using standard epidemiologic logic, the *population attributable fraction* for having had sex was roughly 75% – which still leaves 25% of HIV cases unexplained by sex. Among men aged 15-24, in turn, those reporting no sex (nearly half of all men in that age group) had the same HIV prevalence as all men (1.1%) – which, interestingly enough, suggests that having had sex explained no HIV (TACAIDS 2008, p.123). I thank David Gisselquist for drawing my attention to this point. That being said, the synergistic interaction between modes of transmission described below makes it less relevant to calculate the exact proportion of infections due to each mode of transmission.

¹²⁰ The evidence cited in this section is far from being exhaustive. For a variety of similar studies, see the references in the works of David Gisselquist (e.g. 2008) and Savanna Reid (e.g. 2009a; 2009c; 2009b).

¹²¹ Claims that such important numbers of children are infected through sexual abuse are not supported by any evidence.

¹²² Surprisingly, the authors conclude that “[t]he risk of nosocomial and non-perinatally acquired HIV infection appears low among these populations”. As Gisselquist (2009, p.841) underlines, this illustrates the implicit double standards of some AIDS researchers: “A similar conclusion would have been unacceptable for WHO as well as for national ministries of health if 1% of inpatient children had been found with unexplained HIV infections in almost any country outside Africa”.

Demographic and Health Surveys in Uganda in 2004-5 (Ministry of Health Uganda 2006, p.116)¹²³, Swaziland in 2006-7 (Okinyi et al. 2009), and Mozambique in 2009 (INS 2010, in: Class 2012) show that 13%, 22% and 31% of HIV-positive children under the age of 5 had HIV-negative mothers. Also suggestive is a serosurvey conducted in the rural north-eastern part of Tanzania in 1995. This survey showed that 4.6% of self-reported virgins aged 15 to 24 were HIV-positive (Tengia-Kessy et al. 1998) – a phenomenon that has been documented in even higher proportions in several other sub-Saharan countries (Brewer, Potterat, et al. 2007).

The most obvious risk is unsafe blood transfusions, which have a transmission efficiency close to 100%. While blood screening has considerably increased over the last years, most sub-Saharan countries have been extremely slow in adopting the necessary safety measures.¹²⁴ In 1988, for instance, tests of malnourished children admitted to the Muhimbili hospital in Dar es Salaam found 51 HIV-positive children. 47 of the 51 mothers of these children were also tested and 7 (14%) of them were found to be HIV-negative. All these seven children had received blood transfusions (Mgone et al. 1991, p.912).¹²⁵ Similar accounts of unsafe medical practices in sub-Saharan Africa abound (cf. Gisselquist 2008). Gruénais et al.'s (1999) describe the more general context that helps explain the low importance given to medical safety issues by African health authorities and health workers. Based on a study in Senegal, Congo (Brazzaville), and Côte d'Ivoire during the 1990s, they write:

In the public facilities in rural areas, [...] in which even basic equipment (detergents, disinfectant products, single-use syringes, etc.) was unavailable [...], it was hardly conceivable to take into account the hypothesis of an infection with HIV during the treatment of patients. Often, the risk of HIV transmission was not even considered in the case of transfusions. When facing a severe anaemia, pressure from the patient's family, and the difficulties with blood collection in small facilities, transfusions were administered without any possibility to take into account the risk of HIV infection. [...] In the different countries, the question of the risk of HIV transmission via transfusions did not give rise to any specific discussions within national AIDS control programmes or to administrative cooperation between health services [...]" (1999, paragr. 21+23, *my translation*)

In many African countries, similar situations perdured until into the 2000s. In a statement to the US House of Representatives in 2006, the coordinator of blood transfusion safety at WHO reported:

Thirty-three (83%) of the 40 sub-Saharan African countries which provided data to WHO reported that they do not have fully operational quality systems in the blood transfusion service, including HIV testing. Around 2.7 million units of blood were collected in these 40 countries in 2004; 88.5% of these were not tested for HIV in a quality-assured manner. (Dhingra 2006)

This statement (among others) has probably contributed to the uptake of blood safety within PEPFAR programmes. A multilateral agent remembers the beginning of this effort in Tanzania:

¹²³ For a discussion of the data, see : <http://dontgetstuck.wordpress.com/uganda-cases-and-investigations> (Accessed August 15, 2012)

¹²⁴ The Kenyan government, for instance, also began to screen blood supplies as late as 1987, and only in Nairobi and Mombasa (Turshen 1989, p.236).

¹²⁵ Both the HIV-infected children with HIV-infected mothers and the mothers themselves can, of course, also have been infected iatrogenically.

They actually went down to the facility level and looked at what they were equipped with, and at the different things you need to do safe blood screening. Was it something like 40% of the health facilities that were not adequately equipped to do proper blood screening?! We have to address this! It might not be as much as sexual transmission, but that is an alarming figure! (Multilateral-17)

Well aware of the Tanzanian situation, a senior Tanzanian official underlines, “blood ‘safety’ can be very dangerous...and we are testing the wrong blood – that of voluntary, repeated donors” (among whom HIV prevalence is relatively low) (GovSector-12).¹²⁶ Although the problem has been widely recognised since the very beginning of the epidemic and has been seriously tackled by PEPFAR over the last few years, the risk of HIV transmission through blood transfusions is obviously not yet excluded in most sub-Saharan countries. As late as 2011, Bjørn Lomborg, the director of the Copenhagen Consensus Center, which conducted the first-ever comprehensive cost-benefit analysis of different HIV-prevention interventions, underlined that “[m]aking blood transfusions safe costs almost nothing, but we’re not doing it” (quoted in Dorel 2011).

Another risk of health-care transmission stems from the reuse of non sterilised injection equipment (needles and syringes). This risk is far less acknowledged among the interviewees. One bilateral agent, for instance, simply denies its existence:

HIV transmission via needles, that’s a myth just like HIV transmission through mosquitoes. The survival period of HIV outside the body is extremely brief. (Bilateral-30).

Contrary to what is frequently asserted, when in contact with air, HIV remains infectious for hours, if not days. Outside the human body, the virus has been documented to survive for over a week on dry surfaces (Kramer et al. 2006) and for over six weeks in wet settings, such as used syringes (Heimer & Abdala 2000).¹²⁷ Although difficult to measure, the average risk of HIV transmission via an unsafe medical injection involving a needle and/or syringe that was previously in contact with HIV is estimated to be around 2% (Reid 2009b).¹²⁸ The WHO estimates that African adults receive on average 2.1 injections per year, and that 17-19% of these were unsafe in 2000 (Hauri, Hutin, et al. 2004).¹²⁹ A review by Simonsen et al. (1999) of injections in low-income countries suggests that “[e]ighteen studies reported a convincing link between unsafe injections and the transmission of [...] HIV”, and that “[a]t least 50% of injections were unsafe in 14 of 19 countries (representing five developing world regions) for which data were available”.¹³⁰ In a historic analysis Drucker et al. (2008) point to the sharp growth in the

¹²⁶ Similarly, WHO warns that “in many countries the recipients of blood and blood products remain at unacceptable risk of acquiring life-threatening infections that could easily be prevented” (2009a, p.1).

¹²⁷ The following anecdote, recounted by one interviewee, is quite telling in this respect: “In 2007, [an American researcher] published a paper in the British Medical Journal saying that the virus dies out quickly. I challenged him and asked for laboratory studies. He didn’t get back to me. [...] Johns Hopkins even had it [the assertion that the virus dies very rapidly outside the body] in their syllabus for nurses on the web! I told them I was going to sue them if they weren’t changing it...they took it off.” (Research-13)

¹²⁸ This probability is lower, but still substantial if the equipment was cleaned, yet not sterilised (Reid & Juma 2009) and concerns both intravenous and intramuscular injections – the former being more infectious because it immediately gives the virus access to the blood stream.

¹²⁹ As an illustration, in 1989, each patient at the emergency department of the Peletier hospital in Djibouti received on average 1.3 injections per consultation (Anglaret 1991).

¹³⁰ This figure is congruent with data quoted in (Drucker et al. 2008)

use of medical injections in some parts of sub-Saharan Africa, many of which were due to mass public health campaigns in the 1950s and 1960s. Vachon (2010, p.35-37) describes how, during the 1970s, the re-usable glass syringes (which were easy to sterilise in hot water) were rapidly replaced by so-called 'single-use' plastic syringes, which are impossible to sterilise because they are not heat resistant.

Reid and van Niekerk (2009, p.816) point to the fact that "recent observation reveals routine failures in infection control in South African maternity and paediatric wards and in public dental clinics". They strikingly underline that "[i]mmunization injections received at public health facilities are associated with HIV infections in children", and that "[o]ver 25% of new infections identified in South African adults [...] in 2005 were in individuals reporting they had not been sexually active in the past 12 months" (2009, p.816).¹³¹ Similarly, regression analyses comparing sub-Saharan countries among them and low- and middle income countries more generally, show that "nonuse of autodisable syringes is associated robustly with greater HIV prevalence" (Deuchert & Brody 2007). These findings are in line with studies of health-care practices in several African countries. Okwen et al. (2011), for instance, report that reuse of injection equipment is practiced by 44% of health workers at public hospitals in the Northwest Region of Cameroon.¹³² Similarly, drawing on data from an observational survey in South Africa and Ethiopia, Reid (2009b) underlines that "many health workers consider injections safe when the needle is changed but the syringe is reused", and that 30% of the surveyed health workers in South African public maternity and paediatric wards "did not see the need to use a new needle for each patient".¹³³ Nevertheless, having high HIV prevalence and a relatively operational health system, South Africa is frequently used as an example to claim that unsafe medical practices have a negligible effect on African epidemics. More generally, recent reports on iatrogenic outbreaks¹³⁴ and unsafe medical practices in the US show that health care is not safe in highly industrialised countries either (Pugliese et al. 2010).¹³⁵ If even the US

¹³¹ These findings resonate with Brewer's (2011) study showing that, particularly in Southern Africa, people aware of blood-borne HIV risks are less likely to be infected than those who are unaware of these risks – a correlation that is all the more interesting as knowledge of condom use as a way to prevent HIV transmission was *positively* associated with prevalent HIV infection.

¹³² They conclude that "[i]njection safety interventions could prevent an estimated 14 336 HIV infections, 248 661 HBV [hepatitis B virus] infections and 7 114 HCV [hepatitis C virus] infections each year in these health districts". Given the difficulty to determine precisely the average rate of HIV transmission per event, these figures are obviously but a rough estimate.

¹³³ Another considerable risk stems from the insufficient awareness that new (or newly sterilised) injection equipment needs to be used *for every injection* – and not just every patient – if multi-dose vials are involved. Indeed, the reuse of the same equipment for two successive acts concerning the same patient (say drawing blood, then vaccinating) can lead to the contamination of vials. The consequences of a contaminated vial are dramatically different from the direct reuse of non sterilised needles or syringes between two patients. Since multi-dose vials are used for multiple patients, reusing an unsterilized needle to draw a drug or vaccine from a vial can contaminate the vial – the content of which is then injected into multiple other patients. A recent case of contaminated vials in the United States, for instance, has exposed as many as 14,000 patients to an otherwise non communicable, potentially lethal type of meningitis. As of 10 April 2013, 733 people were infected, of whom 53 died (<http://www.cdc.gov/hai/outbreaks/meningitis-map.html>, page updated weekly). If the disease transmitted is rather common, and if the delay between the iatrogenic exposure and the first symptoms is long (both of which is the case with HIV in sub-Saharan Africa), the likelihood that iatrogenic outbreaks go unnoticed is very high.

¹³⁴ See for instance: <http://www.cdc.gov/hai/outbreaks/meningitis-map.html> (Accessed April 10, 2013)

¹³⁵ A survey of US medical personnel conducted by Pugliese et al. (2010), for instance, shows that 6% of the health workers surveyed report using single-dose or single-use vials for more than 1 patient, that nearly 1% of them reuse syringes (but change the needles) for use on a second patient, and that 15.1% reuse a syringe to enter a multidose vial (6.5% of whom save that vial for use on another patient).

health system cannot guarantee health-care safety, how can one seriously suggest that medical practices are safe in the severely resource-constrained settings of most African countries?

In their review of 39 cohort studies associating HIV incidence in African adults with medical injections, Gisselquist and Potterat (2004) show that people who received injections had a higher probability of acquiring HIV than those who did not – which excludes reverse causation due to people seeking health care because of AIDS-related symptoms. The median population attributable fraction (PAF) of HIV incidence associated with the receipt of medical injections was 19%. Although this figure is only an approximate estimate, it is compatible with a recent update of the WHO model of the global burden of disease from unsafe injections. This updated model takes into account the prevalence of HIV in health-care settings, rather than the much lower prevalence in the general population. This more realistic model suggests that between 12% and 17% of new HIV infections in 2007 might be due to unsafe medical injections (Reid 2009a).¹³⁶

Male circumcision and female genital mutilation, have been shown to be associated with HIV prevalence in virgins and adolescents in Tanzania, Kenya and Lesotho – indicating transmission through unsafe invasive procedures (Brewer, Potterat, et al. 2007) – a finding that echoes with the statement of a bilateral agent:

[Male circumcision] is a pretty invasive procedure. [...] It's a surgery, not a drop-by-your-doctor kind of thing. [...] And you need qualified people. How many qualified people are there in Tanzania to do safe circumcisions? I don't know how many Tanzanian people I would trust to cut off my foreskin! (Bilateral-29)

In Zanzibar, HIV prevalence was found to be 1.9 times higher in people who reported having had a surgery as compared to those who reported no surgery (Croce et al. 2007), and in Calabar, Nigeria, “seroconverters were substantially more likely to report one of a set of blood exposures that cannot be explained as a consequence of unprotected vaginal sex or of health care for symptoms of HIV infection” (Peters et al. 2009). Deuchert and Brody (2006, p.749) show that “Kenyan women who received prophylactic tetanus toxoid injections during pregnancy are 1.89 times [...] more likely to be HIV-1 seropositive than women who did not receive this vaccination”, while sexual behaviour such as the number of partners or condom use was not related to HIV status.¹³⁷ The possible risk of vaccination campaigns is confirmed by Drucker et al. (2001, p.1991), who underline that “as recently as 1998, WHO

¹³⁶ This figure abstracts from transmissions through blood transfusions, dental procedures, informal abortion, cosmetic procedures, unsafe male circumcision or female genital mutilation. For evidence on the sharing of razor blades for incisions to administer herbal medicines, for instance, see the references in (Brewer, Rothenberg, et al. 2007).

¹³⁷ Again, the authors underline that “[t]he findings are unconfounded by reverse causality” since “all injections were purely prophylactic rather than for treatment of any HIV-related illnesses” (Deuchert & Brody 2006, p.749). The fact that reverse causality alone could not explain the association between injection history and HIV prevalence was already established by Mann et al. (1986). The authors found that 39% of HIV-positive children 2-24 months old had seronegative mothers, and that “[f]actors associated with seropositivity among hospital children with seronegative mothers included male sex, increased lifetime number of medical injections, and previous blood transfusion or hospital admission”, and that “[a]mong children who had not previously been transfused or admitted to hospital the seropositives had received more medical injections than the seronegatives”.

still recommended re-use of syringes up to 200 times in vaccination programmes, relying on sterilisation routines that WHO's own studies show are usually not followed".

In Tanzania, there is ample evidence of a general lack safety in health care settings. The 2006 Service Provision Assessment Survey by the National Bureau of Statistics (2007), for instance, reviews health-care safety in Tanzanian STI facilities. The results are striking. While only half of the facilities have running water, in only 25% of them are all items considered important for infection control (e.g. soap, latex gloves, disinfecting solution, sharps containers) available (*ibid.*, p. 158).¹³⁸ "Use of sterilised equipment for pelvic examinations is very low", underlines the survey, and "[o]nly 20 percent of speculum examinations employed sterilised or high-level disinfected (HLD) equipment" (*ibid.*, pp. 164 + 163). More generally, 44% of Tanzanian health facilities do not have the necessary equipment and knowledge to perform adequate infection control (*ibid.* chap. 3).

What do these findings tell us about HIV transmission through unsafe medical practices? To be sure, self-reported virgins can lie and many other confounding factors intervene. Access to health care (which is positively correlated with HIV prevalence) coincides with urban residence (which allows for more dense sexual networks, making sexual transmission dynamics more effective). STI treatment involves many injections – making it difficult to sort out the respective importance of sexual and health-care transmission (Vachon et al. 2003). Some HIV-positive children with HIV-negative mothers could have been infected by other HIV-positive women who wet-nursed or cross-fed them. At the same time, the percentages of HIV-positive children with HIV-negative mothers might still underestimate the number of iatrogenically infected children, since the fact that both the mother and the child are HIV-positive does not necessarily imply mother-to-child transmission. The risk of vertical HIV transmission by treatment-naïve mothers being anywhere between 14% and 43% (McGowan 2000), only genetic viral screening could determine if the two infections have a common source. And even in that case, mother *and* child could have been infected iatrogenically, or the iatrogenically infected child could have infected the mother, rather than the other way around. Indeed, vertical transmission is even more efficient from the breastfeeding child to the mother. Little et al. (2012) report studies showing that HIV-negative women who breastfeed HIV-positive children have a 40-60% chance of getting infected themselves. Some of the seroconcordant mother-child pairs could thus be due to nosocomially infected children who passed on the virus to their mothers (and possibly to other cross-feeding women). In this case, even genetic screening could generally not distinguish mother-to-child from child-to-mother infection.

The risk of HIV transmission through contaminated blood transfusions and the reuse of needles or syringes for injections has been pointed to from the very beginning of the epidemic (e.g. Turshen 1989, chap.12; Vachon et al. 1985; Mann et al. 1986). Yet, it has not been seriously followed up on. Peter Piot, the subsequent executive director of UNAIDS, even co-authored a study on the causes of HIV incidence

¹³⁸ Surprisingly, "[h]ospitals are the least likely to have all of the items needed for infection control" (*ibid.*, p. 158).

in children in Kinshasa (Mann et al. 1986) which concluded that “[p]ublic health measures are urgently required to prevent parenteral and vertical transmission of HIV” (see footnote above). Strikingly, with respect to iatrogenic transmission, this appeal has gone unheeded in most African countries as well as within UNAIDS itself. The 2010 and 2011 UNAIDS reports, for instance, do not even mention the risk of transmission through non sterile needles and syringes in formal and informal health-care settings.¹³⁹ In Tanzania, the case of blood transfusions and IDUs excepted, the risk of infection through unsafe medical practices is ignored in today’s HIV-prevention policies. This is also true for most HIV-related research. Today’s exact proportions of sexual and blood-borne HIV transmission in sub-Saharan Africa are unknown.¹⁴⁰ The existing data, however, make it irresponsible to dismiss these findings on the sole basis of possible statistical bias.

D-1) Trying not to know? Public denial and scientific ostracism

“If you are looking for an example of a corporatist, hermetic, narrow-minded profession, don’t hesitate, take doctors!”
(Latour 2001, pp. 32-3)

“There is evidence out there, and the reaction is: ‘Will you please shut up and go away, we’ve been trying to ignore this for 20 years now. You are really getting irritating!’.”
(Research-13)

A fairly simple way to put an end to today’s debates concerning the relative importance of different modes of transmission in sub-Saharan Africa exists. “To determine modes of transmission with confidence”, Brewer et al. (2007, p.55) rightly stress, “researchers should trace incident cases and uninfected controls’ contacts about the full spectrum of time- and place-specific sexual and nonsexual exposures and sequence infected persons’ HIV isolates”.¹⁴¹ The fact that this strategy is “usually the first used for investigating emerging infections, including HIV in the United States in the early 1980s” (*ibid.*) makes it all the more puzzling that no such investigation has yet been carried out in sub-Saharan Africa. Interestingly, one interviewee points to the fact that the only countries where HIV-related outbreak investigations did take place (e.g. Romania¹⁴², Libya, Kazakhstan, Kyrgyzstan, or Russia) were countries where Western health agencies had little influence. He underlines:

Development advocacy organisations are so ‘pro health care’ that you can’t get them to do outbreak investigations, even if it’s for health care safety. [...] We know we don’t have the answers as good as we’d like, but we *can* know where the infections are coming from: ask people about sexual networks *and* dental

¹³⁹ In these reports, the words “injection” and “syringe” are exclusively used in relation to injection drug users, not to medical practices. More generally, the risk of HIV transmission through unsafe injections is readily admitted in the case of injection drug use and dismissed (if not actively denied) in the case of health-care related injections.

¹⁴⁰ An interesting example of scientific controversy on this issue can be found in the debate following reactions to Lopman et al.’s (2005) paper asserting a lack of association between injection history and HIV incidence (see *Plos Medicine*, vol. 2, no. 5, May 2005)

¹⁴¹ Similar suggestions for study protocols can be found in (Brody & Potterat 2005) and (Gisselquist et al. 2009).

¹⁴² In their disquieting historic analysis of nosocomial HIV transmission, Drucker et al. underline that “[i]n Romania, 10 000 children were infected, i.e. >50% of all the paediatric AIDS cases reported in Europe since the beginning of pandemic were nosocomially produced in <1 year” (2008, p.761).

care, injections, etc....and sequence the viruses! In Masaka and Mwanza, they have all the evidence in the freezers. It's like a magnet that repels: they don't want the evidence! (Research-13)

Indeed, most large-scale HIV-prevention studies and trials simply assume that people who acquire HIV do so through sexual intercourse, without tracing the virus or asking people about possible health-care exposures (Gisselquist et al. 2003, p.148; Gisselquist 2011). Most studies concerning HIV transmission within sero-discordant couples, for instance, simply assume any new HIV infection to be sexually transmitted by the other partner.¹⁴³ In this respect, one interviewee's account of the French surveillance system during the early years of the HIV epidemic illustrates similar biases in data collection. Talking about the national protocol to report on new HIV cases and on how these individuals were infected, he recalls:

There was a bias in the administrative system: It said, 'For any patient who is neither IDU nor homosexual, rather than checking [the box] "other", check "hetero"'. And then, they tell us 'It's all heterosexual transmissions, look at the statistics!' [...] If you code all those who were neither drug addicts nor homosexuals as 'heterosexual transmission', how do you want to reach another conclusion? The conclusion was imposed! (Research-12)

Up until today, many studies on the spread of HIV in adults in sub-Saharan Africa continue to classify patients – and thus to collect data – according to sexual categories only, implying that the virus is exclusively transmitted sexually. In Tanzania as well, the vast majority of epidemiological research on HIV concerns behavioural variables only – excluding de facto the production of evidence concerning both iatrogenic HIV transmission and cofactor-related drivers of infectiousness and susceptibility.¹⁴⁴ Reid (2009b) describes this vicious circle in which the production of knowledge is determined by the type of data collected:

WHO assurances that medical injection risks are minimal are not credible, and reflect a pattern of suppressing evidence that heterosexual sex explains less than 90% of HIV transmission in Africa. [...] In a crude irony concerning the social construction of disease, the WHO is defending a 90% estimate that was arrived at by a process of elimination; that is, not on the basis of positive evidence that 90% of HIV infections can be traced to sex in Africa. In fact infection tracing has been consistently avoided in cases of reportedly non-sexual HIV transmission identified in epidemiological research.

Notwithstanding the disquieting nature of evidence concerning iatrogenic HIV transmission, many of these 'bulky facts' – about the survival of HIV outside the body, the lack of sterilisation and unsafe reuse of injection equipment, or the unexplained HIV cases – were simply ignored. In this sense, many of the studies concerning unsafe medical care and HIV provide what Latour calls "lagging facts" (*des faits qui traînent*), i.e. research results that, although not contested on scientific grounds, are not taken up within institutions that would provide these facts with the necessary legitimacy for them to become considered as a serious problem that should be tackled. Given the necessarily collective nature of the validation process of scientific statements, these facts remain "seemingly suspended in mid-air in the anteroom of

¹⁴³ As Sawers (2013, p.18) describes, a similar assumption can be found in models concerning concurrency.

¹⁴⁴ One bilateral agent's description of her agency's endeavour to improve the 'evidence base' illustrates this behaviour-centred bias: "How do you build an evidence base on what works in Tanzania and what doesn't work? We are engaged in several behavioural studies within our strategic information and prevention sections to get more of an evidence-based platform." (Bilateral-19)

science, between fiction and acknowledgement” (Latour 2001, p.46 + 44 resp., my translations). Again, “cognitive dissonance” (Festinger 1957) could play a role in the dismissal of iatrogenic HIV transmission by institutions predominantly managed by medical doctors. Indeed, health policymaking is based on the firm belief that doctors ‘do good’ and heal people. Although contradicted by various critical analysts (e.g. Dupuy & Karsenty 1974; Illich 1976; Callahan 1998) and frequent newspaper headlines about medically-induced illness, the doctors-do-good belief system remains deeply enrooted.

In the meantime, those who openly warn against the risks of blood-borne HIV transmission or ask for better evidence to replace speculation are frequently ostracised by the scientific community.¹⁴⁵ One of the early ‘whistle-blowers’ remembers,

Every time I would talk about [iatrogenic transmission], people told me: ‘Mister XY, stop making mischief: look at Africa, there are vaccinations going on!’. [...] At the conferences, I was told several times ‘You’ll be responsible for far more deaths than those dying from AIDS, because of people who won’t get vaccinated anymore!’. I responded that the use of non sterile syringes was a sanctioned practice in France ; so why would we tolerate it in Africa?! [...] It’s ostracism. Those who want to express themselves are not even allowed to speak! (Research-12)

Another researcher describes how the WHO reacted to a series of publications (of which he was a co-author) underlining the possible underestimation of blood-borne HIV transmission in Africa:

When we had published about half a dozen papers by 2003, we went to WHO and had a meeting there [to present the available evidence on iatrogenic transmission]. They published a ‘damage control’ press release, which was written before the meeting started and published before the meeting ended. [A friend of mine] saw the release on her colleague’s desk, days before the meeting! (Research-13)

Having described another case of ostracism concerning one of his colleagues from the US, this interviewee concludes,

You can talk about it in private, but not in public! If you do, that’s it: you’re out. It’s a good way to lose your job! [...] If you do talk about it they’ll say : you are actually killing people by scaring them from health care. So they think they better kill your career, and they do it, so you’re out. (Research-13)

This interviewee also describes a case where the superiors of a CDC researcher who submitted a paper on iatrogenic transmission to a scientific journal tried to block its publication by pressuring the journal’s editor. These accounts of ostracism (and censorship) were indirectly confirmed by the reaction of one of my interviewees in Tanzania. Commenting on a draft paper in which I mentioned a possible underestimation of health-care transmission of HIV, he warned me: “I don’t agree with you on the issue of sterilisation...you wouldn’t want to be pushed in the wrong corner.” (Bilateral-30).

The fear to be “pushed in the wrong corner” also concerns researchers interested in non-behavioural drivers of *sexual* HIV transmission. This is probably due to some fundamentally misleading commonalities between this field of research and the claims of HIV denialists, who have caused much

¹⁴⁵ The stigmatisation of ‘whistle-blowers’ is, of course, nothing new in the history of science. See: <http://sciencescitoyennes.org>

harm in South Africa (S. Epstein 1996, part.1; Fassin 2007, chap.1-3)¹⁴⁶. While both look at similar issues (e.g. nutrition and other poverty related conditions of ill health) and sometimes use common vocabulary (e.g. “cofactors”), the assumptions about the causative pathway differ *radically* between the two approaches. Indeed, the “cofactors” referred to above have nothing to do with the ‘cofactor theory’ of AIDS causation, professed by people like Duesberg and supported by the South African government until the early 2000s. This theory claimed that HIV was not the cause of AIDS, which was said to be a direct, non virologically caused consequence of poverty-related ill health (see: Fassin 2003). For that reason, talking about nutrition-related determinants of susceptibility to HIV infection frequently raises suspicions due to the former South African government’s emphasis on nutrition – rather than antiretroviral therapy – in treating HIV/AIDS. The South African history of HIV denialism – which needs to be understood in its political context (Fassin 2007) – has led to a strongly polarised perception of HIV-related epidemiologic controversies and to an *a priori* loss of credibility of environmental explanations of the uneven global spread of HIV. The resulting conformism certainly discourages some researchers from inquiring deeper into the non-behavioural or non-sexual drivers of HIV transmission. Being (erroneously) labelled as a denialist can put a sudden end to one’s career as an AIDS researcher. The awareness of this conformism pushes those who do criticise the dominant paradigm to continually justify their approach by explicitly distancing themselves from HIV denialism, repeating that questioning the importance of sexual behaviour does *not* amount to questioning the sexual transmission of HIV – let alone the existence of the virus or the fact that it is the cause of AIDS.¹⁴⁷

To conclude on the issue of unsafe medical practices, serious enquiry into the relative importance of the sexual and blood-borne modes of transmission would be very useful. Yet, at the operational level, more research is not necessarily needed. Even if ‘only’ a few percent of new HIV infections in Africa were due to nosocomial exposures, that would be a large enough scandal to justify massive action in favour of safe health care.

Sub-conclusion) On synergies, policy sensitivity and intrinsic health benefits

Cofactors and iatrogenic transmission have affected the various regional epidemics in different manners and to different extents. Since the sexual contagiousness of HIV is too low to provoke generalised heterosexual epidemics in otherwise healthy populations, it is highly plausible that increased population susceptibility due to ubiquitous cofactors and a widespread lack of sterilisation in formal and informal medical settings in sub-Saharan Africa have provided a uniquely fertile terrain for the virus to reach a threshold for epidemic spread. Despite the fact that variations in sexual behaviour do not explain the

¹⁴⁶ Very conservative estimates consider that the underuse of ART entailed by HIV denialism in South Africa resulted in approximately 365,000 premature deaths between 2000 and 2005 alone (Nature 2008).

¹⁴⁷ Stillwaggon, for instance, attaches particular importance to explicitly distancing herself from HIV denialism – see the section called “What this book is not”, in: (2006, p.16-17). Concerning the ‘AIDS denialism’ attacks against researchers working on iatrogenic transmission, see a book review by Potterat (2009), tellingly named “AIDS denialism is not the same as AIDS dissent”.

disproportionate African epidemics, today's official narrative of the spread of the virus in Africa remains predominantly based on – and frequently limited to – behavioural variables. Interestingly, the insights concerning the contribution of cofactors and unsafe medical practices to HIV transmission shuffle the dominant conceptions of both 'risk behaviours' and 'risk groups'. As Stillwaggon puts it,

It is clear from the data we have about schistosomiasis and other parasites that one of the riskiest activities in Africa is to be a little girl or boy who gathers water for the family in a slow-moving stream, or helps with the family laundry at creek-side, or bathes or plays in fresh water. When he or she grows up, that child will have a much higher risk of sexual transmission or acquisition of HIV because of schistosome infection than a healthy person with similar sexual behavior. (Stillwaggon 2006, p.57)¹⁴⁸

Similarly, the French doctor quoted above amends the definition of 'risk groups' with respect to iatrogenic transmission in Africa:

When non-rich people go to the doctor or to the injectionist on the market (where you bring your own drugs), everybody's injection is made with the same syringe. STI clinics are the worst...all STI treatments are injections! [...] In this situation, the most-exposed 'risk group' are those patients who received an injection with the same syringe, the same morning! (Research-12)

Importantly, a more complete acknowledgement of the available evidence points to a synergistic interplay of different drivers and modes of transmission that is still only very incompletely understood (Stillwaggon 2009; 2012). This interaction has various dimensions. Since many of the cofactor conditions discussed above share determinants of susceptibility, they are highly co-endemic in many parts of sub-Saharan Africa.¹⁴⁹ Many of these conditions not only increase people's vulnerability to another one of them; they jointly increase population-level susceptibility to HIV infection. While isolating each of these cofactors' effects on people's contagiousness and susceptibility to HIV infection is a necessary first step, estimating the combined impact of cofactors on HIV transmission dynamics by merely summing up their individual effects is insufficient as it omits their synergistic interactions (Stillwaggon 2006; 2009). Given the strong geographic overlap of many cofactors, their actual effect on HIV-transmission dynamics in the multi-burdened populations of sub-Saharan Africa is considerably underestimated.

In addition, various interrelations exist between different modes of HIV transmission. Higher viral loads, possibly caused by co-infections and/or malnutrition, are likely to increase the risk of sexual, vertical, and iatrogenic HIV transmission (Apetrei et al. 1995). Furthermore, because of the treatment they entail, several cofactors such as malaria, anaemia, and STIs are related to injection frequency – which makes it difficult to disentangle the respective role of each mode of transmission (Vachon et al. 1985; 2003; Packard & P. Epstein 1991a, p.778–9). Finally, basic epidemiologic reasoning suggests that the different modes of transmission – sexual, iatrogenic, and vertical – synergistically interact with one another.

¹⁴⁸ In this sense, the term 'non-behavioural' refers to determinants of transmission that do not (or only very distantly) depend on the individual behaviour of the person 'at risk' of HIV infection. Of course, any HIV infection can ultimately be related to human behaviour, be it a doctor's failure to use sterile injection equipment, or a little girl's 'choice' to expose herself to genital schistosomiasis (and the permanent genital lesions it leaves behind) by washing her family's clothes in an infested lake.

¹⁴⁹ WHO (2004, p.1), for instance, acknowledges that "Malaria and HIV/AIDS are both diseases of poverty and causes of poverty and they share determinants of vulnerability".

Gisselquist (2008), for instance, underlines the indirect effect of iatrogenic transmission on the dynamics of HIV epidemics. Measuring only the number of direct infections due to blood exposures, he argues, underestimates their total contribution to the spread of HIV. Not only can people who acquired HIV iatrogenically transmit HIV to others via sex or blood exposure (who, in turn, pass the virus on to a third person, etc....), but “HIV transmission through blood exposures accelerates sexual transmission by allowing HIV to jump from one sexual network to others” (2008, p.156).¹⁵⁰ While the potential impact of this interaction between modes of transmission has yet to be modelled, what is known about the role of networks in epidemic dynamics suggests that a ‘trans-network’ effect of iatrogenic transmission of HIV could turn out to considerably accelerate its sexual transmission.¹⁵¹ Preventing health-care transmissions of HIV could thus have an over-proportional effect on the reduction of HIV transmission in general. Similarly, since cofactors interact to over-proportionally increase a population’s susceptibility to HIV, the positive effects of cofactor control can be more than linear. The list of synergies is long and provides powerful rationales for action (Stillwaggon 2006, chap.2+3; 2009). Breaking synergistic interactions between cofactors and between modes of transmission in this way could give a new meaning to today’s oft-repeated mantra of ‘combination prevention’.

It is utterly insufficient to reason on the basis of a model that simply juxtaposes different risk factors or even considers them as mutually exclusive. Nevertheless, there is still much we do not know about the synergistic effects of cofactors and modes of transmission, and, consequently, about possible thresholds. We do not know to what extent even small variations (in cofactor prevalence or iatrogenic transmission rates) could strongly affect the epidemic dynamics of HIV. These non-linear dimensions of the spread of HIV remain a blind spot of today’s individualistically biased epidemiological enquiry (Stillwaggon 2006, chap.8). That being said, it is important to not only understand the biological interactions, but to consider the broader social and socio-economic determinants of people’s exposure and susceptibility to these different factors. More fundamentally, these insights suggest that it is indispensable to analytically and programmatically re-embed the African HIV epidemics within their broader socio-biological context, and to conceive HIV infection as the result of a complex interaction of social and biological processes which we need to understand better. Rather than limiting our analysis to single aspects of what Sawers (2013, p.13) fittingly calls people’s “very complicated lives”, we need to explore these interrelated processes that condition people’s risk of contracting one or several of these cofactors and/or of being exposed to unsafe medical interventions.

¹⁵⁰ Gisselquist gives the following example: “If [...] a husband and wife are both HIV-positive and have no other sex partners, their HIV has no chance to reach anyone through sex. But if the husband transmits HIV to someone through a dental clinic, the HIV can get into another sexual network, where sexual transmission again becomes possible” (2008, p.156). The role of such a “turbo effect” of iatrogenic transmission during the early phase of the African HIV epidemics was first mentioned by Vachon et al. (1985, p.1950). This reasoning, of course, works either way (sexual transmission helping the virus to spread from one ‘patient group’ to another) and also applies to vertical transmission (the virus entering a new sexual network by passing from one woman to another through mother-to-child and child-to-mother transmission via cross-feeding or wet nursing).

¹⁵¹ French et al. (2006) did model sexual and iatrogenic spread of the virus. Beyond the unrealistic hypotheses they used, they modelled one mode of transmission ‘versus’ the other (rather than modelling their *interaction*), which obviously makes no sense.

Lastly, prevention interventions aiming at cofactor control and at improving the safety of medical practices share a common and crucial feature: they are, to a large extent, *directly* amenable to change through policy measures. Without having to rely on people’s willingness or ability to change their sexual behaviour, public health authorities can prevent and treat many of the co-infections; they can regulate medical safety issues, ban non auto-disable syringes, train health workers, and adequately equip health facilities.¹⁵² They cannot impose sexual behaviour change, but only try to indirectly affect it by informing, persuading, and, at best, acting upon the social and economic environment of behavioural decisions. As Stillwaggon puts it, “[g]overnments can educate and exhort; they cannot enforce behaviour change” (2006, p.191). An important additional rationale for action is provided by the fact that – unlike sexual behaviour change – both the control of parasitic diseases, co-infections and nutritional deficiencies, and the improvement of health-care safety have *intrinsic* positive health effects.

The acknowledgment that the current framing of HIV/AIDS is based on a biased reading of the available evidence necessarily raises questions about the origin of this bias. Pervasive evidence has been ignored and disquieting data have not been considered – and this even though the policy solutions suggested by the different causal narratives are not mutually exclusive. While the proponents of non-behavioural approaches underline that behavioural variables cannot explain the disproportionate spread of HIV in sub-Saharan Africa, they do not question the fact that HIV transmission can be fuelled by unsafe sexual practices. As discussed in Chapter 2, the determinants of individual risk and the determinants of population-level incidence of diseases are distinct (G. Rose 1985; Schwartz & Carpenter 1999). HIV is no exception in this respect. Opposing individual and population-level prevention strategies is thus not necessary *a priori* (although resource constraints do, of course, impose trade-offs). In any case, the at least partial complementarity of these different prevention interventions makes the consistent omission of certain types of knowledge all the more puzzling. The next chapter explores possible reasons for the limited political resonance of non-behavioural causal narratives of HIV transmission in sub-Saharan Africa.

¹⁵² This is true for blood-borne risks in formal settings. As Drucker et al. (2001, p.1991) underline, “the huge frequency of use of unsterile medical injections outside formal health care [has] particularly ominous implications for attempts at control”. Yet, a national ban on non auto-disable syringes, for example, would also positively affect health care safety in informal settings.

Chapter 2) Causal narratives and the depoliticisation of HIV transmission

“A man walking down a street meets someone he recognizes as an old acquaintance. ‘Why, Jenkins,’ he cries, ‘how good to see you. But how you have changed. Last time we met you were quite fat, but now you are really very thin. And I remember that you used to have a beard, but now you are clean-shaven. And, now I come to think of it, Jenkins, old boy, you used to have a wonderful head of hair, and now, well, you are almost completely bald-headed.’ And the man replied: ‘My name isn’t Jenkins, it’s Jones.’ ‘Oh, so you have changed your *name* as well!’”
(Widdowson 1990, p.37)

This story, which illustrates how preconceived ideas can determine the interpretation of data, is as straightforward a definition of a paradigm as any. As discussed, the dominant explanatory paradigm of the African AIDS epidemics suffers from a double reductionism: it omits iatrogenic transmission, and, concerning sexual transmission, it focuses nearly exclusively on the immediate cause of exposure to the virus (unprotected sex), neglecting the biological determinants of individual and population susceptibility to HIV infection. No doubt, Kuhnian paradigm effects (Kuhn 1962) and the pre-analytical bias they induce help explain the reductionist fixation on sexual behaviour. But are paradigm effects alone sufficient to explain the persistence of this scientifically questionable narrative?

The evidence presented above points to the fact that the inordinate spread of HIV in Africa is fuelled by population vulnerabilities that are due to a variety of unmet basic needs. Based on this assessment, this chapter explores why the dominant causal story of AIDS in Africa suffers from such epidemiologic amnesia that leads to the omission of some of the core lessons of the history of infectious disease in terms of the link between social inequalities and susceptibility to infection. Moreover, the undue individualisation of causal narratives of ill health is nothing new. Since these narratives can put at stake economic interests and socio-political hierarchies, the individualisation of disease, and the ascription of blame to the sick that such an approach entails, is a central, oft-implicit thread of the social history of disease (Ryan 1971; Rosenberg 1988; Turshen 1989; Rosenberg 1992; Rosenberg & Golden 1992; Thébaud-Mony 2008; 2011).

Although the politics of disease framing was a prominent issue in the North and during the early years of AIDS, the political underpinnings of the individualised narrative of the African AIDS epidemics has received surprisingly little attention over the last two decades. This confirms Gilbert and Henry’s (2012) observation that the analysis of the framing of health problems is all too often limited to the sole moment of (often intense) agenda-setting struggles – omitting that the struggle over the framing of these problems is an *ongoing* process that does not cease once problems have effectively reached the policy agenda. Moreover, while a variety of authors acknowledge or deplore that certain aspects are omitted in the dominant causal narrative, they stop short of analysing the political underpinnings of the remarkably persistent depoliticised framing of AIDS in Africa. One reason why such a specifically political analysis is rare might lie in the theoretical and methodological challenges it poses by raising inextricable

questions of agency. I attempt here to push the political analysis a bit further – or at least to formulate it in a more explicit manner than it has been until now.

Section A argues that, in order to grasp the political dynamics that underlie the biased framing of the African AIDS epidemics, one must broaden existing approaches in terms of the social study of science through an analysis of the political economy of the uptake (or omission) of evidence. Developing upon the causal narratives described in Chapter 1, Section B analyses the politically mediated nature of disease narratives and looks at why certain causal stories have more political resonance than others. Today's dominant paradigm, I contend, has considerable depoliticising 'side effects': by putting the blame on some and exonerating others, the prevailing causal story of the spread of HIV in Africa allows for poverty-inducing and -perpetuating power relationships to be kept off national and international political agendas. By examining two of the mechanisms that render HIV/AIDS politically innocuous, this section analyses how the focus on individual behaviour decouples the problem of HIV/AIDS from matters of distributional justice, drawing attention away from socio-economic inequality and exclusion from access to essential goods and services. Section C addresses some of the challenges that arise when studying depoliticisation processes in general, and the political economy of the framing of HIV/AIDS in particular. One of these challenges concerns the assessment of intentionality; another one consists in the need for an explicit, normative definition of the underlying concept of the political.

A) From the social study of science to the political study of evidence uptake

“Before we spend millions on the type of behavior modification model of intervention now being developed, we must have a higher degree of certainty about how HIV is being transmitted and what the real risk factors are [...]. Too many studies have taken an authoritative tone which is not warranted by the data available and in doing so have encouraged a premature closure of African AIDS research.”
(Packard & P. Epstein 1991a, p.781-2)

Drawing on the two historic examples of TB and syphilis research, which have known a comparable narrowing to behavioural variables alone, Packard and Epstein warn that the omission of structural and environmental factors of vulnerability can harm health agencies' ability to control epidemics:

Like research into TB and syphilis, early inquiries into AIDS in Africa centered on efforts to understand why African experience with the disease differed from western experience. [...] [E]arly medical researchers quickly constructed theories to explain the peculiarities of the African disease experience. Given the deficiencies in medical and social knowledge that existed at the time, these theories were inevitably influenced by cultural assumptions about Africa and Africans, and tended to focus on the peculiarities of African behavior. [O]nce these theories were constructed, they shaped the course of subsequent research, privileging certain lines of inquiry while largely excluding from vision or marginalizing other potentially important areas of research. (1991a, p.771)

Their remarkably ignored paper is probably the most complete early critical analysis of the construction of (research on) AIDS in Africa. Over two decades ago, they already pointed to cofactors and unsterile injection practices as under-researched potential drivers of the epidemic:

[A]ssumptions about the importance of sexual promiscuity in the transmission of HIV in Africa [...] served to shape both the questions which AIDS researchers asked and the way in which they interpreted data. This narrowing of research in turn discouraged serious consideration of the role of alternative avenues of transmission, such as injections, or of the role of possible co-factors, such as high background levels of infection and malnutrition and associated problems of poverty and maldevelopment which may be as important in the heterosexual transmission of HIV as the frequency of sexual contacts. (1991a, p.781)

In 1991, their analysis was mainly driven by sound critical thinking, rather than abundant data corroborating their hypothesis – indeed, the lack of data was precisely what they deplored. Yet, as discussed in Chapter 1, recent research findings confirm, rather than invalidate, many of their concerns.

In line with Packard and Epstein, who deplore the “premature closure of African AIDS research”, Stillwaggon denounces what she describes as a regression of today’s HIV research and prevention policies to a pre-epidemiologic era. As she writes,

International AIDS policy seems to exhibit amnesia regarding everything that epidemiologists know about disease transmission, in poor populations in particular, and everything economists and other social scientists know about the environment of poverty in the developing world. (2006, p.10)

Different authors have proposed a variety of plausible explanations for the biased nature of AIDS research. While Stillwaggon (2006, chap.8) blames the individual bias in the methodology of health economics and epidemiology for perpetuating the narrowly individual-centred focus of the behavioural paradigm, she also underlines that “[p]eople get distracted by sex” (2006, p.11). No doubt, Western preconceptions about African sexuality certainly did favour behavioural and disfavour non-behavioural explanations of the African epidemics (Sabatier 1988; Packard & P. Epstein 1991a; A. Katz 2002; Stillwaggon 2003). One interviewee’s statement resonates with Stillwaggon’s analysis. Underlining that basic epidemiologic knowledge has been ignored in the formulation of the response to HIV/AIDS, this French medical doctor (who was involved in the early response to AIDS in France and Africa) blames the dismantling of departments for tropical medicine and infectious disease in Western hospitals and medical faculties during the 1970s and 1980s for the regression to pre-epidemiologic thinking described by Stillwaggon:

When AIDS hit home, there weren’t that many epidemiologists around any longer. Infectious diseases were considered as being a thing of the past. So there was nobody to epidemiologically analyse the phenomenon... But there were a lot of immunologists and virologists – so it was they who took the matter in hand. (Research-12)

Rosenberg (1988, p.27) describes the state of the medical world into which HIV/AIDS arrived in similar terms:

We were not entirely prepared. Antibiotics had removed much of the fear traditionally associated with acute infectious ills. Most laypersons have come to assume that such afflictions had succumbed to the laboratory’s insights. [...] The age of great and intractable epidemics seemed to have passed, and most laypersons assume – whether accurately or not – that medical therapeutics deserved the credit.

Understandably, epidemiology was not considered a priority in this context.¹⁵³ That being said, social scientists have played a key role in the sexualised construction of the African HIV epidemics. As Stillwaggon suggests, since “[m]ost social scientists [...] do not read much of the [bio-medical and epidemiologic] literature, [...] their understanding of the AIDS pandemic is unduly influenced by unscientific notions that derive from unsupported but familiar preconceptions about behaviour, a field in which social scientists feel more at home” (2006, p.31). Omitting the socio-economic and physiological characteristics of the populations within which they study the spread of HIV, many behavioural scientists have become party to the culturalist interpretation of the epidemic in sub-Saharan Africa (see below). They jumped at the chance to receive funding to study issues such as sexuality, social exclusion, ‘deviant’ behaviour, or gender relations – the analysis of which is their professional *raison d’être*.¹⁵⁴ In their analysis of the structure of research on AIDS in Africa, Packard and Epstein blame the subordinate relation of social scientists in their collaboration with epidemiologists and medical researchers for the premature narrowing of research questions:

[T]he main reason why anthropologists failed to challenge the dominant paradigm in AIDS research stemmed from the conditions under which social scientists were brought into the AIDS inquiry. [...] [T]he medical research community defined the parameters of the social science input in line with the dominant behavioral model, [...] ask[ing] anthropologists and other social scientists to provide information about the ‘risk behaviors’ which might facilitate the transmission of AIDS (1991a, p.774).

The unbalanced power relations underlying interdisciplinary research on AIDS in Africa, they contend, led to the narrowing of the relevant research question from the broader social context within which HIV transmission occurred in Africa to the sole patterns of sexual behaviour supposed to place Africans at risk of infection. This is true beyond doubt and their analysis strikingly underlines the real-world relevance of the conditions of the involvement of social scientists in health-related interdisciplinary enquiry, saliently described by McKinlay (1971) and discussed in the introduction.

These critiques of the behaviour-centred framing of the African AIDS epidemics assign the primary responsibility for the inadequacy of today’s policy responses to incomplete or inappropriate knowledge due to the biased character of AIDS research – which is itself attributed to the internal dynamics within the research community. Whether directly or indirectly, these approaches explain policy failure through the social study of science. No doubt, Western preconceptions about African sexuality, the individualistic bias in AIDS research, and the Kuhnian paradigm effects that both entail (Kuhn 1962), undeniably played, and continue to play, a key role in shaping today’s research agendas and results. Nevertheless, despite its fruitfulness, this approach pays insufficient attention to the specifically political dimensions of disease-control policies and the causal narratives that underlie them. Consequently, it seems

¹⁵³ Proposing a different interpretation, Oppenheimer suggests that epidemiologists, during the early years of the epidemic, have actually “laid the basis for an effective public health campaign” (1988, p.291). Given the subsequent evolution of the epidemic in Africa, this is, however, a questionable assertion.

¹⁵⁴ When confronted with HIV/AIDS, behavioural scientists did what they had been trained to do: look at behaviours – irrespective of the question whether analysing behaviours was helpful in understanding radically different epidemic trajectories. As Kuhn (1962, p.5) puts it, “research is a strenuous and devoted attempt to force nature into the conceptual boxes supplied by professional education”.

appropriate to shift the analytical focus. Although the premature closure of AIDS research denounced by a variety of analysts was – and still is – real, it is incomplete. While we certainly still do not know enough, we know considerably more about non-behavioural drivers of HIV in Africa than we did when authors such as Turshen or Packard and Epstein denounced this closure over two decades ago.¹⁵⁵ To be sure, social studies of science can help explain why the questions most AIDS researchers ask about the causes of the spread of HIV are so limited. Yet, insufficient knowledge *alone* can no longer explain the continued omission of *now existing* evidence on non-behavioural drivers of HIV in today's prevention discourses and policies. While plausible during the 1980s, explaining this omission as a mere unfortunate side effect of the internal logic of scientific enquiry seems politically naive today.

It remains important, of course, to analyse the lack of scientific enquiry concerning non-behavioural drivers of HIV transmission. Yet, exploring the reasons for low policy uptake of readily-available evidence might be even more crucial in today's context. In other words, one needs to focus both on existing biases in the production of scientific knowledge *and* on the determinants of the highly divergent policy resonance of different types of evidence both in the official narratives and in HIV-prevention programmes. Not looking at the second issue amounts to implicitly assuming that health policies are indeed primarily evidence-driven and that the uptake of evidence is not politically mediated – an assumption Chapter 3 shows to be incorrect. In this sense, the following section looks at the political factors that affect the selective use of evidence in the official causal stories about AIDS in Africa.

B) Political determinants of the uneven resonance of disease narratives

“African governments [...] and international institutions have proved remarkably effective at managing the HIV/AIDS epidemic in a way that minimizes political threats”
(de Waal 2006, p.3)

As discussed, the behavioural paradigm is facing mounting challenges due to its lack of explanatory power concerning the magnitude of the African AIDS epidemics. Confronting the evidence on non-behaviour-related drivers of HIV with the dominant discursive framing of AIDS in Africa points to the political underpinnings of aetiological debates concerning the African AIDS epidemics. Indeed, the relation between what is *known* about HIV, what is *said* about it, and what is *done* about it is far from straightforward. The links between knowledge, discourses, and policies are, at best, weak. While many HIV-prevention discourses and interventions are inappropriately backed by evidence, even convincing evidence about non-behavioural drivers of HIV transmission in Africa have not altered the official narratives.

¹⁵⁵ As early as 1989, Turshen (1989, p.232) underlined that “[s]ynergies of malnutrition and infection [...] can compromise the immune system and leave people more vulnerable to several communicable diseases, including HIV infection”. Turshen (just as Packard and Epstein) had the right, informed intuition. Today, the list of cofactors relevant to HIV transmission, and of data concerning their synergistic effects, gets longer and longer as research advances.

Why do various explanatory approaches of the spread of HIV have such diverging political resonance? What makes certain types of knowledge politically more attractive than others? Answering these questions about the political construction of causal stories implies going beyond the sole explanation of biases in the production of knowledge. It requires addressing the resonance of explanatory approaches not only within the scientific community, but among those policymakers who tell causal stories of the spread of HIV. From an issue related to the sociology of knowledge, the question becomes one of political incentives and interests – a problem of political economy. Saying that behavioural explanations of the African AIDS epidemics met such a receptive audience because they echo researchers' and policymakers' preconceptions about 'African sexuality' is certainly true. Yet, it is only part of the story. Concerning the relation between evidence and causal 'storytelling', Stone rightly notes that "[p]roponents of causal theories [...] appeal to scientific studies [...] in their quest for political support" (1989, p.295). Science does place certain constraints upon the successful assertion of causal theories. Yet, as Chapter 1 illustrates, a causal story's scientific correctness is not sufficient, and sometimes not even necessary, for it to gain broad political support. "[H]aving some science on your side may help", suggests Stone, "it will not guarantee that a causal theory will become the guiding assumption of public policy" (1989, p.295).

Stone distinguishes four different categories of causal stories: "two relatively strong, pure positions – accident and intent – and two relatively weak, mixed positions – mechanical and inadvertent cause" (1989, p.284). Accident and intent can be excluded, since the epidemic spread of HIV is neither purely contingent (which would make any HIV-prevention strategy futile), nor is it the result of intentional wrongdoing. Practically all competing causal stories thus fall within the category of "inadvertent cause", i.e. the domain of "unintended consequences of willed human action" (Stone 1989, p.285). These unintended consequences, Stone suggests, can be either due to ignorance, negligence or recklessness. Ignorance is at play "when people do not understand the harmful consequences of their willful actions"; when "the consequences are predictable by experts but unappreciated by those taking the actions" (1989, p.286). Ignorance is more frequently attributed to the people than to governments – such as in the assertion by TACAIDS that "lack of knowledge of HIV transmission" is one of the main drivers of HIV in Tanzania (TACAIDS 2012a). Carelessness is a type of inadvertence frequently invoked to explain problems of occupational safety. It can be attributed either to labour or management:

In management's version, workers understand the dangers of machines or chemicals; but they decline to use protective gear and safety devices because their tasks are easier, more comfortable, or faster without the precautions. In labor's version, management understands the hazards; but it does not monitor equipment conscientiously or provide safety gear, hoping it can keep productivity up without any undue mishaps (Stone 1989, p.286).

Recklessness, in turn, is a form of inadvertence that involves a conscious trade-off and thus comes close to intentional action – for instance if "management knowingly stints on safety in the interests of profits" (Stone 1989, p.286), or when men are accused of "irresponsible sexual behaviour" (TACAIDS 2012a). Beyond the question of whether the spread of HIV is due to ignorance, negligence or recklessness, the

political struggle over causal stories concerns the question of whose ignorance, carelessness or recklessness is to be blamed. Developing upon Stone’s categorisation, the following table classifies some explanatory threads of the spread of HIV in Africa.

Table 1: Whose ignorance, negligence or recklessness?

	the people	public authorities
ignorance	people do not understand that their (sexual) behaviour puts them at risk of HIV infection	governments are unaware of the threat HIV/AIDS poses to their people, or are unaware of the non-behavioural drivers of HIV transmission
negligence	people know their behaviour puts them at risk but do not take the necessary precautions – by indifference or by poverty-induced negligence (e.g. sex workers unwittingly sacrifice their own and their clients’ health in trying to survive)	governments are aware of the threats posed by HIV but do not take adequate measures to prevent its spread, either by negligence or because they consider that other issues deserve higher priority
recklessness	people know their behaviour puts them at risk but are willing to ‘take the risk’ in pursuit of personal advantage (pleasure, gain, will to harm, etc.) or to conform with social norms	governments intentionally refrain from implementing ‘upstream’ prevention policies because they feel this would question their current economic and social privileges; incomplete prevention policies are ‘the price to pay’ to maintain these privileges

While they are seldom mobilised in such ideal-typical form, these explanatory threads illustrate different narrative options upon which people can draw in the formulation of causal stories. Today’s dominant causal story of the African AIDS epidemics primarily draws on the two upper left explanatory threads, i.e. individual ignorance and negligence.

Based on the controversy regarding what makes HIV transmission so exceptionally efficient in sub-Saharan Africa, this section argues that the political resonance of different explanatory approaches is not random. The following sub-sections look at two political ‘side effects’ of the dominant causal story of HIV/AIDS – which, by focusing nearly exclusively on sexual behaviour ascribes blame to individuals, and by consistently denying or downplaying iatrogenic transmission dismisses claims of government responsibility. While these side effects are not necessarily intentionally mobilised by AIDS policymakers, their closer analysis helps explain the implicit political stakes of the debates over the spread of HIV in Africa.

B-1) 'Stop HIV – Play your part!'¹⁵⁶: minimising political threats by emphasising individual behaviour

“[I]t is the individual’s responsibility to protect oneself from HIV infection. Despite the prevailing economic situation, poverty should never be taken as an excuse for contracting HIV infection [...]. The Government will continue to provide an enabling environment [...]. HIV/AIDS is preventable. Its prevention must start from us as individuals. [...] It is possible, play your part!”
(Frederick Sumaye in: TACAIDS 2002)

With these words, the former Tanzanian Prime Minister introduced the first National Multi-Sectoral Strategic Framework on HIV/AIDS, Tanzania’s key AIDS policy document. This statement can be interpreted in at least two ways: One possibility is to consider it as a political appeal to the Tanzanian people, or more precisely to every single Tanzanian, to ‘play their part’ in fighting the epidemic. This interpretation supposes that the Tanzanian Prime Minister is addressing the wrong audience, since such a moral appeal seems out of place in a technical document written for national and international policymakers, not for the general public.¹⁵⁷ Another, compatible option is to consider that the aim of the Prime Minister’s statement is not to convince Tanzanians to change their preventive behaviours but to reiterate the behavioural causal story of the spread of HIV. In this perspective, all the Government can do is to “provide an enabling environment”. Several government officials draw on the same causal thread. One of them suggests:

If we create a proper understanding of how HIV is transmitted and everybody ensures that it must stop, the transmission of the virus will stop. If *everybody* becomes conscious of HIV for *every* sexual intercourse, *then* we can control it. (GovSector-7)

This quote illustrates the widespread individualistic vision of HIV/AIDS in Tanzania. Tesh (1988, chap.7) or Stillwaggon (2006, chap.8) have analysed how individualistic methodology and ideology affect the analysis of disease. Individualism leads to asking questions about the immediate causes of individual illness and obscures structural drivers of ill health (e.g. population-level susceptibility to infection). As Tesh (1988, p.161) underlines, the individualistic approach to disease omits uncomfortable political questions by design:

Individualistic ideology [...] supports a politically conservative predisposition to bracket off questions about the structure of society – about the distribution of wealth and power, for example – and to concentrate instead on questions about the behaviour of individuals within that structure. One consequence is the assumption that health education is the best way to prevent disease.

In a sense, analysing why a person acquires HIV in Africa by focusing on individual risk behaviours is like trying to explain massive unemployment during a global economic crisis by looking, one by one, at how certain unemployed individuals do not ‘try hard enough’ to find a job. Although lazy people might have a higher chance of ending up unemployed and ‘evidence’ pointing to the laziness of unemployed workers

¹⁵⁶ Slogan on the wheel caps of TACAIDS cars.

¹⁵⁷ The Prime Minister’s preface could, of course, be quoted in the press, and thus indirectly reach a more general audience.

can be easily produced, it is impossible to explain the economic crisis that caused structurally high unemployment rates by individual laziness. The fact that the causes of differences in health-related risks between individuals *within* a certain population can be entirely different from the causes of differences in the risk *between two populations* has been repeatedly and powerfully underlined (e.g. G. Rose 1985; Schwartz & Carpenter 1999). Drawing on the particularly telling example of homelessness, Schwartz and Carpenter, for instance, argue that “[s]tructural factors such as the amount of affordable housing largely determine the rate of homelessness, whereas individual-level risk factors are likely to determine who becomes homeless” (1999, p.1177).¹⁵⁸ They warn that “examining the distribution of a disease within a population only tells us about causes that can be distinguished among these individuals”, but does not allow one to “detect any causes of disease that are ubiquitous or relatively invariant within the population under study” (1999, p.1176). Ubiquitous causes of population susceptibility to HIV, such as many of the co-infections and other conditions of ill health mentioned above, thus become ‘invisible’ if one exclusively focuses on differences between individuals within a given population. Omitting the difference between interindividual variations and variations *between* populations leads to what Schwartz and Carpenter call “type III errors”, i.e. to giving the right answer to the wrong question.¹⁵⁹ While they rightly underline that the often undue focus on interindividual variation, in part, stems from the tools of epidemiological analysis¹⁶⁰, they also point to the political nature of the bias this induces:

The focus on interindividual variation has value-laden and political implications because such analyses, implicitly or explicitly, consider ubiquitous exposures uninteresting, unchangeable, or outside the purview of epidemiologic consideration. If the effects of such exposures and contexts are not investigated, they are not as available for intervention. (1999, p.1179)

Getting back to the initial example of unemployment and economic crisis, the fact that ‘unemployed-people-not-trying-hard-enough’ remains a widespread narrative suggests that its popularity with policymakers might not be exclusively due to the individualistic ideology or to the methodological biases of scientific tools. The individualised narrative is also used because it is politically convenient.

Over the last 30 years, declarations such as those by the Tanzanian Prime Minister and the government official quoted above have become a commonplace in many African countries. As Gruénais et al. (1999, paragr. 29) note, the heads of African National AIDS Programmes are “constructing a discourse in which, although the patient has rights and must be accepted, not stigmatised, etc., the infected person is

¹⁵⁸ Interestingly, they add: “Yet even researchers who recognize that these are distinct issues with distinct causes often conclude that both types of studies are important for reducing the rate of homelessness. We argue, however, that homelessness represents a situation in which information about interindividual differences (i.e., individual-level risk factors) is not necessary for reducing the rate of homelessness” (1999, p.1177).

¹⁵⁹ This error, they conclude, “can lead to research with little potential for significant public health consequences” (1999, p.1179) – which is the case with certain studies on sexual behaviour in sub-Saharan Africa.

¹⁶⁰ “Since all statistical methods require variation”, they underline, “research questions are best addressed with data that include substantial variation in the variables of interest. Because variation is often maximal at the individual level as opposed to the population level for factors most frequently examined in epidemiology, interindividual differences within populations often become the focus of attention, even when the original question is not about such interindividual differences.” (1999, p.1177)

guilty”.¹⁶¹ To be sure, national and international AIDS agencies have clearly distanced themselves from the moralistic and self-righteous interpretations of HIV/AIDS as a behavioural sanction – a narrative still widespread in religious circles.¹⁶² Nevertheless, the appeal to individual responsibility has remained at the heart of their discourses and the public health message ‘protect yourself’ still is the key element of HIV-prevention policies in sub-Saharan Africa.

Some might, of course, argue that, since the spread of HIV depends in part on individual behaviour, there should be a difference between what is said about HIV/AIDS and what is done about it, i.e. that discourses should continue to repeat the ‘protect-yourself’ mantra while actual prevention policies could address the non-behavioural drivers of transmission.¹⁶³ Yet, not only are (too) many HIV-prevention interventions discursive in nature, but African governments’ discourses about AIDS are frequently what Austin (1962) calls “performative speech”, in the sense that saying *is* doing.¹⁶⁴ African governments ‘do things with words’. By talking about how they struggle against this terrible ailment, they are not merely saying what should be done to prevent HIV transmission, they are *doing* something: they frame the problem of ‘AIDS in Africa’ in a politically convenient manner by assigning blame for its continued spread to individuals. As mentioned, the ascription of blame for sickness to the individual or to cultural practices is nothing new in the domain of public health (Ryan 1971; Sontag 1989, part.1; Fassin & Naudé 2004) and both Farmer’s (1992) and Sabatier’s (1988) analyses illustrate that AIDS is no exception in this respect. As Sabatier notes,

The process of attributing blame does not always require evidence, and tends to focus on people who are not considered normal by the majority, especially minorities or foreigners. Epidemics of dangerous infections such as plague, smallpox, syphilis or even influenza have historically prompted social responses based on blaming others for spreading the disease by their ‘deviant’ behaviour. (1988, p.2)

The focus on behaviour-change communication that dominates discourses about HIV prevention is the logical consequence of the behavioural paradigm. Nearly a decade before the discovery of HIV, McKinlay (1974, p.525) described this relation between causal stories and disease prevention policies as follows:

From the assumption that individuals and groups with certain illnesses or displaying at-risk behavior are responsible for their state, it is a relatively easy step to advocating some changes in behavior on the part of those involved. By ascribing culpability to some group or social category (usually ethnic minorities and those

¹⁶¹ The exaltation of individual responsibility is a dominant public health ideology based on a conception of health as an individual ‘capital’ that each person has the duty to preserve.

¹⁶² Generally speaking, the policy resonance of the behavioural narrative was facilitated by the fact that many of the prevention interventions it points to (e.g. delaying sexual debut, abstinence or partner reduction – condom use excepted) coincide with the conservative moralistic agenda of religious institutions (among which the Catholic Church), African governments, and the two Bush administrations (father and son) in the United States. As recently as 2011, the Pope, for instance, claimed that “only a strategy based on the education towards individual responsibility within a moral conception of human sexuality, in particular through marital fidelity, can have a real impact on [HIV] prevention” (<http://tempsreel.nouvelobs.com/societe/20090530.OBS8634/pour-benoit-xvi-la-fidelite-est-le-meilleur-barrage-face-au-sida.html>, accessed on 28 January 2013). Since the beginning of the Obama administration, PEPFAR has marked a clear turn towards a less moralised conception of sexuality. Yet, the underlying behavior-centered narrative is not changing perceptibly.

¹⁶³ As discussed, this claim can lead to the non-dissemination of essential information about HIV transmission.

¹⁶⁴ As Fassin (2000) argues, in line with a Foucauldian perspective on biopolitics, “doing public health” always, at least partially, consists in discursive practices.

in lower socio-economic categories) and having this ascription legitimated by health professionals and accepted by other segments of society, it is possible to mobilize resources to change the offending behavior.

A widespread variant of the ascription of blame to individuals is the ascription of blame to the cultural practices of the most-affected groups – a culturalist causal story. Fassin and Naudé define culturalism as “a common sense theory that essentializes culture and overemphasizes the understanding of social reality by its cultural aspects” (2004, p.1859).¹⁶⁵ Pointing to possible reasons for the high resonance of culturalist causal stories, they write:

Practical culturism is socially efficacious, particularly in the field of health and medicine, first, because it gives an acceptable form to prejudices against others (shifting the blame from individuals to the abstract concepts of origins and traditions), and second, because it avoids putting a political perspective on social problems (transforming inequality issues into educational questions). (2004, p.1859)

The parallel with the framing of the African AIDS epidemics is obvious. Indeed, many AIDS researchers’ fixation on Africans’ sexual behaviour recalls the focus of US and French public health authorities on the ‘cultural attitudes’ of lead-poisoned children and their parents (in France mainly African immigrants; in the US mainly African-Americans) in explaining the epidemics of lead poisoning during the 1960s in the United States (Ryan 1971, p.23-6) and 1980s in France (Naudé 2000; Fassin & Naudé 2004). Instead of questioning the social and economic hierarchies that resulted in poor immigrant populations living in run-down houses whose floors were contaminated with dust and fragments of lead-containing paint (the sole source of contamination), public health authorities blamed Africans’ medico-spiritual practices and the children’s pica behaviour (the ingestion of sweet paint flakes) for the high incidence in African families. The pica behaviour was either said to be due to their taste for mineral substances traced back to their mothers’ culturally determined ‘geophagic practices’ (West African women were said to eat clay when pregnant), or considered as being the result of mental disorders due to relational problems or disturbed mother–child relationships (Fassin & Naudé 2004). Thirty years earlier, Ryan already analysed lead poisoning in the United States in a strikingly similar way:

[N]o one would argue against the idea that it is important to spread knowledge about the danger of eating paint in order that parents might act to forestall their children from doing so. But to campaign against lead paint *only* in these terms is destructive and misleading and, in a sense, an effective way to support and agree with slum landlords – who define the problem of lead poisoning in precisely these terms. [...] [L]ead poisoning is a social phenomenon supported by a number of social mechanisms, one of the most tragic by-products of the systematic toleration of slum housing. (1971, p.23-4)

A recent report to the French health administration (Epelboin & Delavigne 2010) illustrates that culturalist explanations of lead poisoning are not entirely a thing of the past. The very same reasoning applies to the African AIDS epidemics and the focus on behavior-change programmes. Interestingly, the role played by social scientists (primarily anthropologists and sociologists) in the scientific legitimisation

¹⁶⁵ Or, as Packard and Epstein (1991b) put it: “much of the work on sexual behavior and AIDS in Africa [...] posits culture as a conservative force which determines behavior patterns, rather than as the means by which people mediate experience. It thus implicitly denies that cultural values are protean and are themselves shaped by changing patterns of social and economic development.”

of the culturalist, behaviour-centred narratives of the two diseases is strikingly similar.¹⁶⁶ Fassin and Naudé (2004, p.1859) note that, in the case of lead poisoning,

this search for cultural causes went so far as to call on ethnologists for assistance to study African family cultural practices. [...] They concluded that minerals, clay in particular, can be 'at the same time a delicacy, a medicine and a nutriment for these people, as well as a trading item, subject to gift and counter-gift'. Therefore, 'the active ingestion of paint fragments in Paris should not be related to the European biomedical or cultural norms, but rather more to autochthonous norms that approve and value geophagy'. This interpretation suggested that African families were not to blame but rather that their cultural differences needed to be understood. [...] It led many public health and housing agents to encourage the implementation of educational programs stressing behavior change, rather than considering the insalubrious housing, the extreme poverty, and the illegal status of immigrants as priorities for taking public action.

In their analysis of research on AIDS in Africa, Packard and Epstein (1991a, p.775-6) describe the role of social scientists in very similar terms:

The result of this emphasis on 'risk behaviors' was that anthropologists found themselves being asked to dig through the ethnographic record on African cultures in order to identify possible patterns of behavior which might facilitate HIV transmission. This exercise resulted in [...] an array of information which was often excised from its social or economic context and presented in much the same way as ethnographic artifacts are presented in natural history museums. [...] Instead of providing information which might have encouraged medical researchers to develop a broader perspective on the social and economic factors that may be shaping the AIDS epidemic, [social scientists] contributed to a narrowing of research and to the development of a medical model centered on the problem of African sexuality.

In differentiating the behavioural explanatory models for lead poisoning, Fassin and Naudé distinguish between a *psychologised* one, which "add[s] moral judgments that amounted to blaming the victims ('The mothers give their children too little attention')" and a *culturalised* interpretative framework, which is often based on "the more or less conscious intention of avoiding stigmatisation ('It is not their fault, it is because of their culture')" (2004, p.1859). The similarities with the *choice-based* and *structural* narratives of the spread of HIV in Tanzania described above are obvious. The structural narrative, however, is not limited to cultural factors but includes economic reasoning such as 'it's not their fault that they are promiscuous; it's because they are poor, hungry, ignorant, etc.'. More generally, the specifically cultural dimension of this widespread causal narrative should be put into perspective. Discourses on occupational disease (e.g. 'these workers simply won't wear their protective gear!') or workplace accidents (e.g. 'the agent did not respect the safety procedure...') follow comparable discursive structures (Thébaud-Mony 2008). Neither the blame-the-victim, nor the it's-not-their-fault narrative are thus necessarily culturalist; they simply need to identify the ill as the *Other*. Ryan illustratively describes the deeply political nature of framing social problems:

Blaming the victim depends on a [...] process of identification (carried out, to be sure, in the most kindly, philanthropic, and intellectual manner) whereby the victim of social problems is identified as strange, different – in other words, as a barbarian, a savage. Discovering savages, then, is an essential component of, and prerequisite to, Blaming the Victim, and the art of Savage Discovery is a core skill that must be acquired by all aspiring Victim Blamers. They must learn how to demonstrate that the poor, the black, the ill, the jobless, the slum tenants, are different and strange. They must learn to conduct or interpret the research that

¹⁶⁶ Many political scientists, economists and other researchers from various disciplines have, of course, willingly accepted and propagated these fundamentally biased causal stories.

shows how 'these people' think in different forms, act in different patterns, cling to different values, seek different goals, and learn different truths. [...] This is how the distressed and disinherited are redefined in order to make it possible for us to look at society's problems and to attribute their causation to the individuals affected. (Ryan 1971, p.10-11)

To be sure, today's behavioural paradigm is more subtle than the crude victim blaming around HIV/AIDS in the 1980s as it no longer blames 'risk groups' – such as the '4H': homosexuals, heroin users, haemophiliacs¹⁶⁷, and Haitians (see: Farmer 1992) – but 'risky behaviours'. Yet, the sometimes desperate efforts of well-meaning researchers to find a behavioural explanation to the African AIDS epidemics – although non-behavioural explanations abound – do echo Ryan's description of philanthropic "Savage Discovery". It results in a politically convenient fixation on the specific behaviour said to cause illness (be it children's pica behaviour, workers' alleged negligence in safety matters, or Africans' alleged promiscuity). Consequently, the relevant question for prevention policymakers becomes 'How can we change people's bad habits?', not 'Why do poor children grow up in lead-poisoned apartments?', 'Why are workers exposed to toxic products?', 'Why is health care safety not a priority in many African countries?', or 'Why is the risk of HIV transmission per unprotected sexual intercourse so much higher in sub-Saharan Africa than in Germany?'

The belief that 'these people act in different patterns' has an immediate political side effect: it undermines those who formulate political demands based on the claim that the over-proportionate magnitude of the African epidemics is due to the widespread political failure to guarantee essential access rights. Baldwin's (2006) comment on de Waal's *AIDS and Power* illustrates this reasoning:

AIDS is especially prevalent in Africa and has become a heterosexual epidemic there in large measure because of particular forms of behavior. Both men and women are more likely than elsewhere to have multiple ongoing sexual relationships. [...] Ultimately, AIDS is not a disease caused by poverty, gender disempowerment or social dislocation. Its epidemic spread is caused by transmissive behavior, either drug injection or, more importantly in the African case, sex of certain sorts. De Waal's central problem is: Why has the AIDS crisis not caused a major political upheaval in Africa? It seems to me that the real mystery is, why would one expect it to do so in the first place? AIDS is the result of behaviors that are enjoyed, considered natural and obvious, and whose enforced removal or change would be resisted – much like overeating and slothful energy usage in America.

It is not a coincidence that Baldwin's AIDS expertise is limited to the industrialised world. The epidemiological misinterpretation due to such an uncontrolled transfer of a causal story from the United States and Europe to the African context brings with it an implicit political theory. Precisely because the dominant causal story suggests that the spread of HIV in Africa is principally due to individual behaviour, protest against the authorities' failure to control the epidemic is viewed as being out of place, if not as absurd. At the end of a long interview with a former Tanzanian AIDS official, I raised the question of the absence of political crisis due to AIDS, explicitly referring to de Waal's analysis. Interestingly, when asked about the limited political reaction of the Tanzanian people to the AIDS crisis, this official's response is very close to Baldwin's explanation:

¹⁶⁷ Hemophiliacs were arguably perceived as 'pure victims' from the very beginning.

Why *should* they claim from the government if it's their own promiscuity that brought it [AIDS] about?! When you get it, you're yourself responsible for it...so people here are more intelligent than that author. (GovSector-4)

Speaking in terms of causal stories, this argument pushes the issue from the sphere of ignorance into that of negligence, if not recklessness. If HIV spreads due to people who voluntarily put their health at risk, not only can government not be blamed for the failure to check the epidemic, but its prevention efforts become infallible as their ineffectiveness can be attributed to peoples' lack of receptiveness to public health messages.

This exonerating side effect of individual-based prevention policies might help explain why, contrary to Stillwaggon's sensible suggestion that "[t]he priority in strategies should always be those over which the agency can reasonably expect to exert control" (2006, p.191), so many prevention players focus on individual sexual behaviour – a variable they can hope to influence only very indirectly. This interpretation makes some policymakers' apparently paradoxical reasoning somewhat less puzzling. In a discussion about cofactor-based prevention interventions, a senior bilateral agent, for instance, contends:

It's all about individual control. Individuals have complete control over their sexual relations. But people cannot diagnose and treat themselves against [neglected tropical diseases]! So the HIV people have felt that they could do more through behaviour change programmes than on systemic issues such as deworming, nutrition, etc.... (Bilateral-12)

This statement is instructive in several respects. Not only does the term "HIV people" refer to people engaged in behaviour-change activities (illustrating the confusion of HIV prevention and behaviour-change communication), but this interviewee suggests that prevention players have intentionally focused on those aspects with a *low* policy sensitivity. While the apparently paradoxical focus on variables with low policy sensitivity can be partially explained by the incomplete convertibility of prevention players' competences (see Chapter 3), the reasoning also reveals a deeply political vision of health policymaking inspired by individualistic ideology. Although invoking "individual responsibility seems politically neutral" (Tesh 1988, p.162), it implies an implicit political theory. As Garfinkel writes,

The individualistic question takes the structural conditions as given. In particular, it requires that we not question why these structural conditions are what they are but that we limit our questioning to states of affair consistent with the structure. [...] The theory that accepts social structure as given [...] it is not an alternative to moral theories; it is one among them. (1981, p.152-3; quoted in Tesh 1988).

Part of the success of the behavioural paradigm stems from the fact that it allows culturalist and individualistic narratives to converge on a behaviour-centred explanation although they are *a priori* antithetical (the culturalist narrative being essentially non-individualistic). The behaviouralisation – be it via individualistic or culturalist narratives – and the politicisation of disease behave as communicating vessels. The acknowledgement of non-behavioural drivers of HIV, by de-individualising and de-culturalising the spread of HIV, implies an increased politicisation of the African AIDS epidemics. Responsibility to act would be moved from the private sphere to the public, political domain. The next

section argues that this overstatement of the role of individual behaviour goes hand in hand with the understatement of government responsibility concerning the transmission of HIV in health care settings.

B-2) Dismissing claims of government responsibility by understating the role of iatrogenic transmission

“Why aren’t the two universally acknowledged modes of contamination, sexual contact and iatrogenic blood-borne transmission, taken into account jointly and equally vigorously, in those countries where they both cause such damage?”
(Vachon 2010, p.47)

The still ongoing character of the epidemiological debate on the importance of iatrogenic transmission of HIV in sub-Saharan Africa in no way detracts from the fact that the political implications of (and potential reasons for) its likely underestimation have not received adequate attention. Different authors put forward potential explanations for the omission of evidence for iatrogenic transmission. Gisselquist et al. (2003, p.148+158), for instance, explain the discounting of evidence through preconceptions about African sexuality, health authorities’ fear of a loss of trust in health care, and the fact that condom promotion efforts coincided with pre-existing birth control efforts in sub-Saharan Africa.¹⁶⁸ No doubt, scientific conformism, prejudices about African sexual behaviour, and the medical profession’s will to preserve people’s trust in vaccination campaigns and health care certainly explain part of the story. What most analysts do not mention, however, is that clear political incentives exist to inflate artificially the estimates of sexual transmission. Since, in contrast to sexual behaviour, HIV transmission via unsafe health care is directly amenable to change by public authorities, it can be associated with the failure of African governments – and arguably of their Western counterparts. As discussed, the drastic budget cuts and privatisations entailed by the so-called ‘structural adjustment programmes’ imposed by the World Bank and the IMF have considerably weakened many African health systems (e.g. Turshen 1999). By intentionally depriving public health facilities from even the most essential resources, these programmes have often made it impossible for health-service providers to deliver *safe* medical care. A blatant lack of resources at the service-delivery level obviously encourages the reuse of ‘disposable’ injection equipment. Acknowledging iatrogenic transmission would lead to an at least partial ‘redistribution of blame’ to governments – which arguably helps explain public denial.

Even a brief stay in many African hospitals and health centres suffices to raise safety-related concerns. The Tanzanian example is telling in this respect. The main national policy documents on HIV/AIDS claim – generally right up front, as if to clear responsibility – that about 90% of new infections are due to unprotected sexual intercourse (without, however, mentioning where these estimates come from).¹⁶⁹ At the same time, several policy documents assert that 100% of the needles and medical equipment used

¹⁶⁸ This reading concerning birth control efforts is explicitly based on Turshen and Thébaud-Mony’s (1991) analysis ; see (Vachon 2010, p.46-7).

¹⁶⁹ The National Policy on HIV/AIDS, for instance, asserts that “heterosexual intercourse [...] accounts for about 90 per cent of all infections” (URT 2001, p.9-10).

in health care settings are either disposable or have been effectively sterilised, and that 100% of all blood transfusions in the country have been screened for HIV. This is not surprising since anything else would be considered an inexcusable failure of public health authorities. The ensuing national estimates of iatrogenic transmission of HIV are vanishingly low, if mentioned at all. Notwithstanding these impressive figures, however, various players in Tanzania, including PEPFAR, frequently raise the improvement of blood screening as an urgent priority. The mere existence of this priority puts the official figures into question.

That being said, in many cases, discourses about public health and actual health policies require at least partially separate analyses. Indeed, although the existence of unsafe medical practices has been – and still is – quite consistently denied, some health authorities have started to take action. Over recent years, many sub-Saharan countries (including Tanzania) have banned non auto-disabling syringes (some only for immunisations procedures), and both PEPFAR and WHO have contributed to improving injection safety (Reid 2009b; 2009c). While much remains to be done,¹⁷⁰ some aspects of health care safety have changed for the better. Interestingly, although some evidence remains absent from public narratives, health care safety is – partially and slowly – taken up in some prevention policies. Policymakers thus post reassuring figures on safety in health-care settings while, at the same time, collaborating to improve blood screening and other measures to prevent iatrogenic HIV transmission. The discursive acknowledgement of a causal pathway is thus not a necessary precondition for preventive action. Perhaps policymakers are well-aware that not adequately addressing iatrogenic risk could become politically explosive in the future, should health-care transmission turn out to be a significant driver of some local or national epidemics. This combination of the impossibility of acknowledging the role of iatrogenic transmission and the necessity to act against it might help explain some governments' and donors' recent paradoxical stand: they now declare that health care safety has improved, although the previous lack thereof had never been acknowledged as a problem. "We discourage unsafe injection use", states a bilateral agent, adding "things have changed...[safe injections] are now available" (Bilateral-21). 'Don't worry, there was no problem, but we took care of it' seem to say some donors and health officials. The problem is acknowledged once action has been taken to address it; as long as this is not the case, denial prevails. That being said, the action taken still remains insufficient.

Despite its ambiguous effects, the increasingly biomedical framing of HIV prevention since 2010 (Nguyen et al. 2011) probably contributes to the promotion of 'technical solutions' such as improving the safety of medical practices. Indeed, significant changes can be rapidly obtained through fairly easy technical measures (such as national bans on non auto-disabling syringes). Just as in the case of cofactors, the existence of technical, closely circumscribed control measures, however, coexist with more structural drivers of iatrogenic HIV transmission. As Drucker et al. underline,

¹⁷⁰ Some of the issues not addressed above include the sterilisation and safe reuse of medical equipment such as surgical forceps, specula, or dental instruments, for which appropriate training (and material) is lacking in many health facilities (Reid 2009b).

Ultimately, the driving force behind massive unsterile injecting is the global demand for injectable drugs and their therapeutic effects. But the risks that injecting these drugs entail are a function of continuing disparities in access to modern medical care. If these large political realities and the imbalances in the global marketplace in drugs and the technology to use them are not addressed, unsterile injections will continue to spread infectious diseases, and possibly create new ones, throughout the 21st century. (2001, p.1991)¹⁷¹

Similarly pointing to the risk of considering medical safety as an exclusively technical issue, Packard and Epstein suggest that “we need to examine the political economy of health care and not simply the incidence of improper needle use as has been recently advocated by the WHO” (1991a, p.779).¹⁷²

Unsafe medical practices are dismissed as a driver of HIV for a variety of reasons. Governments’ willingness to avoid blame and escape responsibility for the spread of HIV is probably one of them. While acknowledging the existence of this political incentive structure does not necessarily imply that policymakers *intentionally* perpetuate reductionist visions of epidemic causation to defend their legitimacy, it does seem useful to take the underlying political incentives seriously. Doing so helps illuminate the – otherwise difficult to understand – tendency of policymakers to tackle health problems downstream, rather than upstream.

B-3) The political economy of struggling ‘downstream’

“There I am standing by the shore of a swiftly flowing river and I hear the cry of a drowning man. So I jump into the river, put my arms around him, pull him to shore and apply artificial respiration. Just when he begins to breathe, there is another cry for help. So I jump into the river, reach him, pull him to shore, apply artificial respiration, and then just as he begins to breathe, another cry for help. So back in the river again, reaching, pulling, applying, breathing and then another yell. Again and again, without end, goes the sequence. You know, I am so busy jumping in, pulling them to shore, applying artificial respiration, that I have no time to see who the hell is upstream pushing them all in.”
(I.K. Zola, quoted in: McKinlay 1974)

Developing on Zola’s remark, McKinlay deplores that “we always seem to arrive on the scene and begin to work after the real damage has already been done”. “So long as we continue to fight the battle downstream, and in such an ineffective manner”, he adds, “we are doomed to frustration, repeated failure, and perhaps ultimately to a sicker society” (1974, p.521). He suggests that there are three levels of health realities, which are typically addressed by three different types of health interventions: curative, preventive, and ‘upstream’ interventions. While the two latter are preventive in nature, he distinguishes preventive activities that address individual behaviour and those that address the structural causes of disease at the collective level (interventions with a political economy focus). Developing on McKinlay’s framework (1974, p.527), Table 2 proposes a classification of different types of HIV-related interventions.

¹⁷¹ For an interesting parallel, see (Dupuy & Karsenty 1974).

¹⁷² As one interviewee underlines, because of the high prevalence of counterfeited pills, which do not always contain the active agent they are supposed to, asking for an injection is perceived by many Africans as a way to ensure that they actually receive an effective drug.

Table 2: Levels of health realities and types of HIV-related interventions

Level of health realities	Level of health intervention	Type of interventions
Observable morbidity and mortality	Intervention with a curative focus	Care and treatment with antiretrovirals (also: anti-parasite treatment, treatment of STIs, etc.)
'At-risk' behaviours and quality of health care	Intervention with a preventive focus	Behaviour change communication, condom distribution, prevention of mother-to-child transmission, needle exchange, blood screening, safety measures concerning injections and contaminated medical equipment
Structural causes of ill health and populations' vulnerability to disease ¹⁷³	Upstream intervention with a political economy focus	Policies aiming at reducing the biological 'risk per exposure' (e.g. universal health care and insurance, nutrition security, safe water, housing and sanitation), or at altering the socio-economic context within which people make behavioural decisions (income poverty, economic and gender inequalities, labour migration, etc.)

Today's AIDS-control policies in Africa confirm McKinlay's four-decade-old observation that upstream interventions are consistently neglected. Antiretroviral treatment has become the main focus of AIDS control and HIV-prevention strategies continue to focus primarily on the immediate (behavioural) causes of individual exposure to the virus, disregarding population-level drivers of HIV infection such as high transmission efficiency due to widespread biological cofactors or unsafe medical care. Importantly, although curative in nature, certain interventions (such as anti-parasite treatment, TB control or the treatment of STIs) prevent HIV transmission 'upstream' because they reduce a population's susceptibility to the virus by reducing the average risk of transmission per exposure. In this sense, and unlike the most widely accepted definitions (including McKinlay's), these curative measures can be considered part of 'structural' or 'upstream' HIV prevention because they alter the 'fertility' of the biological terrain on which the virus flourishes (see Chapter 3).

In the short term, many parasitic infections and micronutrient deficiencies can be addressed through inexpensive, comparably simple measures such as parasite treatment (Hotez et al. 2009; Walson et al. 2008), some types of vector control, or targeted food fortification.¹⁷⁴ Many of these measures (such as deworming campaigns or a ban on non auto-disable syringes) are arguably 'win-win' interventions, the absence of which is chiefly due to government negligence rather than to its intention to protect vested interests. Yet, as discussed above, mass drug treatment, for instance, is but a short term fix in many cases, not a long term solution. Policy responses that would tackle the structural drivers of population susceptibility to HIV infection in an effective and sustainable manner are considerably more far-reaching.

¹⁷³ McKinlay provocatively calls this level the "activities of the manufacturers of illness". While this is *a propos* concerning issues such as industrial pollution or job hazards (Michaels 2008; Thébaud-Mony 2011), its use is more problematic in the case of infectious diseases, where it might be more appropriate to speak of the 'inactivity of public authorities to address the structural causes of ill health'.

¹⁷⁴ In Tanzania, several hundred thousand children have been treated against soil-transmitted helminth for as little as 3 or 4 cents per capita (P. J. Hotez 2008, p.25).

Indeed, a look at the potential political and economic implications of genuine upstream interventions helps explain why these measures have not been promoted more consistently by policymakers in sub-Saharan Africa.

The exposure of a population to cofactors depends on people's access to safe water, sanitation, adequate housing, a balanced nutrition, and quality primary health care (including vector-control and deworming campaigns). Satisfying these basic needs as a national priority would imply a major shift away from current national and international policies.¹⁷⁵ To name only a few, it would entail fundamental changes in domains such as land tenure and agricultural policies, including a shift from export-orientation to supporting small-scale farming (e.g. Lappé et al. 1998; Ziegler 2004), international trade policies (K. P. Gallagher 2005; R. H. Wade 2003), legal systems, distributional and tax policies, and international development agencies' loan or debt relief conditionalities¹⁷⁶. Similarly, the profound political implications of setting up genuine primary health care in resource-poor settings tend to be vastly underestimated (see Part 3). This might explain some observers' recurrent surprise concerning many African governments' repeated failure to implement often ambitious plans to develop primary health care.¹⁷⁷ Addressing some of the root causes of the epidemic spread of HIV in sub-Saharan Africa would entail profound changes in the living conditions of the poor, i.e. the vast majority of the population. Policies aiming at seriously reducing inequality are, however, fundamentally at odds with today's dominant economic paradigm. They would not only involve a major reallocation of resources,¹⁷⁸ but challenge established political, economic, and social hierarchies. Such changes would imply a fundamental transformation of the national and international balances of power. Genuine 'upstream' prevention is politically subversive.

In some countries, HIV/AIDS will cause the premature death of nearly half the population. If a convincing causal story puts even partial responsibility for the epidemic on governments, the latter are likely to face serious legitimacy problems. De Waal (2006, p.119) is right in noting that "AIDS has been politically domesticated" and that it "has turned out to pose a political threat no greater than familiar pathologies such as hunger and homelessness".¹⁷⁹ With good reason, many authors underline the role of the free distribution of antiretrovirals in defusing the situation. Yet they forget to mention that the dominant explanatory paradigm of the spread of HIV in Africa substantially contributes to the political domestication of the epidemic. As Stone puts it, "causal theories [can] implicitly call for a redistribution of power by demanding that causal agents cease producing harm and by suggesting the types of people

¹⁷⁵ Of course, all African countries have policies (and discourses) in these domains. Few cases excepted, however, these policies seriously lack scale and scope and their implementation is haphazard.

¹⁷⁶ In Uganda, an IMF-imposed budget ceiling on health expenditure hampered the increase of HIV/AIDS expenditures in the time period of 2005-2010. The 2008 Mexico AIDS Conference even convened a special session on "IMF Policies Blocking the Response to HIV/AIDS" (see: www.aids2008.org/Pag/PSession.aspx?s=356).

¹⁷⁷ For an insightful analysis of the deeply political nature of the choices involved, see (Thébaud-Mony 1980).

¹⁷⁸ Indeed, it is not only political legitimacy that is at stake in the struggle over causal stories. Beyond the mere 'discursive' dimension (avoiding blame and preserving political legitimacy), it is also about material issues such as resource allocation (e.g. avoiding policies that are 'costly' for political and economic elites).

¹⁷⁹ Considering hunger and homelessness as 'pathologies', however, is a questionable biologisation of social ills.

who should be entrusted with reform” (1989, p.300). In other words, Packard and Epstein have probably over-hastily concluded that the AIDS authorities’ “stress on behavioral modification may not have been as manifestly self-serving as the [...] efforts of medical authorities working with TB to see overcrowding and malnutrition as the result of African ignorance” (1991a, p.775). The focus on the immediate (individual) causes of infection (i.e. *fighting downstream*) is in part due to an interest-driven incentive structure. By decoupling HIV/AIDS from matters of distributional justice and access to essential goods and services (or by defining distributional justice as access to free ART), this depoliticised framing of the epidemic prevents existing patterns of (re)distribution from being called into question. It acts as a cover-up of the widespread neglect of mass poverty and access rights denied due to an exploitative economic system, as well as the absence of social welfare programmes and safe primary health care in much of sub-Saharan Africa.¹⁸⁰

While its effects are fairly obvious, analysing the *process* of depoliticisation is less straightforward. Given the political incentive structure, it seems understandable that African governments subscribe to the behavioural causal story. Many African governments, however, obviously formulate their HIV-prevention policies (and the causal narratives that underlie them) in a highly heteronomous political context, where policymakers’ practical experience about funding opportunities can prove just as important as their beliefs about causation (see Parts 2 and 3). Yet, the fact that most international organisations and bilateral donor agencies (and many social scientists) also echo these ideas is more troubling, and arguably more difficult to explain through incentives alone. To be sure, most donor agencies in Africa have at least indirectly provided health services for decades (making them possibly ‘co-responsible’ for iatrogenic HIV transmission), and the effects of culturalism, individualism, as well as Kuhnian paradigm effects (which entail a pro-conformist incentive structure) can help explain donors’ and social scientists’ support for the behavioural narrative. Nevertheless, even if the depoliticisation of AIDS is conceived as a process that is driven by a variable (and incompletely understood) interplay between players’ worldviews and incentives, the question of agency poses a number of serious challenges.

C) Who depoliticises African AIDS epidemics? Challenges in analysing the framing of disease

“[G]reater changes will result from the continued politicization of illness than from the modification of specific individual behaviours”
(McKinlay 1974, p.528)

By inverse reasoning, McKinlay’s statement suggests that the best way to maintain the status quo is precisely to keep illness depoliticised. Interestingly, reading this very sentence in an early draft version of

¹⁸⁰ In this sense, the evidence on cofactors and iatrogenic transmission accumulated over the last twenty years powerfully confirms Turshen and Thébaud-Mony’s (1991) analysis. “[T]he use of the social perception of AIDS as an exclusively sexually transmitted disease”, they underlined over two decades ago, “allowed the complete dissociation of the problems posed by this epidemic from African countries’ socio-economic context, from worsening social inequalities, and from the deterioration of basic health services” (*my translation*).

this chapter, one interviewee commented: “That’s right! That is why they created a [disease specific] Global Fund, rather than following Alma Ata!” – i.e. the 1978 declaration on Comprehensive Primary Health Care (see Part 3). Given its underlying causal narrative, the international response to HIV/AIDS has contributed to the depoliticisation of the epidemic in Africa. That being said, it is considerably easier to show *that* this is the case and to convincingly argue *why*, than to document *how* this happened by giving a detailed empirical account of the underlying political process.¹⁸¹ Analysing the politics of disease framing in terms of ‘depoliticisation’ presents at least a double challenge: it requires a theoretical clarification of the concept and its underlying conception of the political, and it presents the methodological and epistemological challenge of grappling with the inextricable question of agency.

C-1) ‘Depoliticisation’ or the illusion of conflict-free public policies: some theoretical considerations

“Spotlight on concepts! Far from neglecting the concept, we should learn to take it for what it is: a strategic entity.”
(Latour 2001, p.31, my translation)

At its origins, HIV/AIDS was a highly publicised epidemic that was manifestly perceived as a political issue in both Europe (Setbon 1993) and Africa (Dozon & Fassin 1989). Yet, as Gruénais et al. (1999) describe, the epidemic has not become a major issue in broader public debate in most African countries. Up until today, HIV/AIDS is not hotly debated in the Tanzanian public sphere. The epidemic’s “transformation from a public health problem to a public problem”, as Gruénais et al. put it, has remained utterly incomplete (see Part 2). As discussed, different authors have provided various complementary explanations for the non-politicisation of AIDS in most African countries, including its *relative* lack of importance in a context of generalised poverty, the weakness or low political autonomy of civil society, and the more general absence of democratic institutions or public controversies.¹⁸² While these explanations seem plausible, the depoliticising side effects of the behavioural causal story are omitted in the analyses of the limited politicisation of the African epidemics. All too often, the depoliticisation of certain issues is analysed or denounced without reference to a definition of the concept itself, let alone to its theoretical underpinnings. I will therefore take one step back to provide an at least tentative definition of ‘depoliticisation’ and of the concept of the political that underlies it.

So what do I understand by ‘depoliticisation’? Suggesting that the behavioural causal story contributes to the depoliticisation of African AIDS epidemics means that they have been (and continue to be) framed in a way that the political context that allowed the virus to spread with such unique efficiency is obscured. Rather than as a collective, political issue, HIV/AIDS is considered as a problem of individual

¹⁸¹ As Becker (1998, p.58-60) underlines, *Why?-questions* are far more difficult to answer for social scientists than *How?-questions*. Yet, this does not mean political scientists should not try to answer the former, be the answers tentative and incomplete.

¹⁸² Concerning the lack of politicisation of AIDS in Côte d’Ivoire, Cornu, for instance, asks: “In a country without public controversies, without debate between political opponents – a country without a truly functioning democratic system, can AIDS become a political issue?” (Cornu 1996, p.44 quoted in Gruénais et al. 1999, *my translation*).

conduct. In Tanzania, another aspect of this multifaceted depoliticisation process (described in more throughout the following chapters) concerns the invisibilisation of the political trade-offs that underlie the formulation of the *responses* to the epidemic – responses, which are codetermined both by the dominant explanatory narrative and by the highly heteronomous nature of AIDS-control initiatives in Africa. While the behaviour-based causal story pushes the problem of HIV/AIDS from the political to the private sphere, the illusion of purely evidence-based policymaking pushes the decisions that underlie the formulation of HIV-prevention policies from the political to the technical domain (see Chapter 3). From a public issue in need of a political response, the epidemic is transformed into a private issue addressed via technical interventions (see also Part 3).

Such changes in the perception of issues is brought about by what Bourdieu (1982; 1984; 1989) describes as the “struggle over classifications”.¹⁸³ This continuous struggle, which is co-constitutive of politics, results in an oft-implicit taxonomy that defines certain issues as *political* and thus as legitimate objects of political debate, while defining others as *non political* and thus as illegitimate political objects. Depending on how issues are categorised (or framed), they fall within the province of one category of people or another: in the case of the behavioural causal story, positive change is expected to come from individuals rather than governments; in the case of ‘evidence-based’ prevention policies, it is considered legitimate for epidemiologists and health economists to decide on the priorities, rather than to allow a controversial process to formulate political compromises concerning the value trade-offs these policies involve (see Chapter 3). In symmetrical reasoning based on Lagroye’s definition of *politicisation* processes, one could thus define depoliticisation as a “re-qualification of social activities” (2003, p.360). As Bourdieu underlines, “modifying these classifications is not merely an intellectual, but a political operation” (2000, p.67), or as Arnaud and Guionnet put it, “the attempts to displace the boundaries of the political frequently appear as ways to participate more or less directly in politics, by seeking, through a redefinition of [these boundaries], legitimating resources in order to get it one’s way” (2005, p.24, my translation).

A theoretically founded critique of the depoliticisation of certain issues can only draw on a comparison between the empirically observed boundaries of the political and a normative definition of these boundaries. Put differently, a critique of depoliticisation presupposes that certain issues are *inherently* political and should thus be subject to political debate and decision. Consequently, it is insufficient to content oneself with simply considering as ‘political’ those issues that have been successfully politicised and as ‘non political’ those questions that have been successfully depoliticised. In line with Schmitt (1932b) and Mouffe (1993),¹⁸⁴ I consider that the defining feature of the political is the struggle over

¹⁸³ Bourdieu very broadly defines the struggle over classifications in the field of politics as a “struggle for the monopoly of the legitimate representation of the social world” (1982, p.13-14, my translation) – a definition that is very close to Bourdieu’s (1984) definition of politics itself as the “struggle for the imposition of a legitimate perception of the social world”.

¹⁸⁴ As Mouffe argues, Schmitt’s concept of the political (which is based on ‘hostility’ and the friend/enemy distinction) can be extended so as to allow grasping both real hostility (including the physical annihilation of the enemy) and the mere existence of incompatible interests and values (social antagonisms), which imply a lower intensity of conflict.

incompatible interests and values. Concerning, for instance, the boundaries between the political and the technical domains, one can thus distinguish two types of problems: those which can be *technically solved* since there is either harmony of interests or agreement about the ends or the criteria of evaluation (and their hierarchy), and those which put at stake irreducibly conflicting interests and values.¹⁸⁵ Their incompatibility can only be acknowledged in order to find acceptable compromises – not definite solutions – via political process. This essential feature of the political is what Mouffe calls the existence of *radical diversity* or irreducible social conflict. Irrespective of their framing in the political process, some issues are thus intrinsically political in nature as they imply the formulation of trade-offs between irreducibly conflicting interests and/or incommensurable values. Even if ‘depoliticised’ (i.e. framed as essentially uncontroversial) these questions therefore remain intrinsically political in nature. In other words, the political cannot disappear; it can only be concealed as the result of political power relationships (Schmitt 1932a, p.72+76).¹⁸⁶

In the context of the African AIDS epidemics, this concept of the political underlies the different but related meanings of the term ‘depoliticisation’ alluded to above. The first one, mainly referred to in this chapter, concerns the framing of these epidemics themselves: their depoliticisation consists in the ascription of responsibility to individual sexual behaviour rather than to inequalitarian socio-economic structures shaped by the unequal distribution of political power and widespread public mismanagement. The second meaning, which is discussed throughout the following chapters, concerns the responses to HIV/AIDS. In this case, the depoliticisation consists in the negation of the existence of irreducible conflict. This illusion of conflict-free AIDS control can be entertained on the assumption that ‘optimal’ HIV-prevention and -treatment strategies can be *rationally* formulated based on technical criteria alone (Chapter 3), or by the outright negation of scarcity and of the need to choose it implies (Chapters 4 + 5). Lastly, only such an ‘essentialist’ conception of the political allows one to criticise a last form (or modality) of depoliticisation, namely the limitation of public participation via the confinement of decision processes to non-public spheres (Part 2), or via the heteronomous imposition of (health) priorities (Part 3). If ‘experts’ are able to define *optimal* policies, the participation of non-experts in decision processes loses its legitimacy. Similarly, if there is no need to choose because resources are unlimited, the call for public participation in allocative decisions makes no sense.

The assumption of non-conflictuality (or harmony) can stem from an ill-informed idealistic understanding of health policymaking, from self-serving cynicism, or from a combination of both. In any case, the persistently depoliticised framing of the African AIDS epidemics is not without raising questions about agency and intentionality – a messy analytical ground.

¹⁸⁵ Put differently, a political issue requires arbitration between different ends; a technical issue exclusively concerns the choice of the appropriate means to reach *predetermined* ends. As Weber rightly underlined, even a technician frequently has to take decisions by choosing the lesser of two evils. However “one component of [his] decision, and one of central importance, is generally *given*, namely the *end*” (1917, p.104; my translation).

¹⁸⁶ Unlike Schmitt, authors such as Arendt (1993) or Castoriadis (1974) consider that the political, at least in the qualified definition they retain, can actually disappear.

C-2) The challenge of assessing intentionality: a tightrope walk between conspiracy theorising and political naïveté?

“[W]hen society places hundreds of proletarians in such a position that they inevitably meet a too early and an unnatural death [...]; when it deprives thousands of the necessities of life, places them under conditions in which they *cannot* live [...] knows that these thousands of victims must perish, and yet permits these conditions to remain, its deed is murder [...]; disguised, malicious murder, murder against which none can defend himself [...] since the offence is more one of omission than of commission. But murder it remains.”

Friedrich Engels (1845, p.106-7)

“[I]n politics, the distinction between actions that have purpose, will, or motivation and those that do not is crucial. So, too, is the distinction between effects that are intended and those that are not, since we know all too well that our purposeful actions may have unintended consequences.”

Diane Stone (1989, p.284)

Unlike Engels in his now-classic indictment against the British bourgeoisie, considered guilty of murder against the country’s proletarians, Sabatier (1988, p.5), in his analysis of the framing of causal narratives of the AIDS epidemic during the 1980s, suggests that “[i]t would be foolish to follow the present epidemic of blaming others with an analysis of who is to blame for casting blame”. Both Engels’ accusation of collective intentional harm-doing and Sabatier’s call for ‘non-investigation’ are, however, ultimately unsatisfactory analytical positions with respect to HIV/AIDS. It is, I believe, possible to develop a both politically informed and non-teleological conception of the exercise of power that underlies the framing of the African AIDS epidemics and the formulation of HIV-prevention policies. That being said, the omission of health-care transmission and that of the role of cofactors demands at least partially distinct analyses. This section’s primary focus concerns the omission of cofactors, as the underlying political conflict of interests is more apparent.¹⁸⁷

As discussed, plausible explanations of the omission of the non-behavioural drivers of HIV transmission have been provided by approaches in terms of the social study of science, which point to the role of paradigm effects, individualism, and Western preconceptions about African sexuality. Yet, part of the strikingly consistent omission of evidence remains unexplained. The evidence concerning these non-behavioural drivers as complies with widely-accepted scientific standards, is readily available and hardly ever scientifically challenged. The old question of ‘Who gains?’ might thus be helpful – or, as Ginzburg (1989, p.102) more subtly puts it: “When causes cannot be reproduced, there is nothing to do but deduce them from their effects”. The domination-perpetuating implications of a depoliticised conception of African AIDS epidemics might help explain why so little is done to ‘re-politicise’ them. Is it mere coincidence that the dominant explanatory paradigm – thanks to its compatibility with the social,

¹⁸⁷ National public health authorities who, amidst a generalised HIV epidemic, refrain from banning non auto-disable syringes, for instance, obviously commit manslaughter by omission. While the lack of action concerning unsafe medical practices in many cases persists against better knowledge (thus making it intentional), it is quite unclear who actually benefits from such a state of affairs. In turn, given the aforementioned redistributive consequences of genuine upstream prevention concerning cofactor-related issues, it is much easier to identify the political incentives for inaction. That being said, Chapter 3 argues that the omission of cofactors from HIV-prevention policies can, in part, be explained by factors not immediately related to the political will to preserve the status quo.

economic and political status quo – prevents existing hierarchies and patterns of (re)distribution from being called into question, favouring those who are in power and disfavouring those who are not? If it is not, does that necessarily imply that policymakers intentionally conceal the political nature of the epidemic to design policies that further their interests? On the one hand, it seems exaggerated to consider the depoliticisation of HIV/AIDS as the result of collective intentional action. Real-life processes are more complex than that and there is no doubt that neither Western donors nor African leaders want Africans to die from AIDS. On the other hand, there are clear disincentives for African leaders (and Western governments) to tackle some of the root causes of the epidemic. The often implicit assumption that governments are willing to do ‘everything it takes’ to stop the epidemic (but just do not know how to go about it) seems politically naïve. Put differently, to what extent are those currently in power willing to accept fundamental changes in the allocation of political and economic resources in order to address the epidemic’s structural drivers effectively? The question has been largely ignored in most of the scientific literature and public debate on the African AIDS epidemics. No doubt, there are no easy answers to the question of intentionality. Yet, does this mean that we should simply carefully omit it – as many AIDS scholars and other political scientists seem to suggest?

In a debate over economic development, Krugman (1996) once acknowledged that it happens that “bad ideas flourish because they are in the interest of powerful groups”. Chomsky (1996) readily replied that “[i]t not only happens, but does so with impressive consistency”. Bachrach and Baratz’ (1962) analysis of depoliticisation processes might help explain why dominant ideas generally happen to favour the powerful and disfavour the poor. “[P]ower may be, and often is, exercised by confining the scope of decision-making to relatively ‘safe’ issues”, they note. In other words, “power is also exercised when A devotes his energies to creating or reinforcing social and political values and institutional practices that limit the scope of the political process to public consideration of only those issues which are comparatively innocuous to A” (1962, p.948). In line with this argument, the ‘misunderstanding’ of the African AIDS epidemics – i.e. the success of the behavioural causal story albeit its lack of explanatory power – could, in part, be due to the fact that the solutions deriving from a biased framing of the problem happen to be politically less burdensome for those in power. Drawing on Schattschneider’s analysis, one could say that telling causal stories of HIV/AIDS contributes to the *mobilization of bias*: “[s]ome issues are organized into politics, while others are organized out” (1960, p.71). The consistent repetition of the behavioural causal story by political leaders and officials contributes to organising the structural (i.e. politically determined) drivers of the African AIDS epidemics out of African politics and out of the politics of ‘development cooperation’. Without fully meeting the analytical challenge, it probably helps to reformulate the (overly simplistic) question of intentionality into a more indirect one about why different causal stories have such uneven resonance, both at the discursive and the policymaking levels. Asking the question in this way points to the fact that disease framing is intricately related to political ideology, which mediates the uptake of explanatory narratives at every step of the reception and

policymaking process (Tesh 1988). Far from being a purely intellectual construct, political ideology should be understood as inseparably related to interests (Mannheim 1929).

While ideology plays a key role, other reasons just as firmly anchored in social structures can help explain the uneven political resonance of causal stories. In what could be described as a 'lower-intentionality variant' of the analysis developed above, Becker suggests that being part of an institution necessarily affects the perspective on social problems adopted by "responsible officials":

They have been entrusted with the care and operation of one or another of our important institutions: schools, hospitals, law enforcement, or whatever. They are the ones who, by virtue of their official position and the authority that goes with it, are in a position to 'do something' when things are not what they should be and, similarly, are the ones who will be held to account if they fail to 'do something' or if what they do is, for whatever reason, inadequate. Because they are responsible in this way, officials usually have to lie. [...] Officials must lie because things are seldom as they ought to be. For a great variety of reasons, well known to sociologists, institutions [...] do not perform as society would like them to. Hospitals do not cure people; prisons do not rehabilitate prisoners; schools do not educate students. Since they are supposed to, officials develop ways both of denying the failure of the institution to perform as it should and explaining those failures which cannot be hidden. (H. S. Becker 1967, p.242-3)

Beyond motivations related to political ideology or material interests, people's struggle to preserve institutional legitimacy thus helps explain the low resonance of those explanatory approaches that point to institutional failure – whether specific, such as that of public health authorities to prevent iatrogenic transmission, or more generally, such as a government's inability to counter widespread ill health and the increased population susceptibility to HIV infection it entails. An interesting consequence, in line with Becker's analysis, is that the resonance of causal stories depends on the size and the organisational structure – or the degree of internal coherence – of the group they put into question. Becker makes this point by explaining why causal narratives of school failure that blame pupils rarely face serious challenge. He underlines:

Even though the failure of a school *may* be the fault of the pupils, they are not so organized that any one of them is responsible for any failure but his own. If he does well, while others all around him flounder, cheat and steal, that is none of his affair [...]. As long as the sociological report on his school says that every student there but one is a liar and a cheat, all the students will feel complacent, knowing they are the one exception. (1967, p.243)¹⁸⁸

The ascription of blame implied in the behavioural paradigm is similar in the sense that it does not create much resistance since it blames (nearly) everybody. The behavioural paradigm is rather easy to accept as nobody is said to be individually responsible for (or feels individually challenged by) the alleged collective failure to abide by safe sex rules – all the more so as the causal story allows for 'exemplary' individual exceptions. Its responsibility-diluting effect, and the lack of organisation of the sexually active share of any population makes it politically attractive. Doctors and public health authorities (most of which are run by medical doctors), in turn, constitute a smaller and far more organised group. Blaming unsafe medical practices for a significant portion of HIV infections, for instance, would thus be perceived

¹⁸⁸ The unequal power relation between pupils and their schools is, of course, another important explanation for the absence of protest. A similar configuration can be found with respect to AIDS activism in Tanzania (see the introduction to Part 2).

as ascribing responsibility not merely to an anonymous group of people, but to individuals and to the collective failure of a coherent, comparatively circumscribed group of people – making it less acceptable, and politically unattractive.

In sum, acknowledging incentives to keep ‘politically uncomfortable’ aspects of the epidemic off the public agenda and stating that the depoliticising side effects of today’s dominant paradigm might be more than coincidental does not require resorting to conspiracy theory.¹⁸⁹ Describing (and sometimes even explaining) the existence of partly unintended outcomes is, at least in part, what social sciences are all about. Nevertheless, as Ryan’s explanation of the ubiquity of victim-blaming illustrates, the functionalist paradox remains:

Blaming the Victim is an ideological process, which is to say that it is a set of ideas and concepts deriving from systematically motivated, but *unintended*, distortions of reality [...]. It is important to realize that Blaming the Victim is not a process of intentional distortion although it does serve the class interest of those who practice it. (1971, p.11)

The claim that distortions of reality are “systematically motivated, but *unintended*” is both true and perplexing. Against what he perceives as a functionalist bias, Boudon – a founding father of methodological individualism – attempts to explain outcomes he considers as unintentional by what he calls “composition effects”. Suggesting that social ills are frequently “due to nobody and do not benefit anybody”, he underlines that “an explanation always consists in finding the individual action at the origin of the regularities one observes at the macro-sociological level” (1977, chap.2). A major methodological challenge when studying depoliticisation processes, however, is that it is often not actions, but *inactions* that one is interested in. While a lack of action can be the outcome of a political process, seeing intentional inaction behind every absence of action would obviously be an over-interpretation. This makes it extremely difficult to assess the degree of intentionality underlying depoliticisation processes, i.e. long-term *non-events*. This is certainly one reason why *politicisation* processes are more frequently analysed than *depoliticisation* processes. As Becker stresses, social scientists generally modestly try to get an idea of *why* things happen, by looking at *how* they happen (1998, p.58-60, 196). Yet, how can one describe how certain things happen if their defining feature is precisely that they are *not* happening?

Indeed, a successful attempt to politicise an issue results in an observable outcome: its inclusion into public debate. In contrast, successful depoliticisation leads to the absence of results: certain questions are not even raised. Any analysis of depoliticisation processes is thus based on analysing ‘non issues’, i.e. things that *could have* happened, but did not (e.g. the inclusion of cofactors and iatrogenic transmission into HIV narratives and prevention policies). The analysis of depoliticisation phenomena is as tough an

¹⁸⁹ Conspiracy theory claims that problems are the result of deliberate and coordinated, but concealed human action. It is intuitively appealing, as it provides a global, simple and coherent explanation of why things happen. The problem is that conspiracy theory is as theoretically appealing as it is empirically problematic. While conspiracy clearly exists in the field of health (the criminal cooperation of the global asbestos industry being one illustration), drawing on conspiracy theory to explain the biased framing of the African AIDS epidemics can amount to choosing an easy way out. On the conspiracy-like activities of what McKinlay fittingly called the “manufacturers of illness”, see (Michaels 2008).

empirical challenge as it is a scientific necessity. It surely is a good idea, as Boudon proposes, to try to find individual actions at the origin of macro-sociological regularities. Yet, the impossibility to do so in some cases should not keep us from taking into account that many of the policies that perpetuate existing power relationships and maintain economic and sanitary deprivation are due to political incentive structures that favour such policies at every step of the way. Does the acknowledgement of the existence and perpetuation of structural causes of ill health necessarily turn the social scientist into a political ideologist? As Bachrach and Baratz (1962) underline in their article on the “two faces of power”, it is not because it is extremely difficult to measure the power exercised by people who prevent certain questions from being raised (or from reaching policy agendas), that this ‘face of power’ does not exist and is not mobilised by policy players. Even if one moves on slippery grounds when addressing such issues, is it more scientifically sound simply to ignore these questions and to act as if agenda-narrowing or conflict-obscuring power did not exist? Epistemologically speaking, is it really always possible to explain macro-social regularities as the aggregation, however unfortunate, of identifiable individual decisions? Although the telling of causal stories consists in observable discursive actions, methodological individualism might not be enough and a more holistic approach – even if it necessarily falls short of an ‘explanation’ in Boudon’s sense – might be necessary to improve our grasp of depoliticisation phenomena.

Sub-conclusion) Ideas, incentives and institutions

Although it raises as many questions as it answers, the acknowledgement that the dominant causal story of AIDS in Africa is the result of political struggle is arguably a good start. This causal narrative is neither an unbiased translation of existing evidence, nor can its bias be explained by cognitive or ideational phenomena alone. Yet, stressing the specifically political nature of the framing of AIDS in Africa by underlining the role of incentives (and institutions) by no means suggests that explanatory approaches that draw on people’s worldview and on the social study of science are not relevant; they are. Gaining a better understanding of depoliticising causal stories thus requires a close articulation of idea-based and incentive-based approaches, including incentives to preserve institutional legitimacy. In any case, one should be careful about over-arching, all-explaining analytical narratives.

A differentiated study of the relation between evidence and policies presumes to differentiate analytically the related processes of evidence production and evidence uptake, and to distinguish discourses about disease causation from the formulation of prevention policies – considering them as different but complementary levels of analysis. While this chapter looked at the politically mediated resonance of scientific evidence in the construction of causal narratives, Chapter 3 looks at the political determinants of the uptake of evidence on structural drivers of HIV transmission in the formulation of HIV-prevention policies in Tanzania. Although discourses and practices are all the more tightly interwoven as discourses *are* practices, this distinction between the predominantly discursive level

concerning the ascription of blame and responsibility, and the policymaking level – a distinction to which I refer below as that between the ‘politics level’ and the ‘policy level’ – is a useful analytical approach. Indeed, most governments want both to avoid blame *and* to have effective HIV-prevention policies. Since several fairly easy-to-implement technical solutions (e.g. anti-parasitic treatment, disposable syringes, food fortification, etc...) exist to at least partially address some of the structural drivers of HIV, it is theoretically possible for them to avoid the acknowledgement of inequality-based structural drivers at the discursive level, while nevertheless adopting limited, technical measures to address some of these issues at the policy level. That being said, the next chapter shows that even the uptake of evidence concerning non-behavioural drivers of HIV transmission that would be comparably easy to control is very limited in Tanzania. This, I argue, is not primarily due to the politics of avoiding blame, but to the nature of the HIV-prevention policy process itself.

Chapter 3) Limits to Evidence-Based Policymaking: Policy Hurdles to Structural HIV Prevention in Tanzania

“[A] failure to appreciate the political dimensions of HIV can frustrate efforts to promote and implement evidence informed policy”
(Buse et al. 2008, p.573)

Sexual behaviour is frequently invoked as the main driver of the African AIDS epidemics and a significant portion of prevention funds are channelled into policies that aim at changing individual behaviour. Proponents of structural prevention have underlined the constrained nature of individual choice in preventive behaviours and the ensuing need to address the broader legal, political and socio-economic contexts in which behavioural decisions are made (Gupta et al. 2008; R. G. Parker et al. 2000; Barnett & Parkhurst 2005; Sumartojo 2000; Padian et al. 2011). Omitting to do so, they argue, condemns behaviour-based prevention strategies to failure. While these ‘structural’ approaches have overcome naively individualistic notions of sexual behaviour, most continue to adopt a reductionist conception of HIV transmission. Sumartojo, for instance, defines “HIV-related structural factors” as “barriers to, or facilitators of, an individual’s HIV prevention behaviours” (2000, p.3). Similarly, Gupta et al. consider that the defining feature of a structural approach is that it “addresses factors affecting individual behaviour, rather than targeting the behaviour itself” (2008, p.766). Ultimately reducing HIV prevention to indirect (mainly sexual) behaviour change, most proponents of structural approaches omit HIV transmission through unsafe medical practices and the role of non-behavioural determinants of the risk of sexual transmission.

As discussed, differences in sexual behaviour cannot explain sub-Saharan Africa’s incommensurably high HIV-prevalence rates, but a wide range of evidence points to the fact that various co-endemic conditions of ill health synergistically interact to increase populations’ susceptibility to HIV (see Chapter 1). In line with these findings, this chapter labels as ‘structural’ any interventions that, rather than attempting to modify individual behaviour at the ‘last minute’ (e.g. once people are in a situation that puts them at imminent risk), act *upstream* (McKinlay 1974) by addressing group-level economic, legal, social, political and biological drivers of HIV transmission – the probability of which is determined by the number of exposures to the virus and the per-exposure risk of transmission.¹⁹⁰ The facilitating role of cofactors in the sexual transmission of HIV is well-documented and several of them (e.g. genital schistosomiasis, geohelminths, lymphatic filariasis or micronutrient deficiencies) can be controlled – though not eradicated – through inexpensive, comparably simple measures such as parasite treatment (P. J. Hotez et al. 2009; Walson, Singa, et al. 2008) or targeted food fortification. Controlling cofactors that facilitate

¹⁹⁰ In this sense, the prevention of HIV transmission through unsafe medical practices is, of course, part of structural HIV prevention. Yet, this chapter focuses on structural interventions concerning the non-behavioural drivers of sexual HIV transmission. The political factors that underlie the omission of iatrogenic transmission differ in many ways from those discussed here (see Chapter 2).

HIV transmission is highly policy-sensitive, medically safe and epidemiologically and economically sound (Sawers et al. 2008; Kaul et al. 2011).

Despite the well-documented role of highly co-endemic biological cofactors in facilitating HIV transmission and the availability of comparatively inexpensive tools to control them, cofactor-related interventions are only hesitantly included into African HIV-prevention strategies.¹⁹¹ The mere existence of strong rationales in favour of these interventions is thus obviously an insufficient condition for policy uptake. Against this background, this chapter analyses the low uptake in Tanzanian HIV-prevention policies of this body of evidence regarding non-behavioural determinants of HIV transmission.¹⁹² As discussed in Chapter 2, some obstacles to the adoption of these approaches are clearly situated at the *politics-level*. Certain aspects of genuine upstream prevention (e.g. a radical improvement of access to clean water, sanitation and balanced nutrition or giving top priority to quality primary health care) would question fundamental socio-economic compromises concerning agriculture, health and broader economic policies while also challenging existing political hierarchies. Fully implementing a genuine upstream approach to HIV prevention would be nothing short of a social revolution in many African countries.¹⁹³

As discussed in Chapter 2, the focus on behaviour in explaining the spread of HIV in sub-Saharan Africa assigns responsibility to individuals and limits the political cost of inaction concerning non-behavioural drivers of the epidemic. While these political considerations certainly do hamper the formulation of more broadly conceived, structural responses, they obviously do not overdetermine all HIV-prevention policies. The persistence of the behavioural meta-narrative and the underlying political will to preserve the socio-economic *status quo* is not the only obstacle to structural prevention. Indeed, some cofactor-related interventions have a low potential for conflict and some would actually result in win-win outcomes. The policy hurdles these measures encounter, both during the policy-formulation and the implementation phase, can be described as *process-related*. This chapter mainly focuses on these *policy-level* obstacles, which could be at least partially overcome even without fundamental political change. Analysing the formulation of HIV-prevention policies in Tanzania, it compares the empirical observations with the recent literature on evidence-based priority-setting, the political economy of health-policymaking and classical, but oft-omitted, public policy analysis. Confronting the players' reading of the

¹⁹¹ Although obviously related, the question why many of the cofactors discussed above are not considered on their own merit should be differentiated from the question why they encounter such difficulties to be included in HIV-prevention programmes (which is the question this chapter addresses). Answering the first question, a Tanzanian official suggests: "It's because of the chronicity of these diseases. It's because they do not kill...at least not in a direct way. So they were not considered as a problem at all. Until very recently, [...] it was: 'Either you kill, or you don't'. [...] And if you don't kill, well, then you can just wait a little bit or you are put somewhere in a closet. Now, we are changing our lens and we start to see serious problems: psychosocial ones, economic ones...and we see that NTDs exacerbate conditions such as HIV/AIDS. For a long time, the focus was very mortality-oriented. Conditions with high morbidity but low mortality were not seen as an issue. They were a *non-agenda!*" (GovSector-13). In this sense, the establishment of a pathological relation with HIV/AIDS certainly did help several neglected tropical diseases to be associated with a 'killing disease', and thus to reach the political agenda (concerning this 'coupling' process and its limitations, see Chapter 7).

¹⁹² This chapter is based on, and in some aspects develops upon (Hunsmann 2012b).

¹⁹³ This remark draws on a comment by Janet Bujra (personal communication).

Tanzanian situation with this theoretical framework, this chapter aims to improve the understanding of how prevention interventions are prioritised as well as shed light on how and why this process differs from the linear, rationalistic ideal of policymaking most HIV-prevention specialists implicitly assume exists or explicitly call for. Given the recent surge of economic evaluation studies concerning HIV prevention and the substantial research efforts aimed at optimising national responses, a realistic understanding of relevant decision variables in prevention policymaking seems crucial for both researchers and AIDS policymakers.

A) Policy-level obstacles to structural HIV prevention

In the interviews, I consistently raised the issue of structural prevention efforts based on the growing evidence concerning the role of cofactors in HIV transmission. Due to the unbroken dominance of the behavioural paradigm, this issue is still frequently met with blank expressions by many interviewees. When asked about the low uptake of evidence concerning cofactors, one multilateral agent, for instance, underlines: “You will not find this type of interventions in Tanzania because that debate is not taking place. In any case, prevention policies are very little evidence-based...there’s a bunch of epidemiological studies...just sitting there, but do not serve” (Multilateral-6). A bilateral agent responds to the same question: “I don’t know much about them...that probably already tells the tale a little bit!” (Bilateral-29). Other interviewees acknowledge the pertinence of the approach, but underline the difficulty to integrate this perspective into their short-term programming activities. Many share their broader analysis of the possible hampering factors for this type of structural prevention efforts in Tanzania.

Drawing on the policymakers’ reading of the Tanzanian situation, I argue that the continued neglect of structural HIV-prevention approaches is better understood if one takes into account 1) that assuming cost-aversion as a spontaneous reflex of policymakers is empirically wrong and analytically misleading, 2) that political constituencies induce a path dependence of allocative decisions uncondusive to structural prevention, 3) that interventions’ political attractiveness depends on the nature of their outputs and the expected temporality of political returns, 4) that policy fragmentation entailed by vertical disease control disfavours the consideration of broader causalities, and 5) that cofactor-based measures are hampered by policymakers’ perception of structural prevention as being excessively complex and ultimately tantamount to poverty eradication, a seemingly unattainable goal. Finally, I suggest that in some cases stigma is perceived as an obstacle to the formulation and implementation of integrated prevention programmes (6).

A-1) The limited role of cost-effectiveness in priority-setting processes

“We should dare to ask questions about efficiency! In the aid and AIDS industry, we seem to be a bit resistant to make an analysis of what would be the most efficient way to channel our aid. It’s somewhat surprising. [...] And people are not only resistant to this question, some are actually defensive about it. [...] Now, don’t quote me wrong : I’m not saying there is too much money in HIV. There is not enough money for HIV! But the way it is allocated could have been analysed way earlier.”
(Bilateral-20)

While few interviewees question the potential effectiveness of cofactor-based interventions, most do not consider these interventions to be cost-effective, and some invoke this as a reason for their non-integration in existing HIV-prevention policies. However, the interviewees’ assumption of low cost-effectiveness obviously results from a vague feeling rather than from any knowledge of existing studies. Indeed, evidence on prevention measures’ *comparative* cost-effectiveness is rare and no systematic assessment of cofactor interventions’ cost-effectiveness as elements of HIV prevention exists (Walker 2003; Stillwaggon 2009). Galárraga et al. (2009, p.S5), for instance, conclude their review of the cost-effectiveness of HIV-prevention measures as follows:

There are several types of interventions for which CE studies are still not available or insufficient, including [...] most structural interventions. The sparse CE evidence available is not easily comparable; thus, not very useful for decision making. More than 25 years into the AIDS epidemic and billions of dollars of spending later, there is still much work to be done both on costs and effectiveness to adequately inform HIV prevention planning.

That being said, even without accounting for their effects on HIV transmission, the high cost-effectiveness of parasite control, water and sewage programmes, STI treatment, and many nutrition-related measures is well established. Taking into account the potential hampering effect of these types of interventions on HIV transmission would further increase their cost-effectiveness. Based on this reasoning, a Tanzanian official involved in the control of neglected tropical diseases (NTDs) denounces the failure to include these diseases in the country’s HIV programmes:

Overall, there are strong rationales for a closer integration of NTDs with HIV... There is a strong case, particularly because of the tools that are available – they are all there! If they still had to develop them, it might be a different story, but the tools already exist! And they are very easy to implement and extremely cost-effective! It makes it almost crazy *not* to consider this in the ongoing framework of the big three! You spend so much money...not considering them *together*, for me, is almost insane! The scientific and social basis is there. From economic perspective, the rationale is there. And even from a system perspective, it makes sense. [...] Given the amount of money spent on other things, it’s a scandal – a shame – that NTDs are not taken up within the programmes to fight the ‘big three’ [HIV, malaria and tuberculosis]. [...] Why can’t you combine the distribution of a fifty-cent pill with these programmes? It would be very cost-effective! [...] Even if you would be very cruel and look at it in a cold rational way, and not consider NTDs on their own merit, it makes sense to do so! (GovSector-13)

Two features of the priority-setting process help explain the limited relevance of cost-effectiveness in the formulation of Tanzanian prevention policies: the incremental nature of policymaking and the absence of a cost-driven decision environment. Indeed, one implicit assumption underlying CEA is the existence of a linear, evidence-driven policy process. This would imply that decisions are preceded by a clear definition of policy goals and a systematic comparison of the costs and benefits of all alternative

ways to achieve them. However, as a multilateral agent underlines, this is not how prevention priorities are set in Tanzania:

Of course, ideally, cost-effectiveness should feed into the selection of activities, regardless of the selection of priorities. [...] Indeed, the assessment of cost-effectiveness should take place before the definition of priorities. One should look at how much a type of intervention costs and then see what coverage would be needed or could be reached... [...] But this is not what's happening! It's an iterative process, not a systematic process of cost-effectiveness analysis. They tune interventions as they go along! (Multilateral-2)

A bilateral agent points to a similar difference between the theory and practice of policymaking:

Based on the NMSF [National Multi-sectoral Strategic Framework], three funding scenarios were elaborated. The costing should have been compared to these funding scenarios. Going from there, one would have to ask oneself: Where are my real priorities: on nutrition or on care and treatment...? That's, of course, not the way one takes decisions, but these are the questions we should ask ourselves. (Bilateral-31)

While the majority of the interviewees clearly considered cost-effectiveness to be important, it was not explicitly discussed in any of the prevention meetings observed. When asked about its actual role in the decision process, none of the interviewees considered cost-effectiveness as an important criterion in the ongoing debate over prevention priorities.¹⁹⁴ "Cost-effectiveness issues are still not really coming up so much", states a multilateral agent, "People here say: 'Let's just push for prevention...we'll see for cost-effectiveness later...'" (Multilateral-17). Another multilateral agent participating in the formulation of the Prevention Strategy confirms: "The issue of cost-effectiveness hasn't come up so far at all. Until very recently, we have not even discussed *costing!*" (Multilateral-18). A bilateral agent explains this situation as follows:

Nobody worried about cost-effectiveness in the formulation of the Prevention Strategy. Partly because we are put under enormous pressure to get something done and to get it done quickly. (Bilateral-24)

A researcher involved in the formulation of the Strategy confirms this reality:

Generally, cost-effectiveness does play a role...but not in Tanzania. They [the donors] ask: 'How much money do you want to spend?' They only want cost, not cost-effectiveness. (Research-11)

Prevention policymakers are thus primarily interested in absolute cost. More fundamentally, both the observed meetings and the interviews indicate that cost is only rarely considered as something negative. As discussed in Chapter 4, costing is generally seen as an advocacy tool (the higher the estimated cost, the bigger the unmet needs, the more legitimate the call for additional funding), not as a means to prioritise interventions and optimise resource allocation. Similarly, most in-country donor officers, government officials and NGO workers are principally interested in spending more, not less. While the needs are indeed immense, the ability to allocate funds also is a crucial component of the legitimacy of organisations, bureaucrats and politicians: increasing one's expenditures is fundamentally desirable as it

¹⁹⁴ This illustrates that the alleged cost-ineffectiveness of cofactor interventions is invoked as an argument against their implementation even though efficiency is not a criterion for those interventions that have actually been taken up in HIV prevention policies. This 'double standard' underlines both the practical effects and the *pre-analytical* nature of the behavioural paradigm.

expands the spender's hold over his or her environment and, in the case of politicians, their chances to be re-elected.

The second condition for cost-effectiveness to be politically relevant is the existence of a cost-driven decision environment, which presupposes a shared feeling of scarcity. In Tanzania, the available resources for HIV/AIDS have increased approximately fifteen-fold between 1997 and 2007, reaching USD 520 million annually (TACAIDS 2010), which was roughly the equivalent of the nation's health budget for all other non-HIV health concerns combined at that time (Foster et al. 2008).¹⁹⁵ Commenting on the years following the creation of PEPFAR and the Global Fund, a Tanzanian AIDS official notes, "money was literally poured into this country like anything!" (GovSector-9). Another bilateral agent confirms this impression of abundance and deplores: "Nobody asks for it to be more efficient; it's like: 'just apply for more money and you'll get it!'" (Bilateral-14). Having reassured themselves about anonymity, two interviewees admitted that their organisation had difficulties spending its rapidly-increasing budget between 2005 and 2008: "Last year, [we] had a 40% budget increase – that is practically not feasible; it's not manageable!" (Bilateral-16).¹⁹⁶ As discussed in Part 3, the *average annual growth rate* of international aid for HIV/AIDS between 1998 and 2007 was a staggering 48.1% (OECD in: Shiffman et al. 2009). Another bilateral agent explains this situation as follows: "The problem is that, nearly overnight, there was a lot of money, which had to be spent rapidly. But the system was not prepared to absorb it...we wanted to move too quickly" (Bilateral-26).

Since spending money can prove challenging, an intervention's low cost can actually hinder its implementation. As a bilateral agent notes concerning a collaborative HIV-malaria activity in the 2008 Malaria Operational Plan,

[I]t is a very small initiative with only 150,000 dollars budget, [...] but we haven't even started to implement it. We have so many other things to do... And my colleagues at PEPFAR don't care about it. They are like: 'Hey, this is only 150,000 dollars – so don't waste our time!'. (Bilateral-22)

Understandably, cost-effectiveness is not a major concern in such a situation. This more realistic conception of the role of cost in policy processes makes AIDS policymakers' limited interest in including deworming pills – at only a few cents each – into HIV-prevention programmes less surprising. As a bilateral agent concludes his reflections on the use of evidence in HIV-prevention policies in Tanzania, "[a]ll this money and the very rapid increase in activities...it has definitely weakened the evidence-based

¹⁹⁵ Exchange rate in February 2008. Since then, AIDS funding has decreased slightly, while the general health budget has increased (see Part 3).

¹⁹⁶ Importantly, the fieldwork was conducted towards the end of an unprecedented rapid surge of AIDS funding, channelled through narrowly earmarked mechanisms. This explains the impression of abundance evoked by several interviewees. Rather than the absolute abundance of AIDS funds, it was this often extremely narrow definition of what policymakers were allowed to spend them on that has led some observers to conclude erroneously that African AIDS programmes had a problem of 'absorptive capacity'. Moreover, the impression of abundance was obviously amplified by players' comparison with, and indignation about, radically insufficient budgets for other health-related issues. In any case, it has undoubtedly decreased since, as the ongoing financial crisis disrupts AIDS funding.

analysis” (Bilateral-20). In line with this reasoning, several interviewees anticipated efficiency considerations to gain policy-relevance as AIDS funding would level off – a prediction discussed below.

A-2) Political constituencies and path-dependent allocative decisions

“HIV is big business! Unfortunately, thousands and thousands of people make a living from HIV/AIDS in Tanzania. What are they going to do if the funding dries up?”
(Multilateral-2)

As mentioned, external support for AIDS control in Tanzania represents over 10% of public expenditure and one third of all aid flowing into the country (Foster et al. 2008). This inflow of resources has led to the emergence of what several interviewees call an “AIDS industry”.¹⁹⁷ While treatment is principally provided through the public health sector, HIV prevention is implemented by various public and non-governmental organisations, virtually all of which work in close collaboration with international donor agencies. These organisations focus on specific aspects of HIV prevention, many on individual behaviour change. This relative specialisation results in a situation where any shift in prevention priorities puts the institutional existence of implementing organisations at stake. This state of financial dependency of the implementing agencies leads an international NGO worker to conclude provocatively, “I’m sorry to say this, but many people in Tanzania would prefer HIV being there for a while!” (INGO-4) – a statement that echoes that of another interviewee, who suggests:

Not everybody is dying from AIDS ; many people make a very good living off it. And for them, it shouldn’t stop too quickly... I say that maliciously, but it is true to a certain extent. (Research-12)

While this situation is an open secret, and in no way specific to Tanzania¹⁹⁸, its practical implications for HIV-prevention policymaking are probably underestimated. An organisation specialised in abstinence workshops or information, education and communication (IEC) campaigning, for instance, is unlikely to be a suitable implementing agency for most non behaviour-based prevention measures.

The degree and nature of this rigidity obviously differs between types of organisations. While the Bush administration, for instance, let faith-based organisations (FBOs) play a central role in HIV prevention in Tanzania, church ideology can explain part of their organisational inflexibilities: No Tanzania-based FBO I know of would, for example, accept to replace their ‘abstinence’ and ‘faithfulness’ seminars by STI-control initiatives with sex-workers. NGOs are certainly more flexible institutional entities. Nevertheless, the core competences of the various former ‘population’(-control) NGOs who progressively became a centrepiece of HIV-prevention programmes in Africa differ from those necessary for many cofactor-

¹⁹⁷ A multilateral agent, for instance, slightly ironically comments the way PEPFAR functions in Tanzania: “Have you seen all the USG cars? There are hundreds of them! And all the US NGOs get the tenders... It’s a roaring industry that pays for lots of American salaries...well, that’s great!” (Multilateral-5). This quote helps explain why several Tanzanian officials question the aid figures published by PEPFAR, arguing that they ‘don’t see the money’. On the sometimes huge differences between total aid figures and “real aid”, as the NGO ActionAid provocatively puts it, see the NGO’s “Real Aid” reports, e.g. (ActionAid 2011, chap.4).

¹⁹⁸ Kalofonos (2008, p.372-3), for instance, describes strikingly similar narratives in Mozambique.

based interventions. Finally, and as discussed in more detail in the introduction to Part 3, comparable institutional rigidities are also at play within government administrations. The politically convenient medicalised variants of many cofactor-related interventions¹⁹⁹ favour health-sector administrations and service providers over ‘non health’ players (e.g. TACAIDS). When prompted about the absence of cofactor-based prevention interventions, a bilateral agent, for instance, anticipates “We would have to sit down realistically with the prevention people and see where you can fit that in... [...] But you’ll have the behavioural folks complain: ‘Great...another biomedical intervention!’. And you can’t do it all!” (Bilateral-19). While this statement refers to broader discussions over what some describe as a ‘remedicalisation’ (e.g. Nguyen et al. 2011) of the recent response to HIV/AIDS (see the introduction to Part 3), the mere expression of “the behavioural folks” points to the existence of an at least partially coherent group of players.

In any case, the *relative* inflexibility of organisations’ mission and area of expertise suggests that a shift in today’s prevention strategy would imply taking funds away from some organisations and directing them to others. Consequently, there is a political constituency for keeping behaviour-centred preventive priorities unchanged. In line with this reasoning, the above-quoted multilateral agent spontaneously explains the absence of cofactor interventions in the National Strategy by saying, “there is probably not much of a constituency for it” (Multilateral-2). Indeed, while some potential advocates of a cofactor-based prevention approach attempt to become part of HIV/AIDS programmes (Chapter 7), they constitute a highly heterogeneous group, rather than a coherent political pressure group for structural prevention.

As discussed in Chapter 4, in Tanzania, the policy arenas where prevention priorities are discussed are composed of the very players who implement and/or fund the policies decided upon. Although the number of bilateral donors involved in HIV control (and thus the number of players around the table) has dropped since the creation of PEPFAR and the Global Fund,²⁰⁰ international donor agencies continue to drive the prevention policy process. The observation of priority-setting discussions shows that most donor and implementing agencies try to feather their own nest by pushing for the type of interventions they are currently involved in to be included in the upcoming National Strategy or proposal to the Global Fund. The complaint of a bilateral agent suggests that this tendency is particularly strong in the field of HIV/AIDS:

AIDS is sickening, because everybody wants to muscle in! With TB and malaria, the whole process is a lot easier...they do their thing and that’s it! (Bilateral-13).

Players ‘push’ issues either directly through statements at the meetings or comments on draft policy papers, or indirectly by funding a consultant to assist the drafting process on a specific issue (e.g. ‘most-

¹⁹⁹ On the medicalisation of structural interventions, see Chap. 7.

²⁰⁰ As discussed below, the number of smaller bilateral donors actively involved in the Development Partner Group on HIV/AIDS has dropped drastically since the arrival of PEPFAR and the Global Fund.

at-risk' populations). While this reality is widely acknowledged, several interviewees regret that what they call "vendor's-tray" or "shopping-list" policies – the non-prioritised listing of interventions for donors to choose from – undermines priority-setting and induces deleterious policy rigidities. Paradoxically, interviewees working for bilateral agencies are among the most vocal critics of this situation while their own agencies contribute to hampering *strategic* prevention policymaking by ensuring that the projects they fund (within the Tanzanian administration or local NGOs) or continue to run themselves are covered by the collectively formulated 'priority interventions' (see Chapter 4).

The path dependence of allocative decisions further increases as AIDS funding levels off. As a bilateral agent notes,

Now, the funding will be static for the next five years. So if we want to do new activities or new programmes, we have to take the money away from somewhere... Our margin of doing new things is narrowing down considerably. There is only so much you can do! [...] And ARVs will become more expensive as we progressively shift to second and third generation drugs. So our margin of operation is decreasing even though we have constant funding. (Bilateral-15)

Directing resources towards treatment entails a ratchet effect since it becomes close to impossible to cut funding later on. While treatment contributes to prevention, such political irreversibility impinges on the future funding of non treatment-based prevention approaches. Commenting on the agenda-narrowing effect of what he describes as an excessively treatment-centred response over the last years, a Tanzanian AIDS official underlines:

The momentum we have created started off on the wrong footing, so it will be a challenge to formulate a balanced response. [...] Sometimes, the decisions we make are actually *obstacles*, not solutions to our problems... (GovSector-12).

This "junk-effect of funding care and treatment", as a bilateral agent (Bilateral-31) more provocatively puts it, indirectly reinforces the path dependence of allocative decisions *within* the field of prevention.²⁰¹

A-3) The expected time frame for political returns and policymakers' preference for the present

"People are so much in the 'fire-fighting mode' that they don't stand back. They are just trying to put the fire out..."
(Multilateral-2)

The anticipated time span before an intervention shows any effect is a major concern both for Tanzanian policymakers and international donor agents. Many interviewees believe that the indirect nature of the effect of cofactor-related interventions on HIV rules out their potential for rapid impact.²⁰² They

²⁰¹ See also Chapter 5

²⁰² This view is contradicted by Sawers et al. (2008, p.494) who consider that "Of the numerous economic, biological and social determinants of HIV epidemics, treating cofactor infections may be the most policy-sensitive and least expensive interventions and have the most immediate return on investment".

generally consider them to be long-term responses to be implemented once other interventions have been effectively scaled-up. As a multilateral agent puts it,

One can distinguish three types of preventive interventions: behavioural, medical and structural ones. We have to look at the behavioural issues first, then take the next step... [...] But the first priority to bring down HIV should be to look into the behavioural aspects! (Multilateral-4)

Behavioural interventions are clearly expected to yield quicker results. A bilateral agent holds a comparable view concerning the appropriate order in which different prevention strategies should be implemented:

These interventions will certainly be included in a second round. Of course, one could do a lot of different things, but we work on an evidence basis and the priority is on interventions with a direct impact. We do maximal impact interventions. Eventually, somewhere down the road, hookworm might become a preoccupation, too. But one cannot do everything! (Bilateral-15)

Similarly, when prompted about the inclusion of cofactor-related issues into HIV-prevention strategies, a multilateral agent replies,

We have to go step by step. For us, sex is the main mode of transmission. And you still have these behaviours out there. There is transactional sex [...] and multiple concurrent partnerships.²⁰³ (Multilateral-9)

Another multilateral agent is even more categorical:

That is going to be for the next generation. People are not ready here... And I'm not sure that the time for this type of interventions has already come, because even interventions such as PMTCT [prevention of mother-to-child transmission] and VCT [voluntary counselling and testing] are not yet generalised. (Multilateral-5)

Even though rapidly rising, the coverage of PMTCT was generally referred to as being still below 50% during fieldwork,²⁰⁴ and interventions focusing on populations such as commercial sex workers, men having sex with men or injection drug users are still either haphazardly implemented or non-existent. "Even the prevention interventions for commercial sex workers have not gone to scale yet", underlines a Tanzanian AIDS official, adding: "That's because our legal framework does not allow them to exist; so people are scared to work with them. And then there is a...say... a 'societal' obstacle: We consider ourselves as religious people, so we stick our heads in the sand and don't want to talk about it" (GovSector-10). More strikingly yet, condom distribution is still far from being generalised. "Even condoms, until now, have remained an urbanised issue, as far as access is concerned", underlines a multilateral agent, "In remote areas of the country, a piece of condom becomes a scarcity!" (Multilateral-16). An NGO worker confirms: "There are not enough condoms...and we are not distributing everywhere! [...] There has been a huge public sector condom shortage!" (INGO-5).²⁰⁵ Moreover, a bilateral agent's criticises:

²⁰³ This statement, again, illustrates the confusion, discussed in Chapter 1, between sex as a mode of transmission and sexual behaviour as the main determinant of sexual transmission.

²⁰⁴ By far the most optimistic estimation (70% coverage of PMTCT) can be found in (WHO/UNAIDS/UNICEF 2010, p.90).

²⁰⁵ This interviewee announces that his organisation (which is one of the biggest condom distributors in Tanzania) "will distribute 79 million condoms every year, over the next 3 years". Although the absolute number might sound impressive, it only represents about 3 condoms per sexually active person in Tanzania per year...which is certainly better than nothing, but

The very minimum should be in-school prevention. That should be there. It's not. The Ministry of Education is very challenging on that. I don't know why. That should be the highest priority! This many years into the epidemic, it's hard to understand why these things are not happening! (Bilateral-24).

While, 30 years into the epidemic, this general situation can seem surprising,²⁰⁶ it certainly points to the fact that the sense of urgency is not as widely shared at lower policy levels as many international and Tanzanian officials' rhetoric about the 'emergency response' might suggest. At any rate, the incomplete implementation of these 'standard' HIV-prevention measures it entails could potentially hamper the adoption of more upstream-oriented approaches.

The idea that structural prevention merely plays a subsidiary role is closely related to the fact that behavioural interventions are widely expected to yield rapid results, despite the at best mixed evidence concerning their effectiveness. "If you ask me", says a Tanzanian official, "they have spent a lot of money to little or no effect...people are not changing their behaviours" (GovSector-11). In a similar vein, a multilateral agent criticises mass IEC campaigns:

The evidence for its effectiveness is, at best, pretty sketchy. What you end up with is a coverage that is very variable and an impact that is very variable. But people just continue to spend millions on it. Why? Because it makes it look like you're doing something! You have billboards everywhere and messages on TV and on the radio...that's very visible! But in terms of actual impact, it is probably very limited. (Multilateral-2)

Beyond these doubts about the effectiveness of today's behavioural interventions,²⁰⁷ a look at the history of the African epidemics also puts into perspective the oft-quoted role of behaviour change in the reduction of incidence. Indeed, using incidence estimates, UNAIDS (2011b, p.7) situates the height of the sub-Saharan epidemics in 1997 – a year in which approximately 2.6 million people were newly infected with HIV. After 1997, incidence has started to drop (and continues to do so) in most sub-Saharan countries. The massive international response to HIV/AIDS only became effective in the early 2000s. This suggests that HIV incidence in sub-Saharan Africa has started to decline well before behavioural (or any other) prevention policies were rolled out at a significant scale in most countries.²⁰⁸ The evolution of the Tanzanian HIV epidemic (e.g. Somi et al. 2006; W. Urassa et al. 2006) confirms that HIV incidence has started to decline for reasons unrelated to behaviour-change interventions. While the actual reasons for this decline remain ill-understood, this simple chronology suggests that, in the field of HIV/AIDS as in other development sectors, the (understandable) tendency of development practitioners to "shoot anything that flies" and "claim anything that falls" (Rubin 1988) should not be taken at face value.

nowhere close to universal coverage – even when combined with the condoms distributed by the Ministry of Health and, more recently, PEPFAR.

²⁰⁶ This confirms Hanson's (2000; 2007) account of low implementation of various HIV-prevention measures in Tanzania.

²⁰⁷ One should distinguish between targeted interventions focusing on so-called 'high-risk' groups, and mass behaviour-change communication campaigns – the actual effectiveness of which is yet to be demonstrated. In Tanzania, the effectiveness of these campaigns has certainly not been helped by the extremely allusive nature of their messages, most of which are strikingly unspecific about *what precisely* people can do to 'play their part' in stopping HIV.

²⁰⁸ In some countries, centrally implemented transfusion- and injection-safety measures might have had a comparably rapid effect on the spread of the virus via unsafe medical practices.

Independently of their public health impact, the outputs of different preventive approaches differ in their public visibility and in the time needed to demonstrate effectiveness. In this sense, the ‘inputs’ of behaviour-change communication campaigns (e.g. mass media messages) are, politically speaking, ‘outputs’. Put simply, the incentive structure of elective political systems, and – just as importantly in the Tanzanian case – of short donor-funding cycles, makes *rapid-output* interventions politically more attractive than *deep-impact* interventions. Although the policymakers interviewed are bureaucrats or political appointees, not elected politicians, they act within this incentive structure shaped by the ministries and donor headquarters involved in AIDS control.²⁰⁹ This incentive structure disfavors structural interventions, which are generally (though erroneously) considered as long-term measures. Policymakers’ strong time preference for the present is further reinforced by the framing of HIV/AIDS as a health emergency, which entails a response that combines vertical treatment roll-out and preventive interventions believed to have a rapid impact. Referring to the prioritisation process preceding the Global Fund Round 8 proposal, a multilateral agent underlines that this quest for quick returns hampers the formulation of integrated and structural interventions:

The WHO proposed to simply improve the [rejected] Round 7 proposal. It was a broader, more integrated proposal, with a very interesting integration of reproductive health...which, as a result, has never seen the light of day. And the proposal was evaluated quite positively! Not much additional work would have been needed to come up with a perfectly acceptable project. But NACP and the Ministry [of Health] objected. The *only* thing that counted for them was: ‘We have to find the drugs!’ (Multilateral-6)

While the Tanzanian government certainly did play a role, the influence of PEPFAR in this process should not be underestimated. Indeed, at the time, the US programme to roll-out treatment depended on Global Fund money to ensure its provision with antiretroviral drugs. Even though nobody in Tanzania questions the fact that HIV is there to stay and that no quick fixes exist, most decisions continue to be shaped by what the interviewee quoted above fittingly describes as a “fire-fighting mode” of policymaking.

A-4) Vertical donor support and fragmented disease control

“I can’t think of any HIV-NTD linkages in Tanzania. And only few linkages between HIV and STIs have been made. Little has happened... It is hard to raise funds if it is not for closely HIV-related actions.”
(Bilateral-16)

As discussed, close to 98% of Tanzania’s AIDS-related expenses are donor-financed and 90% stem from two disease-specific, vertical programmes: PEPFAR and the Global Fund (TACAIDS 2010). Generally speaking, the more vertical a programme, the more restrictive the definition of its targets and the more likely it is that some positive outcomes may be considered ‘external’ and thus not taken into account in programme evaluation. Non integrated disease-control programmes are externality-prone. Structural

²⁰⁹ In this sense, many interviewees point to time pressure imposed ‘from above’. As the bilateral agent quoted above puts it: “we are put under enormous pressure to get something done and to get it done quickly” (Bilateral-24). See also Chapter 6, Section D.

interventions aim at reducing population-level susceptibility to HIV infection. Because of the broad nature of their positive outcomes, they face a problem of unrecognised externalities (Stillwaggon 2006, pp. 173-6). A multilateral agent spontaneously establishes this link:

Many people mention 'structural causes' as impediments to everything: health, education... It's going to take some time for it to make its way into policy. [...] And the broader the externalities of an intervention, the less likely it is to actually become a policy. And then there is the question of who is going to fund it? If you put in the Global Fund proposal that you want to put up pit latrines and bore holes [for drinking water], is it going to fund it? Probably not... If the [Government of Tanzania] took over this kind of issue within a more general process, that might make it more likely for such issues to be included. At least, as we move towards the funding of more general policies, that should lead to this kind of decision that take into account broader externalities... (Multilateral-2)

When evaluating their interventions, both donors and their implementing partners (i.e. government agencies, NGOs and FBOs) tend to take into account only those effects that concern each project's or programme's precisely defined objectives.²¹⁰ A Tanzanian NGO worker underlines: "There is a phenomenon of closure...a lot of thinking in boxes. People think HIV is a different issue than NTDs, which is different from nutrition, etc...." (NGO-1). Various other interviewees denounce such "thinking in boxes" and deplore the fragmented nature of the response, considering it a cause, and sometimes a consequence, of the ineffectiveness of the national coordinating body (TACAIDS).²¹¹ Among these critics are several bilateral agents previously involved in attempts to coordinate donor support in view of favouring more integrated responses (the Sector-wide approach (SWAp) and the Health Basket Fund), an endeavour which, they consider, was jeopardised by the massive arrival of vertical AIDS funding (see Chapter 6).

While most multilateral institutions limit their work to programme-level collaboration with the Tanzanian administration at the national and sub-national levels (some via the Health Basket Fund), many bilateral donors additionally run HIV-related projects in specific regions or districts. "Donors want to be visible, admits a bilateral agent, "they want to claim success, and say: 'We did this and we did that'...it's a lot about visibility" (bilateral-20). A Tanzanian official confirms:

For donors, the attribution of outputs is very important. If the output is just a strong health system, donors fear they will lose their identity. Donors want to say: 'Of these ten people put on treatment, 5 are mine!'. (GovSector-12)

One bilateral agent (and Tanzanian national) is even more categorical about some donors' tendency to claim 'ownership' of certain projects or even project regions:

²¹⁰ This analysis points to certain commonalities between the causes for low evidence uptake concerning cofactor-related and iatrogenic drivers of HIV. Indeed, when asked about the reasons for the neglect of iatrogenic HIV transmission, one interviewee, responds: "The health industry is vertically oriented: they deliver specific interventions to as many people as possible...and health-care safety runs across that; it runs counter to their objectives" (Research-13). The vertical design of health services in many African countries thus disfavours both cofactor-based prevention interventions and the prevention of iatrogenic transmission.

²¹¹ Concerning the role played by TACAIDS, see Chapter 4 and the introduction to Part 3.

Everybody among the donors is prostituting themselves to be seen... [One bilateral donor agency] 'stole' the guidelines...[an international NGO] opposed to lab training by the CDC in Mbeya... I am using a very hard word, but it's so sickening! (Bilateral-25)

In some cases, this project-driven mode of action actually entails an implicit attribution of geographic competence: certain regions being progressively considered as the territory of one or another bilateral donor agency. PEPFAR, in turn, has built up an entirely parallel, regionalised system of implementing organisations, mainly composed of US Government departments, and US and Tanzanian NGOs and FBOs. As a bilateral agent underlines:

[T]he big problem with PEPFAR is its verticality. [...] PEPFAR represents 60% of the total expenditure. So when you say they're off-budget, you could almost argue that they are on-budget because they *are* the budget! (Bilateral-29)

The increasing role of the Global Fund over recent years somewhat counterbalances the hegemony of PEPFAR. Yet, the fact that 85% of international AIDS funding in Tanzania continues to be spent off-budget (TACAIDS 2012b) inevitably limits the government's 'ownership' of the national response and its ability to formulate a coherent, balanced health policy (see Part 3).

More surprisingly, *on-budget* donor support can lead to policy fragmentation *within* the public system. As a bilateral agent notes, "everybody has their own small projects, on budget, within the Ministry of Health" (bilateral-29). In order to keep up appearances of national ownership and to avoid potential administrative obstruction, several bilateral agents describe how they (sometimes desperately) look for counterparts within national administrations who will allow them to smooth the implementation of their programmes (see also Chapter 4). A multilateral agent (and former Tanzanian official) describes the effect as follows:

People in the MoH [Ministry of Health] have seen so many donors coming in for different issues and interventions...but they don't come with a whole package. Their projects never cover the whole country! Nobody has developed sustainable capacity... The reason for that is fragmented support. [The donors] are keeping the government and the MoH busy! And on the side of the government, nobody is committed and capable! They think: 'I have a project to manage...' Every programme manager within the MoH accounts to individual donors. Therefore, they get financial and other advantages... Even an NACP [National AIDS Control Programme] programme manager, when talking to his colleague, will ask him: 'How is your project going?' and he'll respond: 'Fine. How is your project going?'... Nearly every head [of department] has his own donor-driven project to keep running! (Multilateral-6)

Fragmented funding and reporting processes do not impel project managers to contribute to collectively elaborated (and monitored) cross-sectional goals by considering the broader outcomes of their activity. When asked about such fragmentation *within* the Tanzanian administration, a Tanzanian official replies:

It's true! But that's due to structures: When you come with one million dollars and put them in the health system, you have no numbers to report on. If you put that money into one project or district, you have numbers to show! But if you *really* want to strengthen health systems, you must accept to put in funding for

some years without seeing results and to have nothing to report on. Only if you accept *that*, then you can improve health systems. (GovSector-12)²¹²

At the implementation level, in turn, the absence of broadly-conceived structural interventions is not merely an incentive issue. As an international NGO worker states,

I don't have the luxury to look at the broader prevention issues and to make the best choice in focusing on the activities that work best. I only have money for behaviour change communication for youth. And we really don't know what the efficiency of our interventions is. We don't have the data. We look at the cost and take decisions on a project basis. (INGO-8)

The fragmented nature of the response restricts the implementing players' ability to include interventions that are not part of their narrowly defined vertical framework of action. While implementing organisations generally have their hands tied, in-country representatives of international donor agencies are progressively learning to increase their leeway in the use of funding earmarked for HIV interventions (see Chapter 7).

A-5) Complexity and perceived infeasibility as obstacles to structural prevention

When asked about the inclusion of structural approaches into HIV-prevention programmes, many interviewees stress the need to maintain a focused response. One bilateral agent, for instance, replies to a question about cofactors:

It's a good question. There is a lot about STIs... At the OGAC [Office of the US Global AIDS Coordinator]-level, there was a lot of concern that our response was getting too diffuse... [...] They felt like people were pulling on it for things not proven to be effective. [...] Our feeling is that we could do STI programmes with high-risk groups, but not with the general population. Because then we would just be doing an STI programme... (Bilateral-24)

Addressing the biological cofactors that drive HIV transmission within the AIDS policy framework, they feel, exceeds their mandate as it would amount to equating HIV prevention with general health-service delivery, or even with poverty eradication. A bilateral agent stresses,

HIV money can't solve the continent's development challenges! [...] And these are very long processes: decreasing poverty, changing gender norms, improving the level of nutrition status... We'll never be able to do that! (Bilateral-12)

Similarly, another bilateral agent notes,

You'd have to see the cost and benefit of each [cofactor] intervention. You still have to be accountable for what you are spending the money on. They'll tell you: 'HIV prevention is not here to do poverty eradication!' (Bilateral-19)

Other interviewees express concern about the wide variety of issues they would need to deal with, were they to adopt a genuine upstream approach to HIV prevention. Addressing the structural drivers of the epidemic, they suggest, would amount to opening a can of worms: it could oblige them to engage with

²¹² See also Chapters 6 and 7.

an unmanageable multitude of new challenges and problems. As the deputy country director of an international NGO notes, referring to the inclusion of nutrition-related measures into HIV/AIDS policies,

It's a huge thing! The [Tanzanian] government says: If you start, where do you end up?! It's not only HIV patients, also TB patients, for example. I think, they [would] attract a lot of interest in other patient groups. And nutrition is not only a health issue; it's also about agriculture. (INGO-9)

In a similar vein, a Tanzanian official underlines,

Concerning the link between [NTDs] and HIV, people think: 'We don't want to complicate our messages. We had some clear messages out there and we don't want to complicate them... and if we include those, where do you stop!?' That's why the Global Fund has been so reluctant. (GovSector-13)

Apart from the apprehension that a more structural approach could open up a boundless field of policy interventions politically difficult to refuse, this quote reflects the idea that the acknowledgement of non-behavioural drivers of HIV transmission would send out the wrong prevention message. Behaviour-centred aetiological simplicity is believed to be the better prevention strategy. When asked about including cofactor-related measures into HIV-prevention programmes, an international NGO worker warns:

That issue is so difficult to tackle, because the public would think that such interventions would give them a 'protection' from HIV...so they would have a 'solution'. People would feel safe and may not protect themselves anymore. (INGO-6)

Beyond the fear that broadening the prevention strategy might send out the wrong behavioural signals, policymakers' perception of structural approaches as highly complex certainly hampers their inclusion into existing programmes. As a multilateral agent stresses concerning nutrition-related interventions, "the issue of nutrition is linked with issues of food production, food prices, agricultural policy...it's so complicated!" (Multilateral-7). The scepticism of several respondents concerning cofactor-related prevention is thus not due to doubts about effectiveness, but to their belief that structural approaches are too complicated to be feasible. Taking nutrition as an example, a bilateral agent notes,

General nutrition will probably never be an HIV intervention because of insufficient funding. I believe it was in Malawi that the [World Food Programme] proposed to introduce general nutritional measures as HIV prevention. 50% of the children there were stunted...so you would have to feed half of Malawi all the time! The cost was estimated at something like three times that of the existing HIV measures! (Bilateral-12)

Referring precisely to this type of reasoning, a multilateral agent involved in food fortification and nutritional education stresses,

People are always looking for ways *not* to do things. They will say, for instance, 'That's too expensive!'. But that is an excuse not to do stuff! Look outside that narrow box [of the large-scale distribution of ready-to-use therapeutic food]! There are other ways of addressing nutrition support. (Multilateral-10)

These two statements illustrate the deeply political nature of the distinction between what is considered feasible and what infeasible. The ends considered attainable are predetermined by the solutions policymakers believe to have at their disposal. Considering, as the bilateral agent quoted above does, the medicalisation of malnutrition (through the distribution of food) as the only possible response to

malnutrition makes it appear infeasible to address nutritional problems in an HIV-prevention strategy. Indeed, several interviewees involved in cofactor-related interventions argue that these interventions are erroneously considered infeasible, underlining that measures such as nutritional education, NTD control or food fortification are already implemented in some Tanzanian regions or neighbouring countries, although frequently in a non-systematic manner and at an utterly insufficient scale. Consciously or not, many AIDS organisations thus take widespread parasitic infections and malnutrition as an invariable given. Changing a whole continent's sexual behaviour, in turn, is considered a feasible endeavour. A restrictive definition of the variables one considers as being amenable to change through public action favours technical 'solutions' over political decisions, i.e. choices implying the acknowledgement of irreducibly conflicting interests and values and the need for a collective formulation of temporarily acceptable compromises (Mouffe 1993). It allows for the adoption of limited, 'pragmatic' strategies. It enables AIDS players to propose manageable, 'rapid-impact' interventions and to leave aside the complex determinants of populations' susceptibility to disease.

A-6) Stigma, an obstacle to integrated prevention?

One last factor that could potentially hamper the formulation and implementation of cofactor-based prevention interventions is stigma. Addressing the possibility of including such interventions into HIV-prevention programmes, several NGO representatives mentioned HIV-related stigma as an obstacle. In a discussion with two NGO players, for instance, the representative of an organisation active in both behaviour-based HIV prevention and in the access to safe water mentioned that "[i]n Uganda, they developed a package for people living with HIV/AIDS, with condoms, bed nets, and a Water Guard" (INGO-5). His colleague continues,

We thought about doing the same, but our fear was stigma. We didn't want our Water Guard to be stigmatised with HIV/AIDS... We didn't want people to link the Water Guard to HIV. Then, what will happen? People would think: 'If I use the Water Guard, people will think I'm HIV positive...' So the two are different programmes dealing with different issues. (INGO-6)

By fear of stigma, some implementing players thus choose not to integrate certain HIV-specific elements into broader health-related programmes.

Although its importance should not be overestimated, stigma could thus be an obstacle to integrated prevention responses. To be sure, as Farmer (1992, p.xiii) forcefully argues, the fear of stigma should not be used as an excuse for inaction, and stigma is decreasing rapidly as the access to ARVs becomes more widespread. Yet, it seems important to be aware of the reluctance expressed by some of the implementing actors in this respect and to take into account the possibly hampering effects it might induce.

In sum, far from being strictly evidence-driven, HIV-prevention policies result from a politically negotiated aggregation of competing, frequently non-optimising rationalities. Discussing these results,

the next section argues that the failure to consider the invariably political nature of the choices involved hampers the formulation of realistic, politically informed HIV-prevention strategies.

B) Towards a realistic political economy of HIV prevention

“You know, a lot of the HIV stuff is very much interest driven...and unfortunately, there are a lot of interests and very little evidence base. [...] You probably get a better understanding of what is going on and why, if you apply a political economy framework rather than a medical one.”
(Multilateral-2)

Insights concerning the potential benefits of structural HIV prevention have only incompletely translated into public policies and, in Tanzania, prevention efforts largely continue to rely on individual, end-game behaviour-change strategies. The existence of strong biological, epidemiological and economic rationales for the inclusion of cofactor-based interventions into HIV-prevention strategies has obviously been insufficient for the inclusion of these measures into public policies. The continued neglect of structural prevention is better understood if one takes seriously the context-specific incentive structures that underlie allocative decisions (Putzel 2003) and considers several neglected features of HIV-related prioritisation processes. Cost, political constituencies and the structure of the AIDS response, as well as the perceived feasibility of interventions and the expected time scale of political returns all influence the definition of policy content in ways sometimes drastically at odds with rationalist decision-making models.

B-1) Some practical implications of analytical realism

The low relevance of cost-effectiveness, for example, indicates that many health economists fundamentally misconceive the role of cost in priority-setting processes. While it arguably overestimates African specificities, Chabal and Daloz's (1999) analysis of the political “productivity of economic failure” underlines the broader implications of the probably universal role of ‘inefficiency’ as a central element of government. This reality is brilliantly summarised by one respondent in Kingdon's (1984, p.145) study of US transportation and health policymaking. Discussing the choice between different public transport systems, this high-level transportation official stated: “It has always been apparent to me that subways are not the way to go. But they take so much money, they are so inefficient, that there is a great deal of support for them.”, adding “For a politician, the costs are the benefits.” This quote not only illustrates that one institution's costs are another one's resources, but it sums up an oft-omitted truism of political sociology: the ability to allocate (i.e. to spend) money is a key resource for any politician or organisation. In this sense, spending more, rather than less, is fundamentally desirable, because it expands the spender's reach and power over his environment.²¹³ In both Western and sub-Saharan countries, it thus seems empirically wrong and analytically misleading to assume that policymakers consistently and

²¹³ Although many of his political conclusions are questionable, Niskanen (1971) is among the most prominent analysts of bureaucratic logic. This institutional incentive structure is one explanation for TACAIDS' attempt to establish a parallel, *ad hoc* AIDS bureaucracy, that would reach all the way down to the district level and be answerable to its headquarters (see Chapter 5).

spontaneously attempt to avoid cost.²¹⁴ More generally, a realistic analysis of the role of cost thus suggests that the levelling off – and even the recent decrease – of global AIDS funding (Kates et al. 2011) might increase the actual policy relevance of efficiency considerations only marginally, and certainly not automatically.

To be sure, the omission of the positive externalities and synergistic effects of cofactor interventions does make their contribution to HIV prevention falsely appear cost-ineffective (Stillwaggon 2009). The development of more comprehensive tools for cost-effectiveness analysis of combined structural interventions could thus help highlight their complementarities. Yet, both the serious methodological challenges of cost-effectiveness analyses concerning structural HIV prevention (Bonell et al. 2006),²¹⁵ and the observed limited policy relevance of cost considerations suggest that one should not overestimate the actual potential of more comprehensively designed cost-effectiveness studies to induce significant shifts in prevention priorities. While producing and circulating solid evidence about non-behavioural drivers of HIV transmission could increase political incentives to adopt structural prevention measures, additional evidence alone – be it biomedical, epidemiological or economic – is unlikely to bring about policy change in the absence of a politically informed strategy to push for a more broadly conceived response. Moreover, given the excellent ‘stand-alone’ cost-effectiveness of many cofactor-related interventions (e.g. food fortification or TB, malaria and NTD control) (Hotez 2008), addressing HIV within a broader public health framework makes sophisticated attempts to isolate these interventions’ *HIV-specific* cost-effectiveness superfluous.

The importance of the time scale of political returns on different preventive interventions suggests that, in order to increase the political attractiveness of structural interventions, their short-term contributions to HIV control need to be made visible. Indeed, although cofactor interventions have a number of unquestionably positive impacts on health and society, their specific effect on HIV is not always immediately perceptible. In this sense, quantifying the effects of these interventions as well as their impact timeline might make them more prominent on national and international prevention agendas, and might be more policy-relevant than complicated cost-effectiveness calculations. In parallel, underlining the positive effects of cofactor interventions on HIV-*treatment* programmes (Walson, Singa, et al. 2008; Sawers et al. 2008) could modify policymakers’ time scale by bringing closer the moment when interventions’ political returns are anticipated to set in. Time projections and political risk are closely related. Independently of cost considerations, risk-averse policymakers “prefer smaller, certain returns to larger, less certain returns” (Bertozzi et al. 2008, p.840). This not only biases funding away

²¹⁴ From a more anthropological perspective, this sheds an even more perplexing light on the emergence of what Nguyen describes as a “strange market for testimonials” as a result of international institutions’ need to legitimise their programmes by illustrating (cost-)effectiveness (2010, Chap.1).

²¹⁵ Beyond the intrinsic limitations of cost-effectiveness analysis, the frequently ill-informed use of its conclusions for real-world policy choices also suggests that it should be viewed with caution (see: Drummond et al. 1995; Birch & Gafni 1994; Disease Control Priorities Project 2008; and Walker 2003). In a sense, these limitations actually let policymakers’ hesitance to use economic evaluation for decision purposes appear rational.

from prevention, as Bertozzi et al. underline, but clearly disfavours structural approaches – whose impacts are perceived as less certain, although they could radically alter disease dynamics.

As a population's susceptibility to HIV infection is intimately related to its general health status, there are strong medical and economic rationales for addressing HIV prevention and treatment within a broader public health approach (Stillwaggon 2011, see also Chapter 7). The present analysis of HIV-prevention policy processes further strengthens the case for integrated disease control. Vertical programming implies narrowly earmarked funding, short programming cycles, a constricted definition of desirable outcomes and thus of interventions' 'effectiveness', and it encourages the emergence of disease-specific constituencies – all features which are un conducive to structural prevention approaches. The political attractiveness of structural interventions closely depends on what outputs are considered politically relevant. Considering structural interventions in a broader public health context would allow for their positive 'externalities' to be politically internalised, i.e. to be considered as positive outcomes and political returns. As discussed in more detail in Chapter 7, a system-oriented response would lower some of the barriers to evidence-informed policymaking specific to vertical disease control. As several key donors tardily but surely emphasise the need for health system strengthening (cf. The Lancet 2011), this shift in the structure of the AIDS response could open a *policy window*²¹⁶ for those structural prevention measures that depend on well-performing health systems (e.g. parasite and STI control, blood and injection safety, etc.). However, explicitly articulating cofactor-related measures that address insufficient *non-health* infrastructures or policies (e.g. water and sanitation or nutrition security) within HIV prevention will require a more comprehensive, and not solely medicalised vision of public health action (McKinlay 1974). The AIDS field being comparatively well-endowed, organisations implementing HIV-related health and non health-sector activities have a financial incentive to collaborate with HIV/AIDS programmes and projects. Impetus for structural prevention can thus come from lower-level initiatives. At the implementation level, many cofactor-related players already push for the inclusion of their activities into the Tanzanian HIV Prevention Strategy, learning how to use existing institutional flexibilities to access earmarked AIDS funding (see Chapter 7). The change-resistant effect of behaviour-related constituencies on Tanzanian prevention policies suggests that the potential advocates of structural HIV prevention could be effectively strengthened through the building of coalitions and policy-networks.

The analysis of cofactor-based prevention interventions in Tanzania illustrates how an issue's alleged infeasibility can effectively prevent it from reaching policy agendas (Hall et al. 1975). As Kingdon aptly analyses, a problem's chances of rising on the decision agenda decrease if policymakers consider it overly vast and complicated:

²¹⁶ Policy windows are moments in time when conditions align favourably for a specific issue. They open when issues attract policymakers' attention because problems, solutions and broader political developments converge (Kingdon 1984).

One possibility, indeed not uncommon, is that the entire complex of issues falls of its own weight. Most participants conclude that the subject is too complex, the problems too numerous, and the array of alternatives too overwhelming. Their attention drifts away to other, more manageable subjects. (1984, p.185).

This is what happens to structural HIV prevention in Tanzania. That being said, the perception of an issue's complexity is closely linked to that of its scope. Problems tend to be perceived as overwhelmingly complex if they cannot be solved by purely technical arrangements that leave existing hierarchies and allocative compromises untouched, but would require truly political responses. AIDS policymakers deem many structural interventions infeasible precisely because they would require measures they consider beyond their jurisdiction. This confirms Gupta et al.'s (2008, p.767) observation that structural interventions are frequently "passed over by the health sector as being too broad, too diffuse, and outside the remit of health programming". Policy windows for even widely acknowledged problems tend to close again in the absence of credible solutions and, as Kingdon (1984, p. 150) notes, "[t]he chances for a problem to rise on the *decision* agenda are *dramatically* increased if a solution is attached". Proposing feasible responses to structural drivers of HIV by elaborating manageable policy packages (Sumner et al. 2011) including a limited set of interventions (e.g. P. J. Hotez et al. 2006) might thus significantly increase cofactor interventions' chances to rise on decision agendas. The need for these responses to be delineated clearly for policymakers to consider them feasible is not necessarily incompatible with the broad nature of structural prevention. As Gupta et al. (2008, p.767) underline, "total change of a [...] structural factor might not be needed to exert its effect on HIV vulnerability". These packages could include a variety of measures, among which in-school deworming and massive drug administration against NTDs, food fortification and micronutrient supplementation measures, as well as increased integration of malaria and tuberculosis control and HIV-prevention and -treatment services in high prevalence regions. In any case, they should be carefully tailored to sub-national epidemiology and existing local responses as universal turnkey solutions would be utterly inappropriate to address widely differing situations. That being said, it remains challenging to formulate 'feasible' short-term strategies without labouring under the illusion that essentially technical arrangements alone could be a sufficient response to the epidemic in the long run.²¹⁷ Indeed, while some cofactors can be controlled through fairly simple and closely circumscribed technical solutions, addressing other structural drivers of HIV would require in-depth responses, including improved access to safe medical care, water, sanitation and housing, as well as nutrition-oriented agricultural and pro-poor trade policies. Being related to deep-rooted socio-economic inequalities, these measures involve politically sensitive social justice dimensions (Tesh 1988; Hunsmann 2009).

²¹⁷ Food fortification, for instance, is a cheap and policy-sensitive measure against widespread micronutrient deficiencies (which affect mucosal and systemic immunity) Yet, it neither solves the continent's nutritional problems, nor does it address the deep socioeconomic and political divides that drive malnutrition in the first place.

B-2) Beyond the rationalist fallacy: HIV prevention as politics

All these findings show that HIV-prevention policies are not as exclusively evidence-driven as many analysts' apolitical conception of policy formulation suggests. Even though HIV "prevention strategies seem largely to ignore the existing evidence base" (Bertozzi et al. 2008, p.835),²¹⁸ most key programmatic publications (e.g. Potts et al. 2008; Schwartländer et al. 2011; Piot et al. 2008; Bautista-Arredondo et al. 2008) fail to consider the decision-making and priority-setting literature (e.g. R. Robinson 1999; Goddard et al. 2006; Sumner et al. 2011; McCaughey & Bruning 2010; Youngkong et al. 2009; Burris et al. 2011; WHO 2007; Lin & Gibson 2003). Implicitly or explicitly, they continue to refer to a linear, evidence-based policy process as the norm (e.g. Bertozzi et al. 2008, fig.8) although economic theorists (Kahneman et al. 1982) and political scientists (Kingdon 1984; Shiffman 2008; Lindblom & Woodhouse 1992; Stone 1989) have long shown this rationalist assumption to be a fallacy. This idealised vision of policymaking leads to an incomplete understanding of real-world decision processes, which are quite far removed from a 'rational' selection of interventions based on a systematic *ex-ante* evaluation of their costs and benefits.

Not only are medical, epidemiological and economic considerations only three among many variables at play in the formulation of prevention policies, but the incremental nature of policymaking – "muddling through" as Lindblom (1959) calls it – is a rational response to time constraints, uncertainty and the limited ability of the human mind to process information. In most cases, what Baltussen and Niessen (2006) call "*ad hoc* priority setting" is thus the empirically observed norm. Fully acknowledging the underlying limits to rationality (R. Robinson 1999; Goddard et al. 2006) challenges the very foundations of evidence-based policymaking (McCaughey & Bruning 2010). Consequently, and irrespective of the oft-contested nature of the evidence they mobilise, bold calls for science to guide HIV-prevention policies – or lamenting about the persistence of "bad politics" (Piot et al. 2007; 2008) – will continue to have limited impact if voiced in a political vacuum that abstracts from what we know or need to know about *real-world* policymaking.

While Bertozzi et al. (2008) explicitly address political barriers to evidence-based policymaking in real-world decision settings, the nature of the policy-hurdles observed in Tanzania cautions against expectations that these barriers could be substantially lowered by improving information and planning capacities alone. No doubt, problems of data availability, quality and comparability exist, and the policy uptake of cofactor interventions is hampered by the fact that they cannot easily be tested with randomised controlled trials (Bonell et al. 2006), as well as by the biased, highly reductionist nature of today's CEA (Stillwaggon 2009). Yet, the Tanzanian case suggests that the lack of evidence-based policymaking and the ensuing neglect of structural approaches are not merely due to inappropriate data or policymakers' insufficient ability to process it. This mitigates enthusiasm concerning recent attempts

²¹⁸ It should be noted that the evidence-base to which these authors refer is not the same as that presented in Chapter 2.

to improve the rationality of policymaking through multi-criteria decision analysis (Baltussen & Niessen 2006; Youngkong et al. 2010) or by disentangling cognitive biases in decision processes (McCaughey & Bruning 2010). Based on the idea that policies can be improved by making decision criteria and processes explicit, these approaches might help overcome certain capacity-related shortcomings and cognitive limitations in information processing. However, they implicitly assume that the optimisation of population health is the overriding rationale in allocative decisions and that impartial procedures would allow rational consensus. The process-related constraints to evidence-based policymaking observed in Tanzania suggest that this assumption is rather optimistic.

Improving HIV prevention supposes an in-depth understanding of actual policy processes. Beyond the sole *content* of policies (Padian et al. 2011), future research should thus deal with the competing rationalities (Lin 2003) at play in the formulation of national HIV-prevention strategies and their selective, politically mediated implementation. While an increasing body of literature critically analyses evidence-based policymaking, political economy approaches should become more specific about which conditions encourage evidence-informed policy environments (e.g. Sumner et al. 2011). As Prewitt (2006) argues concerning the syllabus of public policy courses, rather than “seek[ing] an elusive evidence-based policy”, HIV-prevention research should put public policy practitioners in a position to “press for an evidence-influenced politics”. In this perspective, opening up the conceptual black box of what is often vaguely alluded to as ‘political factors’, ‘imperatives’, or ‘impediments’ will provide a more realistic analytical framework. Doing so involves taking a closer look at the specific dynamics of multi-player decision processes in the highly heteronomous settings of most low-income countries (e.g. Husain et al. 2007). Indeed, many recipient governments’ inability to act as ultimate authorities lets rationalist decision models appear even more remote from policymaking realities (see Parts 2 and 3). These perspectives leave ample room for increased cross-fertilisation of political science, health economics and public health approaches to HIV prevention.

While the above findings are context-dependent and should not be sweepingly generalised, they clearly echo situations in other African (and Western) countries. The lack of prioritisation in national HIV-prevention strategies, for instance, is a common phenomenon (Hester et al. 2008; Mullen 2005), although the multitude of players involved in the Tanzanian policy-formulation process certainly accentuates this tendency (see Chapter 4). To be sure, the funding and accountability structures of most African AIDS programmes are different from those underlying Western health policies. Yet, confronting the Tanzanian case with literature on (health) policymaking in the West suggests that neither the limited relevance of economic evaluation studies in public decisions (Hoffmann 2000; Eddama & Coast 2008), nor the ambiguous role of cost and the incremental nature of priority-setting processes (Kingdon 1984; Lindblom & Woodhouse 1992; Lindblom 1959) are specific to Africa or to HIV/AIDS. In sum, when de Waal writes with common sense that “[t]he two basic preconditions for successful measures against HIV/AIDS are that they should be founded on rigorous public health science and that they should be

framed by the real potentialities of African governance” (2003a, p.255), this analysis suggests that these two “preconditions” are not only partially incompatible, but that this incompatibility is by no means due to any African specificity in governance matters.

Sub-conclusion) Towards an evidence-informed policy struggle

“There is no inertia in the uptake of innovations. There are only inadequately analysed interests, or an irrelevant separation between technical choices and organisational choices”
(Latour 2001, p.34, my translation)

This chapter showed that decisions concerning HIV prevention put at stake irreducibly conflicting political interests. While the fact that HIV-prevention policies are based on politics might appear sobering to some, it is neither good nor bad news. Indeed, the fact that HIV-related policies are not primarily evidence-driven does not make them irrational. In the absence of a unique super-ordinate decision authority, Tanzanian prevention strategies result from a politically negotiated aggregation of competing rationalities – the relative importance of which varies as the broader political context evolves. The formulation of HIV-prevention policies not only involves a prioritisation of conflicting interests, but also of incommensurable and at times incompatible values – such as improving public health and protecting individual freedom (see also Part 2).²¹⁹ No technical approach can tell which one to choose over the other. The choices involved are irreducibly political.

No doubt, acknowledging the central role of non-scientific factors (be they value- or interest-based) in health policymaking should not preclude producing relevant data or designing potentially helpful decision-making tools. Nevertheless, a realistic appraisal of priority-setting processes suggests that the potential of technical decision tools to bring about a significant rationalisation or ‘optimisation’ of prevention policies is limited. Indeed, as Prewitt (2006) sharply states, “[p]rogress-friendly policies don’t descend from an amorphous body of evidence. They emerge out of political struggle”. Consequently, developing the players’ understanding of how to engage effectively in evidence-influenced political struggles over priorities might be more instrumental in improving HIV-prevention policies than attempts to sidestep these struggles’ ineradicably conflict-laden character through decision tools meant to bring about ‘rational consensus’ (Mouffe 2005).

As discussed in Chapter 2, the *raison d’être* of the political stems from the existence of radical diversity of interests and values and the ensuing irreducible character of social conflictuality. It is the task of the political to transform this initial social heterogeneity into political homogeneity, i.e. into rules – or public policies – that apply to every member of the *polis*. Denying the very existence of radical diversity and of irreducibly conflicting values, the technocratic quest for ‘optimal’ or purely ‘evidence-based’ HIV-

²¹⁹ Parkhurst (2012b) confirms this argument.

prevention policies depoliticises crucial political choices by negating the *raison d'être* of the political process itself. Indeed, if the inexistence of a universal hierarchy of values is omitted, and interests are considered homogeneous or at least compatible from the outset, it is not necessary to transform *ex ante* heterogeneity into *ex post* homogeneity. Excluding the political nature of prevention policymaking from the AIDS scholars' analysis and AIDS players' consciousness exposes them to repeated frustration and hampers the formulation of scientifically sound *and* politically informed strategies for positive change.

Part 2) A political economy of non-decision: maximising aid flows and evading political responsibility for AIDS-related allocative decisions

“If an ailment is socially defined as real, and nothing is done, then that, too, is a policy decision.”
(Rosenberg 1988, p.30)

The lack of focus is a very common problem within HIV prevention programmes in Africa – which are frequently accused of lacking strategic vision. No doubt, part of the difficulty to prioritise interventions is due to the nature of the virus itself and the various drivers of HIV transmission. Not only is there no magic bullet in HIV prevention, but the variability of epidemic dynamics between and within countries makes it impossible to identify a straightforward combination of measures that would effectively stop the spread of the virus in all those different settings. While the specificities of the virus and the various parallel epidemics help one to understand priority-setting problems, they are certainly insufficient to explain their scale and scope in many sub-Saharan countries. More often than not, observers blame African governments’ lack of ‘capacity’, ‘leadership’, or ‘political will’ for the lack of prioritisation of the national AIDS response and the inexistence of a genuinely *strategic* approach to HIV prevention.²²⁰ A multilateral agent describes the attitude of the Tanzanian government as follows:

One problem in Tanzania with regard to AIDS is that government leadership is very...let’s say...‘loose’. That turns Tanzania into a very ‘welcoming’ country for donors. It allows them to impose their priorities, which is very attractive for development partners: they decide what they want to do and they do it...and the Tanzanian government says: ‘Go ahead!’. So the priorities are frequently dictated by the partners. We try to do exactly the opposite. We want to [...] coordinate action via the Strategic Framework... (Multilateral-6)

Despite the massive inflow of international funding, the resources available for both HIV prevention and treatment in Tanzania remain insufficient to implement all activities contained in the National Multi-sectoral Strategic Framework (NMSF). The predictably incomplete implementation of HIV prevention and treatment policies thus inescapably requires a prioritisation concerning the types of interventions, geographic focus (regions or districts), and ‘target groups’. In defining who gets access to HIV-related services, these allocative trade-offs necessarily involve a form of ‘triage’, i.e. a direct or indirect determination of those who will survive and those who may die. The every-day decisions that underlie the implementation of the national response to HIV/AIDS are thus at the very heart of the political. They involve a permanent exercise of power that constitutes a central component of biopolitical sovereignty (Nguyen 2010). In Tanzania, however, the high stakes of these central societal compromises are in stark contrast with the absence of a larger public debate on AIDS-related allocative decisions.

A variety of explanations of this lack of controversy exist. The low politicisation of AIDS-related decisions in Tanzania must, for instance, be considered within the country’s broader political context. Indeed, a

²²⁰ In this sense, Hydén’s (2005, p.3) observation that “[i]t is rare to read an evaluation report these days that does not identify ‘lack of political will’ [...] when trying to explain why things happen the way they do” – or rather, why things do not happen the way they ‘should’ – certainly also applies to AIDS policymaking in Tanzania.

variety of interviewees spontaneously point to what they perceive as an excessively 'consensual' political process in Tanzania, which suggests that conflict aversion in Tanzania is not specific to the AIDS policy field. "There is a tremendous reluctance to rock the boat in Tanzania" (INGO-4) deplores, for instance, the country-director of an international NGO. Similarly, the head of a Tanzanian NGO underlines:

HIV is not the only sector that is a bit 'quiet'. Tanzania is mostly quiet and in other sectors it's the same. That is due to how Tanzanians have been brought up... And this 'consensuality' translates into policy formulation and implementation. [...] In Tanzania, most non-state actors are non-confrontational. Maybe you can find a little bit of confrontation among political parties, but still. Here, there is a saying 'amai na mshikamano', which means 'peace and solidarity'. Now, that is a nice phrase, which has been used to abuse democracy...because 'if there is confrontation, there is no more peace'. So they [the Government] will say: 'We are all in this together...'. Some things are happening...but more at the level of systematic advocacy, not through confrontation. My preferred way of doing things is to 'build a case'. And that might even bring more results than confrontation. (NGO-4)²²¹

A Tanzanian official expresses a similar view:

Tanzanians are very humble people. Here you [i.e. politicians] can do things which, if you do them in Nairobi, you're on fire [publicly held accountable]! Tanzanians complain *inside* themselves...they don't go out on the streets. Tanzanians are sheep with their tails down! (GovSector-8)

To be sure, sweeping generalisations about Tanzania's 'political culture' are of little help in understanding the complexities of the country's political processes and patterns of accountability (e.g. Lawson & Rakner 2005; and Kelsall et al. 2005).²²² Yet, the analyses of a variety of Tanzanian (Mmuya & Chaligha 1994; I. G. Shivji 2007) and Western observers (e.g. Martin 1988; Hydén 2005) contribute to a better understanding of the oft strikingly non-confrontational appearance of the Tanzanian political arena. Some of the more plausible, interrelated explanations proposed by these scholars include the fact that only a small minority of people are in wage employment, that Tanzanian unions are only starting to regain political autonomy after their post-independence co-optation by the state, that the uninterrupted reign of the CCM party since independence fuels a confusion between the party and the state apparatus, and the still relative weakness of an intermediate bourgeoisie or of what Bayart (1989, p.123) calls an "indigenous private sector". In any case, different forms of patronage – or less hierarchical variants thereof, which Hydén (2005) regroups under the term "economy of affection" – continue to shape political interactions at all levels of government. Although conflict aversion might be particularly pronounced in Tanzania, if one believes the interviewees' comparison with other African countries, its explanations thus resemble many of the well-known patterns of the political sociology of the African state, with major socioeconomic struggles revolving around the appropriation of state resources (e.g. Bayart 1989; Chabal & Daloz 1999).²²³ While it is important to keep in mind these very general

²²¹ This quote echoes Pearce's analysis, who suggests: "In a context characterised by patronage and dependency, the emphasis is on dialogue [...], on the assumption that to inspire change you need to persuade and convince, not confront and demand" (2009, p.18).

²²² The wildcat strikes in the 1960s in Tanzania, for instance, suggest that any homogenised, immutable vision of 'political culture' is obviously insufficient.

²²³ This situation might be slowly starting to change, in part as a result of an increasingly independent press and the emergence of opposition parties.

characteristics of the Tanzanian policy field, the decisions taken within the Tanzanian AIDS policy sphere appear to be *particularly* remote from any form of democratic scrutiny.

Politics 'in a box': the closed shop of AIDS policymaking in Tanzania

“The policy formulation process for HIV/AIDS was, for quite some time, ‘in a box’. It was taking place ‘in a room’. For some reason, it has lately opened up a bit...”
(NGO-4)²²⁴

As alluded to in the introduction, the AIDS policy field in Tanzania has a striking autonomy from the rest of the political process – including Parliamentary debate. Far from being specific to Tanzania, this disconnect is a common feature of most sub-Saharan countries. Indeed, the limitation of the debate over the content and design of the national AIDS response to a relatively small ‘closed shop’ of donor representatives and government officials partially results from the technocratic nature of donor-driven African AIDS control initiatives (see also Part 3), which favours a “predominance of technical-administrative players” (Gruénais et al. 1999). Indeed, the international response to HIV/AIDS in Tanzania almost entirely bypasses often recently created and still fragile domestic democratic structures. As discussed, 85% of all external AIDS assistance, for instance, is spent off-budget (TACAIDS 2012b), i.e. directly by donors (mostly PEPFAR) and their implementing partners, and without any meaningful contribution to priority setting by elected Tanzanian representatives. As an international NGO worker points out:

Parliament is pretty much irrelevant, and in the domain of HIV so much is being delegated to the different administrations: the TNCM [National Coordination Mechanism of the Global Fund in Tanzania], TACAIDS...there is no role for public representatives. (INGO-4).

Even allocative decisions concerning *on-budget* expenditures (mainly Global Fund money) are not discussed in Parliament but decided upon within the TNCM – an *ad hoc* donor-government forum. As a bilateral agent underlines:

It is highly problematic that all these agreements and arrangements completely by-pass the country’s democratic process. If you look at it, the TNCM is a blatant violation of good governance principles! (Bilateral-31)

In addition to the circumvention of representative government, the AIDS policymaking process in Tanzania is characterised by a lack of ‘civil society’ participation. The weakness of Tanzanian AIDS activism certainly explains part of this non-debate over allocative choices. In this sense, my observations and the interviewees’ statements concerning the Tanzanian AIDS policy process confirm Pearce’s assessment that PLWH in Tanzania “rarely challenge authority, question existing power relations or demand more involvement in decision-making processes” (2009, p.18). The creation of many groups of

²²⁴ Interestingly, this same interviewee puts into perspective that assertion a few minutes later, by saying: “There is pressure from outside Tanzania pushing the Government to work with NGOs. [...] The Global Fund says: ‘You don’t get the money until you have those people [from ‘civil society’] together, period’. But that leads the Government to entertain a purely formal relation with NGOs. It makes sure you will come to the meetings and sign to prove that you have been there...but on a practical level, the government is not very keen to work with us.” (NGO-4)

PLWH was actually driven by donors who requested a certain degree of institutionalisation to ensure accountability and to funnel funding. As Pearce describes,

PLHA politics thereby follow the same structures of patronage that characterise general politics in the country, and individual leaders often spend more energy on self-promotion than on representing their members' interests. Within PLHA groups and networks, democratic practice is often absent, leaders [are] authoritarian and claims to representation [are] suspect. (2009, p. 15)

Similarly, Beckmann & Bujra (2010, p.1045) underline that Tanzanian grassroots organisations of PLWH “exhibit a patron-client mode of politics” and “are reluctant to resort to [confrontational strategies], for fear of losing the limited amount of support they enjoy”. Interestingly, the authors add that although PLWH “may present this as a national characteristic (‘our Tanzanian culture is not one of confrontation’) it is most evidently a response to the limited political opportunity structure within which they must operate, where state and donors call the shots” (2010, p.1049).²²⁵ A Tanzanian NGO worker who, as the Tanzanian official quoted above, compares Tanzania to Kenya confirms this situation:

Some people living with HIV will speak about HIV/AIDS as a social-justice issue...but at the policy level, no! That's different in Kenya: HIV is a lot more contentious there! I guess, in Tanzania, there is an over-powering donor influence and dependency on their hand-outs. (NGO-1)²²⁶

Another Tanzanian NGO worker describes her past collaboration with donors and government as follows:

The donors divide us. We have our idea and say: ‘Let’s rather do it this way...’ They’ll say: ‘No, you are too complicated! We’ll go see another CSO to do the job...’. So you end up implementing what others planned! Did they go to the people and ask them? They didn’t! How can they know what is needed? The donor has already identified the ‘problem’ and now they want an ‘implementer’...they don’t want to sit at the same table and plan. [...] We’re being called ‘partners’, but we are not real partners! With the Government, it goes like this: a government person will come and tell us: ‘Tomorrow is the workshop...come and bring 10 participants along with you!’. If we are ‘partners’, we want to be involved from the very beginning! (NGO-2)

‘Civil society participation’ concerning HIV/AIDS decisions in Tanzania still often remains limited to a haphazard, *ad hoc* ‘consultation’ of arbitrarily selected ‘stakeholders’ in order to comply with donor demands. As discussed in Chapter 7, the technocratic nature of vertical international AIDS initiatives is obviously in contradiction with the democratic definition of priorities at lower levels. In any case, the fact that the main role granted by the state and AIDS donors to PLHA in Tanzania consists in “marshal[ling] people for treatment in a depoliticising servitor position” (Pearce 2009, p.17) is obviously

²²⁵ In a separate résumé of the same paper, Bujra concludes that PLWH mobilisation in Tanzania is “politically weak [...] and to a large degree co-opted by state and international aid agencies into depoliticised service delivery”, and adds the following, interesting point: “There are many reasons for the success of the South African movement and the weakness of PLHA mobilisation in Tanzania – one is that PLHA in Tanzania did not themselves have to struggle for ARVs – the politicising work was already done in [South Africa].” (see: www.polis.leeds.ac.uk/assets/files/events/democratization-2009/janet-bujra-abstract.pdf)

²²⁶ A bilateral agent confirms this dependency. He notes: “Concerning accountability, we would like PLWHIV to be like ‘watchdogs’ for the local government. But is that practical or does that only work in theory? In practice, it might not work like that. These people are not protected if they want to speak out...” (Bilateral-19). This statement echoes the description of Pearce (2009, p.18), who writes: “people are very aware of their dependency on patronage for survival and advancement. [...] ‘People complain a lot’, says a long-term female PLHA activist, ‘but they don’t do anything, they can’t. You don’t bite the hand that feeds you. It’s like this: TACAIDS holds the knife’s handle, and we hold the blade. If we pull we’re going to cut ourselves.’ They have learned from experience that insiderism, the use of personal networks, and a submissive demeanour emphasising needs rather than rights, is the most promising route in dealing with authority.”

in stark contrast with the oft-celebrated democratising effect of international AIDS activism and ‘civil society’ in general.

No doubt, one should be wary about naively optimistic conceptions of ‘civil society’ participation and its democratising effects. In response to UNAIDS, which voiced the regret that “in far too many countries, civil society representatives still do not participate in high-level decision-making” (UNAIDS 2004, p.164), Putzel’s question (2004a, p.22), for instance, is pertinent: “In which of the developed democracies do self-declared representatives of civil society participate in the highest levels of decision making and would it be desirable for them to do so?”. That being said, even the involvement of representative government is very limited concerning AIDS policymaking in Tanzania. While international donor agencies certainly have a technical legitimacy, it would be difficult to argue that they have any more democratic legitimacy than Tanzanian ‘civil society’ representatives – be they self-declared. Nevertheless, the decisions involved not only have a direct impact upon the lives – and often the survival – of a significant proportion of the country’s population, but they necessarily involve a prioritisation of irreducibly conflicting interests and values. The fact that most relevant decisions are taken either at the donor agencies’ headquarter levels, or within the ‘closed shop’ of donor representatives and government officials in Tanzania, thus represents a “confiscation”²²⁷ of fundamentally political choices.

In sum, the reasons both for the relative lack of confrontational politics in many African countries and for the absence of a broader public debate concerning HIV/AIDS in Tanzania have been fairly well explored, and these analyses are obviously helpful in understanding the politics of AIDS control in Tanzania. Against this background, this part of the thesis proposes to study the decision processes ‘inside the box’ of donor-government negotiations about the national AIDS response – a relatively unexplored territory of policymaking. Based on the players’ own assessment of a persistent lack of prioritisation within HIV-prevention and -treatment policies, the following two chapters look at different facets of what could be described as a political economy of non-decision. In the context of a nearly entirely donor-funded ‘national’ response, what are the incentives of AIDS policymakers in Tanzania to prioritise interventions or to refrain from doing so? How do they deal *in situ* with the uncomfortable obligation to choose, and to what extent and how do they explicitly express or, on the contrary, implicitly negate the compromises over conflicting interest and values this policy-formulation process necessarily implies? How do policymakers deal with the tension between the inescapable need to ration, and the desire to evade political responsibility for unpopular allocative choices? In this perspective, Chapter 4 studies the politics of indetermination that underlie the formulation of the National Prevention Strategy in a highly heteronomous policy context, while Chapter 5 analyses the paradoxical coexistence of explicit ‘universal access’ policies with the *de facto* management of non-universal treatment roll-out.

²²⁷ The “confiscation” of politics is a term used by Desage & Guéranger (2011) in their analysis of French federations of local governments (*inter-communalité*). The context obviously differs considerably from AIDS policymaking in Tanzania, but the processes at play are comparable.

Conceptually speaking, one can distinguish two parallel processes of depoliticisation. The first one, just described, concerns the exclusion of certain players (e.g. elected representatives, groups of PLWH and other CSOs) from the policy process. The second one, discussed in more detail in Chapters 2 and 3, relates to the non-acknowledgement of AIDS-policy decisions as involving the formulation of compromises between irreducibly conflicting interests and values. The analysis in the following two chapters situates itself at the nexus of these two intimately related dynamics of depoliticisation. The illusion of a conflict-free formulation of AIDS control policies is, indeed, a necessary condition for the legitimacy of 'closed-shop' technocratic policymaking based on allegedly 'objective' criteria. While this last aspect is addressed in more detail in Part 3, the political 'economy of non-decision' proposed in this part explores two aspects of a specific modality of depoliticisation in the Tanzanian AIDS policy process, namely the refusal of choice and the negation of irreducible conflict.

Chapter 4) Manufacturing ‘ownership’: prioritisation and the formulation of the National HIV Prevention Strategy

“Prevention is underfunded. There are not enough resources. But then, prevention is just another area that is not resourced to scale. None of them is. Not a *single* area in Tanzania has the resources it needs to go to scale.”
(Bilateral-19)

Most AIDS-control programmes in Africa are underfunded compared to the identified needs in terms of HIV prevention, treatment, care, and impact mitigation. Consequently, and understandably, ‘prioritisation’ has become a main watchword in AIDS-related policy discussions over the last decade, while the lack thereof is a frequent reproach voiced by international donor agencies against what they denounce as overly comprehensive HIV-prevention strategies. In 2005, a review of African HIV/AIDS strategies of countries participating in the World Bank’s Multi-Country AIDS Program (MAP), for instance, already concluded that “the reviewed strategic documents do not set explicit priorities among the HIV/AIDS interventions they envision” (Mullen 2005, p.5). The study underlines that the actual meaning of ‘prioritisation’ is often unclear:

Most of these documents use the term ‘priority’ to describe most, if not all, of the main components of an HIV/AIDS program, without relating it to any ranking according to importance or effectiveness. Almost all of the reviewed strategies include all but a few of the standard areas of intervention listed above, with no discussion of their relative importance [...] or their relative effectiveness [...]. (Mullen 2005, p.4)

The report acknowledges quite honestly that, during the 1990s, many international agencies championed an all-inclusive approach, arguing that AIDS control strategies should be comprehensive and that every one of its elements was essential and thus equally important. Consequently, “the lack of prioritisation evident in national plans can perhaps be explained by the signals received from the World Bank, UNAIDS, and other international partners” (Mullen 2005, p.5). Indeed, Tanzania’s first National Multi-sectoral Strategic Framework (NMSF 2003-2007) – a document that primarily concerns HIV prevention before the roll-out of ART – explicitly states that its inclusiveness is intentional:

It has to be underlined that the Strategic Orientation of the NMSF is comprehensive. All major elements of the National Response have to be in place if the response is likely to achieve its desired impact. The NMSF does not attempt to prioritize among those objectives or strategies. It insists on the comprehensiveness of the Response, knowing that due to preferences, experiences, resources available etc. priorities will have to be established in distinct areas once Operational Plans and Activities are developed. It is one of the most important tasks of TACAIDS as the main guardian of the National Response to ensure that all areas are covered and balances between the areas are maintained or (re-) established. (TACAIDS 2002, p.ix)

While the discourse has changed since 2002, this quote points to two key issues addressed in this chapter: the Tanzanian government’s willingness to prioritise, and the ability of TACAIDS to coordinate the national response effectively. Without abstracting from the obvious disconnect between national strategies and actual policy implementation, this chapter concentrates on prioritisation processes concerning HIV prevention at the policy level. That being said, it is the policymakers’ increasing

awareness of the gap between what is written in the policy documents and what is actually done on the ground that prompted the call for increased prioritisation of national HIV prevention strategies. Several of the trade-offs involved in HIV-prevention policymaking have been presented throughout the first three chapters. In a sense, after having stressed the wide variety of interventions that have been 'left out' of most African HIV-prevention strategies, claiming that these strategies are not prioritised enough is somewhat paradoxical. Indeed, the exclusion of measures addressing non-behavioural determinants of population susceptibility and health-care safety from these strategies obviously *is* a form of prioritisation. The 'inclusiveness' or 'exhaustiveness' described hereafter thus refers to the non-prioritisation of those prevention measures *that have effectively reached the policy agenda*, without mentioning each time the omissions due to the agenda-narrowing process described in Part 1.

In Tanzania, many interviewees put the blame for the unfocused national response on the insufficient capacity of the Tanzanian administration. Some blame the Tanzanian government's long-lasting (although recently declining) hesitance to differentiate regions and population groups, tracing it back to the country's egalitarian socialist legacy.²²⁸ Both explanations certainly have some truth to them. Nevertheless, studying the policy-formulation process that leads to the adoption of the Tanzanian National HIV Prevention Strategy (TACAIDS 2009),²²⁹ this chapter argues that, far from being merely a matter of ideological heritage or lacking administrative capacity, the widely-denounced lack of prioritisation of the Strategy is largely due to the political economy of AIDS-related development cooperation.

A) A Prevention Strategy, for what sake?

“We have good plans, but when it comes to being focused...that's where issues go astray.”
(INGO-5)

In 2008, the Tanzanian government and the AIDS donors decided to formulate, for the first time ever, a stand-alone national HIV Prevention Strategy. While the legal basis for the national AIDS response in Tanzania is provided by the 2001 National AIDS Policy, the current programmatic and administrative structure of the response is fixed in the 2008-2012 Second National Multi-sectoral Strategic Framework²³⁰ (NMSF) (TACAIDS 2007). Since the NMSF provides only very broad guidance, one objective of the Prevention Strategy was to operationalise further its prevention-related provisions. Beyond the need to guide implementing organisations, the decision to formulate the Prevention Strategy was influenced by the more general context of the AIDS response in the preceding years. Indeed, although

²²⁸ One could also argue that the a-little-bit-of-everything approach of many African countries with generalised epidemics is an ill-conceived form of 'combination prevention' resulting from a lack of knowledge concerning epidemic thresholds and synergistic effects (see Chap. 1-3, as well as: Stillwaggon 2009).

²²⁹ This case study obviously does not account for all domains of HIV-prevention policymaking in Tanzania. Although it does face similar difficulties, the process leading to Global Fund proposals, for instance, follows a different logic in that insufficiently focused proposals run the risk of not being selected. In any case, since the Global Fund finances individual proposals by Round rather than national strategies as such, the whole process is quite distinct from that of the Prevention Strategy.

²³⁰ The first NMSF covered the 2003-2007 period.

prevalence had slightly declined since the late 1990s, the virus continued to spread at an important rate during the 2000s.²³¹ Consequently, there was a common feeling among prevention players in Tanzania that not enough had been done, and that existing prevention interventions were only inadequately aligned with the actual drivers of the epidemic. This feeling was further accentuated by the unprecedented resource flow into antiretroviral treatment efforts since the creation of PEPFAR and the Global Fund. A Tanzanian official describes the context of the emergence of the Prevention Strategy as follows:

The whole issue of prevention came up in 2006 when we talked about ‘scaling up’ all these different interventions. [...] From 2004 on, all efforts and discussion went on care and treatment. So we thought it was crucial to reinvigorate the prevention aspects also! This supposes an ‘unpacking’ of the NMSF 2008-2012. We needed to translate it into doable strategies and we costed it to get a rough idea of – if we decide to do prevention – how much is it going to cost? The costing is important for resource mobilisation.²³² (GovSector-10)

A multilateral agent gives a comparable account of the situation:

Tanzania has really been overtaken by care and treatment. Prevention really fell behind...in all aspects. Today, there is a great need to ensure that prevention is repositioned. Over the last two or three years, we have developed plans, but not much has happened. So together with other partners, we have been making pressure for the Prevention Strategy. [...] In the past, a lot has been done. But everyone had his own programme, and it’s not sure that these were aligned to the drivers of the epidemic. It is important to get more evidence, to get a prioritised two-year plan, and to get it up and running right away! (Multilateral-9)

Another multilateral agent describes the underlying motivations to come up with a Prevention Strategy in strikingly similar terms:

For the last five years, everyone working on HIV in this country has raised his voice that the resources for prevention are very limited. That’s because of care and treatment... [...] That is how the debate has heated up. Now, under the leadership of TACAIDS, there is an effort to work on a prevention *strategy*, not just a *policy*. The NMSF is too large, so let us pull out prevention and select *strategic* interventions to scale up. This is what the costed Prevention Strategy is about. (Multilateral-16)

The formulation of the Prevention Strategy was thus perceived by many as a means to push prevention back onto the national policy agenda, to align preventive interventions with the drivers of HIV transmission in Tanzania, and to introduce the missing focus into the scattered and uncoordinated prevention response. A look at the policy process leading to the Prevention Strategy provides valuable insights both into how AIDS policies are formulated in Tanzania and into why coming up with a ‘focused response’ – a goal to which policymakers themselves repeatedly refer – is such a difficult task.

The Prevention Strategy, a 60-page document²³³, was written (and costed) by a team of 2 international and 10 Tanzanian consultants who worked in collaboration with TACAIDS.²³⁴ The consultants were hired

²³¹ In Tanzania, HIV prevalence probably peaked around 1995 (W. Urassa et al. 2006; Somi et al. 2006). While a 2008 national-level survey (TACAIDS 2008) confirmed this decrease in prevalence, the actual reasons for this drop remain largely ill-understood (and are not unambiguous ‘good news’, as they necessarily involve high AIDS mortality rates). In any case, these new data did not alter the players’ conviction that past HIV-prevention efforts had been insufficient.

²³² Concerning many players’ perception of costing as being primarily a resource mobilisation tool, see Chapter 3.

²³³ Including an annex with a “Two Year Action Plan for HIV Prevention 2009/10-2011”.

on the basis of terms of reference formulated by the Prevention Technical Working Group (PTWG)²³⁵ – a group composed of about twenty members, among whom several Tanzanian officials (from TACAIDS and the Ministry of Health), a variety of bilateral and multilateral donor agents, as well as several (changing) representatives from civil society and faith-based organisations. All members of the PTWG were invited to comment on successive draft versions of the Strategy. The formulation process started in summer 2008 and was finalised in autumn 2009.

The prevention players wanted the Strategy to be based both on epidemiological evidence concerning the drivers of HIV transmission in Tanzania and on the experience derived from past prevention activities in the country. Strikingly, however, even after the publication of the epidemiological analysis, which had been contracted out to another consultant, many players continue to consider that it is not clear at all why HIV spreads the way it does in Tanzania.²³⁶ “The evidence on what drives the epidemic in Tanzania is still not very strong”, underlines a multilateral agent, “for the moment, it’s still like we are shooting a bit in the dark...” (Multilateral-18). Having regretted what she considers a lack of knowledge about the specific causes of the Tanzanian epidemic, the executive chairman of TACAIDS denounces that several AIDS players have accommodated quite well to this lack of evidence: “Even knowledge-based international institutions such as the World Bank are behaving like governments...saying ‘Let’s do business, in whatever way!’. There is no research...”.²³⁷ A multilateral agent, in turn, questions the seriousness of the efforts of the Tanzanian administration to remedy this situation: “TACAIDS talks a lot about research, but I’m not sure about what they are doing to get more data. I’m really not sure...” (Multilateral-18).

Importantly, a consultant involved in the writing of the Prevention Strategy complains about the challenges arising from the weakness of the evidence base: “There is a lack of incidence data! That makes it very difficult...and it’s not meaningful to map drivers according to prevalence” (Research-11). A multilateral agent also insists on this important gap in the evidence:

Given the huge amounts of money that go into HIV/AIDS policymaking, it is surprising how pervasive the lack of evidence-based policymaking actually is. This is not just a Tanzanian problem. Now they work on ‘getting a better understanding of the epidemic’... To be sure, our understanding of the epidemic in Tanzania wasn’t very good! Take for instance the latest [Tanzania HIV/AIDS Indicator Survey]: I looked for the differences and variations as compared to the last [Survey], but there is no incidence data! Nothing! How is that possible?! We don’t know the dynamics of the epidemic! We know something about the numbers of deaths, but even there we have big variations between different sources. That’s quite strange. Even the prevalence data we have are not consistent! (Multilateral-2)

²³⁴ The costing of the Prevention Strategy was part of a broader effort to evaluate the resource needs for the entire national AIDS response by costing all components of the National Multi-sectoral Strategic Framework.

²³⁵ One international consultant excerpted (see below).

²³⁶ A progress report made by one of the international consultants in May 2009 makes this same point (Kirungi 2009).

²³⁷ Statement uttered at a meeting of the Joint Technical Working Group concerning the preparation of the Round 9 proposal to the Global Fund, 3 Oct. 2008, Dar es Salaam. Again, the fact that the Executive Chairman was primarily talking about evidence concerning sexual behaviour suggests that the Tanzanian AIDS administration might not be looking at the most important factors of the spread of HIV (see Chap. 1).

The comment of one bilateral agent illustrates the huge uncertainty arising from the lack of incidence data:

Recently, prevalence levels have gone down in Tanzania, which is a good thing... But that means that *either* the prevention efforts do have an impact – which cannot be completely excluded, *or* it means that the whole care and treatment campaign is not working! (Bilateral-17)

When asked how he explains this situation, the above-quoted multilateral agent responds:

One thing is clear: incidence research is not something that is driven by donors...if it was important to them, it would have already been done... After all, 'ABC' interventions were implemented in so many countries against the will of the government and the population. (Multilateral-2)

The identification of existing HIV-prevention activities, which was intended both to improve the planners' knowledge of what is already being done and to provide unit cost estimates for the costing exercise, also turned out to be a very challenging task. As the consultant quoted above puts it,

The problem is that there is no library or database where you can go and see what interventions are being done where... That's why we are suggesting to have a data unit at TACAIDS. That should have been there from the very beginning! But it's not! (Research-11)

Indeed, a previous attempt by TACAIDS to produce such a mapping of HIV-prevention activities had yielded only limited results.²³⁸ As a bilateral agent recalls concerning the epidemiological study and the activity mapping,

The epi-overview was never finalised!²³⁹ And we encouraged them to stop the mapping because they were doing such a poor job... They randomly included some activities and not others! So we encouraged them to focus their energy on the Strategy. (Bilateral-24)

Given the very limited success of a renewed attempt to map existing prevention activities to inform the formulation of the Prevention Strategy, neither the Tanzanian AIDS administration, nor anybody else, has a comprehensive view of who implements which interventions and with what geographic coverage. As a multilateral agent puts it: "There is some mapping here and there, of this and that...but all this to me is confusion!" (Multilateral-16). When asked if she had any data on expenditure by types of prevention interventions, a multilateral agent replies,

I have no idea about where the money goes to or about how much goes to the different interventions...but it would be interesting! [...] We are not really informed about what each of us are doing in the country. The US Government might have data that we're not aware of. TACAIDS *should* have a research spread sheet and a mapping of HIV activities...it all falls back on TACAIDS' capacity. (Multilateral-18).

Independently of the issues related to government capacity discussed hereafter, this situation is surprising in a country where international donors spend USD 500 million annually on AIDS control. In the absence of a comprehensive overview of who is doing what and where, any effort to coordinate

²³⁸ Several interviewees were critical concerning the rigorousness (and thus the usefulness) of the Tanzania Output Monitoring System for HIV and AIDS (TOMSHA). Surprisingly many interviewees were simply unaware of its existence.

²³⁹ This remark refers to a first attempt of the Tanzanian government and the AIDS "Development Partners Group" to come up with an epidemiologic analysis of the Tanzanian epidemic. Following its lack of success, the study was contracted out to an international consultant.

existing interventions effectively is obviously bound to fail.²⁴⁰ Unsurprisingly, several players complain about the lack of coherence of prevention efforts in Tanzania. A senior bilateral agent laments:

There is no such thing as a costed annual HIV work plan in Tanzania. There is an annual malaria work plan but there is no similar work plan for HIV/AIDS. I can't explain why not! It would create a framework... (Bilateral-12)

In this context of a widely-denounced lack of coordination, the explicit mission of the Prevention Strategy was to provide *prioritised* guidance as to which regions, population groups and prevention interventions the donors and implementing organisations should focus on. As the next section shows, this endeavour was only very partially successful.

B) Not so strategic after all: a prioritised Action Plan or a menu to choose from?

“Prevention is not as strategic here as it could have been. [...] This process will create a wonderful opportunity to have that strategic debate!” (Bilateral-12)

“There's really *everything* in there! The question is: ‘What do I do if I'm the government of Tanzania and I have limited resources!?’ I'm not the US government, who has gazillions of dollars to spend...” (Multilateral-9)

At one year's interval, these two comments on the Prevention Strategy – one preceding the process of its formulation, the other one evaluating its result – sum up the state of mind of many HIV-prevention policymakers in Tanzania. Indeed, the finalised version of the Two-Year Action Plan of the Prevention Strategy identifies 135 “priority actions” – a result widely criticised as unsatisfactory. “Where this strategy is failing is on prioritisation”, exclaims a bilateral agent, “it's like a kitchen sink: all dishes are thrown in...so how are you going to do resource allocation choices?!” (Bilateral-24). While they generally disagree on which elements of HIV prevention should have received more attention (e.g. in-school education²⁴¹, MSM, cross-generational sex, IDUs, etc.), most interviewees converge on the fact that the Strategy is not prioritised enough.²⁴² “The Strategy is good in the sense that it did a comprehensive job of assessing the current situation and what needs to be done”, one of them suggests, “but it didn't go one step further, which would have been to introduce focus” (INGO-8) – an arguably crucial step for a *strategic* policy document. He adds: “Whatever you do, you'll find a paragraph to support your activity. It's not focused! Even concerning MARPs [most-at-risk populations]; they say: ‘We have to focus on

²⁴⁰ No doubt, PEPFAR does have a rather clear idea of the interventions its partner organisations implement in the different regions of Tanzania – although most other donors do not seem to dispose of this information. In any case, although it obviously represents an important share of the AIDS response in Tanzania, confounding PEPFAR with the national AIDS response would be incorrect.

²⁴¹ One bilateral agent, for instance, underlines: “The Prevention Strategy is a very weak document. Schools are completely left out and the Ministry of Education is not even mentioned!” (Bilateral-31).

²⁴² Interestingly, several donor agents both criticise the Strategy for not being prioritised enough *and* deplore the absence of (or lack of detailed focus on) one or another aspect of HIV prevention. In a sense, this is contradictory, as the absence of certain types of interventions or the mere allusion to specific population groups (e.g. MSM, commercial sex workers, primary school children, IDUs) obviously reveals an implicit prioritisation (see: Mullen 2005, p.5).

MARPs', but they throw *everybody* in the category of most-at-risk populations!'. Commenting on the issue of MARPs, a bilateral agent underlines:

The UN pushes for MSM [men having sex with men] and IDUs [injection drug users] to be included in the Strategy. Right now, we are not looking at it at all...we should. But, epidemiologically speaking, we wouldn't want them to be at the top of priorities...the main drivers remain heterosexual. But then, I guess, we – the donors – are not a big help either: We want to include certain groups for human-rights issues, not exclusively for straightforward epidemiological reasons... (Bilateral-24)

Strikingly, all interviewees, independently of their overall appreciation of the Prevention Strategy, recognise that prioritising interventions is an extremely challenging task. In this sense, while regretting the high number of "priority actions" in the Strategy, several interviewees stress that the heterogeneous nature of the Tanzanian epidemic makes it particularly difficult to set country-wide prevention priorities. "In Tanzania, the epidemic has so many geographical variations", underlines a multilateral agent, "in one region they have only 2% prevalence, in other areas it's 15%...so the interventions have to be different, too!" (Multilateral-17). Similarly, another interviewee suggests:

A serious limitation to prioritisation is the fact that there are regionally specific local drivers of the epidemic. That makes things difficult, since people at the regional level have no clue what's going on in their region, epidemiologically speaking. [...] In Tanzania, there is no homogeneous epidemic. Tanzania is a big country, with Muslim regions with high male circumcision rates, Christian regions with no male circumcision; from one region to another the mobility patterns are very different... So it is very difficult to say: 'This is for the whole of Tanzania now!'. (Multilateral-12)

Another multilateral agent argues along the very same lines,

It is very difficult to go through that process; to say 'this is more important than that'. In Kosovo, they actually did come up with such priorities. [...] But in Tanzania, the situation is different. We have a rather generalised epidemic that is not limited to specific groups. (Multilateral-2)

Adopting a more general perspective, a bilateral agent underlines:

Prioritisation is not simply a matter of 'either, or'. Generally, it means 'Yes, I will do both, *but...*'. Only in very rare cases can one actually decide to completely drop an intervention. [...] But then, we don't have to fund *everything* that is written in there...some of it can be addressed through mainstreaming. (Bilateral-31)

One consultant involved in the process, and thus directly confronted with the difficulties entailed by priority setting, stresses:

Everybody said: 'Prioritise!'. We said: 'Show us *how* to do it!'. [...]. We have asked them 'Tell us how to do it'...we asked all of the donors. None of them has come to show us how. They don't know! The very concept of prioritisation is not clear in their heads... (Research-11)

Interestingly, this interviewee's last remark points to a more general difference in the interviewees' conceptions of 'prioritisation', and thus of what the Prevention Strategy is actually aiming at. The very idea of the document's mission differs between those who consider its final version as globally satisfactory and those who strongly criticise it for not being sufficiently focused. In this sense, the just-quoted consultant contends:

We have come up with priority areas, based on drivers. These are in the Strategy. The Prevention Strategy is

the first time they do such a review of drivers and activities. It's a review document! It's a very comprehensive view of the drivers of the epidemic and the existing activities. [...] What people have to understand is that all these strategies come from the drivers of the epidemic. And the drivers come from the data. So it already *is* prioritised! (Research-11)²⁴³

A Tanzanian official involved in the process argues along similar lines:

We might need to prioritise more, but [...] we want to leave the districts and regions the liberty to address local specificities. Some of them are not really addressing the real issues. So the big document [the Prevention Strategy] is just to guide them, to keep them thinking and to make them think out of the box: "What is driving our local epidemic? Is it MSM or multiple concurrent partnerships, or age discordant sex...?" In one area, you might not have all the drivers of the epidemic. It's not just about applying the Prevention Strategy immediately at the local level. It's more like giving you a menu to choose from and then let local governments try to adopt the interventions to their epidemic. (GovSector-10)²⁴⁴

While these arguments seem sensible, a closer look at the recent history and context of the Prevention Strategy suggests that this description of the Strategy as a mere "review document" or a "menu to choose from" for local government authorities is primarily an *ex-post* justification for the failure to prioritise. In what appears as a both lucid and forcedly optimistic evaluation of the document, a bilateral agent suggests: "The Prevention Strategy may become a launching pad to have a prioritisation being done later on...to go from there" (Bilateral-19). This amounts to postponing the initial objective of prioritisation to a later moment. Indeed, while there can be good reasons not to push prioritisation too far, one of the main explicit objectives of the Prevention Strategy was precisely to further prioritise the 'highly inclusive' NMSF (see above). An interviewee involved in the formulation of the 2008 NMSF recalls,

The NMSF is a list of *everything* one could possibly do to prevent HIV.²⁴⁵ We tried to at least introduce *some* prioritisation by focusing on certain groups, not on specific types of interventions. But we have not succeeded...and we were not really satisfied with the result. That's why we are now trying to come up with a Prevention *Strategy*, we hope to operationalise and prioritise the NMSF a bit more. (Multilateral-12)

A bilateral agent confirms just that: "The NMSF gives the main guidance and the Prevention Strategy should start from there, and develop the framework in the same direction" (Bilateral-30). More importantly yet, the list of prevention interventions for local government authorities to choose from already exists in the form of the "essential package" of prevention interventions. The following two interviewees describe this package:

At the sub-national levels, many people don't know how to plan, so [...] we came up with a minimum package of prevention interventions, which we encourage the district councils to put in the district health plans and to cost, in order to mobilise resources. (GovSector-10)²⁴⁶

²⁴³ A Tanzanian AIDS official has a similarly 'inventorial' vision of 'prioritisation'. When asked if he considered the NMSF as being sufficiently prioritised, he responds: "The NMSF is a strategic plan. *Everything* is in there! You've got *all* objectives in there and how you are going to go about it. You should look at it again, it has all the priorities in there." (Lupogo_7-10-2009) [misconception of "prioritisation"]

²⁴⁴ The different drivers mentioned by the interviewee are yet another illustration of the predominance of the behavioural paradigm among AIDS players in Tanzania (see Chapters 1-3).

²⁴⁵ As discussed in the first three chapters, this is incorrect.

²⁴⁶ This statement confirms the above-described conception of costing as a tool for resource mobilisation, not prioritisation.

These are conceived as a list of propositions for district players to choose from according to their priorities, if they don't know how to address the issue of HIV prevention. This package is now ready and [...] will be distributed at the district level for HIV planning. It is actually in the budget guidelines and the districts receive money to implement these interventions according to their priorities. (Bilateral-28)

The Prevention Strategy not only did not manage to introduce further prioritisation among the 80 interventions included in this package, it actually *increased* the number of “priority interventions”.²⁴⁷ Many policymakers who participated in the process thus view the Strategy's lack of focus all the more critically as increased prioritisation was part of its *raison d'être*. Using the example of the “essential package” of prevention interventions, one interviewee proposes what such prioritisation could look like:

The ‘minimum package’ of prevention interventions has different types of interventions: it has ‘must-have’ interventions (there are about 80 of them!), ‘should-have’ interventions and ‘nice-to-have’ interventions... But we should have created a *fourth* category of interventions, which are ‘you-are-going-to-be-executed-if-you-don't-have-them’ interventions! These would have been non-negotiable...and if you don't implement them, you will lose your head! But that has not been done... (Multilateral-12)

Earlier on in the discussion, this interviewee mentioned the prevention of mother-to-child transmission and condom distribution as such “interventions one should not make any concession on”, adding “condoms, for instance, should *always* be sufficiently available – that should be the very first thing!”. Again, the fact that condoms are still not easily available in some parts of Tanzania and that over a decade after its introduction, PMTCT is still far from being a universal service is important to keep in mind concerning the debate over prevention priorities.

While costing can be a helpful prioritisation tool, several interviewees consider that the results of the costing of the Prevention Strategy pressingly illustrate the need to focus on the most important interventions. A multilateral agent notes,

In the strategy, we still have one hundred and some priorities! So there are some hard questions to be asked and answered. Some people think this is a great document...fine, but I think we have to *prioritise the priorities*! They came up with a costing of 500 million dollars for two years. That's more than half of the total [AIDS] budget!²⁴⁸ When we saw the results of the costing exercise, all donors were like ‘Whoa!’. What were the costing assumptions?! The DPG-AIDS said: ‘This is not realistic! We need to be more serious’. The US [Government] spends 300 million dollars a year, of which only 20% go into prevention... Where is the money going to come from?! So even within the drivers, we still have to unpack. For example, we are still talking about ‘in-and-out-of-school youth’, not ‘adolescent girls’. And are we going to implement this *nationwide*?! We should focus on high-prevalence regions! We need to go to the next step. We did a good job in stocktaking...but you cannot have one hundred ‘priorities’. (Multilateral-9)

Interestingly, the conception of the policy relevance of the costing exercise itself differs significantly. While some think that the results of the costing clearly confirm that the Strategy is not prioritised enough, others consider that costing the Strategy has a different goal altogether. As a bilateral agent puts it:

²⁴⁷ This is partially due to the fact that it also includes activities to be implemented at the national level.

²⁴⁸ The estimated annual cost of implementing the Prevention Strategy is actually slightly *less* than half of total AIDS expenditures in Tanzania – which still represents about three times the current expenditures on HIV prevention.

If in the costing exercise they come up with assumptions that make sense to the other donors and participants, the government could put that document on the table to see with donors what they are funding...to see how they buy in. A look at the gap could give a basis for action. (Bilateral-19)

At a meeting of the Prevention Technical Working Group, one consultant involved in the costing exercise describes its merits as follows:

What we came up with is that the full implementation of the Strategy would cost over 600 billion Tanzanian Shillings, that's 474 million dollars, for 2 years. [...] So for five years [the duration of the NMSF], you come up with about 2.5 billion US dollars. The costing of the rest of the NMSF shows that it would cost about 5.5 billion dollars for 5 years, excluding prevention. So our costing shows that prevention would represent about 40% of the activities of the NMSF. So by publishing these figures, we are repositioning prevention!

This conception of the role of cost as a political tool for resource mobilisation (see Chapter 3) is implicitly confirmed by a multilateral agent who, shortly before the publication of the results of the costing exercise, states: "Everybody expects the [costing of the] prevention budget to be off the roof; *nobody* expects it to be realistic!" (Multilateral-18).²⁴⁹ Yet, some interviewees are far more critical. A bilateral agent, for instance, puts into context the resource claims expressed through the general costing of the NMSF – which exceeds today's AIDS spending about threefold, implying a 66% funding gap:

The estimated cost of the 5-year plan to fight AIDS equals the annual budget of Tanzania...and that's *without* counting prevention! These dimensions of costing really don't make sense! [...] Even if the costing is for resource mobilisation, this is exaggerated and might even be counterproductive. If you put numbers like that on the table, nobody is going to put up with your study anymore. They'll simply say: 'Thank you very much...next agenda item, please'. (Bilateral-30)

The costing of the Prevention Strategy showed that the budget that could reasonably be expected to be available for HIV prevention over the next two years would allow implementing only about one third of the interventions included in the Strategy's two-year Action Plan. Nevertheless, the document was not further prioritised. The comment by a multilateral agent with considerable experience in strategic HIV-prevention planning helps explain this decision:

It takes a lot of effort to go through a situation analysis and to come up with a prioritised needs assessment. And then you go through the costing and you see you can't afford it! So then you go back to the drawing board... And I guess there is a lot of pressure to get the plan finished and out the door. Setting priorities is a difficult and long process. And prioritisation leads to deceptions, since you always upset some if they don't get what they ask for. It's a political process! (Multilateral-2)

Importantly, this last remark suggests that the Strategy's widely-lamented lack of focus does not exclusively stem from the inherently complicated nature of priority-setting for HIV prevention, or from the country-specific difficulties due to the multifaceted nature of the Tanzanian epidemic. The next section argues that the non-strategic character of the Prevention Strategy can be partially explained by the nature of the policy process leading to its formulation.

²⁴⁹ One researcher involved in the costing process implicitly suggests that the costing team was asked to come up with high numbers: "The donors didn't want incremental costing, one that would assume that some things already exist, they wanted *total* costing! So that includes medical doctors, hospital beds, etc. that already exist! And for male circumcision, for instance, we used the unit cost of 42 dollars given by WHO – but it's a lot cheaper than that in Tanzania! The idea to do full costing comes from donors, not the government. It does help to know the full cost...but I didn't understand it." (Research-11)

C) Too many cooks spoil the broth: the limits of 'participatory' policymaking

“The intelligent donors will go and ask the Government: ‘What do you want?’. We even look into the national policy documents before proposing activities. But not everybody does that...”
(Bilateral-28)

A naïve observer of official development discourses about ‘ownership’ and ‘alignment’ could expect that international donors (or ‘development partners’, as they are increasingly called) interested in strengthening the Tanzanian Government’s AIDS control efforts would enquire about the existing national strategy and adapt their support to the government’s policy framework. Even a brief look at AIDS policy formulation processes in Tanzania, however, shows that the reality is radically different. Indeed, the fact that the initial initiative for sustained action against the epidemic in Tanzania came from the international donor agencies themselves makes this textbook vision of ‘development cooperation’ obviously inappropriate. The interviewees’ accounts of the Prevention Strategy policy formulation process are surprisingly congruent in showing that, a decade after the heavily donor-driven creation of TACAIDS (the inter-ministerial coordinating body), the Tanzanian government still does not actively lead the national AIDS response (see also: Hellevik 2012a).²⁵⁰ The absence of strong national leadership leaves ample room for individual donor agencies to push for the interventions they consider as the most appropriate ones. A bilateral agent recalls the discussions leading to the formulation of the Strategy as follows: “Always, everyone would push for his own favourite interventions: orphans, education...the US were pushing for a focus on most-at-risk populations...” (Bilateral-28).²⁵¹ A multilateral agent critically remarks, “There are so many partners and so many discussions...everybody had their own priorities, so the consultants had a difficult time” (Multilateral-9) – a statement confirmed by one of the consultants involved in writing the Strategy:

It has been very challenging to put the interests of all the donors together. Some say in their comments ‘Ha!, but we are not in there...our things are not included!’, others say ‘MSM is a very important issue!’... Okay, maybe it is, but there is no data on MSM in Tanzania, so how can you say that? [...] Now, we need no more comments anymore – we just have to *finish* this! (Research-11)

During a discussion at a meeting of the Prevention Technical Working Group concerning the draft Prevention Strategy, a bilateral agent concludes along very similar lines:

We need to prioritise and that’s a challenge. But at the same time, every organisation and every donor wants to make sure that their activities are in there, that their things are captured in the policy! So maybe at one point in time, we have to tell people: ‘Thank you very much for your comments, but that’s it now!’...and stop taking up new comments and interventions. Prioritising implies making difficult decisions.

²⁵⁰ See also the introduction to Part 3.

²⁵¹ The importance to focus on so-called “high-risk populations” in the Tanzanian epidemic is not agreed on by everyone. As a project manager with an international NGO puts it: “One problem with PEPFAR is that it is difficult to segregate ‘high-risk groups’ from the rest. Whatever we do with our lives is our own secret. That makes it impossible to define ‘high-risk’ groups. All young girls and boys are potentially at high risk...it depends on their behaviour and that we don’t know! So what does PEPFAR propose? Do we let them die? We have to address the person as a whole...but who is a ‘high-risk person?’” (INGO-6)

A multilateral agent describes how the number of players involved in the process impacts on the degree of prioritisation that can be reached:

There is always a lot of stakeholders with a lot of agendas. Those who take care of orphans will push for OVCs [orphans and vulnerable children], those who are in VCT [voluntary counselling and testing] will push for that, etc., etc.. There are different interests at play and all of them want a piece of the pie. So I guess, the least controversial thing to do is to give all of them some of it...to give a little bit for everything. (Multilateral-2)

The observations of other policy meetings I assisted suggest that the 'a-little-bit-for-everything' phenomenon is by no means specific to the negotiation of the Prevention Strategy. Indeed, the accounts several interviewees give of their experiences in formulating different policy documents confirm that the lack of prioritisation is widespread in Tanzanian AIDS policymaking. A senior multilateral agent, for instance, describes the preparatory discussions leading to a Global Fund proposal as follows:

During the preparatory process of the Round 8 proposal, we told them that they should focus their project on a limited part of the Strategic Framework in order to come up with a specific proposal, and to demonstrate and implement the existing synergies concerning these specific points. And then, at the first meeting of the 'steering committee' we were more than 150 partners from different institutions! It was a losing battle...it is simply not possible! It took us three months to agree upon *something*. Too much participation makes it impossible to have a very focused proposal: you have the nutrition people, those from PMTCT, from OVCs, the education people...and everyone will defend his turf. Nobody has a strategic view! Well, some individual people here do, but still... (Multilateral-6)

The above-mentioned collective attempt to come up with a package of "essential" prevention interventions for implementing players to choose from suffered from the same structural problem of 'excessive participation'. A bilateral agent actively involved in the process recalls:

We developed a 'minimum package' of prevention interventions and it received heavy criticism [...]. It was criticised for proposing about 60 'priorities'...so they said we should prioritise more – which we didn't. It would have been impossible to prioritise more with so many stakeholders around the table, all pushing for their interventions! If you really wanted to get that type of prioritisation done, you would have to hire a consultant to do the job. [...] So what we did was we changed the name of the package and called it not 'minimum', but 'essential' package of interventions and we ended up with about 80 different interventions... (Bilateral-28)

A multilateral agent who collaborated on the writing of the second NMSF comments on its outcome as follows:

The NMSF looks like a shopping list! It's like a party where everyone brings along the food they wish to eat! Nobody within the government says: 'Let's put the accent here, rather than there...'. But one needs priorities! (Multilateral-6)

These accounts reflect the experience of a former multilateral agent who, later on, was involved as a consultant in the formulation of the Framework:

The strategic process is supposed to be so participatory...so as a consultant, you can't tell them 'You can leave out certain things...' [...] You cannot leave out STIs, youth, or gender...each time you'll have one institution up in arms against that: UNICEF, the [Ministry of Health]... So if, as a consultant, you don't have a very clear idea of what the priorities are, forget it! I got run over by all these participants and interests. I was so obsessed for the process to be as participatory as possible...we even went to the regions to include

youth, the health sector, PSI²⁵², etc.... So if, at the end of the process, you get *any* prioritisation at all, you're lucky! That's the problem of a participatory process: it's not a rational process...that would be against participation! (Multilateral-12)

All these statements converge to underline a fundamental tension – and at times radical contradiction – underlying public health action: that between participatory process and prioritisation informed by biomedical and epidemiological evidence. To be sure, this tension is particularly vivid in the case of HIV/AIDS as the multifaceted nature of the epidemic – a both infectious and chronic disease with different, inter-related modes and drivers of transmission – makes a prioritisation of the response intrinsically more difficult as with many other diseases, such as malaria or even TB. In Tanzania, however, the large number of players involved in the process exacerbates this tension. Importantly, and as discussed in the introduction to Part 2, one should not mistake this 'participatory' process for a 'democratic' one, as most players involved in these discussions – especially the representatives of donor agencies – have no democratic legitimacy to formulate Tanzanian health policies. The ensuing multi-actor policymaking process leads to a 'Strategy' driven not by considerations concerning the best mix of prevention interventions and target populations, but by the donors, who – as one of them readily admits – “have their own things and projects in mind” (Bilateral-24). While efficiency concerns might play a role in donor agencies' *internal* agenda-setting processes, the competitive interaction of their various prioritised agendas during the national-level policy process lets the various policymakers lose sight of the 'common good', i.e. a globally coherent, evidence-informed, and prioritised national Prevention Strategy.

Using Boudon's aforementioned concept, the resulting situation could therefore be described as a “composition effect”. The above-quoted multilateral agent summarises the Tanzanian situation as follows:

Too many partners, too many people...that compromises the response. When I arrived in Tanzania, I was surprised by the number of players...and luckily, in a certain sense, they are not 'quiet' players. But here, for the first time, I see the limits of participation. I never would have thought I'd reach that point one day, but now I struggle to limit it [participation]! [...] But then, the 'too much participation' should be directly related to the lack of government leadership. It's the lack of leadership that makes coordination so difficult. So everybody tends to want to control everything... (Multilateral-6)

The conclusions suggested by this statement are twofold. One is that genuine *strategic* planning might require to limit the number of players involved in the policy process.²⁵³ In this sense, the recent reduction of donors actively involved in the Tanzanian AIDS response could be seen as good news. Indeed, since 2007 the United Nations have reduced the number of agencies actively involved in the policymaking process via the “One UN” initiative – a reform of the internal division of labour within the

²⁵² PSI (Population Services International) is one of the major international NGOs working on HIV/AIDS.

²⁵³ Following a brief discussion over whether the people conveyed to the launch meeting of the Prevention Strategy could provide feedback, the members of the PTWG (which already represents a wide variety of players), for instance, decided to limit any further input as much as possible. While some NGOs criticise the lack of openness of a policy process dominated by technocrats from government and donor agencies, this decision to keep participation limited also illustrates the awareness of the PTWG members that a trade-off between participation and prioritisation exists.

United Nations for which Tanzania was one of eight pilot countries.²⁵⁴ The aforementioned drop in the number of bilateral donors involved in the Tanzanian AIDS response, however, is due to an altogether different dynamic. This trend is mainly driven by the fact that several smaller bilateral donors felt sidelined by the new (and bigger) international players such as PEPFAR or the Global Fund. As a bilateral agent suggests, “their headquarters probably felt like: ‘There is so much money in HIV. Why would we add another 10 million? That wouldn’t change anything...’” (Bilateral-12).²⁵⁵ This interviewee’s analysis, however, suggests that this evolution might not be exclusively good news after all:

There used to be 21 bilateral donors involved, now we’re down to 6! [...] The good thing about the bilaterals moving out of HIV is that this led to an increase of donor resources for the health sector. Now they are about 20 bilateral donors in the health sector. [...] And the decrease of the number of DPs [development partners] has made coordination somewhat easier within the HIV sector, among donors and with the government of Tanzania. The bad thing is that this decrease in the number of partners in the HIV sector leads to a narrowing of the dialogue between DPs, which is not a positive thing! Now, there are so few of us around the table! Small donors used to be a tempering factor. [...] The worst-case scenario would be to have the Global Fund and the US government alone, talking to each other... Influence becomes more consolidated and I don’t think that’s a healthy thing. (Bilateral-12)

While a decrease in the number of players involved might facilitate coordination, the increasingly oligopolistic structure of the AIDS donor landscape this interviewee anticipates would lead to a concentration of power that could further weaken the ability of the Tanzanian Government to steer the policy process – and even further alienate the Tanzanian population from crucial health policy choices.

Getting back to the above-quoted statement on the limits to participation, the second conclusion it suggests is that the number of policy players compatible with meaningful prioritisation depends on the extent to which the national government coordinates the response. While acknowledging the obvious weaknesses of Tanzanian AIDS agencies in this regard, the next section argues that, although real, the widely denounced lack of capacity of TACAIDS is the direct result of political choices.

²⁵⁴ As a result, UN-agencies such as ILO, WFP, FAO and UNESCO, for instance, are no longer considered as ‘active’ but as ‘delegating’ agencies in the field of HIV/AIDS. ‘Delegating’ agencies continue their AIDS-related activities, but do not actively participate in the AIDS policy dialogue (see: UN Tanzania 2007).

²⁵⁵ Another bilateral agent puts things more strikingly: “With PEPFAR, I guess the basic issue is that they just absolutely dwarf everybody else” (Bilateral-29). Concerning the implications of this situation for the US government, see Chapter 5.

D) *'Yes, please do!': TACAIDS between heteronomy and inverse subsidiarity*

“UNAIDS says: ‘The formulation of a prevention policy is not a vendor’s tray, it should be based on a gap analysis’...but it is not one hundred percent clear who takes on this strategic role in Tanzania”
(Bilateral-18)

“It really is a challenge to work with TACAIDS. When we say: ‘We should do this, or that’, they say ‘Yes, please do!’. To a certain extent, that’s understandable: the Government of Tanzania gives them nearly nothing, so they are really ‘donor drugged’...”
(Multilateral-18)

A wide variety of interviewees trace back the cause of the lack of prioritisation to the ‘low capacity’ of the Tanzanian AIDS administration. While some express their reserves about the capacity of several Tanzanian consultants involved in the process of drafting and costing the Strategy, many put into question TACAIDS’ overall ability to head and coordinate the national response effectively. One bilateral agent’s critique is implicit:

The problem is that you need strong leadership to be able to make the different players act according to the national priorities. You have to force the donors and tell them: ‘If you want to do something, then you have to orientate your actions according to *this!*’. Of course, that is easier said than done... If you have no strong leadership, that won’t happen. (Bilateral-28)

Other interviewees more directly question the capacity of TACAIDS to coordinate. Regretting the lack of focus of the Tanzanian AIDS response, a multilateral agent concludes:

At the end of the day, it’s a capacity issue within TACAIDS. [...] It’s all going back to the capacity of TACAIDS. Their capacity is very low! In any case, TACAIDS will do whatever the [development partners] come and say.
(Multilateral-18)

Another multilateral agent, and former Tanzanian health official, is even more straightforward:

There’s no commitment and competence within TACAIDS, that’s all! [...] TACAIDS is supposed to support all the ministries in their public sector response to HIV/AIDS...it’s not happening! They have neither the ambition, nor the capacity to coordinate! (Multilateral-7)

Beyond a general lack of strategic vision, several donors regret that TACAIDS does not adequately play its role as chair of the Prevention Technical Working Group (PTWG), even concerning apparently simple issues such as conveying and preparing the meetings of the Working Group. “We always hear about our prevention meeting the day before the meeting – there is no regularity!”, complains a bilateral agent (Bilateral-24).²⁵⁶ A multilateral agent deplores the effects this lack of organisation has on the functioning of the Working Group:

²⁵⁶ This interviewee underlines that this is a general problem within the Tanzanian AIDS administration. She describes the organisational setting of the Global Fund Round 9 proposal in similar terms: “It was so poorly done! The day it was due, it was sent to us [donors] for comments! So it was like ‘Oh my god!’”. So some of us made all these comments very quickly... For PEPFAR, having a Global Fund proposal on prevention not going through is a real challenge. We can’t fund everything!” (Bilateral-24). As this last remark suggests, this interviewee obviously considers that PEPFAR has an overall responsibility for the response to HIV/AIDS in Tanzania (see Part 3).

It's not clear who is coming to the meetings [...]; it's always the usual suspects plus some random people. Sometimes we are eight, sometimes we are fourteen...and then you never see these people again! (Multilateral-18)

Summarising the way the PTWG functioned during the first months of its existence, a bilateral agent says: “[the initial coordinator] from TACAIDS is not exactly...organised...so we decided to organise as a group as we go along” (Bilateral-18).²⁵⁷

This lack of coordination of the Prevention Strategy process is all the more striking as the very *raison d'être* of TACAIDS is to coordinate the multisectoral AIDS response – which, by definition (and unlike the health-sector response implemented by NACP) is essentially prevention-oriented. As a Tanzanian AIDS official involved in the health-sector response puts it:

The non-health sectors should be doing *only* prevention! What precisely *are* they doing, if not *that*?! [...] TACAIDS is not doing *anything*! Why are they talking about care and treatment if it is not in their jurisdiction? They should have continued to take care of prevention while we were scaling up ART and care... They didn't. [...] If TACAIDS forgets about prevention, it's not our fault! Now they [the donors] come up with 'prevention' to wake them up...they were sleeping! (GovSector-7)

As discussed in the introduction to Part 3, the obvious institutional rivalry that underlies this strongly worded critique stems from the chronology and internal contradictions of the international AIDS response. That being said, the haziness of the Prevention Strategy's institutional framework is indeed striking. Several interviewees point to what a bilateral agent describes as “the absurdity of TACAIDS being absent from prevention”:

TACAIDS doesn't have a prevention team! They have [a programme officer]...that's *one* person! And she's not really a TACAIDS person; she's not on their payroll. It's a real problem for us! We wanted to work with TACAIDS. [...] I really hoped that the Strategy would give political impetus to TACAIDS. (Bilateral-24)

Two multilateral agents comment on the situation in similar terms:

The capacity is not there at the national level. Even the Strategy's institutional home is not sure. For now, it is under [the head of the TACAIDS Policy and Planning division]... But there is no prevention section within TACAIDS...it's a bit of all...it's everywhere in there. (Multilateral-9)

Prevention doesn't have a home in TACAIDS. It was provisionally within the Policy and Planning department, but it is floating around in there... (Multilateral-18)

While the head of the TACAIDS Policy and Planning division acknowledges the hazy institutional setup of the Prevention Strategy at a PTWG meeting (ironically warning the Working Group members: “If you don't have a clear idea of what is the [institutional] home of this strategy, you will not succeed!”), two bilateral agents underline in interviews following the meeting that it would precisely be his job to clarify the institutional arrangement by providing increased leadership. When asked about her interpretation of the haphazard commitment of TACAIDS to the Prevention Strategy process, this multilateral agent

²⁵⁷ These statements echo those of a bilateral agent who remembers that his agency ended up coordinating the writing process of a past Global Fund Round proposal (and hiring several consultants) “because TACAIDS simply wasn't organised” (Bilateral-13).

replies: “I guess that reflects the priorities within TACAIDS. Look at how prevention entered TACAIDS: [the programme officer referred to above] is the link between the UN Joint Team and TACAIDS, but she’s UN-paid!” (Multilateral-18). Indeed, confronted with what they considered as insufficient leadership, the United Nations Joint Team decided to pay a programme officer to assist TACAIDS in the coordination of the PTWG. This programme officer ended up becoming the chairperson of the PTWG, effectively replacing the head of the TACAIDS Policy and Planning division. Reflecting upon the whole policy process, the multilateral agent states:

In the Prevention Technical Working Group, it has always been the ‘usual suspects’ who go to the meetings: UNAIDS, UNFPA, UNICEF, the US Government and some bilateral donors... Of course, TACAIDS was there. But it has always been the same people [the donors] pushing for the meetings to take place. I think, you have felt the temperature in the room, when [the head of the TACAIDS Policy and Planning division] said to us: ‘You have failed to do your job!’. It’s *TACAIDS* who should be driving this process! It is *Tanzania’s* Prevention Strategy! It should be owned by *them*! Of course, TACAIDS is stressed, they are understaffed and all...but the whole process was very much pushed for by the donors. We have been driving the *whole* process. We were the ones who took care of the recruitment of the two international consultants – and who paid for them. Once they were hired, TACAIDS did somewhat take over. But then, the international consultants were supposed to come here in December [2008]...and TACAIDS pushed back that date again and again. Once, one of the consultants literally already had one foot on the plane to get here, when TACAIDS delayed things one more time! The whole process was very donor driven...though not to the point that we overheard what TACAIDS was saying.²⁵⁸ (Multilateral-18)

If it had not been for the donors, the Prevention Strategy might have never existed. Chaired by a UN-funded TACAIDS collaborator, the PTWG meetings were primarily driven by the multi- and bilateral donors, who outnumbered the other members of the Working Group (i.e. Tanzanian officials and NGO representatives) and dominated both the agenda and the speaking time. Most Tanzanian ministries and government agencies concerned with HIV/AIDS have not played an active role in the formulation of the Strategy.²⁵⁹ While the National AIDS Control Programme (within the Ministry of Health) has provided written comments on the draft Prevention Strategy, several donors regret its low involvement in the PTWG meetings. Similarly, several NGOs – mainly international ones – have commented on the draft Strategy, but the (Tanzanian) NGO representatives in the working group meetings did not actively participate in the discussions.²⁶⁰ In contrast, at least one person from each of the main US AIDS-related agencies (PEPFAR, USAID, and CDC) assisted the PTWG meetings, making the US government the most-represented institution.

Being particularly concerned about the little attention Tanzania pays to the classical ‘most-at-risk populations’ (MSM, IDUs and sex workers), PEPFAR even paid a specialised consultant to ‘assist’ the

²⁵⁸ This last comment – or discursive precaution – is all the more interesting in light of the political role of the ‘ownership’ narrative described below.

²⁵⁹ This makes it difficult to explain the lack of focus of the Prevention Strategy – as one interviewee does – by the fact that “so many different ministries are involved” (INGO-8).

²⁶⁰ The spokesperson of a Tanzanian NGO network explains this situation as follows: “The policy formulation process for HIV/AIDS was, for quite some time, ‘in a box’; it was taking place ‘in a closed room’. For some reason, it has lately opened up...TACAIDS has improved on that. Within this framework, there are some challenges: one is the limited participation of NGOs in policymaking. For many NGOs, ‘policies are for the government’... All they do is to report on projects, so they feel policies are not very important for them. So for now, NGOs are not very active in this respect. [...] Quite often, I am having a hard time getting responses [on policy issues] from my constituency [i.e. other Tanzanian NGOs].” (NGO-4)

drafting team of the Prevention Strategy on this issue. “She was a former PEPFAR person”, comments a US programme officer, “so she can understand where we are coming from...that helps for understanding our comments”, adding “it was quite a struggle with the national consultants” (Bilateral-27). The US agencies’ strong staff capacity obviously allowed them to participate actively in the formulation of the Strategy. The interviewee recalls:

We had at least three rounds of review. Within the USG, we all came together, everyone commented, and we compiled our feedback of individuals and US agencies. So we did provide them with really detailed input. But we remained quite discrete about it. (Bilateral-27)²⁶¹

Giving such detailed comment was all the easier for the US agencies as they had just finalised their own prevention strategy for Tanzania a few months earlier, she explains:

Within the USG, we have a ‘Prevention strategy results unit’, which itself has three subgroups [...]. Six months before the TACAIDS process on the Prevention Strategy started, we had actually developed a paper called ‘Prevention Strategy’...so we quickly renamed it so that this wouldn’t create any trouble. Now it’s called ‘Prevention Position Paper’. This document outlines future potential priorities and gaps. When they started to work [on the Prevention Strategy], we were invited to present the document at TACAIDS. If you compare the two documents, you will find that...there are some similarities in the content. It’s not that they are the same, but...let’s say: we wanted to make sure we don’t contradict each other. (Bilateral-27)

The strength in terms of human resources of PEPFAR and its main implementing agencies makes TACAIDS’ relative lack of capacity all the more blatant. That being said, a closer look at the attitude of the Tanzanian government suggests that TACAIDS’ lack of capacity is the result of government priorities. In 2008, manifestly inspired by the (until then) ever-increasing international AIDS funding, the government decided to cut back TACAIDS’ budget by roughly 30%. When asked about the budget cut, a TACAIDS official diplomatically responds:

Yes, the TACAIDS budget was cut, but later, the money was given back. The budget cut was due to a short-term financial conjecture. [...] The government is very much committed and provides a lot of money to AIDS. It represents a low percentage compared to donor funds, but it is an important commitment! (GovSector-14)

A multilateral agent remembers,

I know the World Bank came out with a message criticizing that the government cut 25% of TACAIDS’ budget, and TACAIDS replied that this budget cut looked worse than it was, since the Tanzanian share of the total AIDS expenditures was only about 4% anyway.²⁶² So a 25% cut in its expenditures would, in reality, only amount to a 1% decrease of total AIDS funding... (Multilateral-18)

²⁶¹ Interestingly, no agreed-upon process or methodology guided the inclusion of comments into the final version of the Strategy. When a multilateral agent asked during one of the PTWG meetings “How will our comments be integrated into the Strategy?”, the coordinator of the Working Group plainly responded: “We don’t know...”. One consultant involved in the writing process describes his “methodology” as follows: “When treating the comments, sometimes I was thinking ‘This is important’, so you just stick it in. Other comments are just rubbish... But we included most” (Research-11). As discussed below, the perceived capacity of stakeholders to fund the interventions they propose for inclusion in the Strategy might play an important role in this process.

²⁶² In reality, the Tanzanian government’s contribution to total AIDS expenditure in the country was as low as 2% (TACAIDS 2010).

Many donors, of course, see the Government's decision with a different eye. "Look at the TACAIDS budget decrease because there is too much money in HIV", remarks a multilateral agent, "now that says it all, doesn't it?!" (Multilateral-5). Another multilateral agent comments,

This year, the Tanzanian Government cut down the TACAIDS budget to 64% of last year's budget! The Ministry of Finance thought: 'HIV is getting a lot of money, so we can draw out...'. That is somewhat understandable, but still... It shows that there is no long-term thinking and no resource mobilisation within TACAIDS for own resources! (Multilateral-4)

Indeed, given the fact that several other donor agencies provide financial support for hiring TACAIDS staff and that one bilateral agency agreed to pay for a new TACAIDS office building, the decision by the Ministry of Finance is quite understandable. A look at the funding imbalance between HIV/AIDS and other health issues makes the decision to gear down public support for AIDS control completely rational (see Part 3). Several donors informally acknowledge this situation. One of them states,

If you look at the Medium Term Expenditure Framework, you see that the Tanzanian funding for HIV is decreasing. And I have to admit that I can actually understand the Tanzanian government. There is so much donor money. [...] HIV is what suffers the red pen first when budget cutbacks are made... (Bilateral-13)

Another bilateral agent says things even more openly:

The official version is that 'Of course, the Government of Tanzania is only contributing 5%,²⁶³ because they couldn't afford to put 50%'. I would argue that the Tanzanian government has made a rational decision, because there is already shitloads of money in there! Then, of course, that is not the official position of our government. They talk about 'addressing the challenge of sustainability'... (Bilateral-29)

The comment of a TACAIDS staff member on the issue is revealing. Supporting the government's decision to cut his organisation's budget, he explains:

You know, there are so many ministries...so many priorities! So the budget decrease is normal. [...] With TACAIDS, the government funds are supposed to fill the gaps...to look at what is missing. (GovSector-9)

The massive inflow of donor money for HIV/AIDS appears to result in a complete reversal of perspective: rather than donors 'filling the gaps' of insufficient government funding, the Tanzanian administration follows a reasoning of 'inverse subsidiarity', and considers its own action as *supplementing* that of the donors.

While the low government leadership is obviously in part due to low institutional capacity, this episode suggests that the 'lack of capacity' is at least partially entailed by a political decision.²⁶⁴ Although the budget cut was reversed in 2009 following donor protests, it illustrates that the government of Tanzania intentionally leaves the struggle against AIDS up to international donors – providing a clear illustration that being at the receiving end of an aid relationship does not deprive governments of the possibility of playing strategically with the dependency this uneven cooperation entails. Developing upon this idea,

²⁶³ See the previous note.

²⁶⁴ As discussed in the introduction to Part 3, this analysis is confirmed by Hellevik (2012b), who rightly underlines that the weakness of the coordinating role played by TACAIDS results from the donor-driven nature both of 'multisectoral' coordination, and of the creation of TACAIDS itself.

the next section argues that the manifestly non-strategic nature of the Tanzanian HIV Prevention Strategy is only partially unintentional and results in fact from a deliberate choice on behalf of the Tanzanian Government. Indeed, the lack of capacity of TACAIDS to coordinate the formulation process of the National Prevention Strategy is accompanied by a lack of willingness to come up with a tightly prioritised action plan – which is perceived as a potential obstacle to the maximisation of donor funding.

E) The political convenience of indetermination: the absence of strategy as strategy?

“By reading the Prevention Strategy, it is hard to tell where the government’s relative priorities are. And I’m not sure the government wants to put more resources into prevention... The Strategy simply says: ‘more is needed!’. I’m sure they say the same thing in the [NMSF] section on care and treatment.”
(INGO-8)

As a preliminary report by one of the international consultants in charge of writing the Prevention Strategy illustratively puts it in May 2009, the “current priorities” of the Tanzanian government in terms of HIV prevention consist in “[e]xpand[ing] [the] provision of comprehensive HIV Prevention for the general population, young people and vulnerable groups” (Kirungi 2009, p.7). This all-encompassing definition of “priorities” does not leave out a single imaginable intervention. The identification of “universal access to HIV prevention programmes” as the government’s “priority” in the field of HIV prevention (ibid., p. 8) admittedly pushes the very concept of ‘priority’ *ad absurdum*. More generally, this *de facto* absence of priorities is reflected in the way TACAIDS exercises its coordinating function. A multilateral agent describes a Global Fund preparatory meeting as follows:

I remember the first meeting to prepare the Round 8 proposal. The TACAIDS representative opened the meeting by saying: ‘We’re here, guys, to decide all together what we are going to do in Round 8...’. I said to myself: ‘No way, he didn’t say that?!’ But yes, he did! So the meeting turned into a fish market! [...] There is no strategic debate. In all the TNCM²⁶⁵ meetings I participated in, I *never* had the impression to see a strategic debate...although that is a place where such a debate *should* take place! (Multilateral-6)

Even though its official *raison d’être* is to lead and coordinate the national AIDS response, TACAIDS obviously has no strategic vision, not only for HIV prevention but for AIDS control in general. The Tanzanian AIDS administration’s lack of willingness to prioritise was also revealed during the formulation of the second NMSF discussed above. Concerned about the Framework’s lack of focus, several donors suggested that TACAIDS should submit the draft NMSF for comment to the World Bank’s AIDS Strategy & Action Plan (ASAP) service. Unsurprisingly, the ASAP report identified a clear lack of prioritisation of the Tanzanian Framework. A multilateral agent involved in the process remembers: “This report basically said, ‘Your NMSF is not evidence-based, not strategized, and not prioritised. What do you plan to do about that?’...but the Government didn’t respond” (Multilateral-6). After several unanswered requests,

²⁶⁵ The TNCM (Tanzania National Coordinating Mechanism) is Tanzania’s Global Fund Country Coordinating Mechanism. The TNCM was established in 2002 and restructured in 2005 in order to coordinate funding coming from sources beyond the Global Fund. The TNCM, whose secretariat is hosted by TACAIDS, is under the leadership of the Permanent Secretary of the Prime Minister’s Office. This mechanism is referred to as “CCM” in most other countries, a somewhat unfortunate abbreviation in the Tanzanian case, as the country’s ruling party *Chama cha Mapinduzi* (Party of the Revolution) has the same initials.

ASAP actually had to threaten to suspend their collaboration with the Tanzanian Government for TACAIDS to accept a 'compromise' consisting in the continuation of prioritisation discussions at the upcoming biannual AIDS review – an agreement that effectively allowed TACAIDS to elude the issue and entailed no meaningful additional prioritisation.

The composition effect of non-decision due to the number of donors involved is thus apparently accompanied by a more 'active' aversion of the Tanzanian AIDS administration to prioritise its policy papers. Where does this aversion stem from? The statement by a Tanzanian consultant involved in the formulation of the Prevention Strategy points to a possible explanation:

Prioritisation can only come in sequence: 1, 2, 3... But all we can say is: 'Here are the priority areas'. We can't say 'Start with PMTCT, then do VCT, etc....' No, we can't do that! You cannot sequence because this is not one single organisation! [...] Are we saying 'You should start with A, then B, then C...' or are we saying 'These are the most important drivers, so if you have money please put it *here*'? To me, that *is* prioritisation! And that is what this document does! You ask for it to be a cow? It's a cow already! [...] You can't say 'We start with this or that' or 'You should put the first cent on this, the second on that..', no! That only works if the government implements it all! [...] But here in Tanzania, there are 225 plus implementers! [...] It will be implemented by [Local Government Authorities], donors, NGOs... That's a very heterogeneous group! (Research-11)

A few minutes later, the same interviewee underlines "One problem is that all donors already have their own 5-year work plans!", adding, "they will continue their own work anyway..." (Research-11). The above-described agenda-setting power of the donors during the formulation process is thus a direct corollary of their decisive role in the highly fragmented implementation of the Strategy. Given this structure of implementation, one of the main goals of the Tanzanian Prevention Strategy thus becomes not the prioritisation of interventions but the non-contradiction with the various donors' operational plans. Several interviewees' spontaneous explanations are congruent on this point. A multilateral agent suggests:

I guess, TACAIDS doesn't want to close any doors to anybody. So they keep the policy [Prevention Strategy] as wide as possible. There is some prioritisation concerning the strategies that have been selected, but the different interventions mentioned to address these strategies are not prioritised. And I don't think that will change. (Multilateral-18)

Referring to the aforementioned "essential package" of prevention interventions, a bilateral agent involved in the process comments on the difficulty of convincing the Tanzanian AIDS administration not to inflate the number of 'priorities', and concludes: "Of course, if it was for TACAIDS, there would be over one hundred priority interventions! They would want to get *everything* on board!" (Bilateral-28). A multilateral agent confirms: "In the domain of HIV/AIDS, I have *never* seen *anybody* refuse *any* type of intervention..." (Multilateral-12). The leitmotif of 'consensus' seriously hampers any in-depth analysis of the contradictions that underlie prevention policymaking and that arise from the 'double heterogeneity' of public health objectives, on the one hand, and of the differing rationales of the various donor and government agencies involved in the process, on the other.

No doubt, as described above, the phenomenon of non-decision is in part due to a weak national administration which, overwhelmed by the number of participants in the policy negotiations, chooses the 'path of least resistance' by formulating an all-inclusive policy paper. Yet, part of the explanation for the Tanzanian AIDS administration's aversion to prioritise also stems from *strategic* non-decision. All too aware that the implementation of the Strategy is nearly exclusively donor-driven, TACAIDS considers that a genuine prioritisation of interventions would involve the risk of disqualifying certain donors' interventions as being 'outside the priority framework' – a political message considered as running counter to the maximisation of aid flows for HIV prevention.²⁶⁶ As a result, the actual prioritisation of interventions does not take place *ex ante*, through a collective policy debate over allocative trade-offs, but *ex post* via each donor's individual decision to fund one aspect or another of the nearly all-inclusive list of interventions called "Prevention Strategy". Interestingly, several interviewees acknowledge this matter of fact in a surprisingly explicitly manner. The above-quoted consultant, for instance, explains,

The Prevention Strategy can't be an instructive document saying: 'You should do this or that...'. That should come from those who are funding! We don't say what should come first! [...] In the group of DPs [development partners], for instance, each DP has his own domain: AMREF is doing youth, GTZ is doing PMTCT, etc....²⁶⁷ In that area, the choice of the activities you implement should be your own decision. (Research-11)

In a conciliating statement to her colleagues debating at a Prevention Technical Working Group meeting over the need to prioritise, one bilateral agent hits the nail on the head:

To be sure, one has to prioritise. But I have the feeling that, by saying which of the activities get funding each year, you will come up with a prioritisation quite naturally...

Rather than at the level of policy formulation, the effective locus of decision making is explicitly acknowledged to be situated at the level of the selective implementation of policies according to donors' funding decisions. As discussed below, this implicit acknowledgement of the Prevention Strategy's limited relevance for the prioritisation of HIV-prevention interventions poses a number of questions concerning its *raison d'être*.

Whether or not this non-decision strategy at the policy-making level actually pays off, or whether the anticipatory obedience this strategy in part results from is ultimately counter-productive, is a different issue. Indeed, and somewhat paradoxically, several donors voice harsh criticism of the Tanzanian government's overeagerness to comply with the donors' wishes. One bilateral agent contends:

The biggest challenge is having the Tanzanian government prioritise both across and within interventions. From there on, everything gets easier... Donors have a rational way to respond if there is a rational [national] prioritisation. (Bilateral-19)

²⁶⁶ There are, of course, a variety of motivations for the maximisation of donor funding flows and the reduction of HIV incidence is but one of them.

²⁶⁷ The division of labour among development partners is slightly more complex than this remark suggests.

Similarly, the country director of a large international NGO compares the attitude of the Tanzanian government to that of Ethiopian officials (the country he worked in previously), whose propensity to self-determination he remembers very positively. He deplores,

There is a strong tendency of the Government of Tanzania to say 'Yes' to anyone who turns up... That's very different from what I saw in Ethiopia: They regularly say 'No' to donors and tell them to fuck off. (INGO-4)²⁶⁸

The following anecdote reported by a former high-level Tanzanian AIDS official describing his long-standing working relationship with a senior bilateral agent illustrates that the Tanzanian AIDS administration's propensity to agree to everything donors propose might not always have the desired effect. The Tanzanian official remembers:

He's one of his own kind: honourable, dedicated... When he gives you his advice, you better take it and you better take it all! To tell you an anecdote, once I finally said "No" to one of his propositions. You should have seen him! He was dancing in my office shouting: 'At last! Finally you disagree on *something!*' (GovSector-4)

This apparent contradiction expresses the subtleness and the at times strikingly paradoxical nature of dependency relations and situations of political domination, in which the dominated play an active role.

Whether it is due to a lack of government capacity, to political calculation, or to a combination of both, there is no endogenously formulated HIV-prevention policy in Tanzania (and certainly no such thing as a 'Tanzanian' AIDS policy). While this is admittedly an open secret to all informed observers, the inexistence of an *endogenous strategy* has a variety of analytical implications. One obvious, very general, implication is that, in most cases, it makes no sense to analyse the exercise of power (or the effect of dependency) concerning the politics of AIDS in Africa by looking at donors' ability to influence or re-orientate the beneficiary country's national policy agenda, since no such 'initial' agenda pre-exists the donors' involvement. Put differently, international donors are not merely 'influencing' AIDS policy in Tanzania; they are *co-constitutive* of its very existence. Another analytical implication of the inexistence of a unified prevention strategy (whether endogenous or heteronomous) concerns the utility of the Tanzanian HIV Prevention Strategy itself. Indeed, the non-strategic nature of the document suggests that taking a closer look at its underlying political motives might be helpful. Since the Prevention Strategy's stated objective – or *manifest function* in Merton's (1949, chap.3) sense,²⁶⁹ i.e. to guide HIV prevention policy through a prioritised framework of action – is obviously not met, it becomes reasonable to analyse its potential *latent* functions. In other words: What might the Strategy be good for, if not for providing strategic guidance concerning HIV prevention? Developing upon this question, the next section argues that a key element of the Strategy's *raison d'être* is to provide a political framework that legitimises the

²⁶⁸ This interviewee works with one of the few NGOs who have independent financial resources allowing it to fund the interventions they consider appropriate (most larger NGOs being principally sub-contractors of large international donors, which gives them only a very limited political leeway). Nevertheless, their funding capacity – and thus their ability to push for certain interventions to be included in the Prevention Strategy – remains considerably lower than that of most public donors.

²⁶⁹ As Holmwood (2010, p.5) pertinently remarks, "Merton's terminology of latent and manifest *function* was unfortunate given that his concern was to distinguish between *latent function* and *manifest motive*. It encouraged critics in their view that sociological functionalism neglected agency, just when agency was being identified as a central concern." For an insightful discussion and empirical analysis of the concepts of manifest motive and latent function in development sociology, see: (Ferguson 1994)

pursuit of the donors' activities in the field of HIV prevention and thus the continued flow of international aid.

F) The ownership imperative: the Prevention Strategy as a tool for mutual legitimisation

“All partners felt that this [the Prevention Strategy] was a really important thing. After all, that's what we're all going to live by for the next five years!”
(Bilateral-27)

“Concerning prioritisation, at the end of the day, that [the Prevention Strategy] was a nice story that allowed some people to earn a lot of money and that's about all there is to it. Of course, it's good and important to have an adequate strategic plan, but still...”
(Bilateral-28)

These two statements illustrate that the policymakers' assessments of the utility of the Prevention Strategy differs at times radically. I asked all the interviewees who participated in the formulation of the Strategy to what extent they believed the document would become a useful tool for HIV-prevention policymaking in Tanzania. Some did expect the Strategy to have effects on the ground. “The prevention strategy will help the planners at all levels”, suggests, for instance, a Tanzanian programme officer (GovSector-10), while a multilateral agent declares:

I hope this document will be used during the next planning cycle, that LGAs [Local Government Authorities] and MDAs [ministries, departments, and agencies] will use it for planning...and for the Global Fund Round 9 proposal. (Multilateral-9)²⁷⁰

Interestingly, several interviewees who give a positive answer to the question of the Strategy's utility, do so with reference to its importance, not for policy implementation, but with respect to other components of the broader AIDS-related bureaucratic process. The chair of the PTWG, for instance, reminds its members at the beginning of a working group meeting:

Other milestones depend on this policy as an output. And the planning within the government process starts in October-November and it would be good if this policy could feed in there... So it's important to get it finished!

In a similar vein, a multilateral agent underlines:

Each sub-group of the [Joint Technical Working Group]²⁷¹ has to report on the milestones that are in the NMSF. There are two milestones on prevention. One is to come up with a prevention policy [...]. (Multilateral-18)

When asked if, beyond its bureaucratic utility, she expected the Prevention Strategy to have an impact on the *implementation* of actual HIV prevention policies, this interviewee replies:

²⁷⁰ This remark concerning the Global Fund is contradicted (and rightly so) by a bilateral agent who asserts: “The funding proposal process is very different from the policy formulation process. The Prevention Strategy, for instance, is not what is in the Global Fund Round 9 proposal!” (Bilateral-24) – a statement, which confirms the just-described disconnect between the AIDS policy process and the funding decisions.

²⁷¹ The Prevention Technical Working Group is a sub-group of the Joint Technical Working Group on HIV/AIDS, which is composed of policymakers from all sub-groups (e.g. care & treatment, enabling environment, impact mitigation, etc.).

That's the interesting issue! [...] I *hope* it will trickle down and be used. We'll see... It all depends on if the strategy is relevant for the people at these levels, and I hope it is. [...] I think it will have an impact. And the Strategy is very broad...everybody can get their wishes and activities in. (Multilateral-18)

This last assertion is somewhat paradoxical since the policy impact of a prevention strategy arguably depends on its *strategic* nature; its policy relevance is *a priori* inversely related to its inclusiveness. In any case, it is hard to see how a non-prioritised, nearly all-inclusive list of interventions could affect prevention policymaking. The response of a Tanzanian consultant to a question about the policy impact of the Strategy follows a similar reasoning: "Will the donors stick to the Strategy? Of course they will, because the whole process is donor driven!" (Research-11). The manner in which the two preceding interviewees confirm the expected utility of the Strategy paradoxically underlines its limited relevance. In sum, the donors are expected to 'comply' with a document that exerts no constraint on their ability to pursue their individual agendas, precisely because they have written it themselves.

As the two citations in the epigraph suggest, the interviewees' perceptions of the actual utility of the Strategy diverge considerably. Many consider the document's potential policy relevance as extremely limited – generally precisely because of its broadness. A programme manager within an international NGO remarks:

I doubt the Prevention Strategy will make a big difference. I doubt it for the simple reason that *everything* is in that strategy. [...] [I]t's not going to make a difference. I suspect the donors to say: 'I'm doing my piece, and my piece is in there, so I'll just go on with it...' (INGO-8)

A bilateral agent argues along very similar lines:

The Strategy can legitimise interventions we are doing. If it is in there, that means it's a priority. But then, if they include every strategy under the sun...! [...] I think a lot of donors will figure: 'What we are doing is aligned with it.' It's so broad that not many donors will find that they are outside the strategy! (Bilateral-24)

Interestingly, and in contrast to the above-quoted interviewees, who underline the procedural importance of the Prevention Strategy for the broader AIDS policy process, this interviewee continues:

We have focused so much on the Strategy...but there are other issues we would have to look at. For instance condoms! [...] That's exactly the type of issue that should be discussed, but we are focusing so much on process – on the Strategy – we don't address the *content*! (Bilateral-24)

Adopting a slightly more radical position, another bilateral agent denounces the formulation of AIDS policies in Tanzania as a purely administrative and largely self-referential process with little practical implications:

What I learned in Tanzania is that the whole process of policy formulation is quite an artificial issue. They formulate the NMSF, then the Essential Prevention Intervention Package and the Prevention Strategy, and not much changes on the ground... (Bilateral-28)

So why do policymakers put so much energy into the writing of a Prevention Strategy whose expected policy impact is at best limited? To be sure, given the fact that its low prioritisation is at least partially due to a composition effect, one could simply argue that the players have initially overestimated their

collective ability to come up with a genuinely prioritised policy document. This explanation is contradicted by the fact that many of the participants in the process quite correctly anticipated the lack of prioritisation of the final version of the Strategy – which is not surprising given their past experience of several failed prioritisation attempts during comparable policy processes (e.g. the NMSF or the Global Fund Round proposal negotiations). A look at one of the latent functions of the Strategy – the legitimisation of continued international aid – helps explain the considerable energy devoted to the formulation of a policy document whose capacity to provide strategic guidance is questioned by most of its co-authors.

Put simply, the political legitimacy of international ‘development assistance’ – or ‘cooperation’ as it is now labelled – is based on a narrative asserting that national policies are endogenously formulated by the beneficiary country’s government, and that international donors merely support the government in the pursuit of these policies. This brief ethnography of the formulation of the Prevention Strategy, backed by the simple fact that nearly 98% of the Tanzanian AIDS response is donor-funded (TACAIDS 2012b), exposes the rhetoric of ‘national ownership’ and ‘alignment’ as extremely remote from reality, if not as manifestly absurd. According to the OECD, “alignment” consists in “the provision of aid by donors in ways that respond to partner countries’ development priorities, supporting and using partner countries’ own systems and institutions” (OECD 2012, p.43).²⁷² Concerning AIDS control in Tanzania, the donors’ ‘alignment’ can only concern their alignment *to each others’ policies* (which the Paris Declaration describes as the “harmonization of donor practices”), not the donors’ alignment to any pre-existing ‘national’ AIDS control strategy. Nevertheless, the existence of a national strategy is a crucial prerequisite for the legitimacy of international action in the field of HIV prevention (as in many other domains). Indeed, AIDS policymaking involves fundamentally political decisions that condition the health, survival, and death of a significant proportion of the Tanzanian population. Today, many of the important decisions in this domain are taken by Western governments and by technical staff in the headquarters and country offices of the international donor agencies involved in the struggle against the epidemic (see Part 3). As discussed in Chapter 8, many AIDS policymakers themselves perceive this radical heteronomy and the obvious democratic deficit it entails as politically unacceptable, because incompatible with widely held and officially acclaimed conceptions of accountability and democratic legitimacy. This old problem of development assistance is twofold: the donor agencies’ lack of political accountability to the ‘beneficiaries’²⁷³ of their policies not only constitutes a problem for those governments from high-income countries, which draw their legitimacy on democratic principles; it also challenges the authority of the Tanzanian Government. Indeed, in order to uphold its political legitimacy, the Government cannot but assert that it is at the origin of HIV-prevention policies implemented on the

²⁷² The concept of alignment draws on the 2005 Paris Declaration on Aid Effectiveness and the 2008 Accra Agenda for Action (OECD 2008). Having been conceived as an independent, parallel programme (see Chapter 6), PEPFAR, for instance, is a blatant violation of both the Paris and the Accra declarations.

²⁷³ In the case of HIV/AIDS, the ‘beneficiaries’ of course include ART patients, but encompass the population as a whole.

Tanzanian territory and that it is therefore fully accountable to Tanzanian citizens with respect to the decisions these policies involve.

In this context, and far from being a fool's bargain, the Tanzanian HIV Prevention Strategy provides the formal 'proof' that the Tanzanian government is 'in the driver's seat' – an expression repeatedly used by many interviewees – and that donors merely 'support' one or another aspect of this *Tanzanian* strategy. The extremely broad and non-strategic nature of the Strategy is not an obstacle in this respect, as this mutually legitimising role of the document is independent from its actual relevance for policymaking. Put differently, the latent function of the Strategy is independent from its manifest motive.²⁷⁴ In a process driven by what could be described as 'blind mutual benevolence', both donors and Tanzanian officials close their eyes to the Strategy's lack of focus. This document allows the Tanzanian government ostensibly to put up its ownership of the response while at the same time enabling donor agencies to pursue their activities legitimately by asserting that they are aligned with the 'National Strategy' – regardless of the fact that they have written it themselves.

Several other AIDS-related national policy documents serve a similar latent function of mutual political legitimisation between donors and the Tanzanian government. In this sense, a former high-level TACAIDS official can point to the National Multi-sectoral Strategic Framework and assert: "Yes, TACAIDS *did* manage to play its coordinating role. We got the donors to sign the NMSF and they followed it!" (GovSector-4). Just as the Prevention Strategy, the NMSF provides a formal framework that legitimises the various policy protagonists' activities. The fact that the donors not only 'signed' but 'wrote' the NMSF and that, given its inclusiveness, the Framework is not a very burdensome document with which to comply detracts nothing from its legitimating function. Understandably, especially some of the more senior interviewees make active use of the official narrative, at times repeating the 'ownership-alignment' discourse in an incantatory manner. Some Tanzanian officials reacted very strongly when asked if certain donors were 'pushing' for specific issues. One categorically refused the very idea that policy formulation processes involved the exercise of power and underlined: "Nobody is *pushing* for anything here... We don't have the room for anyone to push for something!" (GovSector-6).²⁷⁵ Similarly, a bilateral agent maintains the official 'ownership' and 'evidence-based policy' discourse:

TACAIDS is taking a strong leadership on the upcoming National Prevention Strategy. We agree with the Government. The DPs don't have to push any particular agenda. The state-of-the-art international literature

²⁷⁴ In a sense, the resource mobilisation element of the Strategy is not completely latent, as several policymakers openly express that they expect the Strategy to help mobilise additional resources for HIV prevention. That being said, the reasoning consists in the idea that resources are mobilised by "convincing" donors through evidence-informed prioritisation – a criteria the Tanzanian HIV Prevention Strategy does not fulfil.

²⁷⁵ The following statement by a former Tanzanian AIDS official also illustrates the 'ownership' narrative. Recalling the massive arrival of US and World Bank funding during the early 2000s, he states: "We had a meeting between TACAIDS and the DPG-AIDS [Development Partner Group]. The donors voiced fear about the Americans and [the World Bank's] T-MAP, saying: 'It looks like we're being sidelined...the Americans will call the tune now'. Then I stood up and said straightforward: 'This will be a *Tanzanian*-led programme! It's not going to be US-owned!' [...] During my time at TACAIDS, I made sure I would take a strong stand, otherwise the donors would move you around!" (GovSector-15)

underlines the need to focus on high-risk groups, such as IDUs, commercial sex workers, mobility out of school youth, etc.

...before contradicting herself a few sentences later, by asserting:

We will continue to push for more prioritisation and for a focus on ‘cultural norms’ such as sex outside marriage, ‘zero grazing’, etc.. [...] The [Government of Tanzania] has become much more open over the last years. (Bilateral-12)

While some carefully stick to the official discourse, many interviewees are actually quite vocal about the political ‘ownership masquerade’ in which they are at times compelled to participate. The following anecdote illustrates just how artificial the ‘ownership’ rhetoric can be. During an informal discussion, a bilateral agent involved in the writing of an HIV-prevention document refers to it as “my” policy paper. When prompted about the formulation, she instantly replies: “No...of course it’s *TACAIDS*’ policy paper”, before explaining:

I just applied for a job at UNAIDS and they asked me to send in a policy paper that I had written myself. I have worked on a lot of policy documents over the last years, but hardly any of them has my name under it! Of course, we frequently worked on them as a team, with different people feeding in comments, but even those papers that I have written more or less myself are generally published in the name of *TACAIDS*! (Bilateral-28)

This is obviously not an isolated case.

Similarly, some donors are surprisingly critical about their own activities and the anti-emancipatory effects of aid dependency (see Chapter 8). Interestingly, some interviewees’ discourse changed perceptibly throughout the interview, becoming increasingly critical as they gained confidence. With some, this tension between their institution’s official discourse and their personal appreciations of the situation led to an at times perplexing superposition of both the ownership and the dependency narratives. Far from being purely anecdotal, this ‘patchwork discourse’ also stems from the fact that the ownership rhetoric is not exclusively a legitimising discourse that policy players repeat against better knowledge; it is also a programmatic, intentionally teleological and optimistic narrative. As one bilateral agent wonders,

Why doesn’t the Tanzanian government show more ownership of their response? That’s what we try to do...*honestly*. [...] We *want* the government to have more of a say on where the PEPFAR money is going...and then report to *them*. [...] It’s kind of a new thing...but had *TACAIDS* been stronger, this would probably have happened earlier. (Bilateral-24)

Interestingly, it is not always easy to distinguish standard official ownership discourse from implicitly critical statements that, if taken at face value, would be utterly misunderstood. When asked about her opinion concerning the degree of prioritisation of the draft Prevention Strategy, the representative of one of the US agencies involved in AIDS control, for instance, responds: “Concerning prioritisation, that’s a question for the government of Tanzania...I mean, it’s *their* document!” (Bilateral-19). One could, of course, consider this statement as an artificially naïve legitimising discourse on behalf of a bilateral agent whose agency has decisively influenced the Strategy. Yet, the way this phrase was pronounced suggests

that it probably means something like: 'It *should* be their document...but it is not'. It is a cry from the heart deploring the Tanzanian government's lack of ownership rather than an assertion that this ownership is a reality.

In sum, several interviewees express a sincere desire for the Prevention Strategy (and other elements of the response) to be owned by TACAIDS and the Tanzanian government in general. Beyond its legitimising function, and far from being a purely cynical element of power, the ownership discourse can arguably also convey a regret that national leadership is not stronger and an implicit but genuine appeal for change.²⁷⁶

Sub-conclusion) On vendor's trays, shopping lists, and kitchen sinks: a depoliticisation by juxtaposition?

Be it a 'vendor's tray', a 'shopping list', a 'kitchen sink' or a 'grab bag', the interviewees use a variety of figurative expressions to describe what they consider as a structural weakness of Tanzanian AIDS policies: namely their over-inclusiveness and their ensuing lack of focus. Although this assessment is manifestly correct, the fact that the donors are among the most vocal players to deplore this situation is fundamentally ambiguous. Indeed, while virtually all donors complain about the weakness of government leadership, Tanzania is among the world's most popular countries among AIDS donors – which is in part due to the fact that they are given a free hand to conduct the interventions they want. So while donor agencies would certainly like a more focused national strategy, most would prefer one that focuses on the issues *they* deem most important (see also Chap. 3). It is the old problem of everybody wanting coordination but nobody wanting to be coordinated.

Beyond its obvious capacity deficiencies, the Tanzanian government is well-aware of the fact that Tanzania's success in attracting this particular type of foreign investment is also due to its 'investor friendliness'. Such an investor-friendly environment appears to be composed of two elements: a discursive assertion of the importance of prioritisation illustrated by the existence of a National Strategy, and a *de facto* permissive attitude towards individual organisations and government agencies willing to 'do business' in the AIDS field. If this (slightly overstated) reading is at least partially correct and the Tanzanian government does consider a certain degree of indetermination to be politically beneficial, the lack of prioritisation is due to the policy process itself and to the constellation of players, rather than to a mere lack of capacity. Politically naive capacity-building approaches might thus be not only insufficient but inappropriate to ensure genuine government 'ownership', increased prioritisation and effective coordination.

²⁷⁶ That being said, the truthfulness of PEPFAR's recent conversion to national ownership is all the more likely as US AIDS agencies are obviously afraid to be permanently burdened with the responsibility to ensure continued treatment for those patients enrolled in US-initiated ART programmes (see Chapter 5).

Analytically speaking, this political economy perspective encourages going beyond a purely evaluative 'lack of leadership' framework in order to observe the politics of HIV prevention as it is being formulated by myriad players with differing preferences and political imperatives. This perspective allows the description of the Prevention Strategy as a bureaucratic device that, by its mere existence, renders compatible some of these institutional players' formal requirements related to legitimacy, accountability, and attributability. By endorsing the formulation of inventorial 'strategy' papers – by 'deciding not to decide' – the Tanzanian administration brings about what would be described as a 'depoliticisation by juxtaposition'. If decisions over the priorities and necessary compromises within a country's AIDS-control programme are considered a legitimate subject of political controversy, intentionally leaving the definition of these priorities up to foreign institutions who are willing to pay for their selective implementation but who are politically unaccountable to the Tanzanian people can be considered an act of depoliticisation. By analysing some political underpinnings of the widespread "universal access" discourse, the next chapter explores another facet of the political economy of non-decision that underlies AIDS policymaking in Tanzania.

Chapter 5) The politics of triage: ‘universal access’ as a political sham?

“Unequal access to HIV/AIDS treatment is likely to become a source of conflict in some societies, and may already be becoming so.”
(de Waal 2003a, p.245)

“As I worked to provide treatment for AIDS in Africa [...] I was gnawed by the awareness that while [HIV treatment] efforts saved lives, they did so in ways that were selective. Not all lives had the same value. I observed how attempts by international and local organizations seeking to respond to the epidemic on humanitarian grounds unwittingly sorted those who should live from those who should go without treatment. This paradox is what I call *triage*.”
(Nguyen 2010, p.5-6)

No doubt, the substantial increase in international funding has allowed an unprecedented number of people in sub-Saharan Africa to start antiretroviral therapy. This has saved and transformed millions of lives and contributes to a spectacular improvement of life expectancy at birth in several African countries (Karim 2012).²⁷⁷ In Tanzania alone, the number of HIV-infected people on treatment has risen from fewer than 5,000 in 2004 to approximately 275,000 in 2011 (CDC 2012).²⁷⁸ Since 2009, however, the financial resources for HIV/AIDS in Africa levelled off and the ongoing global economic crisis, for the first time in over a decade, has provoked a decrease in global AIDS funding (UNAIDS 2012a; Kates et al. 2011; Moatti & Eboko 2010). In Tanzania, the overwhelming majority of the interviewees expect international funding for HIV/AIDS to be *at best* stable in the years to come and even UNAIDS’s (2012a) most optimistic scenario of African domestic contributions to AIDS control falls far short of the estimated needs.²⁷⁹

Just a few years before the beginning of massive treatment roll-out in most sub-Saharan countries, Cheek (2001) proposed an analysis of the political risks related to the rationing of antiretroviral treatment in Southern Africa. Acknowledging that “no Southern African nation currently possesses the economic resources or the health care infrastructure to effectively administer existing HIV treatment to all those who need it”, he outlined possibly dramatic political implications of the ensuing inequalities in access to ART:

It seems certain that the future of HIV treatment in Southern Africa will see a small pool of ‘haves’ among a vast ocean of ‘have-nots’. This division into ‘haves’ and ‘have-nots’, based on income and access to health care, has the potential to polarise society and exacerbate already existing schisms based on income distribution and access to basic human services. [...] Certainly, as some regain their health under HAART while others deteriorate and die, based solely on the vagaries of poverty and urbanisation, social class conflict is certain to erupt. [...] After all, to be denied access to treatment is the same as a death sentence. If

²⁷⁷ Life expectancy at birth in Tanzania increased from 51 to 55 years between 2000 and 2009 (Karim 2012). It seems, however, mistaken to attribute this increase to ART alone. Significant decreases in infant mortality due to improved obstetric care, child health services, nutrition, and sanitation may be just as (if not more) important in the increase of life expectancy at birth.

²⁷⁸ See below for a critical appraisal of these numbers.

²⁷⁹ In 2009, the most-quoted reasons for this prediction were the global economic crisis, the perception that AIDS was sliding off the international development agenda, and a more general feeling of *aid fatigue* among the main donors. The “Robin Hood Tax” on financial transactions was not part of the interviewees’ expectations – and it remains unlikely that the share of this tax levy that would be channelled to AIDS control would be sufficient to cover the needs.

some are to be spared while others condemned, special attention must be given to the criteria for access, as well as public perceptions of discrimination. (Cheek 2001)

The failure to do so, he argued, “could result in widespread violence and state failure”, which could “threat[en] neighbouring states and the entire region with civil violence”. While this paper illustrates the apocalyptic penchant of much of the post-9/11 AIDS-and-security literature, these exaggerated alerts have undoubtedly contributed to the massive mobilisation of international funding for treatment roll-out. That being said, the fears voiced are not *a priori* absurd. Nguyen, for instance, describes this potential for conflict in a less alarming but similarly straightforward manner: “Triage is corrosive to social ties”, he writes, “[i]t introduces mechanisms of selection that inadvertently pit people against one another” (2010, p.177). Indeed, although the massive scale-up of ART programmes has contributed to defusing the situation by increasing the number of ‘haves’ and decreasing that of the ‘have-nots’, decisions about who lives and who dies continue to underlie much of AIDS policymaking in sub-Saharan Africa. Roughly half of the people in need of ART in sub-Saharan Africa still do not have access to antiretroviral drugs, and in most African countries – Botswana, Rwanda, Namibia, and South Africa excepted – ‘universal access to treatment’ remains a distant mirage. In Tanzania, only about 40% of the roughly 660,000 people considered to be in need of ART actually received treatment in 2011 (CDC 2012) – if one believes the optimistic estimates provided by the US government (see below). In any case, HIV-related rationing choices continue to be politically sensitive and the challenges of *triage* remain as intricate as ever.

Triage, Nguyen writes, “describe[s] procedures for prioritizing those who must receive medical care immediately over those who may wait” (2010, p.10).²⁸⁰ Triage is a multi-scale process that results from a variety of implicit and explicit rationing decisions at different levels.²⁸¹ As Mechanic (1997, p.84) rightly underlines, “[m]ost of the ways in which we ration care are invisible, obscured by cultural assumptions, political understandings, and economic realities”. The geographic distribution of health facilities, for instance, obviously translates broader political power relations and inevitably entails a rationing of health care. Concerning HIV/AIDS, the more specific variants of triage range from the formulation of (inter)national treatment or prevention guidelines to a doctor’s decision (not) to enrol an individual patient in an ART programme. The process is considered to be *explicit* when both the rationing decisions and the underlying rationales are openly expressed (and debated); is it *implicit* when neither the decisions to limit access to services, nor the reasoning behind those decisions are clearly expressed or

²⁸⁰ “While triage was initially developed on the battlefield to sort out soldiers who could be treated and return to combat from those who could not, it is an everyday facet of medical practice in emergency rooms, where nurses prioritize patients for care based on the severity of their condition. In its original conception, triage is a calculation that seeks to optimize the use of scarce resources to preserve combat-ready manpower rather than to save lives. In its everyday, civilian use, triage seeks to allocate medical care to those who need it most urgently in order to save lives [...]. In medicine, then, triage can be deployed to different ends, based on criteria that value life differently” (Nguyen 2010a, p.10).

²⁸¹ As Rosen et al. (2005b) put it: “International funding agencies have already begun to express their priorities through the amounts and conditions of their grants. Ministries of health will set policies that reflect national priorities, followed by district and local departments of health. Even individual health care workers, such as nurses at clinics where antiretroviral drugs are available but scarce, will be forced to ration access to patients who meet the clinic’s or their own criteria”.

discussed.²⁸² Irrespective of their degree of explicitness, triage decisions “involve struggles over resources and power” (Nguyen 2010, p.175) at every step of the way. While Nguyen’s analysis primarily (though not exclusively) focuses on the ‘micro-politics’ of triage via individual strategies and decisions at the service-delivery level, this chapter explores the ‘macro-politics’ of HIV-related rationing processes in Tanzania.

Importantly, the stagnation or decline of resources for AIDS control in Africa affects the political nature of triage itself. Indeed, the meaning of triage differs radically between a context where those who do not qualify for immediate access to ART can be consoled with a credible promise for future access and one where universal access is no longer a plausible perspective because of severe funding shortages. The distinction of those who receive treatment immediately over those who may ‘wait’ has manifestly turned into the distinction of those who may live over those who must die. Beyond its health consequences, this situation puts an end to the short- and medium-term credibility of the “universal access” discourse of national and international AIDS officials. This discourse, however, has a major political advantage: by promising universal access in a foreseeable future, it allows decision-makers to refrain from explicitly excluding anybody from access to HIV services (most prominently ART) – an unpopular and thus politically risky decision. The discretionary and largely implicit management of decisions concerning access to treatment within the ‘closed shop’ of donor-government negotiations could lose its political acceptability in a context where the *non-universal* nature of treatment roll-out is obvious. The only slightly declining incidence and the increasingly chronic nature of HIV infection turn HIV/AIDS-related rationing processes into a central issue in Tanzanian politics. Through the “dispensation of life and death” (Comaroff 2007, p.214) they invariably decide upon, AIDS policymakers directly participate in a permanent and unusually literal exercise of biopolitical government (Foucault 2004; 2009). “[I]n the end”, Nguyen rightly underlines, “it is finally about who lives and who dies and how these decisions are made” (2010, p. 175-6).

Developing upon the inescapable trade-offs involved in the treatment and prevention of HIV in Tanzania, this chapter looks at how national-level AIDS policymakers deal with the permanent Sophie’s choice²⁸³ imposed upon them by the insufficiency of resources. It argues that the coexistence of two partially incompatible conceptions among policy players about how to deal best with scarcity fuels a taboo concerning the impossibility to ‘do it all’. Since the decision not to fund certain interventions is perceived as politically risky, AIDS policymakers adopt what can be described as a *non-decision strategy*: ignoring

²⁸² This definition slightly differs from that proposed by Mechanic, who considers that “[e]xplicit rationing refers to decisions made by an administrative authority as to the amounts and types of resources to be made available, eligible populations, and specific rules for allocation”, while “[i]mplicit rationing [...] refers to discretionary decisions made by managers, professionals, and other health personnel” (1997, p.83-4, emphasis added) – which amounts to confounding the *level* of rationing decisions with their nature (implicit or explicit) and excludes the existence of implicit rationing processes at the policy (or ‘administrative authority’) level.

²⁸³ A “Sophie’s choice” describes the choice between two persons that will result in the death of the person not chosen. The expression refers to the 1979 book of the same title by William Styron, in which a mother has to decide which of her children will die.

the existence of scarcity, they continue to pursue “universal access” as an explicit policy goal. Far from making the need to choose disappear, this strategy leads to implicit rationing decisions, which several of the players themselves consider as unsatisfactory and democratically problematic. In this context, to what extent can the “universal access” discourse be considered as a cover-up slogan to avoid the politicisation of unpopular but inevitable choices in the formulation of AIDS-control policies in severely resource-constrained settings? In this analytical perspective, the following three sections successively depict the *de facto* impossibility to provide “universal access” to HIV-treatment and -prevention services in Tanzania, discuss their differing reactions when confronted with inescapable choice, and explore the political rationales that underlie what appears to be a non-decision strategy.

A) An elephant in the room: the infeasibility of universal access in Tanzania

“Most countries will have to revise their political commitment towards universal access to ARVs. And the UN will have to do the same. In Tanzania, universal access to care and treatment alone would require about 1.2 billion dollars a year. It is very unlikely that that envelope will ever exist! I have no idea how they will go about it, but that debate will have to take place. Politically, this debate is not possible yet, but the question will come up very soon...”
(Bilateral-12)

Notwithstanding the impression of abundance in the ‘years of plenty’, when international AIDS funding increased over tenfold in just a few years’ time, all AIDS players in Tanzania acknowledge that financial and human resources remain utterly insufficient to implement all prevention and treatment targets. As a multilateral agent says, “We are far away from the UNAIDS goal of ‘universal access’ to prevention” (Multilateral-16). The impossibility to attain the national policy targets becomes immediately obvious when one confronts the above-mentioned costing of the NMSF with the resources available to achieve these goals. While the ‘funding gap’ of the 5-year 2008-2012 NMSF was roughly estimated at about 70% in 2009 (\approx USD 2.5 billion of funding for a need of USD 8 billion), this estimate seems even more optimistic as time passes, given the currently declining trend of AIDS funding in Tanzania (TACAIDS 2012b). In the foreseeable future, the international AIDS agencies’ explicit policy goal – “universal access to HIV treatment, prevention and care” – definitely remains a forlorn hope in Tanzania.

When spontaneously addressing the insufficiency of resources, most interviewees do not refer to prevention or impact-mitigation interventions, but to treatment programmes – a domain where the funding gap is seen as politically more problematic. One bilateral agent underlines:

Treatment is a hot issue: We still have x million dollars to treat, but that money is limited. People always say ‘scale up, scale up!’ But if we can no longer scale up, then who should we be prioritizing?! And who fills the gaps?! [...] If we have flattening resources, we want the government to have a realistic view of the gaps. They will have to take decisions... (Bilateral-24)

Arguing along similar lines, another bilateral agent points out:

The first challenge is funding, the sustainability of treatment...and coming to terms with not meeting the universal access targets. [...] I don’t think universal access to treatment is happening: Tanzania has a fairly low prevalence, but it’s a large country! (Bilateral-29)

This conclusion, he argues, is compounded by the non-linear nature of progress in treatment roll-out:

Concerning treatment, we have reached a breaking point. We have reached the low-hanging fruit...the easy-to-reach population. But every additional person to treat will be more difficult to reach. (Bilateral-29)

An interviewee from a US donor agency sums up the situation as follows:

At PEPFAR, we anticipate a flat budget in the years to come. So that puts limits to what we can take on. [...] We haven't had a lot of discussion in Tanzania about trade-offs, but I think they are coming. There are not enough resources! (Bilateral-19)

Although most interviewees rather openly acknowledge the insufficiency of funding, they hardly ever raise the question of the actual trade-offs this situation imposes. Indeed, a striking feature of both national and international policy documents and most interviewees' discourses consists in the concomitant but contradictory assertions that resources are insufficient to 'do it all' *and* that universal access remains the explicit policy goal. The following two sub-sections successively analyse the ambiguity of the concept of "universal access", and describe some of the difficult trade-offs its non-attainment involves.

A-1) Public health goal or advocacy slogan: what does 'universal access' mean anyway?

Since 2006, HIV/AIDS is the first – and, as of now, the only – disease for which the United Nations specifically declared the goal to be universal access to treatment. Although it apparently simple, it remains unclear what the oft-repeated goal of "universal access to treatment, prevention and care" actually means. Concerning antiretroviral treatment, the definition of – and monitoring of progress towards – "universal access" is based on the percentage of people in need of treatment who effectively access it. This percentage varies according to the medical definition of a person 'in need of ART' – a definition based on people's CD-4 count, an indicator of their immunological capacity (the lower the CD-4 count, the weaker the immune system). Since early antiretroviral treatment prolongs the life expectancy of people living with HIV, this threshold is somewhat artificial. Today, after a long period of double standards between high- and low-income countries, the WHO considers that Africans (just as anyone else) are in need of ART once their CD-4 lymphocyte count has dropped below 350 per mm³ of blood (and not 200, as before).²⁸⁴ As soon as it was adopted in 2010, this new standard arithmetically lowered countries' progress rates towards universal access to treatment by increasing the number of people 'in need of ART'.

The fact that in Tanzania (as in most other African countries) the estimate of the total number of people on ART is based on a cumulative addition of everybody *ever* enrolled in an antiretroviral treatment programme – a method that allows for double counting and abstracts from dropouts due to low

²⁸⁴ In a country adopting a 'test-and-treat' approach (i.e. every person tested HIV positive and willing to receive ART is immediately put on treatment), the number of people 'in need of ART' thus equals the number of people living with HIV.

adherence or death – illustrates the deeply political nature of these estimates. A bilateral agent points to this fact by saying:

The numbers of ‘people on treatment’ are not real. [...] These figures include people who have already died and people who are still alive, but are not on treatment anymore. They just use that figure because it’s the least inaccurate one. And vertical programmes have a tendency to over report. (Bilateral-26)

A multilateral agent puts things slightly less diplomatically:

In Tanzania, there is very poor adherence monitoring! One can even wonder if it isn’t deliberate... The only data they have is ‘How many people have ever been put on treatment?’. That’s cumulative numbers! And the few existing cohort studies show that the adherence after one year is somewhere around 70%!²⁸⁵ Most of them are marked as ‘lost to follow-up’ – but there is no system to follow up! [...] Who has the cohorts? There is no routine data collection! (Multilateral-12)

When asked about the possible causes of such poor reporting, this interviewee replies:

The Global Fund and PEPFAR are obsessed with targets. So they take cumulative numbers as indicators. They count all people for whom, one time, they have ticked a box: that makes for high numbers! Adherence is never an indicator. They don’t report on adherence within the universal access monitoring criteria. (Multilateral-12)

While this aspect is increasingly criticised – and progressively taken into account by the main players involved in treatment roll-out²⁸⁶ – another, less-frequently mentioned but just as significant aspect of the way AIDS programmes report on their treatment targets concerns the measure chosen: although the idea to report on the proportion of people in need of treatment who have access to it seems rather intuitive, it entails a fundamental bias. Once initiated, antiretroviral treatment is supposed to be life-long. As a result, and since ART is highly effective, those people who initiate treatment generally stay alive – and thus stay on ART. The average life expectancy of untreated HIV-positive people considered as being in need of ART according to the 350 CD-4 count criteria, in turn, is considerably lower – varying between about 3 years for people close to the 350 mark (Freedberg et al. 2007) to a couple of months or weeks for people with very low CD-4 counts. This difference in life expectancy has an immediate arithmetic effect: those people who do not access treatment will die within a rather short period of time – and thus drop out of the category of people ‘in need of ART’. Even apparently encouraging figures of treatment roll-out can thus hide very high mortality rates because of the important ‘turn over’ in the group of untreated people in need of ART. Just as cumulative counting, the very indicator that treatment programmes choose to measure makes the situation look better than it is. In a country such as Tanzania, where antiretroviral treatment reaches roughly 40% of the population ‘in need’, and in the absence of increased resources or considerable efficiency gains (which seem unlikely by now), the chances of a person *newly* diagnosed with HIV to access treatment are far below 40% as most treatment slots are ‘occupied’ by people under treatment who stay alive. In other words, in a country where treatment roll-

²⁸⁵ In 2009, the proportion of HIV positive adults and children known to be on ARV drugs one year after initiating therapy was actually as low as 64.5% (URT 2010, p.7) – an alarming figure, to say the least.

²⁸⁶ This interviewee comments on this evolution as follows: “Now, they are training people for cohort follow-up...but that’s very simple: you don’t need training for that! It’s only about what percentage of those who came last month, came back this month!” (Multilateral-12)

out is reported to be at 40% (of “universal access”), the proportion of people in need of ART who will actually access the drugs before they die is much lower. The use of an indicator such as ‘the proportion of people newly diagnosed as being in need of ART, who can reasonably expect to get access to treatment before it’s too late’ would provide a strikingly less optimistic picture of the current situation.²⁸⁷

Despite these subtleties in its evolving definition and monitoring, the meaning of “universal access to treatment” is reasonably clear to most AIDS players. The same cannot be said of “universal access to prevention”. Indeed, several interviewees explicitly question the pertinence of the concept of universal access in the field of HIV prevention. “What does it mean to ‘go to scale’?”, questions a bilateral agent, “especially in prevention, that’s not clear at all!” (Bilateral-24). Another interviewee is more sceptical yet:

Nobody knows what universal access to prevention means! There are different populations and different interventions. ‘Universal access to prevention’ doesn’t make sense. It was just introduced to have a balance with ‘universal access to treatment’...and it sounded nice. That was a very noble goal... (Bilateral-29)

Indeed, given the number and complex interaction between the various drivers and different modes of HIV transmission, given the disconcerting variety of ‘at-risk’ populations considered as potential beneficiaries of HIV prevention²⁸⁸, and given the myriad behavioural and medical prevention interventions, as well as the virtually unlimited number of structural measures that can be taken to prevent the transmission of HIV, the very concept of “universal access to prevention” – even if not crudely defined as *everything for everybody* – makes no sense in generalised HIV epidemics. As a result, as far as prevention is concerned, some interviewees consider the notion rather as a political slogan than as a concept with any policy-relevance whatsoever. A Tanzanian official prosaically remarks: “The people who are coming up with these strategies of ‘universal access’ or whatever it is are not the same as those who are financing...” (GovSector-14).²⁸⁹ That being said, as discussed below, quite a few players do consider universal access – not only to treatment, but also to prevention – as a politically operational concept and an explicit policy goal. Before addressing the way policymakers respond to this situation, the next sub-section briefly discusses some of the actual trade-offs involved in the management of *de facto* non-universal access in severely resource-constrained AIDS programmes.

²⁸⁷ Stefano Bertozzi made this point quite convincingly at the IAEN Pre-Conference Symposium to the International AIDS Conference in Washington in July 2012.

²⁸⁸ Some of the most frequently mentioned ‘at-risk populations’ in HIV prevention programmes include MSM, IDUs, sex-workers, truck drivers, uncircumcised men, migrant workers, HIV-negative people in sero-discordant couples, pregnant women, and ‘youth’ – itself frequently sub-divided into sub-categories such as ‘adolescent girls’ or ‘out-of-school youth’. The oft-omitted drivers of HIV transmission described in Chapter 1 suggest that additional ‘target populations’ could include a variety of other groups such as the users of formal and informal health care, malaria and TB patients, people with intestinal worms or adults who, as children, used to wash clothes, bathe or swim in schistosome-infested waters (see: Stillwaggon 2006, p.57). This non-exhaustive list illustrates the irrelevance of the concept of “universal access to prevention” in generalised epidemics.

²⁸⁹ Indeed, UNAIDS actively championed the idea of “universal access”, and its underlying principle of non-discrimination is a core element of the United Nation’s Universal Declaration of Human Rights. Yet, the UN’s HIV-related funding capacities are negligible if compared to those of the Global Fund or PEPFAR.

A-2) On dilemmas and trade-offs: the ‘tough choices’ in AIDS policymaking in Tanzania

“Governments in the region will inevitably be faced with the difficult prospect of deciding which of its citizens will live and which will die.”
(Cheek 2001)

“We have to be realistic...and that implies tough choices.”
(Multilateral-9)

As the number of effective interventions to prevent and treat HIV infection increases, the list of allocative choices to be made by AIDS policymakers grows longer and longer. One key question in Tanzania – namely, how much should be spent on AIDS control as compared to other (health) issues – is strongly influenced by decisions taken at the international level. The Tanzanian response to the epidemic being nearly entirely donor financed, this decision is clearly beyond the jurisdiction of AIDS policymakers’ in Tanzania, be they Tanzanian officials or Tanzania-based staff of international NGOs or donor agencies. While questions concerning such cross-sectoral trade-offs remain highly relevant (see Part 3), this sub-section briefly sketches some of the trade-offs *within* the field of HIV/AIDS. The difficult compromises among HIV-prevention interventions and the vivid debates to which these choices give rise have been extensively discussed in the preceding chapters. The numerous trade-offs between different interventions, focus populations, and regions which are necessary to formulate an HIV-prevention strategy, as I argue above, are inherently political since they imply the prioritisation of incompatible interests and incommensurable values (see also: Hunsmann 2012b; and Parkhurst 2012b). Completing this discussion about the political nature of decisions relating to AIDS policymaking, the next two sub-sections briefly discuss the trade-offs involved in the formulation of HIV-*treatment* policies, as well as the much-debated question of a trade-off between HIV prevention and treatment.

A-2-1) Allocative trade-offs in treatment programming

“In its early and untamed form [...] [triage] was unnoticed because it was ignored: it raised too many uncomfortable questions. As triage becomes institutionalized, it remains largely invisible because we only count those who are saved [...]”
(Nguyen 2010, p.176)

As mentioned, the most obviously problematic issues that come to mind when confronted with the need to ration access to HIV-related services concern the allocative decisions *within* treatment programmes.²⁹⁰ Given the impossibility to provide every Tanzanian in need of ART with the highest standard of treatment and care, policymakers inevitably need to take rationing decisions that, in one way or another, answer the question of ‘Who gets access, and to what?’. The allocative decisions that underlie the management of *non*-universal access thus concern both the selection of populations to be granted priority access to treatment and the quality and comprehensiveness of the care and treatment programme itself. A bilateral agent formulates the first question quite straightforwardly:

²⁹⁰ Rosen et al. (2005b) propose a useful overview of how access to ART can be (and is) rationed, both via explicit criteria and implicit processes.

Currently, there are discussions at the global level about how many additional people we can afford to put on treatment. There are discussions at the global and country levels... And then there is the question of 'Who should that be?'... (Bilateral-24)

In Tanzania, a first selection was based on the availability of health infrastructures sufficiently equipped and trained to deliver antiretroviral treatment. The Tanzanian decision to start treatment roll-out in the better-equipped hospitals results from a prioritisation of efficiency over equity. As a WHO report on the roll-out of ART treatment in Tanzania points out,

Efficiency and equity are competing principles in deciding on site selection of ART centres. Those who consider *efficiency* the main concern argue that scaling up should start in urban tertiary facilities, where infrastructure, equipment and trained personnel already exist and where larger numbers of eligible patients can be reached quickly. Those concerned primarily with *equity* argue that the rural and traditionally underserved populations should have access from the programme's outset, and that the existing inequities should be remedied rather than exacerbated by the scale-up. (WHO 2006, p.11)

The Tanzanian decision initially induced a heavy urban bias in people's chances to access ART. Possibly because of the rural-urban divide in virtually all health services in Tanzania, the implicit decision to favour efficiency was fairly uncontroversial – which, of course, does not reduce the obvious inequity it entails. Five years into the Tanzanian ART roll-out, an international NGO worker draws a provisional balance:

We have only managed to cover people in the 6 or 7 major cities of the country: Dar, Arusha, Moshi, Morogoro, Dodoma, Mwanza, Mbeya...that's it! We are far from treating everybody who needs it. (INGO-5)²⁹¹

More fundamentally, the initially crucial question of how rapidly ART should be rolled out in Africa,²⁹² involves the prioritisation of different aspects of population health and has led to a confrontation among players concerning the adequate temporality of action. As the just-quoted WHO report underlines:

Sustainability and urgency are competing principles in decision-making about targets. Those who consider sustainability the main concern propose a slow and careful scaling up. This would take into account the limited capacity of the health-care system to cope with the ART programme and the danger that an already weak health system could be further overburdened and resources diverted from other health priorities towards ART. Sustainability proponents also advocate for setting targets according to committed or expected long-term funding, ensuring that those who are started on ART will receive it lifelong. Those who consider urgency the main concern propose providing ART access to as many eligible PLWHAs as possible in the shortest amount of time to save a maximum number of lives. To this end, urgency proponents advocate that even putting a PLWHA on ART for a few years would be beneficial to the individual and his or her family, and would provide the prospect for extending treatment as more resources become available. (WHO 2006, p.9)

The practical consequences of this debate in Tanzania, which obviously questions the relation between AIDS-control programmes and the rest of the health system (see Chapter 6), are discussed towards the end of this chapter²⁹³.

²⁹¹ Although the number of treatment centres in rural regions has recently increased, Cheek's (2001) prediction that "[d]ue to the nature of the health care system, the vast majority of those able to participate in [ART] programmes will reside in urban areas, where doctors, nurses, and clinics are concentrated" describes the early years of treatment roll-out in Tanzania quite adequately.

²⁹² The recent decline in AIDS funding has turned this question into a less pressing, if not an altogether irrelevant one.

²⁹³ See the section: "'Aim at the sky...".

Another equity-related question concerns the widespread gender imbalance in the access to ART. Since antenatal clinics play a key role in HIV testing and in the access to treatment, roughly two-thirds of ART patients in Tanzania are women – an inequity that points to the crucial relation between HIV testing and the explicit demand for treatment discussed below. The surprisingly uncontroversial nature of this obvious inequity also reveals a certain bias in the way ‘gender issues’ continue to be perceived in the field of HIV/AIDS.

A more openly controversial issue that arose during treatment roll-out in Tanzania concerns the ethically problematic question of whether priority should be given to treating paediatric or adult HIV patients – in other words, whether one should save children or their parents. One interviewee involved in the formulation of the first Tanzanian National Care and Treatment Plan, remembers:

We decided: ‘Since we have limited resources, let’s spend the money on adults’. We thought it was important to keep the parents alive and, at the time, treatment for children was about ten times more expensive and a lot more complicated. But then, UNICEF suddenly came and said: ‘You *have to* put the children on treatment!’. [...] 20% of those on treatment should be children - UNICEF, the Clinton Foundation and Elizabeth Glaser [Pediatric AIDS Foundation] pushed for that...it was against any rationale! [...] [O]f course, PEPFAR is very keen on bringing all these expensive paediatric drugs into the country...they are all patented drugs [...]. So the opportunity costs are very high! So for the price of one child, we could put five adults on treatment!²⁹⁴ And these children will be living with HIV for a very long time and will almost certainly develop resistances... In Tanzania, there was no one standing up and shouting for drugs for paediatric AIDS. It all came from outside! (Multilateral-14)

The reasoning put forward by those who proposed focusing on adults was not only that, at the time, five adults could be enrolled for the price of one child (a proportion that has started to change since, with falling paediatric drug prices), but also that keeping the parents alive would help put a break on the staggering increase in AIDS-related orphans in Tanzania. This idea to give precedence to adults over children was possibly perceived as all the more unjust as, in the dominant behavioural causal narrative, children are obviously ‘innocent’ HIV patients – unlike the ‘misbehaving’ adults still frequently considered as having, ultimately, no one to blame but themselves. For reasons partially discussed above (Chapter 3) and further analysed below, cost-effectiveness considerations or basic reasoning in terms of the maximisation of lives saved did not prevail. The ethically difficult and, to many, shocking nature of the decision to ‘let the children die’ clearly influenced the formulation of a target stating that 20% of the people receiving treatment should be children. While the 20%-target has not been reached,²⁹⁵ the example of paediatric HIV illustrates the type of trade-offs involved in the decision of who will get treatment and who will not.

²⁹⁴ This calculation is due to the fact that the cost of antiretroviral drugs roughly accounts for half of the total treatment costs (which includes a variety of other costs, such as lab tests and, of course, the cost of human resources and health facilities).

²⁹⁵ As of March 2012, even in those programmes supported by the Elizabeth Glaser Pediatric AIDS Foundation the proportion of children (below the age of 15) among the ART patients did not exceed 10% (EGPAF 2012). This might be due to the fact that, as the WHO report on treatment roll-out in Tanzania states, “[d]uring the quantification for the second consignment of drugs, the proportion of paediatric drugs was reduced to 10%, without a clear rationale being available” (WHO 2006, p.13). The exogenous nature of the initial 20% target obviously affected its medium-term implementation.

A second important group of compromises in the roll-out of antiretroviral treatment concerns the trade-off between the number of people to be enrolled into treatment programmes and the quality of the care and follow-up provided by these programmes. In Tanzania, several interviewees criticise the precedence that access to treatment has taken over the quality of the services provided.²⁹⁶ “Initially, the idea was to increase the number of people who access care [and treatment]”, states the deputy country director of an international NGO, “but now we are starting to ask ourselves: ‘How is the quality of that care?’” (INGO-9). The compromise between access and quality of care can concern technical issues such as the testing techniques used for monitoring treatment effectiveness: expensive viral load monitoring vs. cheaper, but less precise CD-4 monitoring. As a Tanzanian official puts it,

In Tanzania, we follow up on CD-4 count, often quite irregularly... The viral load test, don't even think about it in Tanzania! Nobody here can do that test. It's untouchable, too expensive – so it's not available. So we cannot follow up the patients properly. (GovSector-7)

Although CD-4 count has been shown to be considerably more cost-effective (Kahn et al. 2011), the call for viral load monitoring – and thus for a higher quality of care, and fewer cases of drug resistance – remains widespread (e.g. Schooley 2007).²⁹⁷ A comparable, much discussed argument concerns the question of which drug protocols to choose and whether or not patients should be granted access not only to generic drugs, but also to branded ARVs. If one follows the argument of the proponents of branded ARVs (i.e. that an increased choice of drugs improves adherence), this relation reinforces the trade-off between the number of people enrolled and treatment adherence. Concerning first-line treatments, and after an initial opposition by PEPFAR, the Tanzanian government – backed by several smaller donors – has made a clear decision in favour of generic drugs, and thus larger access. More generally, the design of ART roll-out raises a variety of questions concerning the elements to include in the treatment programmes. As the following statements by Tanzanian NGO workers illustrate, adherence to antiretroviral treatment often depends on fairly prosaic things:

In Iringa, many people depend on good Samaritans to give them a ride once a month to the nearest care and treatment centre, which is 80 km away! That causes a lot of complications. The drugs are there, the problem is adherence, which often depends on money for transport. (NGO-2)²⁹⁸

People living with HIV have to know the proper use of HIV drugs. [...] If they are using them properly, they will live long. People are still dying because of bad usage of drugs! They need training. So it's about free treatment AND knowing the proper usage of ARVs and of ART in general.²⁹⁹ Low adherence is due to a lack of information. (NGO-5)

²⁹⁶ See also the passage on ‘target chasing’ below.

²⁹⁷ Interestingly, Schooley has served as a consultant to most of the big pharmaceutical companies and owns stock options in a company which provides tests for HIV monitoring and drug resistance – just another illustration of the fact that financial interests and the call for higher standards of care are perfectly compatible.

²⁹⁸ The importance of transportation is also underlined by another interviewee: “Sometimes there are procurement shortages and the treatment centres decide to ration the drugs even further – so they only hand out drugs for 2 weeks [instead of one month]. So people have to come to the treatment centres more often. This leads to adherence problems, which leads to drug resistances...” (Bilateral-17).

²⁹⁹ This interviewee distinguishes ARVs (antiretroviral drugs) and ART – a more inclusive definition of treatment and follow up of patients’ health status, which includes the knowledge of ‘how to live positively with HIV’.

The patients' ability to reach the care and treatment centre and their treatment literacy can be improved through the reimbursement of transport costs and through peer-training among PLWH – both of which, of course, increase the cost of treatment per person. While the increase in cost is low, compared to the obvious benefits of these measures in terms of adherence and patient well-being, the inclusion of such measures does reduce the number of people that can initiate treatment (although it does not necessarily reduce the number of fully adherent patients). Since the question of patient well-being is key to ART adherence, the trade-offs involved include questions such as nutritional support for ART patients (see Chapter 7), the management of side effects, and (free) treatment of opportunistic infections.³⁰⁰ More generally, similar compromises between the number of beneficiaries and the quality of the services delivered are struck in the domains of prevention and of care for orphans and vulnerable children (OVCs).³⁰¹

Virtually all major decisions that underlie the design of a treatment programme thus involve fundamentally political compromises, the ethically problematic nature of which is exacerbated in a context of severely constrained resources. Addressing another major aspect of rationing, the next subsection focuses on the prioritisation between HIV treatment and prevention – a political process that involves trade-offs which were perhaps prematurely declared irrelevant, either because of the preventive effect of antiretroviral treatment or because they were simply perceived as ethically unacceptable.

A-2-2) The treatment-prevention trade-off: myth or reality?

“Our situation is also due to how we measure success. If a country has put 20,000 people on treatment, people will say ‘Oh, not much is happening there...’, but if a country has put 200,000 people on treatment, that is seen as a success! [...] Now, we’re proud of ourselves, counting how many people we have put on ART and we’ll continue counting until *all* Tanzanians are on ART. We measure success by counting the number of people we have put on treatment...but that’s not a success. It’s a failure! The success is the number of people who are *not* on ART. [...] We talk about universal access to treatment and universal access to prevention, but in there, access to prevention is less prominent than access to treatment. There is a need for a major shift of resources towards prevention! [...] But unfortunately, that shift is not coming. Even at the international level, I don’t see it on the agenda.”
(GovSector-12)

To be sure, nobody in his or her right mind could seriously suggest that making antiretroviral therapy available to Africans was a bad idea, or that one should stop the treatment programmes that have put an end to widespread mortality and shift the resources to HIV prevention alone. While many AIDS policymakers in Tanzania sometimes severely challenge the manner in which treatment was rolled out,

³⁰⁰ The NGO worker quoted above, for instance, complains: “What about drugs for opportunistic infections? They are supposed to be free but just happen to be always ‘out of stock’... and fungus tablets are very expensive! If you are HIV positive, you should get them for free. But they [health workers] sell them to others [patients] to get money for it...” (NGO-2).

³⁰¹ The country director of an international NGO involved in OVC care positively comments on PEPFAR’s decision not to increase its targets to 80,000 children reached: “Now, they have accepted to keep a goal of 55,000 OVCs reached...but to provide more and better services. But still, we have 4 million dollars...that’s 80 dollars a year per child, counting without organisational costs...so in reality, that’s 45 dollars a child. That’s not much!” (INGO-7). That being said, organisational costs of over 40% provide a strong rationale for thinking seriously about simple, institutionally ‘light’ cash-transfer programmes to families who accept to take care of an orphan.

the decision to scale up treatment programmes itself is not questioned. Not only do simplistic ‘either-or’ formulations of the necessary compromise between antiretroviral treatment and HIV prevention make no sense, such binary approaches have become even more absurd since antiretroviral therapy has been shown to reduce HIV transmission drastically by suppressing people’s viral load to undetectable levels (e.g. NIH 2011). That being said, various analysts have argued (e.g. Nguyen et al. 2011) that ‘treatment as prevention’ poses a variety of ethical, medical, financial and operational challenges, all of which suggest that treatment can by no means *replace* HIV prevention in sub-Saharan Africa. In Tanzania, the saying that ‘we cannot treat our way out of the epidemic’ is frequently referred to. When asked about what she considered the ‘hot issues’ of the moment, one bilateral agent, for instance, spontaneously mentioned the challenge to find a better balance between treatment and prevention: “There is no way for ‘treatment as prevention’ to become relevant in Tanzania!”, she underlines, “it’s never going to happen...it’s so impractical in countries like this!” (Bilateral-24). Similarly, when asked about the relevance of ‘treatment as prevention’ in the Tanzanian context, a multilateral agent simply dismisses it with a wave of the hand: “That doesn’t really apply to Tanzania...there are not enough funds!” (Multilateral-14).

As discussed, the annual expenditure for AIDS control in Tanzania amounts to approximately USD 500 million, of which roughly 20% are spent on prevention (TACAIDS 2012b) – depending on whether interventions such as counselling and testing are considered as being part of prevention or treatment programmes. PEPFAR Tanzania, for instance, spends 21% of its funds for prevention (excluding PMTCT), 60% on care and treatment (including PMTCT) and the remaining 19% on impact mitigation. As mentioned above, a variety of interviewees spontaneously criticise the Tanzanian AIDS response as severely biased in favour of treatment and against prevention. Some interviewees merely underline that more should be done: “I think prevention requires more funding”, suggests a multilateral agent, “it has been underfunded” (Multilateral-16). Similarly, a Tanzanian official acknowledges “We have to focus more on prevention...we have not done a lot on prevention yet” (GovSector-14) – a both astonishing and surprisingly self-critical statement. Other interviewees, such as this project manager at an international NGO, directly relate the efforts put into treatment and prevention respectively:

The [first] NMSF was developed before the arrival of ART roll-out. Then, with the arrival of ARVs, we changed *everything!* If you have a well-focused, conceptualised plan, you can change some of it, but not EVERYTHING. Prevention went down... The run on ARVs induced a decline in attention paid to prevention. Prevention will be forgotten! They say that 6% of Tanzanians are HIV-positive...so what about the other 94% of the population?!³⁰² There is a clear imbalance in favour of ARVs... (INGO-5)

Other interviewees stress that the medium-term affordability of treatment programmes directly depends on a stronger focus on prevention in the short term:

³⁰² This very same reasoning was spontaneously put forward by a variety of interviewees.

If they don't get a more serious prevention programme, there is no way they'll be able to afford treatment!³⁰³ The government has to become serious about prevention! (Bilateral-24)

Prevention is not given its true value! We need a clear balance! And drugs are expensive... [...] If the prevalence goes up, the need for money for ARVs will go up, too, in the long term! (INGO-6)

Considering the uncertainties surrounding the long-term international support for ART, one bilateral agent is particularly sceptical about the massive focus on treatment and the relative neglect of HIV prevention:

On the sustainability of ART roll-out, my projections are very, very grim... The whole thing is a big, total catastrophe. [...] The prognostic on drug resistances is very negative. There is no doubt: we will not reach our goals through therapy... They will have to let the people die again! (Bilateral-17)

Several donors point fingers at the Tanzanian government for neglecting prevention as compared to treatment. One multilateral agent, for instance, exclaims: "The majority of the development partners have had it up to here with the minimisation of prevention!" (Multilateral-6). Interestingly, one Tanzanian official points right back at the donors for not funding ambitious prevention programmes:

The international and national response to HIV/AIDS is not driven by what works, but by what people want to fund. Had the international community spent as much money as they spend today on treatment on sensible prevention measures in the 1980s and 1990s, we wouldn't have been where we are now in the first place! Had we implemented a massive prevention campaign at that time, the epidemic would have been averted, or at least controlled. So even if the Global Fund now wants to see more money spent on prevention, it is an unfortunate reality: the policy is not evidence-based! That's why we were not making good progress. [...] The National Multi-sectoral Strategic Framework encompasses both prevention and ART, but all the funding goes to care and treatment. All national documents, the NMSF, the National AIDS Policy...*all* clearly put prevention as the first priority. But when you look at the allocation of resources, things are a lot different! Even the costing of the NMSF suggests to put more money on prevention. That's the way things are in the intentional budget. But in reality, it's the other way around! You never get a blank cheque for prevention. I've never seen a single proposal for prevention applying for a huge amount of money and get it! I've *never* seen that! [...] Nobody is giving us money for [prevention]! They are giving money for things that are more of a humanitarian nature...like for ART. They are saying, and they are right, that there is an ethical obligation to treat these people (GovSector-12)

One partial explanation for this mutual accusation might be the fact that most of the donors interviewed do not work at PEPFAR or the Global Fund – the two institutions which account for the overwhelming majority of AIDS funding in Tanzania and thus control what the money is spent on. As a multilateral agent suggests,

What we know is that, of course, prevention has more returns than curative interventions... So that is where we want to focus if we want to curb the epidemic. But then, with PEPFAR and also with the Global Fund, the priority has somewhat shifted to curative interventions... (Multilateral-15)

That being said, the criticism voiced by several interviewees working with US agencies against the Tanzanian administration for not taking prevention seriously is confirmed to some extent by the above-described role of TACAIDS in the formulation of the Prevention Strategy (see Chapter 4). Beyond the question of who is to blame for the neglect of prevention, a variety of interviewees propose another

³⁰³ Mead Over (2008) makes the same claim.

explanation of why treatment has received so much attention over recent years. A Tanzanian official suggests:

Look at the '3 by 5' initiative³⁰⁴: that was a very clear target to reach. Before, we already had other [preventive] interventions known to be effective. Why didn't we ever fix such a clear goal for effective prevention interventions? So there must be other interests...economic and political interests. (GovSector-12)

Arguing along the same lines, a multilateral agent explains the slow progress concerning mother-to-child prevention by remarking that "PMTCT is not like treating paediatric AIDS...it's not selling any American products" (Multilateral-11). A similar reasoning is widespread among the interviewees.³⁰⁵ No doubt, many donor countries' economic interests related to the sale of patented drugs and/or medical material play a role in their obvious preference for treatment over prevention. That being said, many of the reasons why treatment is given precedence over prevention are strikingly similar to the reasons why prevention policymakers prefer behavioural to structural prevention interventions (see Chapter 3). In this case, too, the expected timeline of politically relevant outputs is crucial. A Tanzanian official notes:

The problem is that prevention doesn't show results immediately, so donors are not interested in that. They want to finance something and see the results the next day! (GovSector-14)

Even on the government side, however, the nearly immediate effect of treatment programmes on people's health defused the politically sensitive situation of the late 1990s and early 2000s.

Similarly, the visibility and measurability of outputs clearly play in favour of treatment. "With ART, it's easy to report and to count," remarks a Tanzanian official, "with prevention, you can't count like that" (GovSector-12). Commenting on the massive focus on treatment in Tanzania, this official adds, "public health would prescribe that we should do something else...". In a similar way, a Tanzanian NGO representative acknowledges:

In prevention, the problem is that there is very little substance that you can *show*. If, for example, I teach people about sexual health, that doesn't make a visible change or translate into immediately visible results. So when treatment arrived, all the focus went on treatment and all the resources went on treatment. That was international pressure. It did make a clear change to put people on treatment. Comparatively, HIV prevention was just people talking... So we forgot to turn off the tap! And that goes back quite a while... So now, we feel that we have to do more prevention. We are now coming back to our senses! (NGO-4)

To continue the parallel with the omission of structural prevention interventions described in Chapter 3, the relative simplicity of treatment and the comparative complexity of HIV prevention also disfavour the latter. A multilateral agent remarks:

³⁰⁴ Launched in 2003 by UNAIDS and WHO, the "3 by 5" initiative aimed at providing ART to three million people living with HIV in low- and middle-income countries by the end of the year 2005.

³⁰⁵ One interviewee, for instance, suggests that economic interests explain why blood safety (which involves a variety of medical material) is now fairly high on the US prevention agenda, another one comments on the debate over drug prices as follows: "[Bill] Clinton came here and said: 'I'll tell the drug companies to lower the price of ARVs.' And they did...but they didn't change the prices of the testing material and the test kits! We just tested 4 million people in Tanzania – that's expensive! So they get their money anyway..." (GovSector-7).

The distortion in favour of care and treatment is due to the nature of the [medical] act – treatment is simple and you can be sure that it'll work. With prevention, it's hard to prove the results...the benefits are always uncertain – that's a huge limitation! (Multilateral-6)

The manager of a prevention project with an international NGO expresses the same idea slightly differently:

Prevention is tough work! Before, I did care and support. That has its own challenges, but at least you know what to do and if you do things right, people have good outcomes. In prevention, that's very different. Everything you do may or may not be effective. And prevention is not as easy to understand, not as attractive to donors, governments and communities. The political will behind prevention is difficult to muster... [...] But we can't just be having people lining up for treatment! Everybody knows we have to do prevention, but that's the tough part of the equation... (INGO-8)

Last but not least, and as discussed in Chapter 3, rebalancing the response in favour of prevention is close to impossible with stagnant budgets, given the heavy path dependency induced by the decision to roll out treatment. The result is a situation the above-quoted Tanzanian official qualifies as follows:

We have incarcerated our thinking! [...] The mistake was in the focus on ART. And if you don't work on prevention, you don't discover how to do it better. There were many innovations in care and treatment in resource-poor settings. We learned how to deliver services better and cheaper. [...] There is a self-reinforcing, or a catalytic effect...if you work in any area, you'll have more innovations, learn how to plan better...and thus get more resources." (GovSector-12)

The dynamic implications of past funding decisions due to efficiency gains and organisational know-how are underexplored. That being said, a bilateral agent more prosaically points to the *political* irreversibility of the choice to scale up treatment and its consequences for investments into prevention:

There is a political commitment by the President for free treatment. So that makes it harder for testing and prevention interventions.³⁰⁶ And 2010 is an election year and headlines about people not getting treatment is *not* what you want in an election year... (Bilateral-19)

To be sure, “[d]ichotomies such as prevention versus cure do not promote good health” (Stillwaggon 2006, p.17). Yet, this interviewee's statement – among many others – illustrates that AIDS players in Tanzania do consider that there is a trade-off between treatment and prevention, and that this compromise presents a serious challenge. Although virtually all interviewees agree that there are sensible reasons *not* to oppose the two interventions, their experience as policymakers makes them perceive the relation between treatment and prevention as one of at least partial (financial) competition.

Beyond the political drivers of downstream health action discussed above³⁰⁷, most AIDS activists' approach in terms of individual human rights – the only acceptable conclusion of which is 'universal access' – introduces a bias in favour of curative rather than preventive interventions. One of the above-quoted interviewees denounces this imbalance and exclaims:

³⁰⁶ The politically interesting relation between testing efforts and the demand for treatment is discussed below.

³⁰⁷ See Chapter 3, as well as (McKinlay 1974)

We should operate a paradigm shift! But there's very little we can do about that at the national level. It must come from a big international movement, with activism at the global level. Like the Treatment Action Campaign in South Africa... Have you been to the international conferences? There, people march on the street saying 'We want treatment!'. People should march and shout: 'We want prevention!'. Activism is necessary! (GovSector-12)

This remark illustrates the crucial role played by what could be called the uneven 'political acuteness' of treatment and prevention interventions. The core rationale for prevention being a population-based long-term reasoning, not one of an urgent response to an immediate threat to individual lives, its chances of becoming 'politically acute' are comparably slim. Despite this interviewee's wish, it is highly unlikely that Africans are going to take to the streets and demonstrate for increased HIV prevention – all the more so as long as the behaviour-based narrative remains the dominant explanation of the African epidemics (see Part 1).³⁰⁸ While there is no political constituency for pro-active prevention interventions, the constituency for treatment and care is obviously more clearly circumscribed (i.e. PLWH and their families), although not strategically organised in Tanzania (see the introduction to this part).³⁰⁹ 'Political acuteness' could be described as the moment when a problem is publicly perceived as sufficiently alarming to require an immediate political response since the obvious negative consequences of inaction would make this attitude transparently condemnable.³¹⁰ As a bilateral agent underlines, "the government [of Tanzania] wants to focus on 3 categories of service obligations: treatment, OVCs, and care – these are obligations!", adding "outside [these interventions], there is a very big scope of possible activities..." (Bilateral-19). To put it bluntly, treatment is perceived as compulsory, prevention as optional. The differential political acuteness of different aspects of the AIDS response suggests that the declining credibility of the "universal access" discourse is politically more problematic in the domain of treatment than in that of prevention.

As discussed below, the individualistic vision of the dominant activist discourse biases HIV programmes towards treatment – which entails a differential valuation of life. More fundamentally, the differential political acuteness of HIV-treatment and -prevention interventions derives from a widely-shared individualistic vision of health priority-setting, which can be summed up in what Jonsen (1986) calls the "rule of rescue". McKie and Richardson (2003, p.2407) define this rule as the "imperative to rescue identifiable individuals facing avoidable death, without giving too much thought to the opportunity cost of doing so". Similarly, when describing what he calls the "rescue principle", Mechanic (1997, p.90) underlines that "studies consistently show that public opinion gives higher priority to saving identifiable lives than to more cost-effective measures to save 'statistical lives'". As the Tanzanian case illustrates, because it implies a discrimination against anonymous individuals, the "rule of rescue" poses a serious challenge to allocative decisions in the field of HIV/AIDS (as in many other domains of public health).

³⁰⁸ That being said, and as discussed in the introduction to this part, a variety of other reasons make sudden HIV-related upheavals unlikely in Tanzania (see also: Pearce 2009; Beckmann & Bujra 2010).

³⁰⁹ The impact of this difference in preferences between PLWH and other stakeholder groups on actual AIDS policies is increasingly acknowledged (e.g. Youngkong et al. 2010).

³¹⁰ Although an issue's political acuteness in no way guarantees an *adequate* policy response, it does make political action more likely.

While the political implications of the “rule of rescue” with respect to AIDS policymaking are manifold and insufficiently appreciated; their detailed exploration would exceed the framework of this study. In any case, as Brock and Wikler (2009) argue concerning HIV/AIDS, there is no “moral imperative to emphasize treatment” if focusing on prevention would save more lives.³¹¹ More fundamentally, there is no unique ‘rational’ solution. As McKie and Richardson (2003, p.2417) conclude,

the [rule of rescue] is likely to remain contentious as it may be both supported and criticised by legitimate ethical arguments and, at present, there is no agreement about how to resolve issues that lead to such a head-on clash of values. Consequently there is probably no unambiguous advice that may be offered to health economists, health service researchers or policy makers except to remember that the evaluation of health services is not simply a technical matter but a quintessentially ethical endeavour, and that in complex societies with divergent values there may be a range of considerations that may ‘trump’ the utilitarian rationality that is implicit in cost-effectiveness analysis.

Although strong arguments exist to invest an increased proportion of AIDS funds into HIV prevention, the decision remains ultimately a political one, as it involves a compromise between incommensurable values and irreducibly conflicting interests (see Chapters 2 and 3). Today, this decision is taken by international AIDS donors.

Finally, and although they are not, strictly speaking, part of AIDS ‘control’, impact mitigation measures such as programmes caring for AIDS orphans or income-generating activities for people affected by HIV are also part of the financial equation of AIDS-related allocative trade-offs. In Tanzania alone, over 2 million orphans and “vulnerable children”³¹² live – and at times barely survive – under extremely precarious conditions. AIDS-related deaths being a major cause of orphaning, the programmes that assist these children are to a great extent financed and implemented via AIDS-related programmes. Again, the decision of which proportion of AIDS funds should be allocated to impact-mitigation activities is part of HIV-related triage. The acute awareness of the implications of these macro-level allocative decisions makes them particularly difficult for policymakers. A multilateral agent sums up the difficulty to increase funding for HIV prevention with the distinctive humour of those who have been in the ‘AIDS business’ for a while: “You can’t just tell people: ‘Listen, give me a break with your orphans, will ya!?’ That’s not politically correct...” (Multilateral-6). This statement hits the nail on the head in terms of the AIDS policymakers’ difficulties facing the need to choose in a context where choosing – and thus deciding *not* to fund certain interventions – is highly problematic. The next section looks at how policymakers confront these intricate choices.

³¹¹ This leads the editors of the issue of *Health Affairs* dealing with difficult choices in AIDS control to conclude that, “if substantially more resources are not made available to combat HIV, then shifting some expenditures from treatment to greater prevention efforts looks justified, painful as such a shift would be” (Health Affairs 2009, p.1577).

³¹² See: <http://www.tacaids.go.tz/thematic-areas/impact-mitigation.html>

B) AIDS players confronting scarcity: when you cannot have your cake and eat it, too

“I heartily support both treatment and prevention (including the preventive interventions I repeatedly refer to as end-game, last-minute, and even paternalistic). [...] The prevention of disease and other forms of oppression needs to be moved upstream as well as being continued in the behavioural forms that it now takes.”
(Stillwaggon 2006, p.17)

Coming from an AIDS economist well aware of the need to make uncomfortable decisions, this statement illustrates just how difficult the decision *not* to implement certain interventions is in the AIDS field. Chapters 3 and 4 show that the oft-lamented difficulty to prioritise interventions and the low resonance of economic reasoning in HIV-related decision processes³¹³ are, in part, due to the number and constellation of players in the Tanzanian AIDS-policy arena. In a complementary approach, this section argues that the difficulty to come up with clear policy targets and an explicit prioritisation of interventions is also due to a tension between two co-existing, yet radically divergent rationalities in dealing with scarcity. The tension between these frameworks of reasoning – described below in an ideal-typical sense as the ‘activist’s’ and the ‘health official’s’ logics – is omnipresent in the interviewees’ statements about HIV-related trade-offs. To my knowledge, and although most AIDS players are well aware of them, these competing rationalities which underlie most HIV-related allocative decisions have not yet been explicitly distinguished or described in their internal coherence – nor have the consequences of their at least partial incompatibility on priority-setting processes been fully appreciated.

B-1) Policymakers facing a Sophie’s choice: denounce scarcity or manage it?

When discussing one or another of the ‘tough choices’ described above, some interviewees call for these uncomfortable decisions to be taken – and to be taken explicitly. Others, when asked about how the insufficiency of resources should be dealt with, avoid the question or give a response that essentially suggests that no choice can or should be made. Interestingly enough, several policymakers shift from one discursive register to the other throughout the interview.

Among those who underline the need to face ‘tough’ compromises, a bilateral agent addresses the question of paediatric AIDS treatment:

Some are saying: ‘We *have to* do something!’... UNICEF had that kind of approach, saying: ‘Children are dying, we must do *something!*’. Great...but let’s try to build our case as rationally as possible! So there’s a lot of friction there. (Bilateral-20)

³¹³ As discussed in Chapter 3, cost-effectiveness considerations are, in some cases, considered to be politically taboo. Interestingly, the acknowledgement of the need for trade-offs itself seems to vary between “private” and “public” settings. While many policymakers underline the need for more evidence-informed prioritisation during the interviews and in closed policy meetings, similar economic reasoning has only a limited legitimacy in broader public discussions about HIV/AIDS, where the non-universal nature of HIV interventions, and especially of treatment roll-out, still appears a political taboo.

Similarly, expressing his conviction that priorities need to be formulated according to available resources, a former Tanzanian AIDS official comments on the aforementioned costing of the NMSF:

I didn't want to do costing. [...] That's a very interesting academic exercise, but it's not worth the trouble! They come up with numbers that are out of this world! You won't get that money. You only have so much money. So then we should sit down and say: 'With *these* funds, what can we do?'. You make your clothes according to the tissue [cloth] you have! (GovSector-15)

Invoking the same example of the NMSF costing, a bilateral agent argues against a reasoning that is popular among those players who refuse to make tough choices:

Look at the costing of the NMSF: it's billions and billions that they don't have and will *never* have. There are going to be some hard questions asked about affordability of treatment and what happens if half of Africa has to go on second line treatment. Treatment is expensive and it's for life. Of course, you can make the argument asking: 'What would be the health-care costs of *not* treating?'. But in Africa, people were not getting anything anyway...they were just dying! So that's a legitimate argument in urban San Francisco, where it would cost thousands of dollars to treat opportunistic infections... (Bilateral-29)

No doubt, antiretroviral treatment is a good economic investment if one adopts a cost-benefit reasoning: not only does it contribute to maintaining or restoring HIV patients' ability to generate their own income, raise their children and care for their families, but by limiting opportunistic infections of PLWH it reduces the burden they represent for the health system.³¹⁴ Yet, this bilateral agent suggests that the 'ART-is-cost-saving' argument has only limited political validity in Africa. Indeed, its relevance depends on two assumptions: 1) the 'avoided' expenditures must be considered real (which is not the case with future health-care expenditures due to opportunistic infections if these infections often go untreated – as in Tanzania), and 2) the current budget must actually be extensible to increase today's investments to save costs tomorrow. In the eyes of most AIDS policymakers in Tanzania, at least one and generally both of these conditions are not fulfilled. Considering that – at their level of influence – the Tanzanian AIDS budget is not extensible, several players take a strong stand concerning the need to prioritise and thus to identify those interventions which are *not* a first-degree priority. "We need to use our brains and not our hearts!", exclaims a programme manager with an international NGO (INGO-6), arguing that, in the absence of additional resources for HIV/AIDS, prevention efforts should receive more attention and, if necessary, be granted precedence over treatment programmes.³¹⁵

These statements illustrate the reasoning that resource scarcity makes the decision of which HIV-related interventions should – at least initially – *not* be implemented inescapable. They indirectly respond to another, diametrically opposed reasoning put forward by a variety of policymakers. Prompted about his vision concerning the relative importance given to behaviour-based vs. structural HIV-prevention interventions, one bilateral agent, for instance, states:

³¹⁴ While HIV treatment is undoubtedly a good economic investment, absolutely speaking, the controversy arising from the question whether or not the same money could not have yielded even greater benefits in other health fields is discussed in Chapter 6.

³¹⁵ Although, in settings with high incidence, it is obviously cheaper to prevent HIV infections than to treat them, the insufficiency of investment into HIV prevention provides another striking illustration of the limited policy-relevance of this reasoning.

Your question is if the efforts to change behaviours are justified if one compares them to how these resources could improve [the response against HIV transmission-facilitating] cofactors. But the two are not comparable. Yes, we have to prevent 'upstream', but there is not enough money to go all the way. We have to do the one without stopping to do the other! (Bilateral-31)

Since no single prevention intervention alone can stop the spread of HIV, a simplistic 'either-or' reasoning is obviously absurd and the intelligent formulation of 'combination prevention' strategies indispensable (e.g. Hankins & de Zaluondo 2010; Kurth et al. 2011). Yet, distinguishing this approach from a simple non-choice strategy requires walking a thin line as an ill-defined conception of 'combination prevention' can easily lead to a refusal to identify *non-priority* interventions, regions or population groups. Recalling the CDC's criticism of the Tanzanian HIV Prevention Strategy as being overly-inclusive and thus unrealistic, a Tanzanian official underlines:

The CDC commented, saying 'This can't happen!'. We replied: 'This is our document and *everything* in there is a priority!'. So if we only have 20% [of the resources needed for full implementation], we'll say to the donors: 'You *have to* buy in! You *have to* support us, or...'. (GovSector-10)

When 'everything is a priority', choice obviously becomes not only impossible, but unacceptable. As discussed above, for economics – i.e. 'scarcity management' – to be legitimate, scarcity needs to be acknowledged and accepted.

A similar decision problem concerns the balance between treatment and prevention. Strikingly, even among those interviewees who voice the harshest critique against the dominant focus on treatment and the relative neglect of prevention over recent years, hardly anyone explicitly suggests that resources should be taken away from treatment and channelled towards prevention. One Tanzanian official, for example, after having forcefully denounced the imbalances between treatment and prevention and called for "a major shift of resources towards prevention" (which, given the context of enunciation, strongly suggests a shift *from* treatment *to* prevention), backs off when asked if this is what he meant to say:

I remember one of the meetings with the donors. TACAIDS said: 'We need more funds on prevention' and the donors replied: 'Okay, if you want more money for prevention, we have to stop enrolling more people into treatment...'. So we said: 'No, the issue is not to stop one and to do the other instead. The issue is to find the right balance'. We said 'We want to do both of it in an equitable manner. For now, 97% of Tanzanians don't get anything because they are not on ART.³¹⁶ That's not equitable!'. (GovSector-12)

Just as concerning the trade-offs *within* prevention, the widely proclaimed will to 'rebalance' the response in favour of HIV prevention without using treatment-related resources to do so invariably entails a call for increased funding as the only solution to avoid having to choose. A multilateral agent's statement illustrates many AIDS policymakers' attempt to square the circle:

What is required is the recognition that we should reduce new infections. Nobody wants to take money away from care and treatment...that's a commitment for life! But we have to invest in prevention! Now, the funding seems to stagnate, so we are concerned. If the Global Fund Round 9 proposal is accepted, it will be okay... And maybe PEPFAR can fund some...but we need more money. (Multilateral-16)

³¹⁶ In reality, patients who receive antiretroviral therapy represent slightly less than 1% of the Tanzanian population.

This choice-aversion, which stipulates that ‘what *has to be* done *can* be done’, is at the basis of the “universal access” framing proposed by UNAIDS and often uncritically adopted by national and international AIDS players.

The two different logics – which, respectively, could be summarised by the expressions “We need to use our brains, not our hearts” and “We have to do the one without stopping to do the other” – are both internally coherent and partially incompatible. This, plus the fact that some policymakers draw on *both* rationalities in constructing their discourse, makes it all the more challenging to disentangle the underlying reasoning at play. By proposing an ideal-typical differentiation of the two logics described, the next sub-section attempts to clarify their components.

B-2) Two coexisting, internally coherent worlds of reasoning

“When DFID and Piot³¹⁷ pushed for ‘universal access’, I told Piot: ‘You know, it’s never going to happen. It’s not a priority! We don’t even have universal access to health coverage...why would we want to put the priority on universal access to care and treatment [of HIV]!?’”
(Bilateral-29)

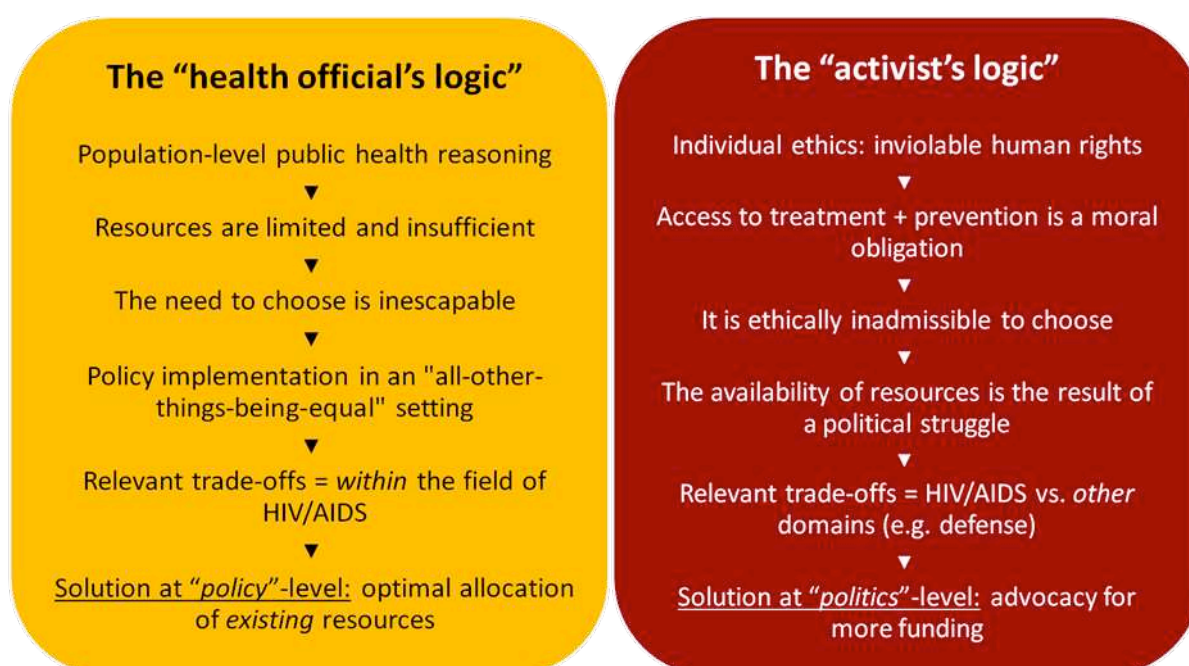
This statement illustrates a fundamental difference in framing, and thus in the identification of the relevant trade-offs, between two responses to scarcity. For analytical purposes, the AIDS players’ statements concerning the attitude to adopt in confronting the insufficiency of resources can be considered to draw on either one of two rationalities: the *health official’s logic* or the *activist’s logic*. In a nutshell, the ‘health official’s’ (or health economist’s) rationality is situated within the framework of a public health reasoning that aims at maximising health outcomes at the population level. Its starting point is the acknowledgement that the available resources are limited and insufficient to implement all desirable HIV-related interventions. From this acknowledgement of scarcity follows the conviction that, however uncomfortable, trade-offs between all initially envisaged measures are inescapable. There is a need to choose or, put differently, to practice triage. I call this reasoning the ‘health official’s logic’ because it considers policy formulation and implementation in an ‘administrative’ all-other-things-being-equal setting. Accepting the funding level for AIDS-related activities as a given, it turns to the necessary trade-offs that implies *within* the field of HIV/AIDS. Consequently, the only possible – although unsatisfactory – ‘solution’ to the problem of scarcity consists in making sure that existing resources are allocated in the best possible manner.

The ‘activist’s rationality’, by contrast, situates itself within the framework of individual ethics and inviolable, universal human rights. Consequently, its starting point is the assertion that the access to antiretroviral treatment and HIV prevention are non-negotiable human rights, which have to be guaranteed effectively. From the ensuing moral imperative for action (in light of the obligation to ‘do it

³¹⁷ DfID is the United Kingdom’s Department for International Development, Peter Piot the former executive director of UNAIDS.

all’) results an ethical unacceptability of scarcity and an inadmissibility to formulate triage policies. Drawing on an explicitly political conception of AIDS control and health policies in general, this reasoning rejects the argument of insufficient funding on the basis of the claim that the availability of resources is first and foremost the result of power relationships and thus of political struggle. It considers that the relevant trade-offs concern not intra-sectoral (e.g. treatment vs. prevention or access vs. quality) but *inter*-sectoral (and international) allocative decisions. The management of scarcity being considered both unacceptable and ultimately avoidable, the ‘solution’ this logic naturally leads to is political struggle and advocacy for increased AIDS funding. Figure 2 ideal-typically synthesises the internal logic of these two rationalities.

Figure 2: Two internally coherent rationalities when facing scarcity



Each reasoning builds on different initial assumptions, which lead to a dissimilar framing of the ‘problem of scarcity’ and translate into divergent conclusions about how to best respond to it. Ultimately, it is the degree of politicisation – and the underlying conception of ‘reality’ this entails – that distinguishes the two approaches. The ‘health official’s’ logic considers scarcity as an inalterable reality (at least within a decision-relevant time frame) that creates immediate obligations to act accordingly, i.e. to manage scarcity through the formulation of prioritised policies and implementation plans. The ‘activist’s logic’ considers scarcity not as a given, but as a socially and politically constructed and therefore alterable situation. While the former logic reasons *within* the AIDS field (accepting national and international inter-sectoral budgetary trade-offs), the latter questions these trade-offs by relating them to the unfair economic (world) order that should itself be challenged (e.g. Schrecker 2012). In this sense, the ‘activist’s logic’ claims that sufficient funding could easily be found, at the national level, by tapping into other

state budgets (i.e. military³¹⁸), by increasing existing taxes (on unhealthy products such as alcohol and tobacco), or by creating new ones (e.g. on international financial transactions or luxury goods and services), and, at the international level, by challenging economic and political domination. This vision is more politicised in the sense that, by establishing a direct relation between the insufficiency of resources for HIV/AIDS and political structures of power, it asserts that prioritisation need not (and thus *must* not) take place *within* the field of HIV/AIDS but *between* HIV/AIDS and other domains. It considers that the ‘real’ trade-offs are made ‘higher up’ – thereby shifting the relevant political arena for addressing scarcity from the discussion of national-level AIDS *policies* to that of cross-sectoral national and international *politics*.

This framing of the relevant sphere of decision making has profound consequences on the conclusions related to rationing choices. To take the aforementioned example of paediatric AIDS, the ‘activist’s’ reasoning suggests that denying HIV-positive children treatment amounts to homicide by omission – i.e. the omission to change current expenditure priorities in favour of AIDS in Africa – an obviously ethically condemnable act (or non-act). If all lives are valued equally, these children should not be condemned to death. Reasoning within a given resource setting, the ‘health official’s’ logic, in turn, makes the argument *against* the treatment of paediatric HIV infection based on the same ethical reasoning of equal value of life. If treating children is more expensive than treating adults, denying children treatment can be considered an ethical obligation for AIDS policymakers if they attach equal value to each life – not at a global level, which they consider beyond their powers, but within the limited policy setting they have an influence on. Within this reasoning, the decision to save the life of one child, rather than those of several adults, appears ethically condemnable. It is thus the reference to one or another of these two frameworks that determines whether, ethically speaking, the decision not to treat paediatric AIDS is an atrocity or an unfortunate necessity. The political point of view one adopts determines the ethical judgement.

Although presented in an ideal-typical way here, these two internally coherent rationalities and the elements of reasoning they contain clearly shape AIDS players’ discourses about scarcity and the need to choose. The tension between these two logics is reflected in the statements made by the interviewees, some of whom alternate between these argumentative logics, sometimes referring to both in the same breath. Contrary to what the admittedly slightly confusing designations suggest – the two rationalities are thus not unequivocally attributable to certain players or groups. Although some interviewees and institutional players tend to put stronger emphasis on one or the other logic (the World Bank, for instance, tends to favour explicit rationing decisions, while UNAIDS generally sticks to the “universal access” discourse³¹⁹), the described logics should be understood as constituting two poles of a tension

³¹⁸ Neusy, for instance, underlines that “[a]lthough international funding for global health increased to \$8.1 billion in 2002, the United States alone spends close to \$5 billion monthly on the wars in Iraq and Afghanistan” (2004, p.84). For another example of such a (re)framing of the relevant trade-offs (in this case concerning NTDs), see: (P. Hotez 2010).

³¹⁹ Being essentially staffed with economists, the World Bank has quite consistently underlined the need to choose, promoting the use of cost-effectiveness analysis to make the best allocative choices. Without stretching categories too much, UNAIDS

within individuals and *within* institutions dealing with HIV/AIDS. One and the same person can, for instance, call for further ART roll-out, stress the need to implement a significant scale-up of prevention interventions, *and* have a highly pessimistic analysis of the prospects for future AIDS funding. Indeed, torn between the ‘absolute’ world of advocacy and the ‘relative’ world of implementation, a certain degree of professional schizophrenia might be an indispensable condition for AIDS players to be able to do their job without suffering permanent psychological damage. Taking one step back, the next section explores some of the rarely acknowledged theoretical underpinnings of this perpetual debate in the AIDS policy field

B-3) The dangers of utopian humanitarianism and the fragility of reality: perspectives from political theory

“Be Realistic. Demand the impossible.”³²⁰

“Unfortunately it is not true that if something cannot be achieved, it can do no harm to strive for it. Like chasing any mirage it is likely to produce results which one would have done much to avoid if one had foreseen them. Many desirable aims will be sacrificed in the vain hope of making possible what must forever elude our grasp.”
(Friedrich v. Hayek 1976, p.133)

The juxtaposition of these two quotes could suggest that, beyond the difference in appreciation of how to deal with the insufficiency of AIDS funding, an ideological divide separates the two rationalities described above. By asking for radical change, the ‘activist’s logic’ would be on the progressive side, while the ‘health official’s logic’, by accepting the established order as a given, would be irremediably conservative, not to say reactionary. Several discussions about cost-effectiveness at the 2010 and 2012 International AIDS Conferences in Vienna and Washington were telling in this respect: those who predominantly situated themselves within the activist’s logic, accused those who dared to point to the need to ration and accepted planning with constant budgets for AIDS control of taking the wind out of the activists’ sails in their struggle for increased funding. For those who did accept the need to reason with stagnant funding, however, being ‘realistic’ was a way to optimise health outcomes, not an implicit acknowledgement that resources were adequate – let alone an endorsement of inegalitarian economic and political structures. The difference between the two logics is obviously irreducible to an opposition between progressive and conservative political ideologies – not least because most policymakers do not *coherently* draw on either one of them. Nevertheless, the two visions of how to deal with scarcity draw on what could be described as ontologically different conceptions of reality. While those underlining the need to formulate explicit trade-offs invoke the need to be ‘realistic’ (i.e. to face the ‘reality’ of scarcity), the activist’s reasoning is based on the idea that reality itself is highly fragile, because socially and

could be described as the ‘activist’ institutional counterpart to the World Bank. That being said, UNAIDS is increasingly torn between its two – not always compatible – roles of advocacy and policy advice. This opposition is described in more detail in Part 3.

³²⁰ This popular slogan during the 1968 social movement is alternately attributed to Che Guevara or Herbert Marcuse.

politically constructed.³²¹ Being essentially an expression of the existing order, ‘reality’ can thus be challenged and changed. This vision is illustrated by the reasoning of Kent Buse – a policy advisor at UNAIDS – who points out that “[t]he 1200 wealthiest people in the world have about \$4.2 trillion in wealth”, suggesting that as little as 0.1% of their total wealth – a less-than-revolutionary proportion – could pay for all global health needs (in: Mazzotta 2012). By reframing the relevant trade-offs in this way, the activist reasoning underlines that things could be different from what they are. To put in Boltanski’s terms, it points to the “fragility of reality” (2009, p.88-98) – a key operation of progressive critique.

In a sense, the recent history has proven AIDS activists right. By imperturbably insisting on the ‘should’, rather than the ‘is’, their action has yielded results that far exceed even the more optimistic expectations of many ‘realists’ of the late 1990s. Having been widely considered as ‘unrealistic’ in the mid- and late 1990s, their claim for generalised access to antiretroviral treatment in Africa has become not only an official policy target, but an everyday reality for at least a significant minority of people living with HIV in most African countries. The drug prices for ART have decreased dramatically (many by up to 99%) in just a decade, transforming “universal access to treatment” from an obvious pie in the sky to an explicit policy target. AIDS is thus one of the few domains where international activism has succeeded in substantially changing the general perception of what is considered possible and what unattainable. To many activists or people who reason with the ‘activist’s logic’ the undeniable successes of international AIDS activism make today’s ‘realists’ – many of whom are health economists – appear less credible. Not only are they perceived as lacking political will, but their often linear cost projections are considered too conservative. The unit cost of interventions changes for a variety of reasons, among which the volume of patients treated, the way drugs and consumables are purchased, the integration of interventions into existing health, transport or educational systems, and the governmental decision to comply fully, or only partially with international patent law. Today’s political decisions, the activist’s reasoning goes, have dynamic consequences on the cost – and thus the feasibility – of tomorrow’s interventions.³²² The identification of the relevant framework of reference thus not only depends on what one considers a realistic estimation of the resources that can be made available, but also on the evaluation of the dynamic consequences of today’s decisions on future costs.

The conception of ‘reality’ that underlies the ‘health official’s logic’ is fundamentally different. With a little conceptual leeway, the argument in favour of political ‘realism’ concerning HIV-related trade-offs follows a reasoning comparable to one of the central messages of Machiavelli’s *Il Principe* – which can be bluntly summarised as ‘it is the denial, not the acknowledgement of evil that is unethical’. In other words, omitting the existence of hostility weakens those who govern and being weak is unethical since it

³²¹ Concerning the idea of “fragility of reality”, see (Rennes & Susen 2010) as well as (Boltanski 2009, p.88-93).

³²² “How do you come up with priorities?”, asks, for instance, a Tanzanian economist involved in the formulation of the Prevention Strategy. Answering his own question, he exclaims: “You have to play with the costing by changing targets, *not unit costs – they won’t change!*” (Research-11). This is precisely the linear – and empirically wrong – reasoning challenged by those drawing on the activist’s logic.

renders the political regime and the people living under it vulnerable to enemies. Getting back to HIV-related trade-offs, the 'health official's' logic follows a comparable reasoning: the insufficiency of resources is a given (i.e. 'evil' exists), and rationing decisions are made whether we acknowledge scarcity or not. Ignoring the inescapability of choice by deluding oneself into 'universal access' scenarios thus leads to far more unethical decisions than those one would take on the basis of the acknowledgement of the need to choose. As Hayek's above-quoted remark concerning what he considered the *mirage* of socialism (or social justice) illustrates, Machiavelli is not the only thinker warning against the dangers and opportunity costs of running after the unachievable. Eric Voegelin's incisive reflection on what he calls the "dream of perfection"³²³ further illustrates this reasoning:

Utopia is a symbolism created by Thomas More to express the Nowhere of a society [...]. The author of the Utopia elaborates his dream of a supposedly perfect society by omitting from its structure an important sector of reality, but he knows what he has omitted and is conscious of his truncated image of reality as a Nowhere. In its contemporary usage by activist thinkers and non-thinkers the meaning of the symbol has been transformed in a peculiar manner. A Utopia still means the model of a perfect society that cannot be realised because an important sector of reality has been omitted from its construction, but its authors and addicts have suspended their consciousness that it is unrealisable because of the omission. [...] [T]he suspension becomes manifest in public as the professed belief that the unrealisable image of perfection can be realised. The Nowhere of Thomas More has been inverted to symbolise the Everywhere [...] of the activist who wants to inflict his dream of perfection by violence on everyman's humanity. (1990, p.316-7)

No doubt, accusing AIDS activists of wanting to impose their dream of perfection by violence would be absurd. If there is violence – and there is plenty of violence in HIV/AIDS – it is caused not by activism but by the widespread "rejection of common humanity" – to use Herzfeld's (1992, p.1) definition of indifference.³²⁴ Yet, with respect to the inescapability of rationing, the term "suspension of consciousness" fittingly describes the state of mind of many AIDS policymakers when they formulate prevention and treatment policies. Denouncing this suspension of consciousness, the 'health official's' logic draws on an anti-utopian reasoning (illustrated here by Machiavelli, Hayek and Voegelin) in arguing that, when dealing with scarcity, even well-meaning self-delusion can do much harm. While this argument of the dangers of running after the impossible or of the counter-productivity of misplaced benevolence is a typical element of reactionary rhetoric (Hirschman 1991), it makes little sense to attribute anti-progressive motives to those who argue in favour of explicit discussions about HIV-related rationing decisions. Indeed, when it leads to obscuring inescapable life-and-death decisions, ill-conceived 'human-rightism' can exacerbate the very conditions it seeks to remedy. Resources are not unlimited, and will never be. While stressing the inviolability of individual human rights (the first of which being the right to stay alive) is obviously sensible, turning this individual-based reasoning into the guiding assumption of policymaking renders it impossible to ration in the *least inequitable* way. Since it invariably entails a refusal of rationing, adopting a radical approach based on individual human rights, in turn, can paradoxically lead to the effective denial of these very rights to an unnecessarily high proportion of people.

³²³ In a different sense, this remark also resonates with well-worn debates over what Illich (1976; 1999) calls "the quest for perfect health".

³²⁴ See also: (Lewis 2006)

The tension between the two logics is closely related to that between a population-based public health vision and the inherently individual-based medical approach, which shares its individualistic conception with the AIDS activists' human rights framing.³²⁵ The combination of these two individualistic conceptions strongly influences how many AIDS players think, talk or keep quiet about the uncomfortable trade-offs involved in the formulation of HIV-prevention and -treatment policies. As de Waal (2003a, p.245) put it a decade ago:

The dominance of medical language, and its related value systems, is so powerful that it is difficult to try to think of HIV/AIDS in another way, without feeling morally uneasy. It is an easy cop out to argue that institutional priorities can be reconciled with medical ethics, simply because they *must* be reconciled. In fact, it is virtually a certainty that as testing, counselling, treatment and care become more widely available in Africa, they will be rationed. If the rationing is not done openly and transparently, it will be done covertly.

Closing one's eyes on the inescapability of choice by adopting a non-decision strategy does not make the trade-offs disappear. By ignoring the *de facto* existence of choice, such non-decision making depoliticises vital choices by precluding explicit discussion and decision. It invariably results in implicit rationing based on non-transparent criteria.³²⁶ The next section argues that, beyond the ideological debate it triggers, the political ambiguity that arises from the tension between these two rationalities has real-world consequences on AIDS policymaking.

C) Choices without decisions: the politics of 'universal access'

“The politics of rationing are messy and treacherous. As long as rationing remained implicit, politicians were shielded from the impact of decisions about who to treat and who not to treat.”
(D. J. Hunter 1995, p.876)

As mentioned, virtually all interviewees agreed that the prospects for AIDS funding in Tanzania were at best stagnant – an assessment that the recent decrease of international assistance proves to be correct (TACAIDS 2012b). Yet, far from being merely an official advocacy slogan, “universal access to treatment, prevention and care” remains a central reference in most AIDS players' discourses and policy papers, and an explicit policy objective at the implementation level. This is in stark contrast with the realistic appraisal of the situation made by Nguyen, who suggests that, as the tide of AIDS-relief efforts recedes, “[w]hat will likely remain is a therapeutic archipelago for the lucky few and not much in between” (2010,

³²⁵ This compatibility (or common reference to an individualistic vision of health) certainly contributed to the emergence of the sometimes turbulent, yet surprisingly durable 'alliance' between AIDS activists, medical practitioners and the pharmaceutical industry.

³²⁶ The controversy – particularly vivid at the 2010 AIDS Conference in Vienna – about the widening of eligibility criteria for ART in Africa (from a CD4-count of 200 to one of 350) is an illustration of the complexity of rationing choices. Although the decision was obviously justified on medical grounds, it substantially increased the number of eligible people even in countries where the resources were insufficient to ensure treatment access to people with CD4 counts *below* 200. Those who adopted the 'health official's' logic argued that resources being already insufficient to treat the patient in most dire need of ART, widening the eligibility criteria for ART would lead to decreased efficiency in the allocation of scarce resources, and favour implicit triage over explicit CD4-count based rationing. Those who adopted the 'activist's logic' argued that the decision to extend the eligibility criteria acknowledged the universal right to access ART, putting an end to an ethically condemnable situation of double standards (between high- and low-income countries). They also underlined that, practically speaking, the fact to refuse treatment to people whose immune system is already damaged (those having a CD-4 count below 350, but above 200) considerably increased the risk of losing them to follow-up.

p.183). Despite its practical uselessness in the Tanzanian context, “universal access” continues to be a key concept within organisations involved in the formulation and implementation of HIV-related policies. Despite the implicit rejection of the need to choose that it entails, the concept coexists surprisingly well with the call for an increased prioritisation voiced by these very same institutions. More often than not, the allocative choices concerning the trade-offs involved in HIV-prevention and -treatment programming in Tanzania are taken at the headquarter level of international donor agencies – the predominance of which is reinforced by a national-level policy process characterised by a collective aversion to choose (see Chapter 4).

Beyond the various factors hampering prioritisation as described in the two previous chapters, this section suggests that the aversion to choose – or the continued centrality of the reference to “universal access” in discussions about policies that *de facto* ration people’s access to HIV services – is also due to contradictions arising from what could be described as a *confusion of roles*. These contradictions arise when the players’ manner of taking decisions does not coincide with their own projection of future AIDS funding, i.e. when they do not formulate their choices within the conceptual framework of reference their own evaluation of resource availability would identify as the relevant one. In Tanzania, the tension between the two aforementioned logics led many AIDS policymakers, who did not believe AIDS funding would rise in the foreseeable future, to act ‘as activists’ by continuing to operate allocative choices within a “universal access” scenario. By deliberately ignoring scarcity, they successfully evaded uncomfortable discussions about the ‘tough choices’ described above. In light of the two ideal-typical logics proposed above, I use the term *confusion of roles* to describe a decisional configuration characterised by an unclear delimitation of the ‘internal’ (the level of sectoral *policies*) and the ‘external’ (cross-sectoral, and/or international *politics*). Put differently, the distinction is blurred between questions that should be answered through an ‘internal’ reasoning within the field of HIV/AIDS that aims at efficiency and equity at the policy-making and implementation levels, and questions that are probably best dealt with via an ‘external’ (activist) logic focusing on political advocacy for increased funding for AIDS as a whole.

Where does this disconnect between the players’ analysis of the situation and their collectively formulated response stem from? The high permeability between different categories of players involved in the AIDS response (activists, health workers, researchers, patients, and health officials) is undoubtedly a specificity of the AIDS policy field that helps explain the absence of a clear ‘division of labour’ between the two logics.³²⁷ Indeed, the interpenetration of the activists’ and the policymakers’ worlds in the AIDS-

³²⁷ Beyond the above discussed difficulty to conduct “cold-blooded” research on HIV/AIDS (see introduction), one illustration of the exceptionally high interpenetration of the worlds of AIDS research and AIDS activism is the omnipresence of a specific type of ‘hybrid literature’ (e.g. H. Epstein 2007; Lewis 2006; Gill 2006; Pisani 2008). The authors of the writings falling within this sometimes scientifically informed, but slightly romanced *genre* draw on their role as experts to act as “moral entrepreneurs” (H. S. Becker 1963). Taking frequently the form of a personal narrative, this literature has both greatly contributed to mobilising people and resources, and – as in the case of Helen Epstein’s book – caused harm by spreading conjectures about the epidemic that lack both empirical and theoretical foundation (see: Sawers & Stillwaggon 2010a; Sawers et al. 2011; Sawers 2013).

related policy arena (S. Epstein 1996) has led many AIDS activists to become policymakers at the local, national and international levels. While this presence of ‘activist health officials’ within various AIDS administrations has allowed a rather unique and unquestionably beneficial re-appropriation of health by many AIDS activists and patients, it has also contributed to the ambiguity in dealing with rationing decisions.

Furthermore, the confusion of roles is made possible by the omission of the partial incompatibility of a dominantly individualist human rights approach and a population-level public health reasoning. By maintaining a political taboo concerning triage, this confusion of roles nourishes the obscuring of fundamentally political decisions over life and death. The following two sub-sections further explore some possible explanations of why “universal access”, despite its manifest irrelevance, continues to be an explicit policy goal in Tanzanian HIV-prevention and -treatment strategies. Depending on the perspective one adopts, these sub-sections argue, the AIDS players’ attitude of sticking to “universal access” as their main watchword can result either from effective self-delusion or from strategic omission.

C-1) On ‘impossible facts’ and other reasonable reasons to ignore the elephant

“And he comes to the conclusion:
His mishap was an illusion,
for, he reasons pointedly,
that which must not, can not be”

Christian Morgenstern, *The impossible fact* ³²⁸

The hesitance or outright refusal to acknowledge the need to choose, and the inexistence of an effective political debate on prioritisation it induces, can be attributed to a multitude of different factors. These factors interact in ways difficult, if not impossible to trace, and their respective importance varies between individuals and from one sub-arena of prioritisation to another.

Again, *cognitive dissonance* is a fairly simple psychological explanation (see Chapter 1). In this context, cognitive dissonance could be considered to result from the ethical unacceptability of the need to designate those who will die. The consciousness that most of the suffering and deaths that result from their rationing decisions could be avoided, were sufficient resources available, makes these decisions unacceptable to policymakers. While the avoidable nature of predictable deaths is particularly manifest in the rationing of treatment, it also applies to prevention interventions. As discussed, cognitive dissonance is a situation individuals (and, by extension, institutions) face when confronted with facts or

³²⁸ Translation from German by Max Knight of an excerpt of Morgenstern’s poem *Die unmögliche Tatsache*: “Und er kommt zu dem Ergebnis: Nur ein Traum war das Erlebnis. Weil, so schließt er messerscharf, nicht sein kann, was nicht sein darf.” (http://en.wikipedia.org/wiki/Talk%3AChristian_Morgenstern). The poem describes a person who, having been killed by a car, refuses to die, stands up and walks away – for the simple reason that, since cars were not allowed to drive where he was walking, the car that killed him should not – *and thus cannot* – have been there.

signals that fundamentally contradict their belief system. “Dissonance reduction”, as Festinger (1957) terms the psychological response to cognitive dissonance, occurs through a form of denial due to the sheer inability to face a reality incompatible with our mindset. In this sense, some AIDS policymakers consider that resources *cannot* be insufficient, for the simple reason that they *must not* be insufficient, as this radically contradicts their personal ethics and professional *raison d’être*. Similar implicit choices exist in most health-related policy decisions. Yet, one specificity (although not uniqueness) of HIV/AIDS lies in the fact that those who will or would die can be individually identified and that the effectiveness of treatment is homogenous – which makes it impossible to discriminate ‘rationally’ on the basis of diverging chances for treatment success (see below). While such psychological mechanisms probably play a role in the individual perception and institutional management of scarcity, the constellation of donors in Tanzania and the uncoordinated nature of the policy process described in the previous chapter also contribute to the collective inability to respond to scarcity through effective prioritisation.

That being said, more immediately intentional explanations for many policymakers’ denial of the need to choose exist. Indeed, ignoring the elephant in the room by challenging the obligation to formulate uncomfortable trade-offs can also be a conscious, offensive political strategy. Many AIDS activists – some of whom occupy key positions in important AIDS-related institutions – are well aware that today’s allocative choices have dynamic implications on future funding. In this sense, the decision to proceed with massive ART roll-out in the absence of secured long-term funding not only creates a political precedent, it entails a situation of dependency that makes it politically costly for donors to back out. As a Tanzanian official formulates it carefully:

All grants, from outside or within, are political. One good thing about political things is that, since people have to stay on treatment, even if there are no more resources, our President can do something...and get the donors in. (GovSector-14)

Another Tanzanian official puts things slightly more directly:

500,000 people in Tanzania are in need of treatment.³²⁹ That figure cannot go down; it will only go up. It’s politically sensitive! And what if someone will not provide the money for the people on ARVs? That’s like signing a death verdict! So they will pitch that line and use it...against the donors...against the government. (GovSector-15)

By intentionally abstracting from the need to formulate a treatment/prevention balance and from the serious challenges in terms of sustainability, treatment activists have attempted – and partially succeeded – to create a *fait accompli* that obliges the main AIDS donors to durably provide funding for antiretroviral treatment. An interesting aspect of the political relation that results from this strategic creation of irreversibility is the two-way nature of dependency it entails. As a bilateral agent forcefully underlines:

I don’t like that word, but there is a ‘treatment mortgage’... If you put somebody on treatment, you are committed to bringing that person through. [...] [T]here is so much concern about this within the USG [US

³²⁹ Today’s estimates are about 660,000.

government]. In Uganda, you had newspaper headlines saying ‘The US government decided to stop treatment – People are dying!’. There is fear within PEPFAR about this. That’s why we want the government in... [...] And hopefully, UNAIDS is having that discussion [on the infeasibility of universal access], too. [...] Until recently, this was not an issue within the Government of Tanzania. To be honest, we have been pushing them to look at it, trying to open their eyes! As PEPFAR, we don’t want to be doing this kind of stuff alone...because those are big, scary issues! Nobody wants to have a headline saying ‘PEPFAR decides to save babies, not mothers’. Nobody wants that... We don’t want to go it alone. We really don’t. (Bilateral-24)

Indeed, several interviewees working within US agencies involved AIDS control in Tanzania voice a certain fear of ending up being “stuck with it”³³⁰. Strikingly, one of them underlines: “the rapid ARV scale-up, *it should be remembered*, was the [Tanzanian] government’s choice...the USG didn’t push for it!” (Bilateral-12). While this is in contradiction with most other players’ narrative (see Chapter 6), this fear suggests that key donors on the ground do perceive a form of political irreversibility of their engagement. However, the currently decreasing tendency of AIDS funding – both internationally and in Tanzania – puts into question the solidity of this irreversibility (see Part 3).

In sum, the omission of the need to ration can be due to what could be described as an ‘offensive’ political strategy on behalf of activist individuals and institutions who, by asserting the need to ‘go full throttle on everything’, aim at creating irreversible political commitment. That being said, even if unrealistic, upholding the “universal access” discourse has other political advantages. In this sense, the next sub-section argues that the denial of the need to choose can also be due to a ‘defensive’ political strategy.

C-2) ‘Aim at the sky to hit the top of the tree’...or to avoid uncomfortable questions? The political convenience of “universal access”

“We’ll be forced to revise the targets. It’s the same for the MDGs [Millennium Development Goals]. 2015 is just across the street...it is very close and we haven’t met the targets. We are too ambitious, and maybe unrealistic. We’ll have to revise the targets. But then, it was a good exercise to aim high...‘Aim at the sky, so that you will hit the top of the tree’ as the saying goes...” (Multilateral-15)

The statement of this interviewee is quite representative of the reasoning of many AIDS policymakers. It indirectly points to a key aspect of the “universal access” approach: the formulation of policy targets perceived by most interviewees as obviously unrealistic. “PEPFAR has linear targets with linear funding”, underlines, for instance, the country director of an international NGO, “they want 150,000 people on ARVs in year one, 300,000 in year two and 450,000 in year three...that’s impossible!” (INGO-7).³³¹ Several interviewees denounce the detrimental effect on policy implementation of what they consider overly ambitious targets. Commenting on the WHO’s ‘3 by 5’ initiative, a bilateral agent underlines:

³³⁰ One US agent, for instance, voices concerns about the financial sustainability of the PEPFAR initiative to improve blood safety and laboratory services in Tanzania: “We didn’t look at what they could afford. We didn’t sit down with the Government from the beginning to see what they wanted and to see how our plans, in the end, will also be *their* plan; how to make it sustainable. Otherwise, the US is going to be stuck with it!” (Bilateral-25)

³³¹ Over recent years, PEPFAR’s approach has changed somewhat in this respect and in several domains (e.g. ART roll-out, OVCs).

I remember a TNCM meeting, before PEPFAR, where one of the WHO 3 by 5 guys said: 'We will apply for one billion dollars for care and treatment in Tanzania.' I said: 'Are you in your right mind!?' We had to exercise a veto, the US and [our agency]. These guys were two young folks from WHO, who had never been to a developing country before and who gave smart advice. The Tanzanian government didn't have a *clue* of what they were doing with them! And now they all start to complain, and criticize Tanzania for not being 'sustainable'... (Bilateral-30)

Having been involved in the formulation of the first Tanzanian ART programme, one interviewee describes the effects of target chasing as follows:

We had just developed a plan for ART roll-out in Tanzania. This plan aimed at putting 50,000 people on treatment by 2006 [...]. Then came the WHO with their '3 by 5' initiative and quadrupled the treatment targets to 200,000. They didn't worry about our plan. They went straight to the President and pushed for the goal of 200,000 people on treatment by 2005. [...] It was just a huge mess! They put so much pressure on people here, it was incredible. The whole process was hijacked by the politicians! They didn't even ask any of the technical people... *Everybody* knew it was not realistic! [...] We knew it was an absurd goal! Initially, we planned to do a very careful scale-up...to check adherence... Adherence should be at least 95% and if it isn't, you should have serious doubts whether or not you should go for it, because of increasing resistances. [...] So, unsurprisingly, there came to be a large gap between the official targets and the empirically observed number of people on treatment. [...] So later we said: 'Well, let's just forget about the targets...'. (Multilateral-12)

The 'universal access' mode of action led to what several players describe as a chaotic implementation of ART roll-out. By focusing nearly exclusively on the number of people who would access treatment, it tilted the balance against the quality of services delivered – especially with respect to adherence monitoring and the follow-up of patients.³³² In Tanzania, not only has the relative neglect of 'quality' in treatment programmes caused adherence to be very low, but the primary focus on access did not allow meeting the ambitious quantitative targets. The overall number of people on treatment, several interviewees underline, ended up not being higher than what it would have been according to the initial plan of a more progressive scale-up.³³³ "Had we rolled out treatment in a more calm manner, focusing on high prevalence regions, we would not have fewer people on treatment today", concludes a bilateral agent (Bilateral-31).

In the Tanzanian case, the target chasing induced another questionable allocative decision, strongly criticised by the above-quoted multilateral agent:

Now, [if you] loo[k] at the rationality of decision processes, I think that very often, there is no rationale. Decisions can be completely irrational.³³⁴ For instance, when the '3 by 5' initiative started in Tanzania, there were already 3,000 well-off patients on treatment in private clinics. Being completely obsessed with targets, the first thing they did was to give these people free treatment. They were the easiest to reach! Now, how can you be so stupid!? It's unbelievable! If these people have money to pay for treatment, let them continue to pay for it for a while and let's get the *other* people on treatment first! So many stupid decisions have been taken just for the sake of targets! (Multilateral-12)

³³² This relative neglect of adherence contrasts with the approach championed by the International Union against Tuberculosis and Lung Disease, which attempts to broaden the general provision of care available to TB patients (among other patients) in order to improve the adherence to TB drugs (Ait-Khaled & Enarson 2003, p.74-77).

³³³ This is all the more credible as the official monitoring of "people on ART" does not take into account the low adherence rates (see above).

³³⁴ This statement omits that target chasing does, of course, follow a rationale; it is just not a rationale that primarily aims at optimising health outcomes (concerning the multiple rationalities involved in AIDS policymaking, see Chapter 3).

Beyond being a telling illustration of the side effects of target chasing, this example illustrates an implicit political logic behind treatment roll-out campaigns that are run under the banner of “universal access”: if everybody is said to receive treatment in the very near future, the question of who should benefit from free treatment *first* is less crucial. Put differently, giving free access to ARTs in priority to those HIV patients of the Tanzanian political and economic elite (which is what happened) is less politically compromising if the poor, too, are guaranteed virtually immediate access to treatment. If, as it turned out to be the case, many of them die while waiting for treatment, the deeply political nature of the initial decision to favour some over others becomes immediately obvious. The *no-need-to-choose* ideology leads to implicit rationing. Even if unrealistic, the “universal access” maxim thus yields the political advantage of a non-decision strategy: by implicitly declaring triage irrelevant, it depoliticises the choices the *de facto* non-universal provision of HIV-related services involves. The radical conflict of interests, which underlies rationing, is negated and the decisions over life and death are not publicly discussed. One interviewee explicitly points to the lack of transparency of allocative decisions in the roll-out of ART in Tanzania:

I looked at the trade-offs involved in the decision-making processes between access and quality. [...] [A]ll decisions were made by technicians and the donors and [...] there was simply no clear decision process for that kind of ethical issue. In most cases, the decisions were just taken by technicians on the basis of very flimsy evidence. (Multilateral-14)

Far from being a transparent procedure that allows for public discussion, as well as ethical and scientific considerations (e.g. equity or cost-effectiveness) to feed into the decision process, the formulation of HIV-related policies in Tanzania favours implicit rationing. In this sense, it confirms Crawshaw’s (1990) analysis, which, based on a study of Great Britain, described health care rationing as “a silent conspiracy between a dense, obscuring bureaucracy, intentionally avoiding written policy for macroallocation (rationing), and a publicly unaccountable medical profession privately managing microallocation so as to conceal life and death decisions from patients”. While the case of HIV prevention has been discussed at length in the preceding chapters, the limited evidence this study collected on the process of treatment roll-out suggests that there is no systematic effort to regulate access through procedural rules or explicit decision criteria used to discriminate among interventions, regions or patients medically considered as being in need of ARVs. As Ham and Coulter (2001) rightly underline, the rationing of health care tends to combine explicit and implicit decision-making processes. While patients’ CD-4 count is an explicit *and* objective criterion for triage, the rationing *among* those considered as medically qualifying for ART is predominantly based on implicit decisions.³³⁵

³³⁵ In this sense, the much-debated introduction of so-called “test-and-treat” programmes (which suppress the condition of a CD-4 count below 350 to qualify for ART) in countries with non-universal access to treatment poses serious challenges in terms of equity. Indeed, some healthy HIV patients (those tested positive in a test-and-treat programme) would access treatment before others whose health status is critical and for whom the denial of access to ART means death in a foreseeable future.

An under-researched aspect of the political economy of treatment roll-out concerns the relation between HIV testing and the demand for antiretroviral treatment.³³⁶ As long as people do not know their serological status, this demand remains implicit. Their health need is made explicit, i.e. transformed into a demand, only after people have tested positive for HIV. Due to stigma among other factors, however, only a few people in most African countries spontaneously step forward and stand in line for HIV testing. Testing still needs to be prompted actively by health service providers. An easy way to neutralize the political risks due to the insufficiency of resources for treatment thus consists in simply not inviting people to test. Access to ART can thus be indirectly rationed by controlling access to HIV testing – a less immediately contentious decision. Without lowering the ‘objective’ need for ART within a population, a political management of testing campaigns allows the government to influence the *expressed demand* for treatment. In other words, people who die without knowing are politically less challenging than people who know with reasonable certainty that their lives could be saved by a medicine to which they do not have access because of budgetary constraints.³³⁷ Even a 50% ART roll-out could mean that the *explicit* demand for treatment is met – and thus ensure the political domestication of the epidemic. In the absence of strong grass-root mobilisation, political leaders might therefore only have limited incentives to push treatment roll-out all the way.

In sum, the discursive recognition of a universal human right to HIV treatment or prevention obviously does not prevent the effective denial of this very right to a significant portion or even to the majority of the population. Alex de Waal underlines this contradiction as follows:

There is an interesting convergence between the medicalization of HIV/AIDS programming and the human rights lobby. Both the medical profession and human rights activists are primarily concerned with the individual, and both hold it as an article of faith that all individuals are equal and have equal rights to treatment. The reality of triage [...] has no place in the ideologies of either. [...] As it is contrary to the basic tenets of medical ethics and human rights, such policies are implemented silently. (2003a, p.244–245)

By negating the *raison d'être* of triage, a boldly conceived human rights approach encourages its discretionary management. There is admittedly a fundamental paradox – and a hint of irony – in the fact that the “universal access” framework entailed by the politicisation of AIDS by international activists fuels a *depoliticised* management of rationing decisions at the national and sub-national levels in many African countries. By precluding an open debate about rationing, the AIDS activists’ *politicised* vision of the struggle against the epidemic (based on the conception of scarcity as being politically created) allows for the evasion of responsibility concerning the inequalities and differential valuation of life to which implicit rationing processes give rise.

³³⁶ De Waal points to this variant of rationing by writing that “HIV testing policies for air force units may be different to those for the infantry” (2003a, p.245).

³³⁷ This reasoning suggests that a political geography of testing roll-out – conceived as the decision to ‘activate’ the implicit demand for treatment of people who unknowingly live with HIV – would provide a both challenging and immensely interesting field for enquiry. Mechanic (1997, p.91) rightly stresses that “diverting patients from seeking treatment, when there are treatments that patients would want but are ignorant about, is not acceptable”. The same argument could be made about diverting patients from seeking treatment by keeping them ignorant about their need for treatment (rather than about its existence).

In this sense, because it allows the confinement of the decision process to relatively closed fora and ‘deconflictualises’ its underlying stakes, the “universal access” mantra can be described as a strategy of conflict-aversion – or an *anti-politics machine*, to draw on a terminology used by Ferguson (1994) in a different context. Notwithstanding its indisputable achievements in terms of advocacy, the impressive resonance of this slogan within international and national AIDS institutions owes much to its political convenience. It allows the sidestepping of tough, unpopular choices. Although it is obviously not the only explanation for the so far surprisingly non-confrontational nature of debates over treatment access, the depoliticising effect of “universal access” strategies helps explain why the potential of conflict described in the introduction of this chapter has not – or only very partially – materialised in most African countries.

Sub-conclusion) The challenge of explicitness

Since they decide over who lives and who dies, HIV-related rationing choices are at the very heart of politics in much of sub-Saharan Africa. That being said, “[r]ationing is always a blend rather than a single strategy” (Mechanic 1997, p.83). Far from resulting from any pre-conceptualised biopolitical master plan, this chapter has argued that HIV-related rationing decisions in Tanzania result from multifaceted decisional configurations at different levels and that the tension between the individualistic ‘activist logic’ and the population-based ‘health official’s’ reasoning favours implicit choices over explicit debate and decisions. Yet, does this mean that the incompatibilities between the two rationalities are insurmountable and that triage is irremediably condemned to result from non-transparent decision processes? Probably not.

Given the African situation, the call for increased funding, not only for HIV/AIDS but for health in general, is understandable. Closing one’s eyes to the need to choose and acting as if sufficient funding for all interventions were to be made available in an immediate future, however, is self-deluding and might actually be counterproductive. This is illustrated by the following comment by a multilateral agent. When asked about what he believed to be the major upcoming challenges, he spontaneously mentions the difficulty to maintain the current level of international funding, before adding:

If people in the US get the impression that they are just flushing billions of dollars down the toilet, the current level of funding is not going to last very long... But even independently from donors’ opinions, getting value for money is important. (Multilateral-2)

Future resources for HIV/AIDS control being uncertain, explicit prioritisation might become increasingly important to sustain international support. In this sense, it could be argued that the apparent contradiction between the health official’s and the activist’s rationalities is, in part, a matter of diverging temporalities: in the longer run, their visions become at least partially compatible. No doubt, this reasoning is to a certain extent an intellectual pirouette – since the issue of temporality is one of the

core differences between the two logics.³³⁸ Nevertheless, a progressive shift in perspective seems to have taken place over recent years. Since 2011, for example, UNAIDS tackles the question of prioritisation in a significantly more explicit and pro-active manner (UNAIDS 2011a). Possibly, they have become aware that – independently of its questionable effects in terms of equity and efficiency – allocating scarce resources on the basis of manifestly unrealistic “universal access” principles has become strategically risky.³³⁹

Concerning the prospects for more explicit rationing, it seems important to underline the depoliticisation of health inequalities entailed by implicit triage, while at the same time acknowledging both the medical limits to and the serious political challenges of maximum explicitness in this domain. Health care rationing is what Hunter (2001) calls a “wicked issue” in the sense that it is a problem that cannot be *solved* once and for all but merely *managed* in more or less acceptable ways. The degree of explicitness of HIV-related rationing decisions is frequently considered as a key determinant of their social and political acceptability. Considering that the ‘Sophie’s Choice’ that underlies the rationing of ART “is the root of potential conflict surrounding access to HIV treatment”, Cheek (2001) for instance, stresses that “[i]t is absolutely critical that these decisions be as transparent as possible and free from any perceived or real allegations of abuse”. Rosen et al. (2005a) argue that ART rationing decisions imply trade-offs between social equity and economic efficiency, since “rationing systems that rate high in terms of efficiency generally rate low in terms of equity”. Consequently, they suggest:

African governments can take one of two courses: ration deliberately, on the basis of explicit criteria, or allow implicit rationing to prevail. Implicit rationing is not likely to maximize social welfare, nor does it allow for transparency and accountability in policy making. We believe that the magnitude of the intervention now underway and the importance of the resource allocation decisions to be made call for public participation, policy analysis, and political debate in the countries affected. [...] In the absence of such processes, decisions about access to treatment will be made arbitrarily and will, most likely, result in inequity and inefficiency – the worst of both worlds.

The Tanzanian case in many respects confirms these apprehensions. Other authors propose a similar reasoning concerning allocative decisions about HIV prevention (e.g. Youngkong et al. 2010). “Where discretion is large”, Mechanic (1997, p.90) rightly argues, “there is potential for abuse”.³⁴⁰

The call for these fundamentally political rationing decisions to be made explicitly draws on an intuitive conception of fairness and a democratic requirement.³⁴¹ Nevertheless, a variety of scholars have warned against jumping to conclusions both about the feasibility and the universal desirability of *explicit* rationing (e.g. D. J. Hunter 1995; Mechanic 1997; D. J. Hunter 2001; Coast 2001; Owen-Smith et al.

³³⁸ Saying, as suggests the ‘health official’s’ logic, that one should call for more resources but that *in the meantime* one needs to prioritise interventions through rationing measures, for instance, obviously contradicts the ‘activist’s logic’ – which precisely situates itself in an emergency mode of action – i.e. in the immediate present.

³³⁹ That being said, the official “universal access” discourse, of course, remains unchanged.

³⁴⁰ He adds: “no one doubts that clinical decisions can incorporate social biases that result in discrimination by race, social class, sex, and age or give advantages to those who share the decisionmaker’s values or who appear more attractive or productive”.

³⁴¹ A study in Great Britain, for instance, has shown that most patients prefer to know if their care is rationed (Coast 2001).

2009b; 2009a; 2010).³⁴² Questioning the assumption that making rationing choices explicit systematically improves the decisions and their social acceptability, these authors underline that the right mix between explicitness and implicitness depends on the type of rationing decisions involved. The arguments in favour of implicit rationing – and the resistances to *ad hoc* priority setting based on explicit criteria – are bigger, they argue, if the decisions involved are medically complex and highly context-specific (e.g. D. J. Hunter 1995, p.876; Mechanic 1997).³⁴³ Explicit rationing, in turn, appears more sensible in cases where the medical questions are fairly straightforward and uniform. The negative effects of HIV infection and the positive effects of antiretroviral treatment being quite homogeneous from one person to another, “there is no good basis for deciding who should receive [ART] and who should not” (Health Affairs 2009, p.1576).³⁴⁴ This makes the importance of equitable, open decision processes all the greater.³⁴⁵

That being said, “explicit rationing brings into a public forum conflicting needs and preferences, resulting in acrimony and political mobilization”, notes Mechanic (1997, p.86), who even warns against what he considers an undue politicisation of health issues.³⁴⁶ However, given the inherently political nature of HIV-related rationing choices in most of sub-Saharan Africa, the analysis of how these decisions are managed in Tanzania points to a lack – rather than an excess – of public debate. Making triage decisions explicit is, of course, easier said than done. Shifting from implicit to more explicit decisions not only entails a loss of power for those who formerly controlled (and benefited from) implicit allocative processes; making triage visible poses a more general political challenge related to public debates about who should live and who may die – a challenge that reaches particularly acute proportions in situations where the *explicit* demand for treatment exceeds the available treatment slots. As Coast observes in a different context, “if protest follows [...] openness, it may be difficult [...] to cope with greater explicitness” (Coast 2001). Coping with explicitness is all the more challenging as there tends to be a considerable gap between people’s general approval of health-care rationing and their reactions, when they are individually confronted with its allocative consequences (Owen-Smith et al. 2009a).

Since, “[i]n wealthy countries”, as Nguyen (2010, p.176) reminds us, “triage is a comparatively transparent political process” already – without it causing major political unrest – one might argue that these

³⁴² Mechanic, for instance, writes: “I strongly share the values inherent in fair allocation and evidence-based practice and sympathize with the concerns that argue for shifting the rationing balance toward more visible approaches. [...] But I also believe that the call for explicit allocation, while seductive, is misleading and has the potential for mischief. My sense is that we will do better by muddling through carefully.” (1997, p.84-5)

³⁴³ “The value of implicit rationing is its capacity to respond to complexity, diversity, and changing information in a sensitive and timely way. It builds on the strength of doctor/patient communication and sensitivity to the range of needs and preferences of patients whose life circumstances vary greatly. [...] Implicit rationing requires monitoring and constraints, but it still offers the most meaningful path for thoughtful judgment consistent with the complexities of care.” (Mechanic 1997, p.86)

³⁴⁴ In this sense, ART-related rationing decisions differ from those concerning HIV-prevention, which are more context-specific.

³⁴⁵ While criteria such as age, occupation (e.g. giving a priority to health workers or soldiers) or adherence can be used to discriminate between patients medically in need of ART (McGough et al. 2005; Kimmel et al. 2012), *absolutely* speaking, none of these criteria is obviously anywhere close to satisfying.

³⁴⁶ “Such public conflict has a destabilizing influence on the health care system and makes it susceptible to political manipulation. Once decisions are removed from a dialogue between doctor and patient to a public decision-making process, such decisions easily become the turf around which social, moral, and political battles get fought.” (1997, p.86)

challenges are altogether manageable.³⁴⁷ While, individually speaking, health-care rationing in high-income countries involves just as “tragic choices”³⁴⁸ as the formulation of AIDS control policies in sub-Saharan Africa, there arguably is a difference in scale – which further strengthens the case for a public debate and explicit political decision process concerning African ART programmes. While explicit rationing is tremendously challenging, continued implicitness might also become increasingly difficult, politically speaking. As Ham and Coulter (2001, p.163) underline, the “evasion of responsibility” that comes with implicit rationing “will be difficult to sustain in an environment in which public awareness of decision-making in health care is growing”. That being said, while the population’s growing awareness of these life-and-death decisions increases demands for explicitness, the extent to which a lack of transparency will actually translate into a serious political challenge for rulers depends on a variety of variables, including the more or less confrontational way in which societies deal with conflict. In this sense, the characteristics of the Tanzanian political process described in the introduction to this part put into perspective Cheek’s (2001) warning against the “inevitable civil unrest” that would result from an incomplete ART roll-out.

More fundamentally, the call for an open public debate and an explicit management, by African states, of the rationing choices involved in AIDS control presupposes that the locus of decision is effectively situated at the national level. For national-level controversies and political struggles to inform allocative decisions, and for these irreducibly political decisions to be dealt with ‘politically’ (i.e. via national institutional processes), the possibility to sanction unpopular trade-offs via elections or other political feedback mechanisms is indispensable. Consequently, the largely non-democratic system of policy formulation and implementation put in place over the last decade by international AIDS donors in Tanzania, is completely at odds with calls for explicit rationing via public debate and democratic decision. As Chabrol (2012) describes concerning (the very different case of) Botswana, the formulation of AIDS-control policies puts at stake the ability of African states to “take care of their population” – a co-constitutive element not only of the legitimacy of the state, but of the coherence of the nation. Being the expression of an “elementary form of sovereignty” (Nguyen 2010, p.114), the management of AIDS-related triage is immediately and inherently related to the question of political autonomy – a much talked about but little materialised concept with respect to AIDS in Tanzania.

³⁴⁷ Although it involves a mix of explicit and implicit decisions, triage in Western countries, Nguyen rightly underlines, is “visible in debates over waiting times, treatment priorities, insurance coverage, and the way health budgets are allocated” (2010, p.176).

³⁴⁸ Mechanic (1997, p.89) defines “tragic choices” as “involv[ing] situations in which demand for a scarce lifesaving service exceeds supply and a decision must be made as to who receives the service”. Organ donor lists are probably the most frequently used example. Yet, the fact that the decision to practice organ transplantation (a comparably expensive health intervention) is itself the result of a less visible but more general “tragic choice” frequently goes unnoticed.

Part 3) AIDS and ‘the rest’: heteronomy, biopolitical sovereignty and the politics of health in Tanzania

“HIV is only the latest in a litany of preventable and treatable diseases that shorten the lives of billions. [...] Working in Africa, every day I observed firsthand the toll these preventable conditions took. Regardless, it seemed that the battle against AIDS was all that mattered.”
(Nguyen 2010, p.6)

This account of the impact of massive international AIDS initiatives in West Africa applies to the Tanzanian situation as well. As discussed in Part 2, resources for AIDS control remain insufficient in most African countries. Nevertheless, HIV/AIDS is incomparably better endowed than any other health problem on the continent. The unprecedented success of the international mobilisation against AIDS has multiple effects on the Tanzanian health system. Beyond the crucially important issue of justice among patient groups, this success raises a number of questions related both to the efficiency and effectiveness of the AIDS response itself, and to the ability of the Tanzanian government to formulate coherent national health policies. As discussed in Chapter 6, only very few interviewees consider that HIV-related activities are overfunded absolutely speaking. Yet, many suggest that other pressing health issues deserve just as much consideration and that, relatively speaking, the attention devoted to HIV/AIDS is disproportionate. To use just one example among many, while AIDS funding has increased fifteen-fold in Tanzania between 1998 and 2008, the proportion of the Tanzanian population that has access to an improved water source (a major element in the control of infectious diseases) *declined* between 2003 and 2010 – from 84 to 79% in urban areas and from 45 to 44% in rural areas.³⁴⁹

Looking at the broader political and health context of the international response to HIV/AIDS in Tanzania, the last part of this thesis analyses some of the immediate effects and more subtle policy implications of vertical AIDS control in Tanzania. The relations between HIV/AIDS and other health issues emerged rapidly as a central problem during fieldwork in Tanzania. In this sense, although the following chapters are based on the description and analysis of the Tanzanian situation, most tensions and contradictions that emerge from the discussions with AIDS and health policymakers in Tanzania result to a great extent from the scale and design of the *international* response to HIV/AIDS. The controversies to which these contradictions give rise at the national level both fuel and reflect debates about AIDS control and global health at the international level. Consequently, and before going into specifics in the following chapters, this introduction gives a quick overview of the genesis of the international AIDS response and of its institutional transplant to Tanzania. It then briefly summarises the sometimes passionate debates this largely heteronomous³⁵⁰ (donor-driven) process has prompted among AIDS and

³⁴⁹ Data from the WHO/UNICEF Joint Measuring Programme: <http://data.worldbank.org> (accessed February 19, 2013)

³⁵⁰ Castoriadis (1974) differentiated “autonomous” and “heteronomous” societies. While the members of the former consciously and explicitly create their own institutions (traditions, laws, etc.), those of the latter attribute the existence of these institutions to an extra-social authority (God, the state, ancestors, etc.). Although situations of donor dependency obviously resonate with Castoriadis’ distinction, I use the concept of heteronomy in its general sense, as the imposition of

health policymakers at the global level, and describes the formulation of a national response to HIV/AIDS as an exercise of sovereignty.

International AIDS control: 'An empire based on the argument of exceptionality'

“HIV/AIDS has built quite an empire based on the argument of exceptionality”
(Bilateral-29).

“Is the AIDS pandemic so exceptional a threat that it is in a league altogether different to other infectious diseases or causes of ill health? Is the pandemic so exceptional a threat that its control should not be just one of many Millennium Development Goals but rather an overarching priority, a prerequisite to achieving the MDGs? [...] So exceptional that it demands that we undertake fundamental changes on many fronts if we are to succeed? Ladies and gentlemen: AIDS is exceptional. The response to AIDS needs to be equally exceptional.”
Peter Piot (2005, p.1)

This statement by the former director of UNAIDS, the institutional ‘incarnation’ of AIDS exceptionalism, summarises the state of mind that inspired much of the international response to HIV/AIDS since the turn of the century.³⁵¹ While there has been a virtually uninterrupted debate over the multifaceted concept of AIDS exceptionalism since the 1980s, the meaning of the concept itself has evolved significantly over the last three decades (J. H. Smith & Whiteside 2010). During the early years, when North America was considered the epicentre of the global epidemic, AIDS exceptionalism developed “as a Western response to an epidemic that threatened the lives and rights of specific populations” (*ibid.*). Many of these population groups – such as gay men, injection drug users, or immigrants (Haitians in the US, Africans in Europe) – were already stigmatised before the epidemic. Primarily as a result of the political activism of gay men,³⁵² early AIDS exceptionalism referred to the abandonment, by public health authorities, of “‘traditional’ and effective approaches to communicable disease control in favour of a civil liberties approach” (Lazzarini 2001, p.149).³⁵³ As Smith and Whiteside describe, the highly effective political advocacy by “an exceptionalist alliance, including the gay community, liberal and left-wing parties, and the healthcare and psychosocial professions” resulted in the formulation of a unique response to the Western HIV epidemics:

During the 1980s, public health adopted a human rights framework that took societal-based vulnerability into consideration and increasingly became involved in societal transformation efforts. HIV/AIDS was

rules (*nomos*) by others (*heteros*) – or as Merriam-Webster defines the term: “subject to external controls and impositions” (www.merriam-webster.com).

³⁵¹ An important element in this reasoning was the idea of an unlimited global propagation of HIV (see Chapter 1 on the fear-driven politics of AIDS advocacy). As late as 2005, Piot underlined that a “crucial way in which the AIDS pandemic is exceptional is that an ‘epidemic equilibrium’ or plateau is nowhere in sight”, and that HIV/AIDS has “broken with the general pattern of diseases and natural disasters, which usually create their own brutal equilibrium” (2005, p.2). He probably did not know, but as he spoke the decrease of HIV incidence in many African countries was ongoing and the epidemic was evolving towards the “brutal equilibrium” it has reached today.

³⁵² In this sense, Bayer (1994; in Smith & Whiteside 2010) writes: “The embrace of exceptionalism must be understood in broad political terms, as representing in large measure, a singular victory on the part of gay men, their community-based organisations and their allies”.

³⁵³ Another illustration of AIDS exceptionalism is Alex de Waal’s (2003a, p.251) acquiescing prediction of the creation of an autonomous discipline of “AIDS studies”, with its own degrees, diploma, career structure...an evolution that would certainly have increased even further the already striking disconnect between the study of HIV/AIDS and that of other infectious diseases.

positioned as not only a health condition, but also as a social issue that required a political, as well as a medical, response. The scientific establishment's control on public health was challenged, and a new type of public health initiative was called for: one that provided counselling, protected privacy, and empowered the patient. (J. H. Smith & Whiteside 2010)

This approach, focused on the non-discrimination of the most-affected population groups and the preservation of their rights, was quite effective in bringing the Western HIV epidemics under control and it certainly triggered a positive evolution of medical practice and public health interventions in many parts of the world. Yet, the largely unreflected transfer, not so much of the rights-based framework but of the behavioural causal story from which it emerged and to which it implicitly refers, contributed to the tragic failure of HIV-prevention policies in sub-Saharan Africa (see Part 1).³⁵⁴ As global attention concerning AIDS shifted to Africa during the late 1990s, the key stakeholders of the international response were insufficiently aware that, although facing the same virus³⁵⁵, they were confronted with radically different epidemic dynamics.

From the mid 1990s on, the idea that broad societal action well beyond a purely medical response was necessary to curb the African HIV epidemics became a guiding assumption of the international AIDS response. In 1996, this conception of a 'multisectoral' approach inspired the creation of UNAIDS, the first ever UN institution dedicated to a single pathology. One of its principal mandates was – and still is – to coordinate the 'multisectoral' AIDS response of all sector-specific UN agencies. The African epidemics having been erroneously framed as resulting primarily from risky sexual behaviours due to a complex configuration of 'vulnerabilities', the main idea behind the multisectoral approach was that this epidemic was not merely a health issue to be solved by the usual health-sector responses to infectious disease, but that virtually all sectors (e.g. education, trade and transports, agriculture, labour, etc.) and levels of government should be mobilised in the (behaviour-change) struggle against HIV/AIDS. In a sense, the 'multisectoral' approach is closely akin to the military concept of a 'total mobilisation' of all groups of society for war (here: the 'war' against HIV/AIDS). As discussed below, until the early 2000s, this ambition, however, remained in stark contrast with the actual means at the disposal of international AIDS advocates.

With access to ART becoming close to universal in the industrialised world during the late 1990s, HIV/AIDS transformed "from a lethal disease to a manageable chronic illness", in a way that "[b]y 2000, AIDS exceptionalism, as it had originally been conceived, was over" (J. H. Smith & Whiteside 2010). In the West, the availability of effective medical treatment made AIDS exceptionalism lose its relevance and HIV/AIDS much of its political acuteness (Cattacin et al. 1997, chap.6). At the same time, the international AIDS activists' efforts to draw political attention to the dramatic magnitude of the African

³⁵⁴ The close relation between this first-wave rights-based AIDS exceptionalism and the behavioural paradigm is illustrated by Putzel's (2004a, p.20) argument in favour of a democratically formulated response: "The character of the HIV/AIDS epidemic is such that both individual sexual behaviour change and the transformation of social norms of sexual behaviour lie at the core of prevention and it is difficult to secure these through coercion. It is this that makes the case for democracy compelling."

³⁵⁵ i.e. HIV-1, in most of Eastern and Southern Africa

epidemics during the 1990s was strikingly unsuccessful (e.g. Gill 2006, chap.8; Lewis 2006; Behrman 2009). Despite repeated warnings and alarming studies on HIV/AIDS in sub-Saharan Africa from the early 1990s on, “it took almost another decade for Western governments and international institutions to get worried” (de Waal 2003a, p.240). The mobilisation suddenly bore fruit at the turn of the century. The normalisation of HIV/AIDS in the West was accompanied by a progressive shift towards a new, global form of AIDS exceptionalism. HIV/AIDS was declared a “global emergency” by the UN General Assembly in 2001 (UNAIDS 2002a), and two years later two newly created Global Health Initiatives (the Global Fund and PEPFAR) made available massive funding for AIDS control in Africa. As Whiteside (2009, p.1) notes,

However AIDS became increasingly ‘globalized’, the impacts in developing countries were deemed an issue of global concern with implications for the affluent and powerful. This, assisted by a trend toward securitization and language of ‘global threats’, created new space for mobilization around the disease. [...] The inequity of treatment availability came under the spotlight and there was a mobilization around treatment programmes and international pledging of increased resources. In 2002 the Global Fund for AIDS, TB and Malaria was established. In 2003 President Bush pledged \$15 billion toward his Presidential Emergency Programme [sic] for AIDS Relief (PEPFAR). In the same year the World Health Organisation (WHO) launched the ‘3x5’ campaign to get 3 million people on treatment by 2005. Funding rose from \$300 million in 1996 to \$13.7 billion by 2008.

The unprecedented amounts committed turned HIV/AIDS *de facto* into an exception in the newly emerging (or at least radically restructured and renamed) policy field of ‘Global Health’. This new, globalised variant of AIDS exceptionalism was no longer primarily based on the ‘exception’ from traditional (i.e. slightly authoritarian) approaches to infectious disease control, but on the uniquely devastating impact of the epidemic in sub-Saharan Africa. Among various other factors, the particularly disastrous effects of the virus on the social and economic fabric of many African societies was (and still is) due to the fact that most HIV-infected people are young and mid-age adults. The generation that normally took care of the young and the elderly was dying on a vast scale. For most affected households, an HIV infection meant – and far too often still means – not only the premature death of the infected person(s), but a drastically increased workload for other family members in order to make up for the loss of income, to care for the dying and, more often than not, for the orphans left behind. Although politically mediated (and sometimes manipulated), the vast numbers of people infected, of AIDS deaths, and of AIDS-related orphans in many African countries certainly made a strong case for an exceptional international response.

That being said, the continued neglect of many other dramatic health problems illustrates that a ‘strong case’ alone, is not a sufficient condition to prompt massive international mobilisation. The reasons for the exceptional success, during the early 2000s, of the social and political construction of AIDS as an ‘exception’ have been widely debated and continue to be discussed by policy scholars (e.g. Shiffman 2009; Akpogheneta 2011). Interestingly, this success remains puzzling to many AIDS players themselves. When asked about her interpretation of this success, a bilateral agent exclaims: “That’s a good question for international AIDS advocates! Why were they able to build a solid lobbying base to raise funding for this disease and not, say, maternal health?!” (Bilateral-19). While certain interviewees content

themselves with simply saluting the effectiveness of the lobbying done by international AIDS activists, some suggest that the 'exceptionalist' framing strategy was precisely what made the difference. As a multilateral agent suggests:

We did good advocacy work at the global level. [...] And then there is also the advocacy done by Peter Piot, who did a remarkable job and who was at the origin of the creation of the Global Fund. [...] AIDS was put on the agenda because it was presented as a 'development problem', not merely as a 'health problem'. Otherwise we would have had less funding... (Multilateral-6)

Another multilateral agent argues along very similar lines:

It's maybe the way we construct HIV so that it will gain government support... We construct it as being maybe THE problem of this century...with multiple impacts on all sorts of issues: economic development, gender, poverty... So people end up believing that this is maybe THE thing to deal with if you want to progress in other domains. HIV/AIDS is constructed as being the cause of the rest...of the other problems. (Multilateral-8)

Although correct, this interpretation is only part of the story. Looking back at the last two decades, a bilateral agent points to another important element in the sudden international mobilisation:

You have to go back to the late 80s and 90s, when AIDS hit home in sub-Saharan Africa. During the early 90s, very little happened. At the time, it was international agencies with some programmes that pushed... There was a complete underestimation of the problem!³⁵⁶ From the early 2000s on, the possibility to treat increased the opportunities for action. In the early 2000s, they started to believe that it could be possible to bring ARV treatment to developing countries. Here, treatment arrived in 2004. That brought a lot of momentum with it. (Bilateral-20)

A Tanzanian AIDS official confirms:

ART was the very reason for the increase in resources for HIV/AIDS. The Global Fund was essentially created for ART. Before, until 2001, there were flattening resources... (GovSector-12)

Similarly, having underlined the role played by international human rights activists and by the conflict over treatment access in South Africa, a bilateral agent concludes: "Ultimately, what led to the HIV hype? The hype started when treatment became a relevant alternative" (Bilateral-30). Beyond the mere magnitude of the epidemic's devastating impact on the social and economic fabric of African societies, or the framing of AIDS as a global security problem, the political momentum for action was thus decisively codetermined by the emergence – thanks to pharmaceutical innovation *and* political struggles – of antiretroviral therapy as a credible option for sub-Saharan Africa. Not only did the possibility to treat Africans contribute to broadening the pro-treatment coalition to medical doctors (many of whom hold key positions in international health institutions) and Western pharmaceutical companies, it also allowed Western AIDS activists to frame their governments' inaction as homicide by omission. Beyond the obvious political effectiveness of this framing, the African AIDS epidemics were increasingly – and often over-optimistically – portrayed as a problem that could now be 'solved'. In the years following the massive international investment in AIDS control, the number of Africans on antiretroviral therapy

³⁵⁶ The blatant neglect of HIV/AIDS during the 1990s helps explain what is apparently an absurd statement by one interviewee working within a PEPFAR implementing agency. He claims: "We till the field nobody else is ploughing" (Bilateral-15). By 2008, when this statement was uttered, this assessment illustrates a fundamentally biased interpretation of actual health priorities in Tanzania: HIV/AIDS had obviously become the field *everyone* was eager to till.

dramatically increased from fewer than 30,000 in 2001 (UNAIDS 2002b, p.22-3) to over 6 million today (UNAIDS 2012b, p.50).³⁵⁷ Although this is still less than half of the people in urgent need of treatment in sub-Saharan Africa, it undoubtedly is a considerable public health achievement.

This major shift towards treatment, during the first years of the 2000s, gave rise to what remains one of the fundamental contradictions of the international response to the African AIDS epidemics. Indeed, it was ironically precisely when the newly established national multisectoral AIDS commissions started to exist and finally received the long-awaited means to fulfil their mission that the relevance of their multisectoral framework of HIV prevention was radically put into question by the sudden shift of international AIDS-control efforts towards care and treatment – a decision that powerfully reconfirmed the central role of the health sector. As the next sections shows, this aspect of the history of the international response to AIDS in Africa helps explain some of the institutional tensions and controversies that emerged at the country level.

The ‘Tanzanian’ AIDS response: a belated institutional transplant with limited success

“Before 1995-1998, HIV was not an issue. Neither in Tanzania in general, nor in the [CCM Party’s] National Executive Committee. Actually, it wasn’t such an issue until after 1999, when the President declared AIDS a national disaster...”
(GovSector-4)

Despite its already devastating impact during the late 1980s and the 1990s, this statement by a senior Tanzanian AIDS official and former member of the CCM Party’s National Executive Committee shows that HIV/AIDS was not considered a political priority in Tanzania until the end of the century. The extent to which the history of the institutional response to AIDS in Tanzania has been determined by that of the international response to the epidemic is striking. Yet, neither the blatantly insufficient scale of the response during the 1980s and 1990s nor its entirely donor-driven nature make Tanzania exceptional in comparison to other sub-Saharan countries.³⁵⁸ After the WHO-led creation of the Tanzanian National AIDS Control Programme (NACP) in 1987 and five years of mitigation efforts driven by WHO staff and international consultants (in collaboration with NACP, of course), funding significantly decreased from 1992 on. Due to poor financial reporting, slow disbursement rates to lower government levels, and gaps between funding commitments and actual disbursements, donor funding to NACP declined from USD 7,6 million in 1987/88 to a low of USD 200,000 in 1996 (Hartwig et al. 2005, p.1617).³⁵⁹ This drop in funding seriously jeopardised NACP’s ability to operate at the very period when HIV-infection rates were increasing rapidly in Tanzania (Somi et al. 2006; W. Urassa et al. 2006). “Despite budgetary increases

³⁵⁷ As discussed, these figures include considerable double counting.

³⁵⁸ The history of the institutional response to HIV/AIDS in Tanzania has been extensively documented and analysed by authors such as Hartwig (2001), Hanson (2007), and Hellevik (2012a; 2012b). I therefore limit this summary to those elements I consider to be necessary to contextualise the analysis proposed in the next three chapters.

³⁵⁹ Hartwig et al. (2005, p.1618) strikingly add: “As money and reporting sidestepped the [Ministry of Health] and NACP, the NACP was unable to monitor or manage AIDS dollars going directly to the regions; the actual foreign assistance in AIDS dollars to the country of Tanzania during the decades of the 1990s is unknown.”

beginning again in 1997”, Hartwig et al. (2005, p.1618) note, “the effect throughout the decade 1990–2000 was a weakened NACP with insufficient resources to manage and coordinate the nation’s HIV/AIDS response”.

NACP being virtually entirely donor-funded, most Tanzanian administrations perceived it as “being a WHO entity rather than a Tanzanian government office” (ibid., p. 1617). As a result, “the Ministry of Health and other government leaders seemed to greet [the international AIDS response] with a combination of neglect, apathy and obstruction” (ibid., p. 1622). The simple fact that, between 1996 and 1998, the institutional uncertainty resulting from the shift in global leadership from WHO to UNAIDS entailed a two-year gap in the national strategic planning process (ibid., p. 1617) illustrates the degree of heteronomy of the ‘Tanzanian’ AIDS response.³⁶⁰ As a Tanzanian official suggests, even the President’s declaration of AIDS as a national disaster did not emerge endogenously: “There was international pressure on African presidents to declare HIV/AIDS a national disaster and to move up the respective AIDS coordinating bodies in the hierarchy” (GovSector-3). Indeed, thirteen years after the WHO’s Global Programme on AIDS had created NACP (which was progressively integrated into the Ministry of Health), UNAIDS – with substantial financial backing from the World Bank’s Tanzania Multi-Country AIDS Programme (T-MAP) – successfully pushed the Tanzanian Government to create a multisectoral AIDS Commission. As in many other sub-Saharan countries during the same period, TACAIDS (the Tanzania Commission for AIDS) was established in 2001 by an act of Parliament.³⁶¹ In order to enable it to fulfil its mandate of coordinating the multisectoral – and thus inter-ministerial – response, the Commission was administratively located under the Prime Minister’s Office.

The genesis of both NACP and TACAIDS illustrates the direct repercussions of the changing philosophies of disease-control and institutional arrangements at the global level on the administrative design of the AIDS response at the national (and, as described below, sub-national) levels within highly aid-dependent countries (see also: Gruénais et al. 1999). In Tanzania, the coincidence, during the early 2000s, of the international AIDS agencies’ focus on multisectoral action with the reinvigorated international commitment to an ‘emergency response’ to HIV/AIDS translated into the construction of a vertical and entirely parallel network of *ad-hoc* AIDS institutions (“Multisectoral HIV and AIDS Committees”) at all levels of government – from the national down to the regions, districts, wards, and villages. A Tanzanian official summarises TACAIDS’ mission as follows: “We remove the epidemic from health to transform it into more of a ‘community development’ issue. We told the MoH: ‘You need to mobilise communities! HIV is more than just a disease...you need to *mobilise* people!’.” (GovSector-2).

Although it was intended to boost the national AIDS response through multisectoral coordination, the policymakers’ assessments of this new institutional architecture, and of TACAIDS as its core institution,

³⁶⁰ Both the nature of today’s policy process and the fact that less than 2% of the country’s AIDS control budget are funded by the Tanzanian Government suggest that not much has changed since.

³⁶¹ This was not the case of the NACP, for instance.

are at best mixed. Many interviewees actually depict this new institutional complex as an inefficient, or even a parasitic parallel bureaucracy. “For HIV/AIDS, the structure is already there, but it’s not doing *anything!*” comments a bilateral agent (Bilateral-10). A multilateral agent critically remarks:

Look at the consistently parallel structure for HIV/AIDS from international level with UNAIDS, to the national with TACAIDS, to regional with RFAs [Regional Facilitating Agencies³⁶²], and to districts level with CHACs [Council HIV and AIDS Coordinator] and CMACs [Council Multisectoral AIDS Committees] – is *that* operational?! (Multilateral-13)

An equally critical Tanzanian health official recalls:

TACAIDS even wanted to create a vertical system all the way down to the district level! Can you imagine that!? They wanted to create extra HIV positions who would be answerable to TACAIDS! It didn’t work. It couldn’t have worked... Only then, they started to think about working with NACP-people. Not only have they lost a lot of money, but we have lost so much time! It’s crazy, if you think about it...absolutely crazy! (GovSector-11)

Contrary to what this statement suggests, many sub-national multisectoral AIDS Commissions *were* actually created, most are simply not functioning properly. That being said, only at the regional level is there a Regional Coordinator directly answerable to TACAIDS. This architecture is the in-country institutional transposition of the “empire based on the argument of exceptionality” referred to by the above-quoted interviewee. This bilateral agent remembers:

The WHO was the institution that had the leadership. Then this ‘monster’ was created, which was UNAIDS. That tension translated down to the country level... [...] In comparison to other countries, TACAIDS hasn’t been really empowered. It got dominated by the NACP. It started a bit late and had trouble finding political backing. Even today, it does not seem to really have support at the political level. That’s similar in other countries, the tension between the AIDS commission and the Ministry of Health. TACAIDS could have demonstrated strength in working with other ministries and getting them involved, but that was not the case. (Bilateral-29)

While this narrative contrasts with that of several TACAIDS officials,³⁶³ most interviewees’ statements are congruent with Hellevik’s (2012a) description of a weak coordinating role played by TACAIDS – a weakness that, as Hellevik argues, is certainly in part due to the fact that the multisectoral design of the response and the institutional template that came with it were largely imposed by international donors. More than a decade earlier, Gruénais et al. (1999, paragr.25) already attributed the weakness of African AIDS control programmes – the first, health-sector based generation of internationally prompted AIDS institutions – to the fact that their legitimacy was primarily based on donor support. As Putzel (2004a) underlines, the fact that the establishment of supra-ministerial AIDS commissions has prompted no significant increase of African governments’ political commitment to AIDS control is not surprising.

³⁶² The Regional Facilitating Agencies were created as part of the World Bank’s Multisectoral AIDS Programme. They have been abolished since – in part as a result of allegations of major frauds concerning several of them.

³⁶³ Understandably, several TACAIDS officials underline that their institution leads the national AIDS response. One stresses: “TACAIDS has the capacity to lead the response. We are rightly placed at the PMO’s office and use our leaders to have power... And now, we have some people at the regional levels. [...] These people will be responsible for the information at the regional level and have an overview of who implements and supports where... And there will be regional joint reviews. Planning and budgeting will take place at the regional level. That is additional staff, paid for by the Government of Tanzania” (GovSector-14). Another one argues along very similar lines: “The advantage is the direct access to the Prime Minister’s Office...when they call, everybody is listening!” (GovSector-10). Yet, as discussed in Chapter 4, this vision of TACAIDS as an active coordinating body is not shared by most interviewees.

Multisectoral AIDS commissions, he argues, are an “organisational template [that] attempts to replace what is essentially a *political challenge* of prioritising HIV/AIDS in government and nongovernment sectors with an *organisational fix*” (ibid. p. 20). Indeed, while a certain degree of institutionalisation can help build political momentum for health issues (Shiffman 2009; Shiffman & S. Smith 2007), no institutional arrangement can impose effective coordination in contexts where the prioritisation any coordination implies is perceived as being politically disadvantageous (see Part 2). In this context, a bilateral agent describes the inter-ministerial coordination role of TACAIDS as an uphill battle:

TACAIDS doesn't have an extraordinary dynamism, but getting different ministries to work together is a huge difficulty in Tanzania. Each ministry is a kind of independent kingdom. If you want them to work together, the President has to really commit himself and yell at them. The whole system has an extraordinary inertia. If you want *anything* to move, you have to really shake things. And from the moment you stop shaking the coco tree, the system falls back into inactivity. (Bilateral-26)

Ever since its creation, TACAIDS has encountered significant resistance from other national institutions – most prominently from NACP. Many interviewees refer to major conflicts between TACAIDS and the Ministry of Health – of which NACP is a part. Some even describe cases of active obstruction. “The NACP-people were lobbying against the creation of TACAIDS until the last second before the vote in Parliament”, remembers one interviewee, “but the creation of the Commission had been announced by the President, so there was no way to get around it” (Multilateral-13). Other interviewees even openly suspect the Ministry of Health of having delegated particularly ‘inefficient’ staff to TACAIDS in order to weaken the newly created institution from within. In any case, NACP, which was *de facto* coordinating the national AIDS response until then, obviously perceived TACAIDS as infringing on its jurisdiction. “HIV has been in the health sector for years...they feel, it's their baby and don't want to let go”, comments a Tanzanian NGO worker, who adds: “The MoH has minimal openness with TACAIDS. That creates some...let's say...discomfort” (NGO-4). That being said, although the tensions between NACP and TACAIDS were still tangible in several of the meetings observed, several interviewees – including from these two institutions – underline that the collaboration has significantly improved over recent years.

No doubt, struggles over institutional jurisdictions purely motivated by the maximisation of administrative influence certainly help explain some of the tensions between TACAIDS and NACP. Yet, far from being a simple turf war, the controversies between the two institutions are also due to differences in views concerning the content and the design of the national AIDS response. While most African ministries of health were at the forefront of the (WHO-led) AIDS response during the late 1980s and early 1990s, the continued inexistence, unavailability, or lack of awareness³⁶⁴ of effective biomedical interventions throughout the 1990s progressively led many international AIDS advocates to consider the mandate of ministries of health as being virtually limited to caring for the sick. As Putzel (2004a, p.20□1) underlines, this omission of the pivotal role of ministries of health undermined their legitimacy to coordinate national AIDS responses:

³⁶⁴ The neglect of the contribution of health-care safety and general parasite and infectious disease control to HIV prevention, for instance, certainly reinforced the underestimation of the potential contribution of the health sector to AIDS control.

In reaction to over-reliance on the health sector in the past, the organisational template promoted by the donors has tended to *secondarise* medical expertise, by treating ministries of health as just one among many co-equal (bureaucratic and incompetent) government ministries and the medical dimension of the fight against the epidemic as just one among many co-equal aspects of what must be a multi-dimensional effort.

As alluded to above, a fundamental paradox of the international response to AIDS in Africa is the chance match of the institutionalisation of the multisectoral approach (which entails a relative devaluation of the health-sector contribution to AIDS control) with the sudden emergence of a biomedical ‘solution’ in the form of “universal” roll-out of antiretroviral therapy – an evolution that powerfully reconfirmed the key role of the ministries of health in the response to the African epidemics. This contradiction within the international response exacerbated tensions between the two national AIDS institutions in Tanzania: TACAIDS was brought into being, and began to play its multisectoral coordinating role, at the very moment massive donor funding started to transit through NACP for ART roll-out. This shift towards antiretroviral therapy induced a relative loss of influence for TACAIDS, which was (and still is) widely perceived as being in charge of HIV prevention, not treatment – a distinction further refined below. A multilateral agent describes the resulting institutional configuration as follows:

Who implements? Who has authority? Who has the funding? TACAIDS works with many agencies and gives them guidance. But at the end of the day, it is mainly the Ministry of Health who does the implementation. Care and treatment *alone* account for 64% of total AIDS spending and that’s all with the Ministry of Health. (Multilateral-4)³⁶⁵

In this context, it is not surprising that “the health sector approach continued as the dominant policy paradigm”, as Hellevik (2012b, p.571) concludes her analysis of “multisectoral coordination” in Tanzania.

Beyond the balance between treatment and prevention, the distribution of roles between TACAIDS and NACP results from – and has repercussions on – the balance between biomedical and behavioural *prevention* interventions. While some interventions are relatively ‘purely’ biomedical (e.g. blood screening or STI treatment) and others relatively ‘purely’ behavioural (e.g. the promotion of abstinence, faithfulness, and condom use), simplistically opposing ‘behavioural’ and ‘biomedical’ prevention makes little sense. Indeed, many standard prevention interventions (e.g. counselling and testing, microbicides, male circumcision, PMTCT, or injection safety) involve an indispensable combination of biomedical *and* behavioural aspects in order to be effective. That being said, discussions over the relative importance to be given to behaviour-change vs. ‘biomedical’ interventions are highly controversial, both in Tanzania and in the international literature.³⁶⁶ Roughly speaking, after a first period of a predominantly biomedical response by WHO-driven AIDS control programmes within African ministries of health during the late 1980s and early 1990s, the international response to AIDS became increasingly based on behaviour-change – a trend that was further confirmed by the multisectoral approach in the late 1990s

³⁶⁵ The latest available figures in this respect state that 59% of AIDS funding in Tanzania are spent on care, treatment and support, and 23% on prevention (TACAIDS 2012b, p.II). That being said, although the Ministry of Health is obviously a key player in treatment roll-out, less than 15% of the funding is actually on the Ministry’s budget (*ibid.*).

³⁶⁶ For an interesting example of such a controversy, see (Potts et al. 2008; UNAIDS 2008).

and early 2000s. In the late 2000s, the response took yet another turn with the confirmation of the strong preventive effect of antiretroviral therapy and the progressive emergence of an increasing ‘arsenal’ of biomedical prevention interventions (e.g. male circumcision, microbicides, ARV-based pre- and post-exposure prophylaxis³⁶⁷). This process of “remedicalization”, as Nguyen et al. (2011) put it, was already palpable during fieldwork,³⁶⁸ and it has prompted considerable controversy during negotiations leading to the formulation of the Tanzanian Prevention Strategy. Indeed, especially during debates concerning the costing exercise described in Chapter 4, there was a clearly perceptible opposition between those players in favour of health-sector interventions (e.g. male circumcision, testing, STI control, PMTCT, blood safety) and those who believed behaviour-change interventions should be given higher priority.

Beyond differing interpretations of the epidemiology of the Tanzanian AIDS epidemic, this rivalry owes to the fact that both groups of interventions (‘biomedical’ and ‘behavioural’) involve different implementing players. The struggle over their relative importance thus also is a struggle over resources (see: Chapter 3). While NACP implements the health-sector based ‘biomedical’ prevention interventions, TACAIDS is widely perceived – and perceives itself – as being primarily in charge of *behaviour-based* prevention interventions. As one interviewee from a Tanzanian NGOs puts it: “TACAIDS pushed for the ‘it’s all about sex’ approach” (NGO-1). This implicit division of labour between NACP and TACAIDS has reinforced the affinities between the multisectoral approach and behaviour-based HIV prevention to such a degree that the former was virtually reduced to the latter.³⁶⁹

This turbulent history both of the international AIDS response and of its national transposition in Tanzania is important to keep in mind when looking at the debates about AIDS exceptionalism and the appropriateness of the vertical response to which it gave rise.

Debates over the scale and design of the international AIDS response

All diseases have both very specific aspects *and* share a wide range of commonalities with other health problems. A major challenge health policymakers face thus consists in integrating the necessarily specific responses to any given pathology into a global, transversal approach to public health and health service

³⁶⁷ Both pre- and post-exposure prophylaxis are, however, still virtually inexistent in Tanzania.

³⁶⁸ Nguyen et al. (2011) rightly criticise the progressive shift from “treatment as prevention” (i.e. taking into account the preventive effect of ART) to “treatment *is* prevention” – the idea that a purely treatment-based response (i.e. ‘test-and-treat’) makes other preventive interventions superfluous. Strikingly, this ‘biomedical turn’ has not prompted a more straightforward acknowledgment of the central role of cofactors, although – just as cofactors – it is based on the acknowledgement of the crucial importance of the risk of transmission per exposure (see Chapter 1).

³⁶⁹ The dominant perception of multisectoral action and behaviour-based prevention as being perfectly congruent, however, is detrimental to HIV prevention. No doubt, it makes sense, for instance, to enrol the Ministry of Education into organising in-school prevention programmes. Nevertheless, the evidence presented in Chapter 1 not only suggests that one should not underestimate the contribution of the health sector to HIV prevention (via the control of various parasitic and infectious diseases or improved medical safety), it also indicates that it is insufficient to limit the multisectoral approach to behaviour-change interventions *in different sectors*. Vector control of parasitic diseases, the improvement of nutrition security, sanitation, or access to drinking water are all interventions outside the health sector that could make important contributions to the reduction of population-level susceptibility to HIV, among many other infections (Stillwaggon 2006).

delivery. The degree of 'integration' of disease-control initiatives depends on their articulation with the general health system at three different levels: 1) funding mechanisms, 2) policy formulation, and 3) service delivery.³⁷⁰ Although it has started to evolve since, most of the 'initial'³⁷¹ response to AIDS in Tanzania – i.e., roughly speaking, the response between 2001 and 2008 – was funded, formulated, and often implemented via parallel structures. The antiretroviral treatment programme in Tanzania is implemented though what could be described as 'hybrid design' of service delivery: most 'care and treatment centres' are officially part of the public health system, but are both physically (in terms of the health facilities) and financially independent. Unsurprisingly, a wide variety of health players in Tanzania thus accuse the vertically designed international responses to have caused major fragmentation within the Tanzanian health system.

The governments funding the response to the African epidemics chose a vertical mode of action for a variety of interrelated reasons. Their underlying rationale could be summarised as follows: 1) The African AIDS epidemic is a health emergency of unprecedented scale and, given the weakness of most African health systems, an integrated response does not allow for a scale-up quick enough to counter effectively the exceptional threat it represented;³⁷² 2) Channelling all this newly available money through health systems with limited 'absorptive capacity' would cause major inefficiencies, which is why both the management and the service-delivery capacities of the 'host' system have to be improved first. As a US donor agent underlines:

It is important to have a fine tuned system, so that when there is a shift [from parallel structures to the health system], services will not slow down. We first have to ensure the system's ability to take over...and shift the resources later on to ensure a smooth transition. If you put all our money plus the Global Fund's money in the system, it would cripple the system! And if you look at the 2008 Global Fund audit report of Tanzania, you see that there are strong system weaknesses that might allow fraud. The system is not up to the M&E standards. (Bilateral-19)

Indeed, beyond the sole question of the rapidity of the response, several interviewees working for US institutions invoke problems of accountability as an important obstacle to a more integrated design of their response to AIDS in Tanzania. The fact that disease-specific initiatives tend to produce comparably visible results, which can be reported on using simple (and sometimes simplistic) targets and indicators, thus contributes to the political attractiveness of vertical programmes since it renders outcomes

³⁷⁰ Concentrating primarily on the last two levels, Unger et al. (2003, p.28) define "integration" as "a process where disease control activities are functionally merged or tightly coordinated with multifunctional health care delivery".

³⁷¹ Interestingly, for many AIDS players the 'beginning' of the international AIDS response in Tanzania is not the creation of NACP by WHO in 1987, but the arrival of PEPFAR and Global Fund money in 2004. In this sense, and as late as 2009, one interviewee, for instance, argues that it is yet "too early" to evaluate the response to HIV/AIDS in Tanzania, given the fact that "Tanzania has had plans in the books for 25 years, but it has had funding for an aggressive response only for the last couple of years..." (Bilateral-19).

³⁷² While the inexistence of a counterfactual makes it impossible to draw definite conclusions, the hypothetical inability of the general health system to implement a rapid response has been put into perspective by the empirically observed speed of scale-up of services through vertical programmes – most of which, such as ART roll-out, were much slower than expected (see Chapter 5).

attributable and is perceived as improving accountability.³⁷³ In this sense, the political incentive structure in favour of a vertical rather than an integrated design of HIV-treatment and -prevention programmes is comparable to that which helps explain donors' hesitance concerning structural HIV prevention measures (Chapter 3) or pooled funding mechanisms (Chapter 6).

Beyond explanations in terms of political economy, it is important to remember that the context in which emerged both the international AIDS response and its vertical design was a truly desperate situation caused by an epidemic the devastating proportions of which had been tragically ignored for over a decade. The, for many, unbearable time lag between the staggering death tolls caused by AIDS and the moment when Western and African governments finally responded to what obviously was a health emergency must certainly be kept in mind when analysing the massive investments in narrowly conceived AIDS-control programmes. Moreover, nobody puts into question the tangible results of the international AIDS response. Since the beginning of the new century, the cost of a year's supply of first-line HIV treatment, for instance, has fallen from about USD 10,000 to less than USD 100 per person and access to ART in sub-Saharan Africa has increased more than 100-fold – reaching currently close to 7 million people. Despite their insufficient scale and partially inappropriate design (see Part 1), HIV-prevention interventions have avoided several million new infections over the last decade – the most obvious ones being children born HIV-free thanks to PMTCT programmes (UNAIDS 2012b, p.46) and infections avoided by improved blood screening. These achievements are universally welcomed – and rightly so.

That being said, given the amounts of money funnelled into AIDS-control programmes in Africa, the absence of tangible results would be a scandal. Despite these obvious achievements, the international AIDS response has prompted a series of interrelated debates about the scale and design of the response to the epidemic, as well as about the vertical nature of international health initiatives in general. Broadly speaking, the tensions underlying this debate are due to concern that, however deadly the pathologies they focus on might be, massive disease-specific initiatives cause fragmentation of health systems and impede the effective development of comprehensive primary health care (CPHC) for all as expressed in the 1978 Alma-Ata Declaration (see: International Conference on Primary Health Care 1978). In a nutshell, the CPHC agenda consists in giving priority to the provision of a broad range of *basic* (i.e. technologically unsophisticated) health services as well as of drinking water and sanitation. Shortly after the Alma-Ata conference, CPHC was challenged on the basis of its 'unfeasibility' and "selective" PHC – a combination of 'vertical' initiatives addressing 5 to 8 specific, mainly paediatric, pathologies – was

³⁷³ There is, admittedly, a fundamental contradiction in the donors' focus on 'accountability' (often as an argument to refuse global budget support or health basket funding). While they – understandably – pay close attention to financial 'leaks' within 'beneficiary' countries' administrations, both PEPFAR and the Global Fund, for instance, have considerable in-built 'administrative costs' (due to the salaries they pay for expatriate employees or international consultancy and audit firms). As one interviewee provocatively puts it, "the Global Fund application crap [is] a system based on a consultant bureaucracy, which taps a good part of the money" (Bilateral-30). While many argue as if the 'choice' to be made was between losing money to Western 'aid bureaucracies' or to African administrations, the former certainly does not exclude the latter.

proposed as an “interim strategy” (Walsh & Warren 1979). The progressive abandonment of ‘comprehensive’ PHC and the adoption of vertical initiatives by international health agencies in the following years and decades prompted vivid controversies among health scholars (see: Unger & Killingsworth 1986; Rifkin & Walt 1986; and Cueto 2004). As the revival of scholarly discussions on the occasion of the 30th anniversary of the Alma-Ata Declaration illustrates (e.g. Coovadia & Bland 2008; Haines et al. 2008; Rohde et al. 2008; The Lancet 2008; Walley et al. 2008; Chan 2008; Lawn et al. 2008), the debate over primary health care is still strikingly – and in many ways desperately – topical today.³⁷⁴

International AIDS-control initiatives, however, led to a reframing of the ‘old’ debate in new terms. Not only are donor-funded HIV/AIDS programmes in Africa unprecedented in scale and duration, but the specificities of the epidemic itself turn these programmes into somewhat untypical vertical initiatives.³⁷⁵ Indeed, as treatment access increases HIV becomes both an infectious *and* a chronic disease. Consequently, many aspects of an adequate response to the epidemic require an operational health infrastructure such as clinics and labs, well-functioning procurement and distribution systems for drugs and medical equipment, as well as effective data-management systems. In many ways, responding to HIV/AIDS can therefore contribute to improving the overall performance of health systems (e.g. WHO Maximizing Positive Synergies Collaborative Group 2009; De Cock et al. 2011). The broader benefits of AIDS-control programmes, however, decisively depend on their design and degree of integration with national health systems. As described in Chapter 6, the influx of AIDS funding has, for instance, caused considerable distortions within the Tanzanian health system, in particular by attracting scarce human resources for health into HIV-related services and away from general health care. While this can be justified in countries or regions where the overwhelming majority of patients who come to the health facilities are HIV-infected, the proportionality of the response obviously depends on HIV-infection rates. In any case, questions concerning the proportionality of the response to the African AIDS epidemics are intricately related to questions about the design of AIDS programmes. As discussed in the following chapters, depending on the design of the programme, the same amount of money spent on AIDS control can have widely diverging effects on the broader health system – and thus on the response to other pathologies.

In an inevitably reductionist attempt to summarise complex past debates over the international AIDS response, one can differentiate three distinct but related questions. 1) Is AIDS control so good an investment that it deserves such an important share of national and international health funding? 2) Did the massive investment in AIDS control over the last decade crowd out funding for general health care, or has it contributed to raising investments in other health-related domains? 3) Beyond purely financial

³⁷⁴ The title of the WHO’s 2008 World Health Report “Primary Health Care – Now more than ever” tellingly illustrates this ‘revival’ of PHC (WHO 2008).

³⁷⁵ A Tanzanian official, for instance, underlines: “It’s a chronic, life-long disease... We have to put so many people on treatment for the rest of their lives... That’s different with malaria and TB: those who have received treatment are healthy.” (GovSector-3)

effects, did the international AIDS response improve or undermine the ability of African health systems to deliver health services? While there are obvious affinities between the responses to these different questions³⁷⁶, looking at them separately probably allows one to understand better the different aspects of what is one and the same debate.

Concerning the question of the proportionality of AIDS funding, Shiffman (2009, p.608) underlines that “in the early 2000s HIV/AIDS received more than one-third of all major donor funding for health, despite representing only around 5% of the mortality and morbidity burden in low- and middle-income countries”. Consequently, the question of whether AIDS control is actually such a good investment compared to other health issues has received increasing attention in recent years (England 2007; Over 2012; Grimm & Class 2011). This highly controversial debate³⁷⁷ echoes the tensions between the ‘activist’s’ and the ‘health official’s’ logics discussed in Chapter 5. Again, the question of the relevant political scale or arena of action is a key element of the debate. Health economists such as Over (2012) argue that available resources will always be scarce and that the elusive quest for unlimited funding must not keep policymakers from taking tough decisions. If one admits the absolute scarcity of resources for health, he argues, efficiency considerations – including the fact that AIDS control is by far not the most efficient health investment – must be taken into account. The ‘activists’ – among whom UNAIDS and its successive executive directors – refuse to accept the existence of a trade-off between AIDS and other health issues, arguing that more general allocative decisions between health (including HIV/AIDS) and other domains of public expenditure should not be accepted as a given, as they result from political compromises that can (and should) be challenged via political struggle (TAC 2009; Nattrass & Gonsalves 2009).

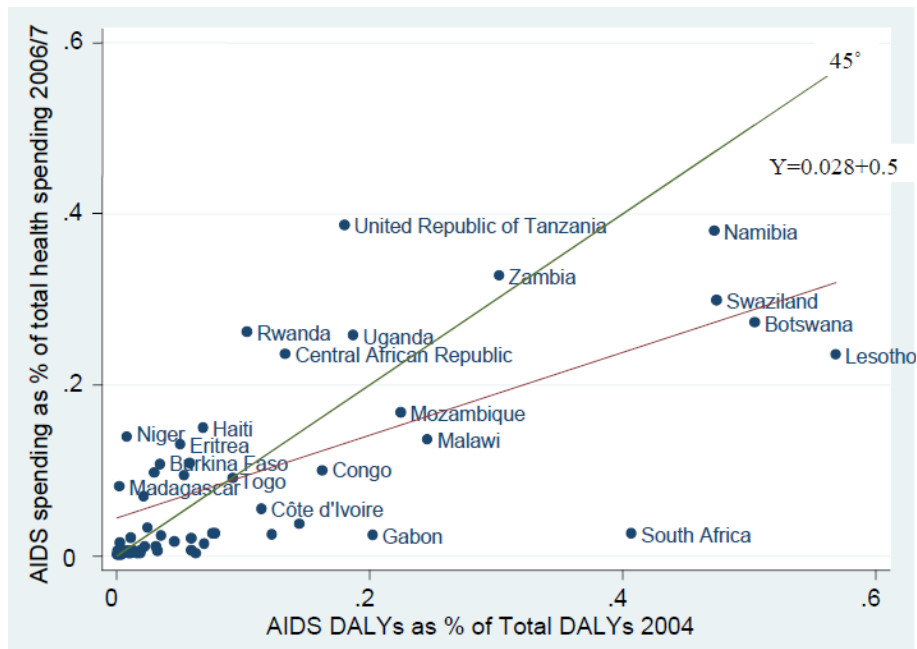
Interestingly, analyses of the proportionality of AIDS spending to the burden of HIV/AIDS in terms of disability-adjusted life years (DALYs) diverge concerning sub-Saharan Africa (Peter Amico et al. 2010; Nattrass & Gonsalves 2009). While Nattrass and Gonsalves (2009, p.3) state that “AIDS spending [...] in 2006/7 as a percentage of total health spending was on average lower than the share of disability adjusted life years (DALYs) lost to AIDS”, Amico et al. (2010) conclude that “when looked at through the lens of morbidity and mortality attributable to HIV in 2008, the proportion of funding for HIV in SSA is higher than the burden of disease”. Given the differences between the studies with respect to the countries included and the year of reference for the estimates of HIV-related burden of disease, both might be right.³⁷⁸ That being said, the data Nattrass and Gonsalves present show that in Tanzania – in contradiction to their general conclusions – HIV/AIDS is clearly *over-proportionally* funded in terms of its share of the total burden of disease.

³⁷⁶ England (2007), for instance, argues that AIDS funding is out of proportion to most countries’ overall disease burden, has diverted funds away from other health issues, and has undermined the functioning of existing health systems.

³⁷⁷ For a video that brilliantly illustrates this debate, see: (World Bank 2012).

³⁷⁸ While Nattrass and Gonsalves base their analysis on 2004 DALYs data, Amico et al. use a 2008 estimate. In the interval, both HIV incidence and HIV-related mortality has decreased in many sub-Saharan countries – and, at least to a certain extent, thanks to the massive international AIDS funding in the past.

Figure 3: AIDS spending as % of total health spending vs. the share of AIDS in the total burden of disease [from: Nattrass & Gonsalves 2009, p.4]



While HIV/AIDS only represents roughly one fifth of the total disease burden in terms of disability-adjusted life years in Tanzania, AIDS spending (according to the figures they quote³⁷⁹) accounted for about 40% of the country's total health spending in 2006/07 – a proportion that rose up to 50% in the following two years.³⁸⁰ No doubt, comparing funding data to disease burden provides no clear indication for action: DALYs are not an all-encompassing measure of health needs, the infectious nature of a disease can justify over-proportional investments to avoid propagation and thus future costs, and the possibility to act effectively at low cost can be invoked to favour some conditions over others (say, immunisation campaigns over PMTCT or ART). While the relative importance allocated to different health conditions remains an irreducibly political choice, the relative specificity of the Tanzanian case in terms of the (over-)proportionality of AIDS funding is nevertheless an important element to keep in mind concerning the controversies analysed in Chapters 6 and 7.

Given the terms of this first debate, the second question – whether international AIDS funding has helped increase or, on the contrary, crowded out funding for other health issues – is politically important. Between 1998 and 2007, donor aid for HIV/AIDS grew at an average annual rate of 48.1% –

³⁷⁹ While the total amount of AIDS expenditures has been reasonably well tracked over the last years, the available figures on Tanzanian total (i.e. Government + donor) health expenditures often remain inconsistent.

³⁸⁰ Burundi is another striking case of over-proportional funding for HIV/AIDS, which receives 28 % of the country's health spending although Burundi has an HIV prevalence of 'only' 2% (Peter Amico et al. 2010). Tanzania is not included in Amico et al.'s study, Burundi is not part of Nattrass and Gonsalves' data set. On the contrary, the South African situation is very different – which might explain the virulent response by the South African Treatment Action Campaign to the claim that HIV/AIDS is over-proportionally funded (TAC 2009).

which equals a dramatic increase of 2,325% over this ten-year period (OECD in: Shiffman et al. 2009).³⁸¹ International AIDS activism obviously contributed to raising additional political awareness for health issues in low-income countries, and most of the increase in AIDS funding was ‘new’ money as overall health aid, too, significantly rose (nearly tripled) over this period. Assuming that most HIV funding occurred at the expense of other health funding is thus historically incorrect. Nevertheless, despite a lack of data and the absence of a solid counterfactual, there is some evidence of crowding-out effects concerning other health issues. Having compared the evolution of donor funding for four historically prominent health issues (HIV/AIDS, population and reproductive health, health system strengthening, and infectious disease control) between 1998 and 2007, Shiffman et al. (2009, p.547), for instance, draw mixed conclusions. While admitting that “it may well be the case that the rise in attention to HIV/AIDS is causally connected to the rise in funding for other infectious diseases”,³⁸² they show that, although both health and overall donor aid have significantly increased during the examined decade, funding for health system strengthening has stagnated. Consequently, they conclude that “the truth of any contention that HIV/AIDS funding has benefited the agendas for health systems strengthening [...] would have to be revealed in ways that go beyond analysis of donor funding trends, which do not support such a claim”, and that “HIV/AIDS has not lifted all boats – and may actually have caused leaks to spring in some” (*ibid.*). Using more recent data, Lordan et al. confirm significant crowding-out effects of AIDS funding on both the funding of health systems and malaria control – the latter of the two effects they qualify as “large and worrying” (2011, p.351).

Comparable crowding-out effects can exist at the country level. Several interviewees, for instance, point to the importance of financial labelling effects in the national budgetary process. “In some countries the share for broader health-system activities has decreased because all this earmarked funding for the three ‘big ones’ is labelled as ‘health’ money”, underlines a multilateral agent (Multilateral-2). He adds: “In Tanzania, this is the case to some extent, but take the example of Uganda: with a stringent budget ceiling on health, 100 million more for HIV means 100 million less for health in general!”. A bilateral agent shares the same concern: “Now we have the Global Fund [money] on the MTEF [Medium Term Expenditure Framework]...that blows up the health budget! So I am very concerned about what will be the impact of this massive funding for three diseases on the rest of the health agenda...” (Bilateral-23). Proposing a “pragmatic way to prevent undue distortions of priorities within the health sector”, another bilateral agent suggests: “We just separate HIV/AIDS expenditures from the rest of the health budget...or we exclude ARVs from the health budget [...]. This would help avoid that the Government draws out of the health sector, saying ‘Look, there is enough funding...’” (Bilateral-11).

³⁸¹ They write: “Between 1998 and 2007, funding for HIV/AIDS control rose from just 5.5% to nearly half of all aid for health. Over the same period, the proportion of funding for health system strengthening declined from 62.3% to 23.9% of total health aid and that for population and reproductive health declined from 26.4% to 12.3%.” (Shiffman et al. 2009, p.545).

³⁸² They rightly argue that the Global Fund, which has dramatically increased funding for malaria and TB as well, might not have been created without the advocacy to address HIV/AIDS.

This leads to the third question concerning the impact of vertical AIDS control on the delivery of non HIV-related health services. Again, the effects are obviously positive *and* negative. The most apparent positive impact of the international AIDS response on the Tanzanian health system is the fact that ART decongests health facilities by drastically improving the health of patients who start therapy. More generally speaking, and contrary to the fears voiced by some opponents of vertical programmes (e.g. De Paepe et al. 2007), AIDS-control programmes have not led to an increased division between ‘public’ prevention and ‘private’ (i.e. individually financed) curative care. In Tanzania, as in many other African countries, the massive investments in the delivery of ART via public health facilities has tipped the balance between private and public care to the benefit of the latter. At the same time, the AIDS response also increased health workers’ workload by creating a variety of new services and diverted qualified health workers away from non HIV-related services by massively recruiting from a limited national ‘pool’ of human resources for health (see Chapter 6).

Despite the highly controversial debates about the effects of vertical programmes on weak national health systems, few *systematic* studies of the effect of the last decade’s global vertical health initiatives on the health systems of low-income countries exist. Two meta-analyses of evaluation studies – one concerning the Global Fund (J. Car et al. 2012), the other one a wide variety of Global Health Initiatives (WHO Maximizing Positive Synergies Collaborative Group 2009) – both underline the lack of robust data and raise caution about swift generalisations. The WHO Maximizing Positive Synergies Collaborative Group rightly underlines that vertical Global Health Initiatives and country health systems are “dynamic, complex entities such that examination of their interaction cannot be a simplistic, single variable, linear analysis” (*ibid*, p. 2161).³⁸³ Given the complexity and multifaceted nature of the question, it is not particularly surprising that both meta-analyses conclude that the effects of vertical programmes on country health systems are mixed. Although the general assessments of the appropriateness of vertical AIDS-control programmes diverge considerably, most analysts agree that the positive and negative ‘side effects’ of vertical programmes vary greatly according to their articulation with general health services and the *ex ante* inclusion of goals concerning broader improvements in health outcomes. Rwanda is a frequently quoted example of a successful integration of HIV services into general health service delivery. Having compared the impact of the introduction of HIV clinical services on overall service delivery in 30 primary health centres where HIV services were integrated with the rest of the centre’s activities, Price et al. (2009), for instance, conclude that “[r]ather than leading to declines in other primary health care delivery, [...] the integration of HIV clinical services may contribute to increases”. More recently, a comparable study (Shepard et al. 2012) found “no adverse effects of the expansion of HIV/AIDS services on non-HIV services among rural health centers” in Rwanda. While this encouraging result is not self-evident, it prompts at least two remarks. One is that, as the authors explicitly

³⁸³ In their meta-analysis, Car et al. (2012) underline that “the majority of the reviewed research did not fulfil the requirements of rigorous scientific evidence”. This is a somewhat awkward critique, as they also they acknowledge that “[n]one of the identified studies explicitly stated that the studies were originally designed to capture or to assess health system effects”. The studies they reviewed thus *did not attempt to produce* the evidence Car et al. ask them to provide.

acknowledge, the Rwandan AIDS response is unusually integrated, and has, from the very beginning, been specifically designed to maximise positive spillovers. Drawing sweeping general conclusions based on this specific case thus seems inappropriate. More importantly yet, both of the just-quoted studies compare health centres without HIV services to health centres with integrated HIV services. Although it is an important finding that HIV-related activities can be integrated within health centres without deteriorating general health-service delivery, the study design does not allow one to draw any general conclusion about the effects of HIV initiatives on the general health system. Indeed, the instauration of HIV services is generally accompanied by an increase in funding and staff. Comparing health centres *with* and *without* HIV services thus amounts to comparing better-endowed and less-endowed health facilities. The study design makes it impossible to measure adverse effects of the *broader* funding distortions due to the priority given to HIV/AIDS at the national level. These distortions could, for instance, hamper progress in ('non priority') health centres *without* HIV services. Yet, since these centres are the 'control group' used to measure the evolution of service delivery in centres *with* HIV services, such a possibly detrimental effect of AIDS funding would artificially inflate the estimated 'benefits' of the AIDS response by increasing the difference between the two types of health facilities (those *with* and those *without* HIV interventions). Given the fairly 'AIDS-independent' dynamic – and significant increase in funding – within the Rwandan health sector over the last decade, such adverse effects of the international AIDS response would certainly be difficult to isolate. While the absence of a counterfactual makes straightforward conclusions impossible, these positive results certainly point to the importance of the design of the AIDS response. Grépin's (2012) study of the impacts of HIV donor funding on non-HIV health service delivery in sub-Saharan Africa between 2003 and 2010 confirms this general assessment. Having documented both crowding-out effects (e.g. on childhood immunisations) and strengthening effects (e.g. on some maternal health services), she concludes:

These mixed results suggest that donors should be more attentive to domestic resource constraints, such as limited numbers of health workers; should integrate more fully with existing health systems; and should address these constraints up front to limit possible negative effects on the delivery of other health services. (p 1406)

It is in this perspective, that several scholars have proposed a 'code of conduct' for disease-specific initiatives to avoid damaging country health systems (e.g. Unger et al. 2003; Pfeiffer et al. 2008).

Car et al. (2012) rightly underline that "the persistent use and generation of anecdotal evidence when evaluating health system impacts is not scientifically justifiable". Although the policymakers' widespread expression of serious concern about the effects of the vertical AIDS response on the Tanzanian health system described in Chapters 6 and 7 is not "anecdotal" but *qualitative* evidence, the methodology of this study admittedly does not allow giving any definite answers to this important and ever-evolving debate. Rather than systematically evaluating the effects of vertical AIDS control on the Tanzanian health system, this last part of the dissertation analyses how these global controversies play out in Tanzania at the very moment of the scale-up of the international AIDS response. By drawing on the policymakers' own analyses, this part explores the tensions and contradictions to which the

heteronomous character of this response gives rise. Indeed, although the slower-than-expected roll-out of ART has drawn renewed attention to the importance of a well-functioning health system for effective disease control, the debates among health players in Tanzania are considerably less consensual than the increasingly unanimous appraisal of 'health system strengthening' by international AIDS-control initiatives might suggest.³⁸⁴

In Tanzania, beyond questions related to the formal design of the international AIDS response, the manner in which it was implemented prompted considerable criticism among the interviewees. An immediately palpable tension is due to the widespread dissatisfaction concerning the highly fragmented policy process during the 'emergency response' to AIDS in Tanzania. While vertical initiatives increase policy fragmentation *by definition* (see above), the sheer number and diversity of players involved, as well as the above-described tension between the multisectoral approach and the massive focus on (health-sector based) treatment interventions by PEPFAR and the Global Fund certainly added to the confusion. Indeed, the aforementioned conflict between NACP and TACAIDS (which has the mission to coordinate, but not the necessary means to do so) reflects a comparable disequilibrium among AIDS donors in Tanzania. As a bilateral agent puts it: "HIV is strongly dominated by the Americans. The UN want to play a big role in this domain, but they don't invest into the dialogue...they want to coordinate things, but don't invest enough to be able to!" (Bilateral-26).³⁸⁵ More generally, many interviewees criticise what they perceive as an overly-ambitious, or even an aggressive mode of action of the most vertically oriented AIDS initiatives. One bilateral agents remembers:

Some organisations were very aggressively pushing, saying: 'Here is what we have to do and that's it!'. In some of the meetings, it was like Bush: if you're not with them, you're against them!³⁸⁶ Even directors of international agencies behaved that way. UNAIDS was putting on *a lot* of pressure in the meetings. And if you had a critical analysis...well, that's tough luck for you! (Bilateral-20)

Commenting on the rapidly emerging disconnect between the vertical programmes' extremely ambitious initial targets and the actual achievements, this interviewee adds:

After some years, the international agencies realised that they were not as successful as they hoped they would be. So something has changed...but then again, not that much. (Bilateral-20)

A former Tanzanian health official remembers the effects of the arrival of vertical international funding (much of which was implemented via NGOs) at the district level:

³⁸⁴ Health system strengthening, as defined by the WHO, consists in the concurrent improvement of six "building blocks" considered as essential components of effective health systems: i.e. health service delivery, health workforce, health information systems, access to essential medicines, health systems financing, as well as leadership and governance issues (WHO 2010). For a more detailed analysis of what a shift towards a system-oriented approach implies for vertical disease-control programmes, see the conclusions of the WHO Maximizing Positive Synergies Collaborative Group (2009).

³⁸⁵ Between 2007 and 2010, assistance by all UN institutions combined fluctuated between USD 11 million and USD 15 million – which accounts for between 2 and 3% of total AIDS expenditures in Tanzania. The UN contribution is expected to drop even further in the years to come (TACAIDS 2012b, p.14).

³⁸⁶ In a very different (though also health-policy related) context, Shiffman and Smith (2007, p.1773) quote an interviewee who makes a strikingly similar statement: "[People became] extremely defensive about their ideas... If you didn't agree with the idea you were bad and wrong... It was kind of like President Bush. If you are against this idea then you are a traitor".

A lot of the money for AIDS was off-budget. It wasn't even going through the [Ministry of Health]! *Nobody* in the Ministry knew who had which resources. I remember in Kagera, one of the regions that was so badly hit, the DMO [District Medical Officer] couldn't keep pace with the number of NGOs doing activities, they were so many! The reporting mechanisms defaulted and hardly anybody was reporting to the MoH. That caused a lot of apprehension...*a lot!* Some people started to wonder who was doing what and why. And why do we allow such massive fragmentation of our system?! If you ask me, a lot of this money had no effect at all...except for being spent. (GovSector-11)

The achievements of the international AIDS response suggest that the last sentence of this statement is somewhat exaggerated. However, the fact that the proportion of international funding that effectively transits through the budget of a Tanzanian ministry stagnates at around 15% (TACAIDS 2012b) does cause continued fragmentation.

AIDS control as an exercise of biopolitical sovereignty

“Sovereign is he who decides upon the exception”
Carl Schmitt (2005, p.5)

Drawing on Foucault's (2009) concept of “bio-power”³⁸⁷, various analysts have described how the power over people's “bare life”, as Agamben puts it, has progressively become a core element of sovereignty in modern states (Agamben 1998; Fassin et al. 2004; Abélès 2006). As Nguyen's (2009; 2010) analyses illustrate, international AIDS control is as straightforward an example as any of the content and stakes of this newly emerging form of biopolitical power – a key element of which is the power to ensure survival. Within this framework, ‘biopolitical sovereignty’ concerning HIV/AIDS is exercised notably via the management of triage (Chapter 5) and the political framing of AIDS as a “state of exception” (Schmitt 1932b; Agamben 2005), i.e. the adoption of AIDS ‘exceptionalism’ – in its ‘second wave’ version – as a guiding rationale for policy formulation. It is the qualification of the epidemic as a health emergency that is altogether in a different league from other (health) problems that justifies the ‘exceptionality’ of the response, including the bypassing of national sovereignty by international AIDS initiatives and the waiver of the possibility of democratic control it implies.³⁸⁸

Biopolitical sovereignty is exercised via many decisions involved in the formulation of AIDS-control policies. Beyond the decisions of who will access life-saving treatment and who will not, a fundamentally important trade-off concerns the allocation of resources between HIV/AIDS and other health problems. As Nguyen underlines, international AIDS assistance (among other global capital flows) “enact[s] a more general triage, whereby the selection of those with HIV who should receive drugs has been displaced by a selection of diseases that merit treatment” (2010, p.181). Instead of “displaced”, one might rather say ‘superposed’, as the decision processes leading to this multi-level triage are parallel and cumulative in their effects. In this sense, this broader triage among Tanzanian citizens on the basis of a

³⁸⁷ Foucault describes “bio-power” as “the set of mechanisms through which the basic biological features of the human species became the object of a political strategy, of a general strategy of power” (2009, p.1).

³⁸⁸ In this sense, the relative confinement of the debate over the content and design of AIDS policies discussed in Part 2 is obviously also due to the highly heteronomous character of the ‘national’ response.

heteronomously defined disease hierarchy is but an additional 'decisional layer' to the wide variety of fundamentally political trade-offs involved in the formulation of HIV-treatment and prevention policies (e.g. the relative importance to be given of HIV prevention and treatment, the respective roles of the multisectoral and the health-sector based response, the more or less vertical or integrated design of the provision of prevention and treatment services, or the type of interventions and 'target' populations). As discussed, technical advice on different interventions' effectiveness, efficiency and equity effects can help inform decisions; it cannot replace the irreducibly political compromises between conflicting interests and values these decisions involve.

In Tanzania, these decisions are taken in an interplay between the headquarters of international governmental and intergovernmental agencies involved in AIDS control and a largely closed national-level donor-government policy process, with minimal involvement of elected representatives, 'civil society' or communities (see Part 2). On the basis of the different depoliticisation processes analysed in the previous chapters, one could describe the response to HIV/AIDS in Tanzania as being subject to a triple depoliticisation – via the illusion of purely technical 'evidence-based' policymaking, the closed-shop policy process at the national level, and the evasion of political responsibility by means of non-decision.³⁸⁹ Although these processes can be at least partially differentiated, they are obviously related to one another. More importantly yet, they are intimately linked to the fundamentally heteronomous nature of the AIDS response in that they are either its direct consequence or a prerequisites for its legitimacy. As discussed below, only a technocratic conception of public health action based on an exogenous definition of health needs can, for instance, justify the exclusion of the 'public' from public health decisions.

Based on the widely-shared acknowledgement that core attributes of biopolitical sovereignty are exercised by Western government agencies and (often sub-contracted) non-governmental entities, Part 3 explores this *overarching* aspect of the depoliticisation of AIDS-control in Tanzania, i.e. the expropriation of the Tanzanian people of decisions concerning their health. Developing upon the historical background and theoretical debates summarised in this introduction, this part provides an empirically founded analysis of the deployment of the international AIDS-control apparatus in Tanzania and of its political effects. In this perspective, Chapter 6 describes the controversies within the AIDS- and health-policy communities over the effects of the vertical design of the international AIDS response since the early 2000s on the Tanzanian health system. Based on a case study of the articulation of AIDS- and nutrition-security policies, Chapter 7 studies how policymakers grapple with the challenges that arise from the disconnect between the massive arrival of earmarked funding for HIV/AIDS and the diversity of the population's health needs. It analyses the power plays among health players prompted by the vertical design of international AIDS control and explores the limits to vertical disease control in a

³⁸⁹ As discussed in Chapters 1 and 2, the dominant (and exogenous) narratives of the causes of the African HIV epidemics also involve a form of depoliticisation. Although the explanation of and the action against an epidemic are closely related, I here only refer to the political management of the *response* to the epidemic in Tanzania.

context of widespread poverty and dysfunctional health systems. Developing upon this empirical analysis of the tensions and contradictions to which the heteronomous character of AIDS control in Tanzania gives rise, Chapter 8 reflects upon the concomitant difficulty and necessity to formulate a radical critique in a context of acute dependency.

Chapter 6) Vertical AIDS control and the Tanzanian health system: controversies over the international response

“For the millions living with HIV who are now on lifesaving drugs [...] the rise of mass HIV treatment programs is something to be celebrated. However, a brief idyll of therapeutic optimism has recently been punctured by the sobering realities of delivering the drugs in a landscape littered with the wreckage of health systems barely able to deliver basic services.”
(Nguyen 2010, p.180)

In Tanzania, as in most sub-Saharan countries, the AIDS epidemic encountered a health system in a dire state, marked by pre-existing structural weaknesses. Both the weaknesses of the health system and the impact of the epidemic were compounded by the devastating impact of the so-called structural adjustment programmes (SAPs) imposed by international financial institutions during the 1980s and 1990s in response to the African debt crisis. It is in this context that the massive international AIDS response – the most important element of which was the roll-out of ART – arrived in Tanzania in 2003 and 2004. While this response did bring rapid relief to many patients, it also put a considerable additional burden on the already highly fragile national health system.

Following a brief description of the state of the Tanzanian health system when the vertical AIDS initiatives arrived, this chapter analyses some of the tensions and contradictions that arose from the roll-out of the international AIDS response since 2003. Rather than providing a detailed evaluation of these initiatives' impact on the Tanzanian health system, the following sections draw on the interviewees' analyses to explore the complexity and ambiguities of today's controversies over health systems and vertical AIDS control. I therefore chose to convey the interviewees' statements and controversies without necessarily attempting to reintroduce an *ex-post* coherence into what frequently appears to be a kaleidoscopic debate. Indeed, many interviewees seem to be of two minds about the international AIDS response, shifting back and forth between a sometimes radical critique of vertical AIDS control and an indulgent acknowledgement of what they consider (or considered) an urgent need to act. Furthermore, in the often passionate statements over who or what is to be blamed for today's situation, it is not always easy to disentangle which aspects of the dysfunction of the health system the players attribute to HIV/AIDS itself, and which aspects they attribute to an inappropriate design of the international response to the epidemic since the early 2000s.

The first section proposes a rapid overview of the state of the Tanzanian health system and the challenges it poses to AIDS control. The other three sections explore the players' debates about the international AIDS response and its effects on the Tanzanian health system. A striking feature of these debates is the contrast between a rather consensual assessment of the distortive effects of the vertical response to HIV/AIDS (Section B), and the considerable differences in view concerning the desirability of these distortions and ultimately the overall appropriateness of the response to the epidemic during the

2000s (Section C). Section D focuses on aspects of this general and multifaceted debate: the impact of vertical initiatives on pre-existing donor coordination efforts in the Tanzanian health sector, and the controversies over the appropriateness and the meaning of 'integration'.

A) A health system on the brink of breakdown when HIV hit home

“[T]he global depression of the late 1970s that reversed Africa’s fortunes coincided exactly with the transformation of HIV into an epidemic disease. [...] During the 1980s per capita health spending more than halved in the poorest countries. Heavily indebted regimes seeking international support had to accept structural adjustment programmes demanding still further economy on services, including user fees at medical institutions that did less to raise money than to deter the poor from using them. In Zambia, utilization of urban health centres fell by 80 per cent. [...] This was the context within which Africans and their governments faced the first and worst of HIV epidemics.”
(Liffe 2006, p.64)

Ever since the discovery of HIV/AIDS, the impact of the epidemic on national health systems has raised serious concern with health officials and analysts. At a time when the United States still appeared to be the epicentre of the global HIV epidemic, Turshen (1989, p.240) already noted: “one major question is whether AIDS will hasten or kill initiatives for a [US] national health service”. While the impact of HIV/AIDS on the US health system was lower than its early dynamics might have indicated, the epidemic’s impact on most African health systems – or on what was left of them after years of SAPs – has been considerable.

A-1) ‘The system is going to collapse!’: old fragilities and new needs

“The advent of the HIV pandemic was a litmus test for the functioning of our health system. And I must say we have failed miserably! Because, when the epidemic arrived, we were found in such a state that it was totally overwhelming for our health system.”
(GovSector-11)

The devastating impact of SAPs on livelihoods and social systems in Africa has been widely denounced (e.g. Turshen 1999; Pfeiffer & Chapman 2010; Lugalla 1995; Mbilinyi 1993; Kiwara 2003), and the specific effects of structural adjustment on the African AIDS epidemics much discussed (e.g. Lurie et al. 1995; Denoon 1995; Barnett & Blackwell 2003). Patterson (2005, p.3), for instance, argues that neoliberal policies imposed by the World Bank and the IMF specifically fuelled the African HIV epidemics both indirectly, by increasing poverty and inequality, and directly by introducing user fees for health services, despite the fact that “primary health care is essential for preventing the spread of HIV, through HIV testing, neonatal care, and treatment for STIs”.³⁹⁰ In any case, not only did “access to medicines f[a]ll sharply during the period in which HIV flourished” (Stillwaggon 2006, p.85), but SAPs annihilated previous efforts in favour of more *coherent* public health and primary health care policies (see Chapter 7).

³⁹⁰ As discussed in Chapter 1, this list should be amended to include the safety of blood transfusion and injections, as well as the control of infectious and parasitic diseases in general.

Interestingly, several interviewees spontaneously suggest that the absence or dire quality of health services in much of sub-Saharan Africa contributed to the spread of HIV in the first place – a plausible hypothesis in light of the evidence discussed in Chapter 1.³⁹¹ As Barker and Turshen (1986a, p.54) wrote at the beginning of the African epidemics:

[T]he IMF is forcing African governments to cut back the social services, including public health and clinical care, that might mitigate the impact of the economic crisis. Health levels are deteriorating rapidly, malnutrition is spreading across the continent in the wake of the current drought, and Africans are more vulnerable to infections — now including AIDS — than ever before.

Beyond the populations' increased vulnerability to infection, the downsizing of the public sector that immediately preceded the African epidemics also helps explain the oft blatant insufficiency of the responses of African states (Patterson 2008). A Tanzanian official, who worked at the Ministry of Health during the period of structural adjustment, remembers:

When HIV/AIDS started, we *already* had a human resources crisis! You know how we got there in the first place? It all goes back to the so-called 'structural adjustment programmes'. We were put on severe restrictions, massive cuts were made. I don't know what scientific rationale was used, but there were massive cuts across the board! There was a *massive* cut of staff! They called it 'retrenchment'... We were retrenched. I remember visiting a health station, where all that was left from the staff was the watchman, so that poor guy ended up prescribing drugs and treating people... [...] Today, the human resources situation is even worse! (GovSector-11)

Several interviewees point to the persistence of comparable conditions in some rural health facilities. A multilateral agent underlines:

[I]n many facilities the trained medical personnel is simply not there, and it's the cleaning lady and the watchman who do the job and deliver the services! (Multilateral-12)

A 2008 report by the UN Food and Agriculture Organization depicts the long-lasting effects of structural adjustment on the Tanzanian health system:

Life expectancy has dropped from 55 years in 1985-90 to 46 years in 2000-2005, partly due to an increasing disease burden including HIV/AIDS. This is further compounded by low access to quality health care services for the majority of the population, insufficiently trained and inappropriately distributed health workers. The decline in human resources has affected all sectors, especially the health and education sectors. A freeze in civil service employment adopted by the Government in 1993 contributed to this situation, the consequences of which are felt now. (FAO 2008, p.8)

At any rate, the Tanzanian health system is still far from having recovered from over two decades of SAP-related budget cuts. This situation leads several interviewees to question whether Tanzanian health services actually qualify as a 'health system'. Referring to the country's level of health spending, a bilateral agent notes: "In Tanzania, per capita [public] health expenditure is 11 dollars a year. [...] In

³⁹¹ One bilateral agent, for instance, notes: "One slightly daring hypothesis to explain the non-proliferation of the epidemic in Western countries is that those infected were taken care of within an existing health care system" (Bilateral-7). This reasoning, however, points to a transmission-hampering effect of Western health systems by providing medical care *to those already infected*. This reasoning is different from that discussed in Chapters 1 and 7, which underlines the relations between poor health care and HIV infection and points to what health systems did *not do before* infection: i.e. decrease population susceptibility to HIV through effective parasite and infection control, and exclude iatrogenic transmission via unsafe medical practices.

Switzerland, annual per capita health expenditure is 3,000 dollars!” (Bilateral-26). In a similar vein, the Tanzanian official quoted above points out:

To deliver the ‘essential health package for service provision’, we need 48 dollars per capita. We currently spend eleven dollars... [...] We only have 30% of our [human resource] requirements! With a deficit of 70%, how do you run a *system*?! (GovSector-11)

Another Tanzanian official exclaims: “The Tanzanian health system is weak! We work with only 40% of the staff...60% of the needed human resources for health are not there!” (GovSector-7). Arguing along the same lines, another Tanzanian official states: “Tanzania only has 40% of the human resources for health of those it currently needs to cover the most basic needs of the population” (GovSector-1). Concluding his very critical comments on the budget cuts imposed by successive SAPs in Tanzania, he underlines: “You don’t cut expenditure by saying people should not get treated, but by doing something about people getting sick!”. Given the initial weakness of basic health services when the HIV/AIDS hit home in Tanzania, the additional stress caused by the epidemic could not but accentuate the crisis of the health system. “HIV/AIDS is a big problem and it is very costly employment wise”, stresses a Tanzanian official, “so inevitably, HIV means an extra workload for the health sector!” (GovSector-3). By increasing the number of patients and creating new health-care needs, the epidemic has put considerable additional stress on an already overburdened health system.³⁹² “HIV/AIDS has kept the health system busy...” as a bilateral agent puts it in a polite understatement (Bilateral-10). Describing the situation during the early years of the African AIDS epidemics, Turshen writes:

AIDS is already distorting African health care. For example, people with AIDS absorb large amounts of scarce resources: they must be treated for intractable forms of common infections such as tuberculosis, requiring more drugs per case, longer stays in the hospital, and more time from skilled medical and nursing personnel. To check the spread of HIV infection by reuse of needles, health services must retrain all health workers in sterilization techniques for needles and other equipment, which removes trainers from other tasks, and governments must divert money to purchases of autoclaves and to pay higher energy bills.³⁹³ (1989, p.238)

Two decades later, the remarks of a Tanzanian health official suggest that the distortions induced by HIV/AIDS and their impact on the ability of the country’s health system to deliver general health services has not significantly changed. He underlines,

HIV demands training on several HIV-related issues: STIs, TB and HIV, VCT [voluntary counselling and testing], HBC [home-based care]... During all these absences, services will not be delivered and when [health workers] come back, they are likely to focus on what they have just been trained on. So we weakened the [health] system! And at the health-centre level, if you send two health workers to training, you close the centre! (GovSector-7)

Arguing along similar lines, a bilateral agent comments on the combined impact of the AIDS epidemic and the international response to it on the delivery of general health services:

³⁹² Several interviewees underlined that, at the height of the epidemic, more than half of all patients in Tanzanian health facilities came for conditions due to HIV-related morbidity. I found no written confirmation of this proportion.

³⁹³ As discussed in Chapter 1, the fact that these sterilisation measures were neither immediately, nor universally implemented certainly contributed (though to an unknown extent) to the spread of HIV in sub-Saharan Africa.

The lack of human resources for health is a big challenge for the Government. Just look at the evolution of the number of outpatients treated between 1998 and 2006: in 1998, they were 4 million, in 2006 they were 25 million! These numbers are from the Health Statistical Abstract, which might not be such a trustful source, but the trend is real. The evolution for the number of inpatients is comparable. At the same time, the number of staff only increased very slowly. This leaves us with a very difficult situation. And then, we are introducing all these new [HIV-related] approaches at the facility level: PMTCT, STI treatment, care and treatment. This considerably increases the workload of staff at primary health care facilities! So they will not provide quality services... The system is going to collapse! (Bilateral-8)

The fact that this interviewee (as several others) indistinctly blames the HIV epidemic *and* the international response to it for bringing the Tanzanian health system on the brink of breakdown paradoxically illustrates that – at least during the early years of the massive vertical response – the crisis of the Tanzanian health system was accentuated both by the increased morbidity due to the epidemic itself *and* by the growing number of HIV-related services introduced by international AIDS control programmes. Importantly, the two preceding statements point to one domain where the arising contradictions are particularly acute and the *systemic* challenges uniquely complex: human resources for health.

A-2) Human resources for health: the Achilles heel of the Tanzanian health system

“One system issue that combines many other aspects is the issue of human resources for health. That is the major challenge that needs to guide everything we do in the years to come! If this issue is not addressed, everything else will not feed through.”
(GovSector-12)

The response to HIV/AIDS both revealed and exacerbated major insufficiencies in several domains of the Tanzanian health system (e.g. equipment, drug procurement, health infrastructure). Yet, most interviewees mention the situation concerning human resources for health as the most dramatic aspect of the health system crisis – or of the “health system catastrophe”, as a Tanzanian official (GovSector-1) puts it, arguing that three decades of ‘crisis’ have rendered the term inappropriate to qualify an obviously *structural* state of affairs. “The availability of human resources for health has been falling since the 90s”, he underlines, “in parallel, the population nearly doubled in 10 years”. Another Tanzanian official remembers: “In the beginning [i.e. from 2004 on], a lot of money came to Tanzania for care and treatment, but it arrived in Dar and we couldn’t scale up because we had no health workers on the ground to give out treatment!” (GovSector-12). Even today, the lack of trained personnel remains a major obstacle to the roll-out of treatment programmes. “We have reached the limits concerning human resources, argues a multilateral agent, if we want to put 400,000³⁹⁴ people on ART, we need more staff!” (Multilateral-6). This shortage leads several players to criticise the rapidity of scale-up of treatment programmes (see Chapter 5). “It all depends on the human resources issue...it’s really overwhelming the health workers”, underlines a bilateral agent, “so it might be better to do the scale-up slowly but surely, rather than to mess up everything by doing it all at once!” (Bilateral-11).

³⁹⁴ This was the official goal before in 2010, when eligibility for ART was broadened – passing from a CD-4 count of 200 to 350. Today, the number of Tanzanians considered to be in need of ART is approximately 660,000 (see Chap. 5).

Well aware that the shortage of human resources was compromising the AIDS response, AIDS players such as PEPFAR, the Global Fund, and the Mkapa Foundation (in close collaboration with the Clinton Foundation)³⁹⁵ have started to tackle the shortage of human resources over recent years. Although these initiatives did contribute to preventing the situation from deteriorating even further, they only very partially compensate for a growing population's increasing health needs due to HIV/AIDS. And, as a bilateral agent notes, training qualified health workers takes time:

In human resources for health, we are *sooo* far away from meeting the challenges! The problem with human resources is that there is a need for a mid- and long term vision: it takes at least two or three years to train a mid-range health worker. (Bilateral-23)

In parallel, the Tanzanian government developed a ten-year (2007-2017) Programme for Primary Health Sector Development ("Mpango wa Maendeleo wa Afya ya Msingi" or "MMAM"). Its initial focus being on the improvement and increase of health facilities, the Programme roughly aims at having one dispensary per village, one health centre per ward and one hospital per city or district. One Tanzanian official comments on this goal as follows:

We have been aiming for every Tanzanian to have a health facility within 5 kilometres, and comparably to other African countries we are not doing so badly... But we are talking about 12,000 registered villages... Right now, we have 5,000 or 6,000 facilities, so we are talking about doubling! It's a *massive* undertaking! (GovSector-11).

A bilateral agent is quite critical concerning the design of the Programme:

They did build quite a bit of new dispensaries and health centres, but they didn't do a lot about the crisis in human resources for health. And there are management problems. So as the next election was approaching, the President realised that having all these empty dispensaries is not a lot better than having none at all... (Bilateral-26)

Indeed, acknowledging that about 600 of the country's approximately 5,000 dispensaries were currently unstaffed, the Parliament's Committee for Social Services suggested to make human resources for health (rather than the increase in the number of facilities) a priority within the Programme. That being said, most donors seem rather sceptical concerning the Programme's potential to create a real momentum for change. The just-quoted bilateral agent underlines:

They only give a total budget, but don't specify the sources of funding. And if you look at the Public Expenditure Review 2008, you'll see that the portion devoted to district health didn't really grow and that the portion allocated to human resources for health development only increased slightly, and certainly not sufficiently to meet the huge human resources challenges. So their commitment on paper doesn't translate into resource commitments. For human resources for health, there is no net budget increase, except in the cities. (Bilateral-26)

To be sure, with annual disbursements of roughly USD 20 million per year (PMO-RALG 2010, p.4-5), which represents less than 5% of the country's annual AIDS budget, the primary health care initiative remains chronically underfunded. The aversion of donors to fund more systemic and (infra)structural

³⁹⁵ The Mkapa HIV/AIDS Foundation concentrates most of its efforts on human resources for health. It was initiated by the former Tanzanian President Benjamin William Mkapa and the Clinton Foundation.

measures (see Chap. 3 + 4) certainly explains part of the government's difficulties in mobilising donor funds for the Programme for Primary Health Sector Development. "The issue of human resources for health cannot depend on project funds", underlines a bilateral agent, "the government has to commit the money itself!" (Bilateral-8).³⁹⁶ These funding difficulties, however, are apparently also due to the unusually endogenous manner in which the Programme was formulated. As the bilateral agent describes:

In 2007, the MMAM programme popped up out of nowhere; it dropped down from the sky like a flying saucer in a vegetable garden! So everybody [i.e. the donors] was wondering: 'What about the Health Sector Strategic Plan...is that still relevant?'.³⁹⁷ The donors were saying: 'Congratulations! You are focusing on the right kind of policies...that's in line with the MDGs. But your commitment is not realistic'. (Bilateral-26)

Another bilateral agent comments on the Programme in similar terms: "The primary health care project is good and very politicised. It's a Tanzanian thing...but they will never be able to do what they plan to do" (Bilateral-20). The term 'politicised' means that the Programme grew out of a Tanzanian high-level political initiative and did not emerge from the ongoing donor-government discussions at the 'technical' level – hence the expression "it's a Tanzanian thing". Against the backdrop of the Programme's difficulties to attract donor funding, this expression points to another aspect of the aforementioned paradox of the 'ownership' discourse: when confronted with a genuinely endogenous Tanzanian policy initiative, donors apparently consider it as infringing the generally more 'collaborative' donor-government process of policy formulation.

Beyond the purely financial aspects, a variety of interviewees insist on the multitude of challenges encountered in the effort to improve the situation concerning human resources for health in Tanzania. The first bottleneck several interviewees point to is the insufficient capacity of the country's medical training institutions. "The medical schools and training institutions for health workers have reached their limits", underlines the director of a multilateral agency, "we don't produce enough medical doctors, nurses, etc...." (Multilateral-6). Similarly, a bilateral agent points out: "We try to do more and more on human resources for health – not just placing people, but increasing the throughput of training institutions and retention ability. Now, PEPFAR funding can be used for that." (Bilateral-12). While the output of training institutions has grown over recent years, all agree that this is still far from sufficient. A Tanzanian official stresses,

We need to increase training output. 10 years ago, 52 graduates at Muhimbili [University of Health and Allied Sciences – Tanzania's biggest public medical training institution], now there are 200, so we multiplied by four. But we need more people to train them! (GovSector-1)

Acknowledging this need, a bilateral agent warns:

³⁹⁶ This quote points to the still widespread idea that donor funding is necessarily *project*-related (an idea contradicted by initiatives such as the Health Basket Fund or Global Budget Support). It also illustrates many donor agencies' short memories: only a few years back, the very same countries who, today, are urging the Tanzanian Government to commit more money to its health sector imposed drastic health budget cuts via their 'structural adjustment' programmes.

³⁹⁷ The Health Sector Strategic Plan (HSSP) being larger than the MMAM, the latter ended up being included into the former.

There is a lack of tutors, of people able to teach their profession. But some very simple measures to increase human resources training, such as giving scholarships to [faith-based organisations], are not implemented. It is very important to ensure the quality of health staff training. If they lose even more in quality, things could start to become worrying. (Bilateral-26)

Beyond the mere number of health workers, several interviewees point to the low quality of medical training as a serious concern. While the above-quoted official suggests that several of the private training institutions are “not always high quality” (GovSector-1), another Tanzanian official wonders: “We reduced the period of training to increase the output of staff...hopefully without compromising quality...” (GovSector-11). A bilateral agent is more outspoken:

The MMAM aims at having a dispensary in every village. But there is no marching order! You can’t construct all dispensaries in three years and have them empty! So what they end up doing is that they fill all these dispensaries with unskilled people! (Bilateral-23)

Although nobody explicitly raised the issue, the quality of medical training is obviously an important factor in reducing the risk of iatrogenic infections.

Beyond the issue of the quality of training, one of those Tanzanian officials underlines, “counting heads alone leads to unrealistic evaluations of the human resources for health that are really available” (GovSector-1). Indeed, training output and actual employment of health workers are two related, but distinct variables. As a Tanzanian health official puts it:

A *huge* increase in training is needed and the most recent figures on the employment of staff show no net increase, even in the last four years! We need to increase the health workforce threefold! That means we need to hire *ten* times the annual number for the next *ten* years! And that is not a simple undertaking... But it’s not just about increasing numbers. There are two other aspects: One is the misdistribution of existing staff – most are in the cities and some have low attendance. 70 or 80% of the doctors in Tanzania are in Dar. They are not where they are required! The other aspect is the productivity of staff: absenteeism is high [...] and most nurses only work daytime, very few work night time. So they don’t assist deliveries at night, which causes maternal mortality. We don’t have skilled workers around, when they are needed! That has to be addressed. The *management* of the existing human resources is a big issue...it’s not just about increasing the numbers. (GovSector-11)

No doubt, merely increasing the number of people trained is not sufficient. Not only does quite a significant share of Tanzanian doctors end up working fulltime or part-time within the Tanzanian health administration or within health projects of international NGOs or development agencies, but several interviewees underline that a significant proportion of Tanzanian doctors and health workers chose to work outside the health sector, or to leave the country. A Tanzanian AIDS official states:

Only training more people does not resolve the issue either. We also have to look at the retention of health workers and their geographic distribution. Health workers need incentives to go work in the rural areas. And if that means doubling their pay, then that is what we have to do! Currently, that issue is not addressed adequately. (GovSector-12)

Arguing in this sense, a bilateral agent stresses: “We should ask ourselves what are the open and hidden incentives concerning individual careers?” (Bilateral-20). Indeed, many interviewees suggest that the incentive structure for medical personnel to work in rural areas also depends on their more general

working and living conditions. These include issues such as equipment and supply of health facilities, as well as staff housing, transportation, electricity, and the availability of adequate schooling for their children.

The human resources situation in Tanzania illustrates why de Cock et al. (2011, p.561) point to “the readiness to re-examine professional roles” within the health system as a potential “game changer” in the response to the African AIDS epidemics. Far from being a new idea, the issue of ‘task shifting’ was at the heart of the innovative practices concerning primary health care in the 1960s, 1970s and 1980s (notably in China and Vietnam), as it allows to increase the efficiency and coherence of health systems by mobilising *endogenous* resources. ‘Task shifting’ describes the transfer of responsibility for a variety of tasks to health workers (or community volunteers) with less general training, but who have been specifically trained for certain tasks. The effectiveness and efficiency of task shifting has been demonstrated in a variety of settings and domains, including HIV testing by laypersons and the provision of ART by nurses, rather than doctors (e.g. Sanne et al. 2010). Although the so-called Chinese ‘barefoot doctors’ inspired Tanzania’s primary health care reforms during the 1960s and 1970s (Gish 1975), today, the Tanzanian administration is very hesitant about the implementation of even moderate task shifting to facilitate the AIDS response. While a wide variety of interviewees point to its potentially important contribution to improving service delivery, a bilateral agent underlines: “Paradoxically, there is a resistance to task shifting” (Bilateral-24). To take one example, despite the urgent need to extend the HIV-testing capacities, the permission to do testing was only very progressively extended from lab technicians to nurses, and later on to health workers.³⁹⁸ A multilateral agent describes the current situation:

Now there are pilot projects that try to bring the testing to peoples’ homes, through home based care [...] But NACP is still very reluctant to let a layperson do the testing. They want the medical personnel to do it. [...] And this aversion to task shifting is also due to the lobbying by the laboratory people...they want to protect the profession. So NACP held it back for a few years. [...] So even a simple issue such as task shifting took a long time...” (Multilateral-14)

There is a certain irony to this situation where Western donor agencies, which in many ways have been and continue to be the vassals of doctor-centred medical ideology, exert great effort to convince the Tanzanian health administration (many key positions of which are held by medical doctors) to adopt what was once one of the core principles of the country’s primary health care strategy.

That being said, although the lack of qualified human resources is a key issue, solving this problem alone is not sufficient to overcome the structural weaknesses within the Tanzanian health system. As the deputy director of an international NGO suggests: “Once the human resources problem is addressed, we’ll say: ‘Now we have smiling faces in all these facilities, but we don’t have the commodities!’” (INGO-

³⁹⁸ As a bilateral agent describes: “At the moment, the law doesn’t allow [task shifting]. It says: ‘tests have to be done by lab technicians’ – but the number of available lab technicians in Tanzania is extremely limited and impossible to expand in the near future! So in 2005, there was an agreement at the political level – not in the law, but in the guidelines – to allow nurses to do the rapid HIV test. That considerably improved the situation!” (Bilateral-8)

9). Pointing to the irreducibly systemic nature of health system development, several players argue that all bottlenecks – whether related to human resources, commodity management, drug procurement, or transportation – have to be addressed in parallel.

In sum, the magnitude of the Tanzanian AIDS epidemic all the more severely compromised the functioning of the country's health system as this system was already on the brink of breakdown before the epidemic reached its peak in the 1990s. It is against this backdrop that the often vivid controversies over the scale, design, and health-system effects of the international AIDS response must be understood. As the following sections show, these debates are structured around a frequently implicit distinction between donor agencies that had been active in the Tanzanian health sector for years, if not decades, before the 'second wave' of the international AIDS response set in, and the new group of AIDS players that arrived in Tanzania during the early 2000s. As a bilateral agent puts it:

Most donors knew, but some new players were shocked that the health sector was so eroded in many African countries. Here in Tanzania, it was nearly ironic! AIDS was like a wake-up call concerning the state of the health system – not for the old people, but for the new people who came in with the AIDS industry. Because AIDS *is* an industry...or let's say: AIDS is *also* an industry. It brought in many new players. And when we told them about the state of the health system, they were like: 'Gee! I didn't know it was *that* bad!' (Bilateral-20)

Beyond the assessment concerning the state of the Tanzanian health system, this statement illustrates the distinction between donor agencies traditionally involved in the Tanzanian health sector (here: "we" or "the old people") and the vertical AIDS initiatives ("them" or "the new people"). As discussed below, these two groups draw on different conceptions of the most adequate design of health and AIDS interventions. Although one should not overestimate the homogeneity within these two groups of players, this difference in views does structure many of the debates over the scope and design of the international AIDS response analysed throughout the following sections.

B) A consensual acknowledgement of disease hierarchies and health inequities

"Total health spending in Tanzania is about 1.1 billion Tanzanian Shillings, HIV/AIDS included. That's 29,000 Tanzanian Shillings per year, per person. More than *half* of that is for HIV/AIDS!" (Bilateral-17)

Although it concerns a specific moment in the history of health financing in Tanzania (see the introduction to Part 3), this statement illustrates the proportions and material consequences of internationally determined disease hierarchies. Western governments' funding priorities directly result in what several interviewees criticise as a fundamentally unbalanced, incoherent health-expenditure structure – the consequences of which one bilateral agent describes as follows:

In Tanzania, there is a syphilis prevalence rate of 7% – that's a lot! But nobody gives money for that: treating syphilis is part of the system, it's the *everyday* work. And maternal and reproductive health has been totally forgotten about! If you don't have a health system that can take care of regular deliveries, that should be a *top priority*! A look at the DHS [Demographic and Health Surveys] shows that maternal mortality hasn't

changed at all over the last years! [...] No one comes from a global health initiative, saying: 'focus on this!'³⁹⁹
(Bilateral-14)

Interestingly, when prompted about possible imbalances induced by the international AIDS response, a few players block the question. The easiest way to stall debates over distortions is obviously to simply negate their existence. In this sense, when prompted, a Tanzanian AIDS official exclaims: "I don't think there *are* any distortions!" (GovSector-6). This interviewee's subsequent insistence on the coordinating function of TACAIDS suggests that the acknowledgment of externally-induced distortions within the Tanzanian health system would amount to questioning the effectiveness of government 'ownership' – which undermines the legitimacy of government action and development cooperation (see Chapter 4). 'Move along, there is nothing to see' seems to be, in essence, the response of several interviewees to questions concerning possible distortions caused by the vertical AIDS initiative. They argue that the policy process through which allocative choices are formulated leaves no room for such distortions to emerge. One multilateral agent, for instance, responds to a question on possible distortions by pointing to the relation between health- and AIDS-policy documents:

HIV/AIDS is part of the Health Sector Strategic Plan III. And there is an HIV/AIDS Health Sector Strategic Plan. These have to be consistent with each other and with the NMSF [National Multi-sectoral Strategic Framework]. (Multilateral-15)

The fact that these policies are explicitly articulated, his argument goes, makes distortions unlikely. Referring to the purely formal aspects of policy coordination allows these officials not to express their opinion on an issue they consider as politically sensitive.

That being said, the vast majority of the interviewees agree that, by prompting massive funding for a single illness, the international AIDS response drastically redefined pre-existing disease hierarchies and exacerbated a certain number of health inequalities in Tanzania. The rapid increase of AIDS funding, combined with the parallel institutional design of the response, entailed significant differences in the attention paid to various health problems both at the service-delivery level and within institutions involved in the policy formulation process.

³⁹⁹ This has started to change since.

B-1) 'Collateral damage' at the service-delivery level

“Vertical programs *do* bring results, of course! But they are undermining the system! So often you can see that, in the health centres, the staff is not there...it's in an NGO implementing PEPFAR or another vertical programme!”
(Bilateral-14)

Comments such as this one are common among the interviewees. Considering the Tanzanian health system as too weak to implement the rapid scale-up of ART, PEPFAR decided to deliver most of its services via newly created facilities, most of which are part of the public health system, but operated in an entirely parallel manner. “Care and treatment centres are separated from health centres everywhere”, notes a Tanzanian NGO worker, “and in those hospitals with care and treatment units, these are in extra care and treatment centres...” (NGO-2). A multilateral agent describes: “PEPFAR projects build their own extra buildings and bring in their own staff” (Multilateral-4). This affirmation should be nuanced, as PEPFAR and its implementing organisations did not ‘bring’ much medical personnel to Tanzania. As alluded to above, they hired staff by recruiting from the national ‘pool’ of trained medical personnel. The staff-related distortive effect of the AIDS response on the delivery of general health services is thus at least twofold: while the treatment and care for AIDS patients has increased the workload of health staff in general health facilities with integrated HIV services, the creation of parallel care and treatment centres has also led a significant proportion of the trained health staff to switch over to these HIV-specific facilities. Having enumerated some of the positive effects of vertical AIDS, TB and malaria programmes in Tanzania, a bilateral agent concludes: “to get there, they caused some collateral damages: infant and maternal mortality is still very high; health staff is overstressed...” (Bilateral-26).

Already in the 1990s – i.e. well before the scale-up of the international response – Gruénais et al. (1999, paragr.21) observed differences in salaries, working conditions and career opportunities between HIV-related and non HIV-related health personnel in a variety of African countries. Similarly, by far the most frequently quoted example of distortions between HIV/AIDS and other health issues in Tanzania is the contrast between the brand new HIV care and treatment centres and the facilities of the general health system, which are often in a dire state. Several interviewees underline that the disparities go well beyond mere appearances:

[F]or health workers, it is more prestigious to work on HIV/AIDS...and in many cases, they get more money if they do HIV-related activities! For instance, if a lab technician got training on how to do HIV tests, he or she will not want to do malaria testing anymore. But it's not only about money. There is also simply the prestige to work for HIV projects: They have new buildings, better equipment... (Bilateral-11)

Similarly, a multilateral agent recalls:

When I was in Uganda, you would always see these completely worn down hospitals, with three people sleeping in each bed, and then you had these brand new, air-conditioned CDC care and treatment centres... This is similar here and at the country level in Tanzania there is a very strong lobby to keep it like this. Most

trained Tanzanian staff want to become HIV counsellors or get into one of the many [HIV related] NGOs... (Multilateral-18)

A bilateral agent sums it up as follows:

[A]ll the [HIV] care and treatment clinics have nice buildings, their health workers have extra allowances and there is always coffee for the staff... So, of course, people want to work in the care and treatment centres. (Bilateral-20)

The differences in funding directly affect the working conditions of the staff, which influence the relative attractiveness of working in one health service or the other.

Interestingly, both a recent public sector pay raise related to the scale-up of ART and an HIV-related Emergency Hiring Project (co-managed by the Mkapa Foundation)⁴⁰⁰ has induced a siphoning off of medical personnel from private sector service providers. “The Mkapa Initiative led to a doubling of salaries in three years”, underlines an interviewee, “many FBO [faith-based organisation] people have moved to government facilities” (INGO-9). A multilateral agent argues along very similar lines:

The roll-out of ARVs had a somewhat unforeseen consequence: it strengthened the *public* health system! The money for ARVs passes through the public, not the private health system. The Emergency Hiring Project by the Mkapa Foundation and the Global Fund created distortions in favour of the public sector. The idea is excellent: it places staff in remote rural areas, where nobody wants to go... But as a result, there is a problem of incentives: the people who are part of this programme earn more than the others...that creates distortions. Many people who used to work for FBOs – most of which are institutions that did a great job – now go work within the [public sector] Emergency Hiring Project. So that weakens the private health system to the benefit of the public system. (Multilateral-7)

This change in the incentive structure for Tanzanian medical personnel inevitably affects the relative quality of service delivery, the attention paid to different conditions – and thus to *people* according to their conditions. A multilateral agent, for instance, describes the inequities that arise from such a selective improvement of health service delivery:

There has been so much training on [HIV] counselling in Tanzania. So now, people know how to counsel an HIV patient, but not a mother who just lost her child! [...] People are so much thinking in compartments...it’s terrible. So they still treat women that come in for delivery like shit and then, at the same time, you have all this pampering and counselling for the HIV people. It’s just madness! (Multilateral-12)

More generally speaking, a bilateral agent concludes that the focus on HIV/AIDS has “led to some other priority diseases being put aside” (Bilateral-11).⁴⁰¹ Beyond these disparities in terms of infrastructure, equipment, and human resources, all of which directly affect service delivery, the scale of the recent international AIDS response also induced some less immediately visible distortive effects at the health-planning and -policy level.

⁴⁰⁰ Between 2007 and 2010, the Mkapa Fellows Initiative (funded by the Norway and the Clinton Foundation) and the Emergency Hiring Project of the Ministry of Health (funded by the Global Fund and co-managed by the Mkapa Foundation) recruited a total of 275 health workers and deployed them in 52 rural districts (<http://www.mkapahivfoundation.org>). Most interviewees indistinctly refer to these two initiatives as one. Even though this additional staff is an important contribution to stabilising the situation, the relatively small number of people hired puts into perspective these two initiatives’ global effect on the Tanzanian shortage in human resources for health.

⁴⁰¹ Interestingly, some interviewees even consider that the over-proportional design of the AIDS response has increased the stigmatisation of people living with HIV, who are accused of ‘grabbing’ scarce health care resources.

B-2) Distortions within policy institutions

“*Everybody* in this building is from PEPFAR. Or, 63 of the 65 people within CDC Tanzania work on PEPFAR, and PEPFAR represents 170 million dollars per year on the CDC-side alone... Its over 300 million a year in total. In comparison, PMI [the US President’s Malaria Initiative] Tanzania has a 52-million-dollar budget per year, but only 2 staff. They are heavily understaffed! [...] In 2010, PMI represents 500 million dollars for 15 countries...that’s like PEPFAR in Tanzania and Kenya alone. So, yes, there *is* a disparity!” (Bilateral-22)

A wide variety of players, even from *within* the field of HIV/AIDS, openly denounce that the vertical response to the epidemic unduly distorted the Tanzanian health policy process. The interviewees suggest that the intensified international response to HIV/AIDS over the last decade has not only led to a rapid (and welcome) increase in resources and players, but has induced considerable bias *within* donor agencies and the Tanzanian health administrations. While the bilateral agent’s statement in the epigraph illustrates the consequences of massive vertical funding for the distribution of staff within institutions, malaria control programmes are comparably *well-endowed* since the recently renewed global attention to malaria. The disease hierarchy this interviewee refers to is thus even more pronounced concerning health issues that do not benefit from comparable international initiatives, such as many neglected tropical diseases, nutritional issues (see Chapter 7), or road traffic injuries.⁴⁰²

More generally, the internal priorities of international health agencies have changed rapidly over recent years. “CDC Tanzania [one of the main implementing agencies of PEPFAR] has known a big increase of its activities and personnel” notes a bilateral agent, adding: “Before, CDC was involved in a number of domains... [...] Now, it has all been overrun by PEPFAR. It’s all about HIV now!” (Bilateral-16). The rapid increase of activities is thus accompanied by a drastic shift in focus. The donor agencies’ change in focus entails a redefinition of the policy agenda of Tanzanian agencies. One bilateral agent, for instance, regrets that PEPFAR’s search for Tanzanian counterparts undermines some domestic health agencies’ more general institutional mandate:

NIMR [the National Institute for Medical Research] was taken over by PEPFAR! Their new building...*everything* was paid for by PEPFAR money. The other day, [a NIMR official] told me: ‘Yes, you’re right, but what should I do about that!?’ She works on HIV against her will! (Bilateral-30)

The international AIDS response has obviously contributed to a redefinition – i.e. a narrowing – of Tanzanian health agencies’ jurisdiction. The dominance of HIV/AIDS over the country’s health agenda is particularly obvious in the preparatory process of Tanzania’s proposals to the Global Fund. Even within this arena of three relatively privileged pathologies (HIV/AIDS, TB, and malaria), AIDS clearly dominates the policy process. A bilateral agent comments on this situation: “TACAIDS is in the driving seat for the whole Global Fund process... They don’t know *anything* about malaria!” (Bilateral-14). The stakeholder meeting for the discussion of Tanzania’s proposals for Global Fund Round 9 illustrates this disease hierarchy quite well. The meeting was chaired by the Executive Chairman of TACAIDS and, although

⁴⁰² According to the WHO (2012), road traffic injuries are the leading cause of death worldwide among people aged 15-29 years.

Tanzania presented a proposal for each of the three diseases, roughly 90% of the about 60 participants were manifestly more interested in HIV/AIDS than in TB or malaria. This proportion is reflected in the number of comments on the different proposals and the discussion time absorbed by debates concerning specific aspects of the HIV/AIDS proposal. The sole issue of AIDS orphans and vulnerable children (OVC), for instance, was discussed at greater length than the two proposals for TB and malaria combined. No doubt, the fact that the AIDS policy community is more controversial than that of most other major diseases helps explain some of this disequilibrium. Nevertheless, the amounts requested for malaria and TB control (USD 173 and 99 million, respectively) in Round 9 nearly equalled the USD 299 million requested for HIV/AIDS.⁴⁰³

In sum, all interviewees openly acknowledge considerable disparities in terms of political attention as well as financial and human resources between HIV/AIDS and other health issues. Notwithstanding most players' agreement on the existence of these imbalances, their assessments of the appropriateness of the international AIDS response differ widely. Looking back at this unprecedented institutional mobilisation, a variety of players question the design and sometimes the scale of the international response. As the next section describes, some consider the resulting disparities as the legitimate consequence of an urgently needed shift in priorities, while others consider them as undue distortions that are highly detrimental to coherence and performance of the Tanzanian health sector as a whole.

C) A thin line between love and hate: 'necessary distortions' or 'a balance completely out of whack'?

“[PEPFAR] did things kind of the ‘American way’: just go in and do it, make it happen. And it would be difficult to argue that they haven’t made things happen... Now, the issue is sustainability. We go more to thinking about things in terms of opportunity cost, rather than a ‘loss’. People think in terms of what they *could* have achieved, had they used all that money to push the Tanzanian system...”
(Bilateral-29)

This remark reflects a general undertone of debates about the effects of the international AIDS response on the Tanzanian health system. Many interviewees' statements combine a mixture of implicit acquiescence and sometimes radical critique. This 'inner contradiction' is probably in part due to the fact that international AIDS-control initiatives did bring significant amounts of 'new' money into the health field. As a result, although many interviewees are passionate about the question of distortions, only few have very clear-cut positions. Even vocal critics of vertical disease control are not always clear about whether they consider the effect of the AIDS response on the Tanzanian health system to be detrimental, *absolutely*, or whether they merely criticise a *relative* lack of attention to non HIV-related health issues. This hesitation probably stems from a widely – though not unanimously – shared feeling of missed opportunities. The concomitant awareness of its obvious beneficial effects and the perception that its excessively vertical design caused a harmful under-exploitation of its potential to entail broader

⁴⁰³ See: www.theglobalfund.org

health benefits explains the ‘thin line between love and hate’ in many interviewees’ statements about the international AIDS response.

One key question underlying the debates over the effects of this response on the Tanzanian health system could be summarised as such: Did the international AIDS response provoke an *undue* allocation of health resources⁴⁰⁴ or did it merely induce a *legitimate* shift in focus in the country’s health priorities in reaction to an epidemic of exceptional magnitude? This section conveys the controversy among AIDS- and health-policy practitioners in Tanzania over the magnitude and desirability of the ‘distortions’ brought about by vertical AIDS-control initiatives. It does so by artificially grouping a continuum of opinions into two argumentative groups: one that stresses the positive externalities and spillovers of the vertical response and describes existing distortions as a necessary evil to get the ball rolling; another one that predominantly underlines the opportunity costs of this massive disease-specific undertaking and its detrimental effects on the Tanzanian health system.

C-1) Not that vertical after all: positive spillovers and the desirability of distortions

A common line of argument in response to the question concerning possible imbalances in the Tanzanian health system induced by the international AIDS response consists in arguing that this response is not that vertical after all, and that HIV-related interventions have considerable positive effects on general health service delivery. When asked about possible distortions, one bilateral agent, for instance, refers to a study on the neighbouring Rwanda:

There is the [Family Health International] study on Rwanda that looked at what happens with HIV money.⁴⁰⁵ The study found that the HIV funds have a positive effect on the general health system, even *without* health system strengthening! (Bilateral-15)

This remark echoes a comment made by an international NGO worker involved in the implementation of PEPFAR activities:

So much of the [AIDS] resources are spent on improving the health system. The outputs in terms of management abilities, etc. are not measurable, but resources *do* go into system strengthening! They spend 500 million dollars per year. Much of it is travelling through the health sector anyway. (INGO-11)

Given the amount of money spent and the considerable increase in activities and health services this funding entails, these interviewees suggest, health system strengthening is a nearly *inevitable* side effect of AIDS programmes, irrespective of their vertical design. The sometimes fierce criticism of PEPFAR makes it understandable that those interviewees involved in its implementation are particularly vocal in stressing the positive effects of the vertical response to HIV on Tanzania’s health system. Yet, other less immediately involved players also point to the positive general effects of the vertical response to

⁴⁰⁴ Even though the interviewees do not coherently use it in this sense, the word ‘distortion’ already reflects the idea of an undue process. The verb ‘to distort’ is defined as “to twist out of shape, [...] to misrepresent; misstate; pervert” (Webster’s new world college dictionary, 1996, 3rd edition, New York: MacMillan). ‘Disparity’, in turn, is merely an “inequality or difference, as in rank, amount or quality, etc.” (*Ibid.*).

⁴⁰⁵ This study is in all likelihood that by Price et al. (2009), discussed in the introduction to Part 3.

HIV/AIDS. Several interviewees consider that AIDS programmes have improved the health infrastructure in a variety of domains. The deputy director of an international NGO, for instance, underlines that “general health policies, such as those concerning commodities, procurement and supply chain management, [...] ‘fit’ into HIV-related interventions” (INGO-9) and can therefore be funded by HIV money. Similarly, considering that vertical funding strengthens the country’s health infrastructures, a Tanzanian AIDS official underlines:

The ARVs strengthened the health system. Many labs were renovated and they are used not only for HIV. They serve also for many other interventions. In the same way, malaria funding is strengthening the system. (GovSector-6)

Another Tanzanian official makes a similar assessment concerning human resources for health:

To be sure, there is a problem in terms of workload for health workers. But the Benjamin Mkapa Foundation has a programme to train human resources for HIV. When you send those people [in the health facilities] for HIV/AIDS, in reality, they do all the other [non HIV-related] duties, too – which is a good thing! Of course, that makes their work load too heavy. But, on balance, I believe that [the response to] HIV is actually strengthening the Tanzanian health system. (GovSector-4)

A multilateral agent confirms these broad spillovers of HIV-specific hiring initiatives :

Initially, the scope of intervention of the health workers hired through the Emergency Hiring Project was supposed to be limited to HIV/AIDS, but in practice, it goes well beyond; it’s a lot broader than that. Fortunately, they end up doing everything. (Multilateral-6)

In the case of orphans and vulnerable children, an international NGO worker argues, the programmes funded by AIDS money now also benefit non HIV-affected children. “The department of social welfare identifies the ‘most’ vulnerable children, and HIV is not a criteria of selection”, he underlines (INGO-7). A US agent also suggests that, since Obama’s arrival in office, the earmarking of PEPFAR money has been loosened and now allows support for a variety of health issues with important non-HIV components, such as family planning, harm-reduction programmes for injection drug users, or blood safety.⁴⁰⁶

Other interviewees globally agree with this positive assessment, but give a more qualified response concerning the impact of AIDS programmes on the Tanzanian health system. One bilateral agent, for instance, points to a positive evolution in the design of the international AIDS response:

It is working both ways! The health system is strengthened, but over-burdened. VCT [voluntary counselling and testing] has brought so many people in the facilities. So now, for the past two years [i.e. since 2007], the human-resources-for-health issue has been addressed with HIV/AIDS money. Now, you can justify this! Even as far as drugs are concerned: now, there are four drug kits per health facility – instead of two, earlier on. This also increases the drug availability for non-HIV/AIDS patients. Things are improving, but they have not concretised so well... (Bilateral-10)

A US agent makes the following provisional assessment:

⁴⁰⁶ In general, those interviewees working within US agencies I interviewed in autumn 2009 are manifestly delighted about the evolution within PEPFAR since the change in US administration in January 2009. One interviewee, for instance, states: “When I started to work at [a US agency], Bush was still in power. I was like: ‘Can I do this...?’ [i.e. ‘Can I square that with my conscience?’] Now we pilot methadone treatment in Tanzania...that’s the first country in Africa! So we do a lot of these cool things...” (Bilateral-24)

There is universal acknowledgement that rapid ARV scale-up added stress to the health system and especially to human resources for health. But it has improved the infrastructure. Many facilities are stronger today than before the ARV roll-out... It is not ideal...but is it sufficient? Probably not. (Bilateral-12)

Lastly, several players – some of whom are very critical vis-à-vis the design of the response – underline that HIV/AIDS programmes did allow some long-neglected but not immediately HIV-related health problems to rise onto the policy agenda. A multilateral agent underlines:

There is a general feeling that AIDS is taking over everything in the last couple of years. But now, with the prioritisation for PMTCT, other issues are coming up. Malaria, child health and maternal care...now these issues are coming back on the radar screen. So the AIDS funding is also beneficial to other sectors. There is a spillover effect. (Multilateral-9)

In a similar vein, another multilateral agent working on nutrition-related issues recalls, “the whole issue of breastfeeding policy came about through HIV...it’s new that people talk about it, and that they talk about *how* to breastfeed!” (Multilateral-5). Beyond purely financial spillovers, the political prominence of HIV has thus allowed some previously neglected issues to rise onto the policy agenda (see also Chapter 7). In sum, despite its vertical nature, the response to HIV/AIDS has thus had a variety of positive spillover effects on the rest of the health sector. Many players argue that the way the AIDS money is spent in practice is not always as disease-specific as the vertical funding structures would suggest – a both realistic and optimistic claim, as discussed below.

Another line of argument among the interviewees consists in acknowledging that the international AIDS response did detrimentally affect the coherence of the Tanzanian health system, while at the same time stressing that the exceptional magnitude of the HIV epidemic in Tanzania made vertical action indispensable. Consequently, some interviewees describe the distortions this response entailed as being not something negative but something fundamentally desirable. A Tanzanian official, for instance, exclaims:

HIV distorts the budget...that’s inevitable! You cannot say, let’s put more money on, say, infant health...HIV is such a huge problem! Yes, there is a lot of money for HIV/AIDS, but it is still not enough. The problem is so massive! (GovSector-3)

Another Tanzanian official reasons along the same lines:

Distortions are necessary! [The vertical response] will distort and that’s normal. Imagine there was a major cholera epidemic and we would put a lot of funds to fight it. That would distort the health system and it would be a good thing! (GovSector-4)

These interviewees argue that drawing increased attention to epidemics deemed to be of particular importance is the very *raison d’être* of disease-specific initiatives such as the Global Fund or PEPFAR. The fact that these initiatives are criticised for actually doing so thus merely suggests that they effectively fulfil their institutional mandate. While maintaining this reasoning based on the socially constructed ‘exceptionality’ of the AIDS epidemic (see the introduction to this part), some interviewees’ support for vertical action is more qualified. A bilateral agent, for instance, argues:

A vertical approach is justified if you want to get the ball rolling, if you want to get some momentum. And doing everything in parallel has always failed...or at least proven to be awfully difficult, if you look at global health successes.⁴⁰⁷ Was it justified for AIDS? Yes, AIDS did need a vertical approach...absolutely. But now, if we could use the money for strengthening the health systems, it would benefit a larger proportion of the population. For malaria, too, the vertical approach was a good thing, initially. (Bilateral-22)

The idea that the vertical response corresponds to a specific moment in the long process of AIDS control is raised by a variety of interviewees. “PEPFAR [...] did some really interesting stuff by getting treatment out there and by doing it fast”, suggests, for instance, a bilateral agent, adding: “the problem is, if you want to do things fast, you don’t address the systemic issues” (Bilateral-29). Similarly, an international NGO worker underlines:

In the beginning, people were dying. People [donors] were coming with the intention to let them live, to make them live longer. Now, that has happened. They are living. Now, we are seeing the weakness of this system. So the issue is how to use that money. It needs innovative thinking within the donors. (INGO-9)

These interviewees, among others, argue that, given the dramatic impact of HIV/AIDS and the weakness of the Tanzanian health system, the vertical nature of the response was justified – initially. Yet, many agree that, today, it is high time to adopt a more integrated response.⁴⁰⁸ A bilateral agent suggests:

Now that the prevalence is decreasing, we have to [...] wonder how we make sure AIDS is integrated into the health and other sectors. How can we formulate a more...not sustainable, but...sustained response? This involves health sector strengthening, human resources for health, procurement practices, health financing... (Bilateral-20)

Interestingly, this interviewee both retrospectively considers the exceptional measures taken against HIV as a legitimate initial response to the epidemic, and very critically assesses the form this response took in practice:

In some areas like South and East Africa, there is a justification for AIDS exceptionalism. Or let me put it this way: HIV is such a major threat to all other problems. It’s a major cause of death. So to approach it with exceptional measures is very much justified. But it was all late, way too late...and not that well targeted. Today, we have to ask ourselves: ‘Is this the best way to channel all this donor money through? What is the most effective and cost-effective way to deliver health aid? Is it through vertical programmes? [...] Should we build up a whole AIDS industry while there are already broader health platforms and coordination mechanisms?’ We were wrong... (Bilateral-20)

This statement reflects the state of mind of a wide variety of players who are seemingly of two minds about the international AIDS response in Tanzania. In the same breath, they successively justify the vertical response to the epidemic *and* consider that its parallel design – a defining feature of vertical programmes – was a mistake, as it encouraged a waste of resources and caused major policy fragmentation within the Tanzanian health system. Several apparently contradictory statements such as

⁴⁰⁷ This statement is interesting in that it invites scrutiny regarding how certain health initiatives come to be constructed as ‘successes’ while other, just as successful initiatives fail to become considered as such. Indeed, the very concept of ‘global health success’ contains a double bias in favour of single-issue disease-control programmes (e.g. smallpox, guinea worm or polio eradication) and against more systemic progresses concerning more horizontal, non disease-specific health issues (e.g. maternal and child health, nutrition, sanitation, management of diarrhoea or respiratory tract infections, etc.). While vertical programmes are fairly easy to report on (even more so if one contents oneself with epidemiologically insufficient but politically effective ‘single-outcome’ measures), health system performance depends on a wide variety of criteria and no universal agreement exists concerning the most relevant variables to use in order to assess success or failure.

⁴⁰⁸ See also Chapter 7.

this one illustrate a fundamental ambiguity of the international AIDS response in Tanzania: it was both urgently needed *and* designed in a manner that further fragmented general health action and exacerbated pre-existing inequities at the service-delivery level (see Chapter 7).

All interviewees agree that a massive response to HIV/AIDS was long overdue when significant international funding finally arrived in the early 2000s. Given the dramatic proportions reached by the epidemic in the 1990s, no interviewee suggests that simply continuing ‘business as usual’ would have been an acceptable option. In a sense, the situation at the end of the 1990s was such that *any* programme – however ill-designed – could not but have improved the situation as long as it came with additional resources. Most critical voices described in the next sub-section thus do not question the scale of the international AIDS response, but the appropriateness of its design. They suggest that these resources could have been allocated in a far more efficient and effective manner, had the response been conceived according to a coherent public health vision. Their general argument concerns the *opportunity costs* of this unprecedented disease-control initiative; they reason not in *absolute*, but in *relative* terms.

C-2) ‘They took verticality too far’: missed opportunities and a health system in jeopardy

“The money should have strengthened, rather than weakened, the national health systems. But quite often, the contrary is the case.”
(Multilateral-2)

Many interviewees deplore that the degree of verticality of the international AIDS response in Tanzania did not allow the maximisation of its potential in terms of broader health benefits. As a bilateral agent underlines:

Unfortunately there was so much verticality and no cooperation, so there are fewer positive spillovers than there could have been. They took verticality too far. It was okay for fundraising, but the money didn’t always go to the right things. (Bilateral-29)

Talking about the distortions the response induced within the health system, another bilateral agent notes:

People and agencies go where the money is. And, of course, the money is in HIV. So if that money is vertical, earmarked money, that has some effects. And if you dare change your approach or if you are too critical, you might not get your funding... So it did have some negative effects. But, again, you need *more* attention for HIV, not less! But if you overdo it in the way you formulate the response, it will have negative effects. (Bilateral-20)

The carefulness with which many players express their reservations about the design of the response illustrates both the ambiguity and the political sensitivity of the issue. The palpable unease in many interviewees’ responses arguably stems from their willingness to voice severe criticism of the AIDS response and their concomitant concern *not* to be interpreted as calling for a decrease in AIDS funding (see also Chapter 8). This political sensitivity explains why one bilateral agent, for instance, states: “I am

extremely worried – personally, *not officially* – about the distortions between AIDS and the rest of health” (Bilateral-23). A former Tanzanian official is more straightforward:

A lot of the interventions were very HIV focused. There were massive distortions! Seriously, I consider them to be a disaster. [...] All donors brought in massive funding, did a lot of research... *Everything* was there, but the cost was high. They were totally oblivious to the fact that, for all that to work, they had to look at systemic issues! [...] The response to HIV has affected the human resources and the whole health system very negatively. (GovSector-11)

Several other players also consider that, on balance, and far from inevitably strengthening the system, the massive inflow of HIV-related funding has actually weakened the Tanzanian health system. In this sense, when asked about his impressions concerning the interactions between the AIDS response and the general health system in Tanzania, an international NGO worker replies: “It *could* be possible but, so far, AIDS money does *not* strengthen the system. That should be considered!” (INGO-3). A multilateral agent answers the same question as follows:

We are really over-stressing the health system! HIV money flows in without strengthening the system. For example, there are about 200 care and treatment centres in Tanzania. Last year, the [Government of Tanzania] wanted to scale up to 500. So they trained the personnel for 300 more such centres...but there weren't enough supplies, not enough supervision...these centres haven't received any ARVs! The government is adding on more and more activities, it's the same for malaria and other diseases...but if you push too much through the vertical system, the general health system is going to explode! (Multilateral-4)

Most critical players' arguments are based on the idea that the AIDS money could have been invested in a considerably more efficient manner, had the national AIDS response been designed to take into account the broader context in which AIDS programmes operate.

Rather than reasoning in terms of an 'untapped potential' of positive spillovers, some interviewees consider the interactions between the general health system and AIDS-control initiatives as a host-parasite relation. “For the moment, general health [services] cannot benefit from the AIDS money”, one bilateral agent underlines, “but the health sector uses a lot of its own money for HIV activities...” (Bilateral-28). A multilateral agent points out:

The AIDS programme is actually undermining the system. It is sucking the system dry instead of strengthening it! Every part of the health system is parasited by parallel HIV/AIDS interventions. And the fruits of the two systems are very different: one produces a healthy population, the other one does not produce healthy people, it produces an increasing share of HIV-positive people. (Multilateral-14)

This last interviewee belongs to the few interviewees who openly question not only the vertical design, but the scale of the international AIDS response. Indeed, some players consider that this response not only adversely affected, but fundamentally jeopardised the coherence of the Tanzanian health system and its ability to deliver services. They therefore conclude that the massive focus on HIV/AIDS alone since the early 2000s was a mistake. One bilateral agent passionately declares:

Honestly, you look through the PER [2007 Public Expenditure Review] and you think: ‘What’s going on?!’ It’s just madness...! Basically, what the PER says is that Tanzania is over-funded for the next 5 years, even if no new money comes in. So what does the Global Fund say?: ‘Go on, apply for the next round!’ That’s pathetic!

The PER says it loud and clear: The balance is totally out of whack! It's just too much! How on earth is this ever going to get back on track?! (Bilateral-14)

The just-quoted multilateral agent draws a similar conclusion: "Look at what happened here: It's just too much! It destroys the whole system...it makes it collapse! But nobody says: 'Stop, that's enough!'" (Multilateral-14).

These statements are uttered by people who are fully aware of the level of unmet health needs in Tanzania. Therefore, against the backdrop of the funding gaps described in Chapters 4 and 5, these statements should arguably be understood as a critique of the scale of the response, *given its vertical design*. These players consider that it was the decision to funnel most of the AIDS funding through vertical programmes that jeopardised the Tanzanian health system's ability to cope and deliver services. They are convinced that a more integrated response would have been possible from the very beginning, and that it would have yielded both a better overall health-service capacity, *and* non-inferior (if not superior) results in terms of AIDS control.⁴⁰⁹ In other words, while the advocates of vertical AIDS control point to the limited 'absorptive capacity' of African health systems to justify the vertical design of their programmes, these players contend that it is precisely their excessively vertical design that overburdens the Tanzanian health system – and thus limits its 'absorptive capacity'.

In sum, while the players' assessment of the exceptionality of the HIV/AIDS obviously influences their positions (the more exceptional they consider the epidemic, the more legitimate they consider the vertical nature of the response), their reflections do not revolve around one single issue. Having thus set the stage of this multifaceted controversy, the next section explores some of the debates over 'integration' among the proponents of vertical AIDS control and their critics.

D) Policy fragmentation and integration: perspectives from a vertical world

"With the same breath, health workers should tell people about HIV, malaria, cholera, and any other infectious diseases! [...] But it's not happening! It has to be done *zusammen* [together], as a certain European tribe would say!"⁴¹⁰
(GovSector-4)

As discussed in the introduction to this part, the controversy over AIDS control and health systems is composed of multiple interwoven debates. One aspect that makes this controversy particularly difficult to grasp is the fact that the players' statements about 'integration' and 'fragmentation' frequently indistinctly refer to policy formulation processes and to outputs in terms of service delivery at the implementation level. The impact of AIDS programming on the coherence of health policy coordination and the actual effects of the AIDS response on the Tanzanian health system's ability to deliver services are two distinct aspects of the same debate. Nevertheless, the vertical design of HIV/AIDS programmes

⁴⁰⁹ See Chapter 5 concerning the adverse effects of 'target chasing', as well as Chapter 7 concerning the counter-productivity of excessive 'verticalism'.

⁴¹⁰ Once again, this statement underlines the reductionist behaviour-centred framing of infectious diseases discussed in Part 1.

at the policy level does not necessarily entail the fragmentation of health services at the facility level.⁴¹¹ That being said, although vertical programming can be compatible with integrated service delivery, it does tend to accentuate the fragmentation of health care.

Developing upon the cleavage between ‘traditional’ health donors and the vertical players mentioned above, the following two sections successively explore the effects of the international AIDS response (and other vertical initiatives) on pre-existing efforts of donor coordination and system-oriented health action in Tanzania, and the ensuing differences in vision concerning both the utility of an increased integration of AIDS-control services into general health service delivery and the very meaning of ‘integration’.

D-1) ‘It’s like they are from a different time...’: when vertical initiatives jeopardise the ‘traditional’ health donors’ commitment to a systemic response

A major point of contention concerns what several interviewees describe as a lack of consideration, by the main players of the vertical AIDS response (primarily PEPFAR), for pre-existing donor coordination structures. Indeed, by the early 2000s, the cooperation of bi- and multilateral donors within the Tanzanian health sector had started to be regarded by many as an example of successful donor coordination. Since 1998, a number of bi- and multilateral donors and the Tanzanian Ministry of Health agreed to increase coordination among donors and Government via a sector-wide approach (SWAp) to health sector reform. In 1999, the parties to the SWAp created a joint funding mechanism – the Health Basket Fund – through which the participating donors decided to funnel a significant proportion of their support in the form of non-earmarked funding for health (Mapunda 2003). “Most donors give money to the Health Basket, which represents about 60 to 80 million dollars per year”, underlines a bilateral agent, adding: “that’s a system approach!” (Bilateral-29). Drawing on slightly different figures, another bilateral agent describes the advantages of the Health Basket Fund:

The Basket represents ten donors and 90 million US dollars – that’s a lot of money and it’s not earmarked in any way. It is the Basket Fund that actually funds district health, materials and drugs. [...] At least, the Basket money is supporting a public system. PEPFAR pays American people and NGOs; it supports *their* capacity to do things. That’s *completely* different: they won’t be here tomorrow!⁴¹² [...] PEPFAR leads to building a parallel system outside the public system! (Bilateral-14)

Although the donors within the SWAp obviously keep a close eye on the use of the Health Basket Fund (notably via their active participation in the annual Health Sector Reviews), the money in the Basket Fund is part of the general budgeting process within the Ministry of Health. Compared to the previous

⁴¹¹ A bilateral agent, for instance, points to PMTCT as an example: “It’s a vertical programme but it’s integrated into primary health care. [...] The goal is to expand primary health care by including HIV interventions” (Bilateral-15).

⁴¹² While several other interviewees also point to the fact that most of the technical personnel that came to Tanzania will leave again as soon as the funding dries up, one bilateral agent who works with a PEPFAR implementing organisation puts this remark into perspective: “People criticise PEPFAR for not building capacity. But that’s a lot of rhetoric. Look at the FHI [Family Health International] youth program for example: from the outside it looks like PEPFAR is giving all that money to FHI. But you have to look a little deeper: FHI has 55 implementing organisations, they build *their* capacity!” (Bilateral-24).

situation of predominantly project-related support, the SWAp and the Basket Fund present a significant improvement in terms of policy coherency and government ownership (C. Paul 2005; Walford 2007; COWI/EPOS/GOSS GILROY 2007).

The massive vertical AIDS funding thus arrived in Tanzania precisely when several key donors of the Tanzanian health sector had just managed – through a long and difficult coordination effort – to somewhat reduce the policy fragmentation that prevailed until the late 1990s. This background is crucial in order to understand some players' critiques of the design of the international AIDS response since the early 2000s. In 2008, one interviewee describes this frustration as follows:

Here in Tanzania, I have the impression that a couple of years ago, there was a real momentum around the SWAp and the Basket Fund. And there were real achievements! The 2008 Lancet article on infant mortality in Tanzania⁴¹³ shows that until 2004, infant mortality had been significantly dropping. That decrease was because of a working system! But since Paris [the 2005 Paris Declaration on Aid Effectiveness], to be honest, we have gone the complete opposite way... We did a complete turn-around! The evidence that this [the Health Basket Fund and the SWAp] is working is only coming out now...but it's too late in a certain sense. The new vertical initiatives have massively upset the SWAp process. Now, even PEPFAR talks 'health sector strengthening'... For God's sake, why don't they find out first what's *already* going on?! Why don't you go and see what is needed on the ground before you start such a massive initiative?! It's only *now* that people are beginning to realise what a SWAp is... And now they [the new AIDS players] realise that they are here to stay. So we [the SWAp and Basket Fund members] are like: 'Okay...let's start again!' (Bilateral-14)

The loss of momentum of the SWAp coordination endeavour described by several interviewees is thus hardly surprising (see also: Walford 2007). Spontaneously referring to the same Lancet article on the reduction of child mortality in Tanzania, another bilateral agent puts things as follows:

The big inflow of HIV money only kicked in by 2004, so the decrease in child mortality has *nothing* to do with AIDS [control programmes]. [...] Between 2004 and 2008, child mortality still declined, but less. At least, child mortality didn't level off...so the HIV money didn't make things worse! [...] The increase in funding for AIDS didn't destroy the pre-existing coordination mechanisms...but there definitely were some negative effects. [...] Very often, health and HIV decisions are more driven by emotion... People say: 'We have to do *something*! Maybe we can do...that'. Sometimes, that's what is driving things. But we should always analyse. Had we thoroughly analysed the situation, maybe we would have said: 'Hey, we already have a good system with the Sector-wide Approach, and the Basket Fund...'? But that's not sexy... It's a lot about personal and institutional interests. So for one reason or another, the donors always argue against a pooled funding mechanism. And those are the same players who signed the Accra Declaration!⁴¹⁴ It can be quite sickening! Take PEPFAR: They say 'We are putting that many people on treatment'...they *never* acknowledge the role of the system, of all the other players: the Government of Tanzania, the other donors...! (Bilateral-20)

In a similar vein, another bilateral agent, whose agency is also part of the SWAp and Health Basket Fund, suggests that, behind the question of coordinating mechanisms lies that of the design of the AIDS response itself:

AIDS has to be mainstreamed, just as any other illness. Some players have a lot of money: the Global Fund, PEPFAR...but they have difficulties with this [integrated] approach. They have done a good deal of spadework, and now that they have put hundreds of thousands of people on treatment, they start saying:

⁴¹³ See (Masanja et al. 2008)

⁴¹⁴ The interviewee refers to the Accra Agenda for Action, the declaration of the follow-up conference to the Paris Declaration – whose main principles are ownership, harmonisation, and alignment (see: OECD 2008).

'Health sector strengthening is great!'. They rediscover it! They have caused a whole lot of problems and now we have to tinker the system. We were stressing the importance of a system approach *for the last 10 years!* We lost a lot of time, energy and money. And concerning prevention, the damage is huge!⁴¹⁵ (Bilateral-26)

The lack of consideration by PEPFAR and other AIDS players for pre-existing coordination mechanisms explains that some of the most virulent critiques of vertical AIDS programmes come from those players – mainly bi- and multilateral agents, but also some Tanzanian health officials – who were the most actively involved in the SWAp and the Health Basket Fund approaches. Well-aware of this situation, one bilateral agent depicts these players' critique as being primarily a reaction to their declining political influence: "With PEPFAR, I guess the basic issue is that they just absolutely dwarf everybody else. And they are the US – and everybody has an opinion on that..." (Bilateral-29).

No doubt, the fact that PEPFAR Tanzania represents about four times the total amount of the Health Basket Fund obviously helps explain some of the critiques by players who actively participated in a coordination dynamic that was 'dwarfed' by US and other global health initiatives. As discussed, following the massive inflow of HIV-related funding through PEPFAR and the Global Fund (which, together, account for 90% of total AIDS funding in Tanzania), many other donor agencies decided to progressively draw out of the AIDS sector.⁴¹⁶ Within a few years' following the arrival of the Global Fund and PEPFAR, the membership of the Tanzanian Development Partner Group on HIV/AIDS (DPG-AIDS), for instance, dropped from 22 to 6 agencies.⁴¹⁷ Many of those agencies that drew out of HIV/AIDS decided to (re)focus on general health issues.

That being said, dismissing these 'traditional' health donors' critiques as being solely the bitter reaction of deposed kings would be missing an essential point: beyond inter-institutional power plays lies the fundamentally political controversy over vertical disease control and primary health care. Beyond the hurt pride of 'traditional' health donors in Tanzania, it is the question of the most adequate health policy design that is at stake in this debate. Interestingly enough, three of the most vocal critics of vertical AIDS-control initiatives among the interviewees received part of their training in Antwerp – a University well-known for its scholarship on and commitment to comprehensive primary health care.⁴¹⁸ It is thus hardly a coincidence that these players have been actively involved in the development of the Health Basket, one of the rare funding mechanisms that is not earmarked in any way. The Health Basket Fund – notably via its two-tiered design, combining a central basket and district baskets – is inspired by a comprehensive vision of primary health care and has been a key tool in the development of community health services in Tanzania (COWI/EPOS/GOSS GILROY 2007). This history of collaboration between the Tanzanian government and several bi- and multilateral donor agencies who are part of the SWAp

⁴¹⁵ For a discussion of the counter-productive effects of vertical AIDS control on HIV prevention, see Chapter 7, Section B-4.

⁴¹⁶ The World Bank's Multi-Country AIDS Programme (MAP), for instance, has not been renewed in 2009.

⁴¹⁷ As discussed in Chapter 4, this is in part due to an increased effort of coordination among UN agencies. Yet, most of the 'development partners' who drew out of the DPG-AIDS are bilateral agencies.

⁴¹⁸ One of the interviewees co-authored the 1985 Antwerp Manifesto for Primary Health Care – an outright dismissal of 'selective' primary health care and the disease-specific, vertical interventions it entails (Annys et. al 1985, see Chapter 7).

explains a certain convergence in views both among these agencies and between them and several high-level Tanzanian officials. In what could appear as a paradoxical defence of Tanzanian policy ‘ownership’, these ‘traditional’ donors sometimes openly take sides with the Tanzanian Government, which they perceive as being overrun and expropriated by PEPFAR and other global health initiatives (see Chapters 7 + 8). A Tanzanian AIDS official remembers:

One day, at a joint TACAIDS-donor meeting, [one of the ‘traditional’ bilateral agents] really became angry, saying to the US: ‘If you have your own agenda anyway, go ahead with it, but leave us out of that!’ And that worked, I think... (GovSector-3)

In all likelihood, the “us” refers to the ‘traditional’ health donors *and* those parts of the Tanzanian AIDS and health administration engaged in coordinated policy formulation.

As mentioned, the difference in perspective between these two groups of donors also emerges from the statement of the bilateral agent quoted in the introduction to this chapter. There is, indeed, a significant difference in perspective between the “new people” this interviewee refers to and those agencies which have worked in the Tanzanian health sector before the ‘scale-up’ of the international AIDS response. The latter quite consistently look at HIV/AIDS from a system perspective, considering the epidemic as yet another – though particularly challenging – threat to the health of the Tanzanian people. While these players situate the debate over the AIDS response within the broader context of infectious disease control, poor general population health, and deficient primary health care, the reference to primary health care is virtually absent from the discourses through which the players of the vertical health initiatives frame their own interventions. These discourses generally evolve around delivering specific services (treatment, prevention, and care) to a maximum number of people.

The unprecedented scale of disease-specific global health initiatives certainly helps explain the vertical AIDS players’ perspective. Using CDC as an example, one interviewee describes the rapid shift in scale as follows:

Outside America, CDC never had, until very recently, any multi-million dollar initiatives. Until very recently, CDC in Africa was one or two people working within the Ministry of Health. 20 years ago, you could count the number of CDC people in Africa on two hands! Today, they have a staff of more than 60 people – of whom 8 full-time American citizens – in Tanzania alone. *Everybody* in this building is from PEPFAR! Or, let’s say: 63 of the 65 people within CDC Tanzania work on PEPFAR, and PEPFAR represents 170 million dollars per year on the CDC-side alone.⁴¹⁹ (Bilateral-22)

The recent change in scale of global health initiatives, this interviewee argues, renders obsolete the ‘traditional’ donors’ critiques against vertical disease control:

The bilaterals are upset. They tell us that what we do is too vertical. But they don’t have a programme to implement and to oversee. They don’t have the funds for it! So many of them work like the CDC did 20 years ago: they work closely with the Ministry of Health... These people have a very different perspective, *because*

⁴¹⁹ USAID, the US Department of State and the US Department of Defense being the other main governmental US agencies involved in the implementation of PEPFAR.

they have no budget! The Irish are the most upset, I guess...and I agree with a lot of their critiques. But it's like they are from a different time... (Bilateral-22)

This last expression provides precious insight into the oft-implicit reasoning of many players involved in the everyday management of multi-million dollar vertical initiatives: the scale of their programmes, they feel, makes it extremely difficult to articulate every one of its aspects closely with the existing – often dysfunctional – health system. The conception of a ‘system approach’ to comprehensive primary health care, which would be implemented in close collaboration with the Ministry of Health of the country they operate in, appears to them as an ideational vestige from earlier times. Having missed the change in scale – and thus the change in nature – of international health action, the ‘traditional’ health donors are fighting yesterday’s battle. Seen from the ‘vertical world’s’ perspective of international health action, these donors are stuck in a bygone era of global health. Disposing only of comparably negligible budgets, they make a virtue of necessity and profess the benefits of coordination and systemic responses.

As discussed, this – admittedly simplistically portrayed – reasoning does not do justice to the more-than-tactically-motivated systemic approach of many bi- and multilateral donors. Far from merely defending what used to be their previously unchallenged jurisdiction, or from being stuck in out-dated conceptions of health action, these interviewees from the ‘traditional’ health agencies criticise the technocratic approach that implicitly underlies vertical initiatives, and that undertakes to improve public health without any significant involvement of ‘the public’ – or, at least, of its political representatives. The opposition between the two conceptions of health action is thus not about ‘backward’ traditional donors and ‘modern’ vertical health initiatives; it involves a conflict between values and conceptions of health (see Chapters 7 and 8).

No doubt, one should beware of an overly simplistic or homogenous vision of these two groups of players. Although some of their agents do draw on a political understanding of health inequalities caused by the dominated position of Tanzania within the economic world order, neither the ‘traditional’ donor agencies involved in the health-policy coordination structures, nor their Tanzanian counterparts fully advocate the social revolution that the adoption of a genuine approach to comprehensive primary health care would involve.⁴²⁰ Similarly, several players within the vertical AIDS initiatives make considerable efforts to ensure that their interventions respond to the patients’ broader needs and have the broadest possible benefits (see Chapter 7). Nevertheless, both their motives and their general frameworks of action differ significantly. The ‘traditional’ donors emphasise the coherency of health policymaking and consider that the health system must be strengthened on its own merit and based on endogenously formulated priorities. The ‘new’ vertical players, in turn, do increasingly consider ‘health system strengthening’ as crucial, but conceive it as a necessary condition for the success of their disease-specific programmes. As discussed in Chapter 7, while the two groups’ explicit goal of ‘system strengthening’ is the same, their perspectives on how to get there and why differ fundamentally. These

⁴²⁰ See Chapters 2, 7 and 8, as well as (Gish 1979; K. Newell 1988).

differences in perspective help explain the differing perceptions of the 'integration' of AIDS control interventions and general health services.

D-2) 'Don't worry...nobody will care': the challenge of 'integration' through the prism of vertical action

“After all, it is the same person having these diseases: TB, HIV, helminths... But we give them piecemeal!”
(GovSector-12)

“Sure, you can say there is political will for a closer integration of malaria and HIV but, in reality, it's all lip service. So when you write your proposals, you try to take these linkages into account and then you are told: 'Don't worry about integration. If it's not in there, nobody will care...?'”
(Bilateral-22)

The players' discussions over integrated service delivery echo the decades of debates over vertical disease control and primary health care described above. As discussed, the integration of vertically funded activities within general health facilities appears as a key determinant of the overall performance of health systems (cf. Unger et al. 2003), and the beneficial effects of AIDS funding vary considerably according to the more or less integrated design of the programme.⁴²¹ At the global level, this insight – combined with the experience of the material limits to vertical disease control in a context of weak health systems – led to an increasingly broad acknowledgement of the benefits of the integration of HIV-related and general health services at the facility level (see Chapter 7). A wide variety of interviewees stress that the often parallel nature of the AIDS response has led to a strong fragmentation of service delivery. Giving various examples, many players denounce the disintegrated care at health-facility level as being highly inefficient and confusing from the patients' point of view. A multilateral agent donor, for instance, underlines:

The more you go down to the ground, the more you see that people from different programs don't talk to each other, that the issues are being addressed vertically. [...] For example: any STI clinic should propose HIV testing, counselling and condom distribution and instructions about their use – at least that is what's in the guidelines... But then you can read in the last Service Provision Assessment⁴²² that only 2 to 3% of the patients who came to a Tanzanian STI clinic actually received counselling and condoms! In the same way, from what I saw on the ground during my previous experience with NGO work, sometimes you will have care and treatment centres inside a hospital that ran out of tests kits and you have a PMTCT project in the same hospital that still has some, but only for pregnant women, so you cannot take those...! (Multilateral-8)

Pointing to a different effect of fragmentation, an international NGO worker suggests that, by exposing patients to stigma, the disintegrated provision of care limits people's access to services:

One bad thing about the vertical approach to HIV/AIDS is that you end up either with special HIV/AIDS clinics or centres, or with special HIV/AIDS units within more general hospitals or health centres. Take for instance the Clinton Foundation and the Mkapa Foundation: In the Lindi and Mtwara regions, they have

⁴²¹ This is precisely what several interviewees point to. One bilateral agent, for instance, underlines: “To some extent, it [AIDS funding] has strengthened the system...at least where VCT [voluntary counselling and testing] is *within* the facilities” (Bilateral-11).

⁴²² The 2006 Tanzania Service Provision Assessment Survey indicates that only 5 % of patients visiting an STI clinic were offered condoms – less than half of whom received adequate counselling (National Bureau of Statistics 2007, Chap.7).

built a special, new building for the distribution of ARVs within the hospital – so people know that people going to that part of the hospital, or entering that door, are in there for HIV...people know! That's what happens when services are not integrated. (INGO-5)

Having enumerated a number of pitfalls of vertical AIDS control, a multilateral agent draws up a similar assessment concerning the fragmentation of care induced by vertical HIV programming:

Another link we are ignoring is the one with family planning and reproductive health. [...] One of the only links that *is* made is the fact that screening is done systematically in ante-natal clinics, but that's about all the integration there is! VCT, for instance, generally is in the same building as ART, which is separate from the other screening services. In most places, all HIV/AIDS services are in their own, separate building. They have an air-conditioned room specially built for the CD-4 machine, they have their own registry and they even have their own pharmacy! The drugs for all other diseases are centralised in the hospital's or health centre's central drug store... They have all these ART clinics with good staff and personnel and then they have the understaffed [reproductive health] clinics...and they're just starting to realise now that there might be a link! (Multilateral-12)

A former Tanzanian official recalls:

To implement the response to HIV/AIDS, you need people. So a complete new system was set up vertically. They were training a completely new group of people! They did training for HIV counselling, etc.. If you ask me, they have spent a lot of money to little or no effect... [...] Then people started to realise: 'Oh, oh...the system is not working!'. So there we had two massive vertical programmes on TB and HIV...each of them was going their own way...they were not interacting, even though they are so interconnected! Then, during the Global Fund Round 9 preparatory process, the WHO comes and says: 'Bring the two programmes to collaborate; that will increase efficiency'... We've been through that whole massive cycle...it's ten steps ahead, eight behind. Our argument is: 'You are dealing with the *same* Tanzanians! They don't care about programmes, they want the *services!*'. Now, there is a transition...after having lost a lot of time and resources. [...] AIDS was a national disaster. But unfortunately, these statements on health system strengthening came a bit late. [...] It's a bit late, but all is not lost. Now, after all that loss and waste, they are suddenly realizing that they were not thinking of system issues. They were thinking of building their own empires! (GovSector-11)

Many interviewees consider today's fragmentation – both at the policy- and the service-delivery levels – as a major source of ineffectiveness and inefficiency. Their assessments converge on the fact that the disintegrated provision of health services is dysfunctional and most agree that the history of Tanzanian AIDS control is fraught with missed opportunities for integration.

Despite the widespread agreement on the need for increased integration of HIV-related services with general health care, however, many interviewees point to a gap between discourses and practice. "I don't get the feeling that it is coming up that much", comments a multilateral agent, "there is a big difference between what is written and what is actually done" (Multilateral-17). Similarly, a Tanzanian health official underlines that a closer articulation of interventions concerning HIV and parasitic diseases is not forthcoming:

At the country level, we have the responsibility to start talking with other programme managers, but the [development partners] have to be convinced that this is an agenda worth being pushed... And countries need some voice at the international level. And [in Tanzania] the HIV managers will say: 'I have funds, but they are limited to HIV-related activities...' (GovSector-13)

Addressing the persistence of fragmentation between HIV/AIDS and sexual and reproductive health interventions, a multilateral agent notes:

In reality, even though many attempts towards greater integration exist, the programs remain vertical. The NACP, for instance, is in another building and another section of the MoH than reproductive and child health...they don't collaborate too much. Historically, with the creation of NACP people started to look at HIV/AIDS as a separate issue. Only later on, with the growing knowledge about the linkages between STIs and HIV, an issue such as STIs has been integrated into the approach.⁴²³ Now, even though the knowledge about links between STIs and HIV is there, implementation of integration still remains a big challenge. On the ground, one can see a lot of verticality. (Multilateral-8)

The interviewees give several reasons for the very slow progress towards greater integration. One is the simple fact that integration is challenging to implement. In an attempt to explain the situation, this multilateral agent, for instance, states:

In reality, integration on the ground is not as easily done as said. [...] Some of the obstacles to integration are technical expertise, logistics, the crisis of human resources for health... Sometimes, practically speaking, integration means adding more activities to already busy health staff. (Multilateral-8)

This remark echoes with that of a bilateral agent, who underlines the difficulties of integration at the programming level:

Recently, [PEPFAR] said: 'We could do some training for human resources...' Now *that* is an activity that needs a lot of coordination and that is hard to articulate with the other activities of other players. So we [i.e. the smaller, 'traditional' health donors] said: 'Why don't you just buy internet, computers and solar panels for all health facilities in the country? That would help. And it's easy, clean and it would be no problem to implement it in a completely parallel manner to all the other activities.' The challenge is to agree upon what they can fund that is helpful for everybody and easy to slot in [the rest of the policy process]... (Bilateral-14)

Beyond the practical challenges of integration, another partial explanation for this continued fragmentation of health service-delivery is the fact that some heads of department within NACP appear not to be in favour of increased integration. "Many people in the MoH are against integration", underlines one interviewee (Multilateral-12). Indeed, when challenged at a policy workshop by a bilateral agent who complained that "services are parallel, and the National Strategies are different for reproductive health and HIV", an NACP project manager responds:

Is that a problem?! They have the same director within the Ministry. The sectors were created at different moments, [...]. They have different mandates. What is the benefit of integration? At a clinical level, you provide quality through *disintegration*. If you integrate, you'll have poor quality. When you disintegrate, quality will go up. The question is: How do we *link*, rather than integrate?⁴²⁴

Having a well-functioning referral system, this official argues, is preferable to an integrated provision of health services 'under the same roof'. Drawing on a Western vision of highly specialised medical practice, this approach appears to be slightly out of touch with the Tanzanian reality as it omits the health system's limited capacity actually to deliver services, given the low density, insufficient staffing

⁴²³ As discussed below, this formulation (which suggests that STI-control has been integrated into AIDS-control programmes, rather than the other way around) illustrates many interviewees' hesitation as to which of the two systems – the Tanzanian health system or the international AIDS response – should be considered as the system of reference.

⁴²⁴ Discussion at a workshop on HIV/AIDS and gender, Dar es Salaam, 6 October 2009.

and equipment of health facilities in most rural areas. More fundamentally, this remark points to differing underlying definitions of the 'quality' of health care. While vertical initiatives ground their legitimacy in the delivery of specific, sometimes highly technical responses to particular health problems, a general approach to coherent health policy planning and holistic care renders an overly-specialised vision of medical practice inappropriate (see Chapter 7).⁴²⁵ While some health officials' aversion to integration can be explained by the fact that they are medical doctors (trained within a medical curriculum that values specialised, technical interventions), the preference for non-integrated programming might also be due to the fact that Tanzanian health officials reap greater benefits from managing a vertical donor-funded project than from contributing to a greater overall coherency of health care (see Chapter 3). A multilateral agent (and former Tanzanian official), for instance, relates fragmentation at the service-delivery level to the structure of international health action that influences the internal functioning of the Ministry of Health:

People at the MoH [Ministry of Health] would like to plan for the 131 districts and implement it all from Dar es Salaam! The same is true for VCT, care and treatment, STI...etc. They all would like to go 'as a unit' to the districts and do the job alone, not in collaboration with the other units of the MoH! The result is incomplete coverage for all these activities, both geographically and as far as the intervention packages are concerned. There is too much fragmentation! [...] The reason for this internal fragmentation is that these interventions come in as projects, they are supported by different donors. If a donor wants to support STIs, they want the MoH to report to them on that. When the MoH takes over these projects, most of the time, they are not ready to do so, the sustainability of the project is not ensured, and full geographic coverage is not ensured either. And the MoH unit in charge will think of going to the districts as such, without consulting other MoH units! This is where the 'verticalisation' is: *inside* the MoH! (Multilateral-7)

More fundamentally, and beyond the straightforward aversion of some individual NACP programme managers, the lagging progress towards increased integration of HIV-services at the health-facility level is due to the fact that integration is perceived as a costly (i.e. time-consuming) undertaking that runs counter to the vertical programmes' core objectives. When asked about her opinion concerning the impact of the AIDS response on the Tanzanian health system, one interviewee from a PEPFAR implementing agency admits:

Of course, everybody talks about the linkages with other health sectors and PEPFAR increasingly looks into linking HIV with reproductive health and family planning, but... I am probably too narrow-minded, but most of my time is eaten up by fighting HIV...so that's not a question I ask myself at my 'technical' level. (Bilateral-27)

Another bilateral agent's response to a question about the integration of vertical programmes into the general health system, and particularly about the closer articulation of malaria- and HIV-related interventions, illustrates how the lack of political will expresses itself through a 'lack of time' in the everyday work of programme officers within vertical initiatives. It is worth quoting at length:

Many people say 'we need better integration', without really knowing what it means to integrate and coordinate activities – it needs *time*...and resources! Nobody has time to do it! [...] For example, we have been trying to put in place a surveillance officer for HIV and malaria in Zanzibar. That position only costs 80,000 dollars per year, but we can't agree on it... Nobody can take that Goddamn decision! I am

⁴²⁵ This difference in approaches is echoed in the more general debates over 'appropriate technology' in the field of health.

embarrassed to tell you how many conference calls we have made and how many e-mails we have written about this... We can't even agree on a 80,000-dollar position! It's always easy to say 'you should harmonise activities'... (Bilateral-22)

Referring to another example, this interviewee continues:

There is a very explicit mandate from both PEPFAR and PMI [the US President's Malaria Initiative] headquarters to do more collaboration at the country level. But, in reality, that happens...very infrequently. It is not given high enough priority by staff. [...] Let me put it this way: I've been here for two and a half years now and I have *never* been invited by PEPFAR to talk about if and how HIV and malaria could be integrated. It hasn't happened! And I'm not throwing any stones or blaming anyone. Nobody has the time! We all have more than enough to keep us busy. [...] The project was to do malaria diagnosis in HIV care and treatment centres. It makes sense to test HIV-positive people with fever for malaria and to treat them if they are infected.⁴²⁶ It makes perfect sense, but it's not done for the time being. And it will happen in the future, but it's not being put in place in a timely manner. And nobody cares about it! I'm not throwing stones here; I include myself in the critique. And on the Tanzanian side, they *definitely* don't care about this. The National Malaria Control Programme – just as the NACP – is completely overwhelmed by their tasks. They are so busy! And they know their funding is coming anyway...much of which from the Global Fund. And, at least until very recently, the Global Fund certainly didn't care about it [integration] either. It might have *said* it did, but... [...] Take another example of an attempt to integrate HIV and malaria: PEPFAR did have the desire to provide bed nets to PLWH in HBC [home-based care] programmes. And the National Malaria Control Programme told them: 'We don't have time for this!' And they might be right. It is true, that would have been a very small proportion of the total population [...]. So I told PEPFAR: 'If you want to provide these people with bed nets, just go ahead and do it. Don't worry about coordination!'. (Bilateral-22)

These statements give an insight into the 'vertical world' of international health initiatives, whose protagonists' dominant mode of action is shaped by the narrowly disease-specific institutional framework in which they operate. The general design and overall coherence of the health system is something most policy practitioners within the 'vertical world' have no professional incentive to think about. As a multilateral agent who actively contributed to the implementation of the AIDS response puts it with respect to its impact on the Tanzanian health system: "You get so swamped by your everyday work that it's only when you get out of it that you realise: 'Oh my God! *What* have we been doing?!" (Multilateral-14). The planning and implementation of integrated service delivery requires active coordination among all involved players, which requires time. Time being a precious resource within vertical programmes that operate in an urgency mode of action and continually chase highly ambitious quantified targets, coordination towards integration is not considered a 'cost-effective' investment with regard to each programme's disease-specific objectives. The potential long-term overall efficiency gains from a more integrated response are lost from sight (see Chapter 3).

Finally, and importantly, the above-quoted statements of the bilateral agent point to a telling feature of the vertical mode of action: when asked about integration, several players spontaneously talk about their efforts to advance integration *between* vertical programmes, rather than the integration of vertical programmes into the general health system. "At the district level, people are very happy about integration", underlines a Tanzanian official, "the challenge at the national level consists in getting vertical programmes to work together as an integrated programme" (GovSector-13). While articulating

⁴²⁶ See the interaction between malaria and HIV described in Chapter 1.

different disease-specific initiatives is better than running them in isolation, this ambiguity about the very sense of 'integration' is a telling illustration of the degree of fragmentation of the Tanzanian health sector. More fundamentally, the policymakers' 'lack of time' for coordination is a direct consequence of the coexistence of multiple vertical programmes. Not only does the vertical policy regime let coordination appear as something 'external' or 'additional', which one can live without, but it considerably increases the need for (and the 'cost' of) coordination among separate vertical programmes. In a horizontal health-policymaking perspective, far from being an additional cost or a burden to avoid, 'coordination' is the very process through which compromises are struck, trade-offs are formulated, and an acceptable balance between different aspects of health is found. Although the players' individual time constraints are real, the claim that coordination – i.e. the necessarily conflictual process of formulating temporarily acceptable compromises – is too 'time-consuming' reflects the technocratic, depoliticised understanding of health action that underlies vertical disease-control initiatives that provide 'technical solutions' to heteronomously defined, isolated problems.

Sub-conclusion) A Copernican Revolution or an irreducible contradiction?

In many African countries, the international mobilisation against HIV/AIDS has given rise to vertical programmes of unprecedented scale and duration. These programmes were accompanied by two other major disease-control initiatives – against malaria and tuberculosis.⁴²⁷ In Tanzania, as in several other African countries, the combined budget of these three vertical initiatives exceeds that of the general health system. Although there has been a slight reversal of tendency since 2010 (with a general health budget that continues to increase, while vertical financing stagnates), this order of magnitude sheds a different light on some players' hesitation as to which of the two dynamics – the newly emerged 'vertical world' or the general health system – is to be considered as the relevant system or sphere of reference. This hesitation is reflected in the statement by the bilateral agent quoted in Chapter 3, who suggests that one could argue that PEPFAR "is on-budget because they *are* the budget!" (Bilateral-29). Similarly, the bilateral agent quoted just above responds to a question about existing integration efforts by talking about the articulation of two vertical programmes (malaria and AIDS control), not about the integration of the vertical programme he is involved in into the general health system. In the midst of discourses on the importance of 'system approaches' and 'health system strengthening', certain narratives leave doubts as to whether their primary reference point is the health system or the 'system' of vertical initiatives they operate in. In Tanzania, this shift in the centre of gravity of health action towards disease-specific action during the 2000s points to an at least partially autonomous trajectory of vertical programmes. Clearly, the mere size of the vertical initiatives makes it possible to argue that they are actually building a *system*. Although paradoxical, it is indeed not absurd to suggest that the recent dominance of PEPFAR and the Global Fund has *decreased* policy fragmentation within the field of

⁴²⁷ Malaria- and TB-control initiatives, of course, pre-existed AIDS-control programmes. Yet, it is only since the creation of the Global Fund (prompted by the international response to HIV/AIDS) and that of the US President's Malaria Initiative (PMI) in 2005 that these disease-control programmes received such significant funding.

HIV/AIDS (though not with the general health system), and the fact that PEPFAR represents about two-thirds of total AIDS spending in Tanzania makes discussions about its 'alignment' somewhat odd (see Chap. 3 + 4).

In this sense, the asymmetric relation between vertical disease control and general health care in Tanzania contains elements of what could be described as a 'Copernican Revolution' of international health action. This raises the question if, hyperbolically speaking, vertical programmes still orbit the Tanzanian health system, or if the health system rather orbits these disease-control programmes. Even though the vertical initiatives materially depend on the health system, the construction or 'strengthening' of this system is increasingly envisaged as being a central task and responsibility of vertical programmes. As discussed in Chapter 7, this is ultimately a contradiction in terms. Reflecting upon the limits to vertical disease control, the next chapter explores the contradictions that arise for in-county policymakers, health workers, and patients from the deployment of this international disease-control apparatus shaped by global power relations.

Chapter 7) Grappling with a continuum of health needs: facing the contradictions of vertical disease control

“We live in a world where, for millions, death stalks every fever, every pregnancy, and even minor injuries. Paradoxically, as mass HIV treatment programs cleave those who benefit from those who do not, this may become a world where sometimes the only way to survive is by having a fatal illness called HIV.”
(Nguyen 2010, p.181-2)

There is an at least partially irreducible disconnect between the dynamics of international fundraising for disease control and the complexity of population health ‘on the ground’. A striking feature of the field of ‘global health’ is the extent to which the varying ‘attractiveness’ of different health conditions and the unequal effectiveness of the political mobilisation in their favour leads to a distribution of funding that often has but a distant relation with the burden or menace represented by different pathologies (e.g. Shiffman & S. Smith 2007; Shiffman 2008; 2010). Part of the disconnect between what international funding is made available for and what lower-level policymakers consider money should be spent on is thus inherent to the policy process itself. That being said, the nature and intensity of the tensions to which this disconnect gives rise at the implementation level also greatly depends on the design of health policies. As discussed, the considerations at the origin of the vertical international AIDS response were related to efficiency, swiftness of impact, traceability, and – less explicitly – to the visibility and the attributability of results. Other than that, and as mentioned in Chapter 3, vertical programmes allow health players to overcome what is sometimes perceived as paralysing complexity. By decomposing – or ‘slicing’ – reality into manageable units, they reduce the perceived complexity of real-world situations and facilitate policy interventions via the formulation of specific measures aiming at ‘solving’ an artificially isolated health problem. The history of international AIDS control suggests that the apparent straightforwardness of disease-specific interventions facilitates effective fundraising. As described in Chapter 6 and as Nguyen’s statement illustrates, the combination of over-proportional funding with a segmented vertical approach can give rise to a form of violence due to the disease-specific disparities it entails between pathologies and patients. In this sense, vertical AIDS programmes add an additional dimension to the cumulative inequalities concerning illness and death.

This chapter proposes to explore the fundamental ambiguity of AIDS-control initiatives in Tanzania by describing how in-country policy practitioners deal with the tensions that arise from the disconnect between comparatively well-endowed AIDS-control programmes and the continuum of people’s health-related needs at the service-delivery level. It analyses how these players attempt (and sometimes manage) to take advantage of the opportunities offered by international AIDS initiatives to formulate what they consider sensible policy responses to the complex real-world situations with which they are confronted. Section A analyses the concrete power plays that emerge between actors from different health-related policy fields as a result of the uneven funding structures entailed by the massive

international response to HIV/AIDS since the early 2000s. Importantly, the choice of nutrition as a case study of the interrelations between vertical AIDS-control programmes and national responses to other health problems in no way suggests that nutrition insecurity is *more* important than other drivers of HIV transmission. This choice derives from the fact that nutrition insecurity was frequently raised as a problem and, to a significant extent, from the contingencies of fieldwork.⁴²⁸ Developing upon the findings of this case study, Section B proposes a more general reflection on the consequences of the international AIDS response on the coherency of health policies in Tanzania, as well as on the limits to and contradictions of vertical disease control in contexts of generalised poverty and weak health systems.

A) Elective affinities between policy responses to AIDS and nutrition insecurity: a case study

“[A] disaster can always be an opportunity – especially when foreign philanthropy is at hand.”
(de Waal 2006, p.3)

It is an oft-stated fact in policy analysis that the rise of a problem onto the political agenda depends not solely on its intrinsic severity or urgency (cf. Shiffman 2009; 2008; Shiffman & S. Smith 2007). The contrast between international donors’ sustained commitment to AIDS control and their discontinued attention to food insecurity and malnutrition proves political science textbooks right. The funds mobilised in the struggle against HIV/AIDS are incomparably higher than those available for fighting hunger and malnutrition. While nutrition insecurity continues to be largely neglected as problems on its own merit, it is increasingly acknowledged as an important component of the struggle against AIDS in sub-Saharan Africa. In 2006, the UN General Assembly, for instance, resolved to make “food and nutritional support [...] part of a comprehensive response to HIV/AIDS” (2006, p.4). Similarly, a 2008 joint UN policy brief underlines that, in sub-Saharan Africa, the two millennium development goals (MDG) on hunger and HIV/AIDS “cannot be reached independently of [one another] and will necessitate addressing HIV-specific issues surrounding food security and nutrition” (UNAIDS et al. 2008).

The relationship between HIV infection and nutrition insecurity is multifaceted and bidirectional. On the one hand, a variety of behavioural, biological, and epidemiological studies point to nutrition insecurity as a driver of HIV transmission – suggesting the inclusion of nutrition-related interventions in HIV-prevention efforts. On the other hand, hunger and malnutrition hasten the progression from HIV infection to AIDS and antiretroviral therapy requires patients to be adequately nourished. The nutrition-related problems encountered during the roll-out of ART in sub-Saharan Africa over recent years have increased public awareness of the high prevalence of nutrition insecurity in many of the countries most

⁴²⁸ Indeed, several countries with high rates of malnutrition and food insecurity have relatively limited HIV epidemics (e.g. India). Nutrition insecurity should be considered as one among many synergistically interrelated factors that facilitate HIV transmission, *not* as a stand-alone cause of the African HIV epidemics. The nutrition players, however, were particularly active – which made it comparably easy to identify and approach them with an interview query.

heavily affected by HIV/AIDS. Food insecurity and malnutrition thus pose a renewed political challenge because they threaten to jeopardise the success of this unprecedented international treatment campaign. Because of its interactions with nutritional issues and its relatively abundant resource endowment, HIV/AIDS has progressively moved to the very heart of nutrition-security policies in Tanzania.⁴²⁹

Both nutrition security and AIDS players selectively mobilise biomedical and epidemiological insights on the interplay between these conditions to suggest an increased collaboration between their respective policy fields.⁴³⁰ In Tanzania, the surge of AIDS funding along with a significant change in framing of the nutritional aspects of the epidemic opened a “policy window”⁴³¹ (Kingdon 1984) for nutrition interventions. Despite the limited scope of the emerging collaboration between the two fields, AIDS has become an opportunity for national and international actors in the domain of malnutrition – a politically neglected problem. Indeed, even a marginal redefinition of the framework of reference in relatively well-endowed domain of AIDS could induce major changes in the formulation of nutrition security policies. It is thus a key stake for nutrition players in Tanzania to succeed the “coupling” (Kingdon 1984) of malnutrition with the AIDS policy stream by presenting nutrition interventions as crucial components of the response to HIV/AIDS. Due to their uneven funding background, AIDS players are in a position to arbitrate the legitimacy of different approaches and actors in the ‘overlapping zone’ of the two fields. The result is a strategic interaction between nutrition and AIDS players in Tanzania. Throughout this asymmetric negotiation, nutrition players attempt to redefine their domain of competence with respect to HIV/AIDS, thereby shifting the boundaries of the field of nutrition security. AIDS players in some cases welcome this effort and engage in cooperation, some even actively seek committed counterparts in the nutrition field. In other cases, they block what they consider an excessively broad and intrusive redefinition of nutrition players’ jurisdiction.

Most of the literature on the relationship between HIV and nutrition security analyses their interactions through the HIV-lens, considering increased food security and adequate nutrition essentially as means to mitigate the epidemic’s effects.⁴³² Few studies look at the issue from the nutrition players’ perspective. Similarly, although a great deal has been written about the detrimental bio-medical and economic interactions between HIV, food insecurity and malnutrition, little detailed analysis of their reciprocal effects in terms of public policies exists. By analysing the interactions between AIDS-control programmes and nutrition-security policies in Tanzania, this section explores the ambiguous effects of a disease-specific international response to HIV and another health-related policy field, perceived as comparably

⁴²⁹ The concept of ‘nutrition security’ includes nutritional aspects into the notion of food security. It can be defined as “adequate nutritional status in terms of protein, energy, micronutrients, and minerals for all household members” (Quisumbing et al. 1995, p.12).

⁴³⁰ On ‘players’, ‘fields’ and their relative autonomy, see: (Bourdieu 1992, p.71-90; Bourdieu 2000).

⁴³¹ Policy windows are moments in time when conditions align favourably for a specific issue. They open when issues rise to policymakers’ attention because problems, solutions and broader political developments converge (see: Kingdon 1984).

⁴³² For a notable exception, see the analyses by the Regional Network on AIDS, Livelihoods and Food Security (RENEWAL): <http://programs.ifpri.org/renewal>

unspecific. The following sub-sections successively argue that, while nutrition security suffers from a lack of political commitment in Tanzania, bio-epidemiological evidence on its deleterious interactions with HIV infection suggests a strengthening of policy links and a closer integration of the interventions in both domains. These scientific insights contribute to the opening of a policy window for nutrition security struggles, encouraging nutrition players to reframe their actions strategically according to HIV-related needs. Due to its relative resource abundance, the policy field of HIV/AIDS expands well into the under-coordinated field of nutrition and determines both the nature of nutrition interventions and the coordination of the nutrition sector itself. The extension of the policy field of nutrition security thus remains closely circumscribed, leaving nutrition players in a subordinate position.⁴³³

A-1) Nutrition and food security: Tanzania's 'forgotten' MDG

“There is a lack of food. Normal households already lack food... so what about poor households? There is no policy!”
(NGO-2)

Since independence, 'self-reliant' agricultural development and the attainment of food sufficiency through collectivised farming were key goals of President Nyerere's Ujamaa policy (Freyhold 1979). Despite these efforts, people's average nutritional status severely deteriorated during the later 1970s – a decline that was prolonged and accelerated by structural adjustment programmes in the 1980s and 1990s. Over recent years, the average calorie intake has slightly risen again – without, however, reaching the level of the early 1970s. Ranging between 10 and 14% during the 1960s and 1970s, the share of government expenditure on agriculture continually decreased during the period of structural adjustment, falling as low as 1.5% in 1995 (Fan et al. 2005, p.19-20). Just as in Mali or Senegal, the state-centred concept of 'self-reliance' gave way to a discourse about 'food security' within a market-based regulatory system (Janin 2008a). Following the limited success of agricultural liberalisation during the 1990s (Cooksey 2003) and the renewed acknowledgement of the economic role of the state, public expenditure on agricultural development has slightly increased over recent years. In June 2009 the Government launched the "Kilimo Kwanza" (agriculture first) – a narrowly productivist agricultural development programme based on the principles of the Green Revolution. Several years into the initiative, it remains unclear if this plan for agricultural modernisation will bring about more substantial change than its numerous predecessors. At the same time, Kilimo Kwanza is heavily criticised by smallholder farmer organisations as a pro-agribusiness development initiative in favour of large and medium-size farms, not small-scale farmers (Mbunda 2011; The Citizen 2009) – the ones most relevant in terms of nutrition.

In the struggle against malnutrition and food insecurity in Tanzania, a wide variety of players contribute unequally to the setting of political priorities (Leach & Kilama 2009a). Most international NGOs (e.g.

⁴³³ The first section of this chapter develops upon a previously published article (Hunsmann 2010).

MSF, CARE, or Save the Children) concentrate on the provision of food and nutritional services in closely defined geographical settings, frequently with a focus on refugee camps or children. Few NGOs, such as Oxfam UK, who support smallholder agriculture in the Shinyanga region, focus on improving nutrition security in a more structural manner. With the notable exception of Helen Keller International (which enjoys the strong support of USAID) in the domain of vitamin A and zinc supplementation, these NGOs have remained on the margins of the policymaking process.⁴³⁴ Within the Tanzanian administration, an institutional separation exists between nutrition and food security. Nutrition is dealt with by the Tanzania Food and Nutrition Centre (TFNC), a semi-autonomous but relatively side-lined body within the powerful Ministry of Health. Food-security issues fall under the jurisdiction of the less influential Ministry of Agriculture and Food Security. Each domain has its own Development Partner Group, of which the World Bank, USAID, the European Union, Irish Aid, UNICEF, the World Food Programme (WFP), and the Food and Agriculture Organization (FAO) are the most active international players.

Despite its considerable agricultural potential, Tanzania remains one of the 20 countries that make up 80% of the world's burden of under-nutrition. 62% of children below five years and 66% of pregnant women are anaemic (TFNC 2003, p.1-2), 38% of children under five are stunted and a recent World Bank report notes that "44 percent of Tanzanians are energy deficient and unable to simultaneously sustain their body and carry out even light physical activity" (2007b, p.ix). While the national administration acknowledges this unsatisfactory situation, there is little political momentum for a determined response to food insecurity and malnutrition within the Tanzanian Government. Indeed, until recently, malnutrition hardly featured in the Government's development discourse. Calling nutrition "Tanzania's forgotten MDG", the World Bank (2008) adopts an unusually clear tone in commenting on nutrition policies in Tanzania: "Few effective interventions were being implemented", it underlines, "and donor support was uncoordinated, limited, haphazard, and mostly unproductive". "Nutrition is a neglected disease", confirms a bilateral agent, "we underlined that at the AIDS review" (Bilateral-30). Several donor agencies openly denounce a lack of commitment by the Tanzanian government. One multilateral agent, for instance, underlines:

The World Bank elaborated a detailed report on nutrition in Tanzania and they can't even get the Minister to do a formal launch of the document! They don't care! (Multilateral-2)

A Tanzanian official confirms this lack of action and clearly blames political leaders:

There is a lot of iron deficiency in Tanzania, we know it causes mental retardation. So what kind of generation are you developing?! Nutrition is neglected by the politicians! People don't see what is going on... But seeing is believing! When you talk, it's as soft as singing a baby to sleep...but in reality, it's a lot different! [...] In Botswana, I believe, nutrition has been put under the Prime Minister's or even the President's office to give it more importance – because nutrition is not just health, not just agriculture, not

⁴³⁴ As shown below, some nongovernmental actors in the domain of HIV/AIDS (e.g. the Clinton Foundation) can nevertheless have a significant impact on the type of nutrition interventions adopted.

just education: it is a cross-cutting issue. [...] Here, the [Ministry of Health] is so big and nutrition is just a small part of it, so it is being marginalised.⁴³⁵ (GovSector-8)

Other interviewees point to a shared responsibility, underlining a lack of high-level commitment and an insufficient mobilisation within the Tanzanian administration. A nutrition expert within an international NGO notes:

There has been a complete disconnect between the nutrition situation in Tanzania and the actions taken. There is no consistent action to do something about malnutrition and hunger. Nobody asks TFNC: 'What have you done about that?!'. There is a high-level lack of action! There is no leadership! [TFNC] ha[s] been invited and named as members of many technical committees...but most of the time, they don't show up! The TFNC has 140 staff members. It's a very large institution! [...] TFNC should do much more coordination...but in the absence of that, we [international donors] created the DPG [Development Partner Group] nutrition. But it interacts fairly little with TFNC. [...] TFNC didn't jump in the leadership role! We [the donors] took that leadership role, always putting TFNC up front. (INGO-11)

This last sentence points to striking similarities with the nature of donor-government relations described in Chapter 4. Interestingly, one multilateral agent points to this comparison (drawing on a slightly idealised perception of the actual strategic leadership of TACAIDS):

The institutional arrangement for nutrition in Tanzania has to change! [...] There is a lack of leadership within nutrition! Nobody is taking the leadership because [nutrition] is so cross-cutting that it is everybody's business and no one's. At least, with TACAIDS, AIDS found itself a home. Maybe it's not a good home, but it is a home. TFNC is not like TACAIDS. There is a lack of vision by TFNC... That causes a lot of the problems here. (Multilateral-5)

At the same time, this player notes that "nutrition is side-lined at the global level also". The Tanzanian situation thus also reflects a broader lack of interest in nutrition by Western governments and NGOs.⁴³⁶

Unlike the political staging of the fight against food insecurity by several governments in the Sahel region during the 2008 food crisis (Janin 2008b), the discursive politicisation of the fight against hunger has been limited in Tanzania. Despite its high rates of malnutrition and although the country has experienced repeated and sometimes severe food shortages over the last decades, the Tanzanian policy arena has remained largely consensual – a phenomenon addressed in the introduction to Part 2. Notwithstanding skyrocketing food prices, the country has known no political unrest during the ongoing global food crisis and many nutrition players remain sceptical that the recently renewed publicisation of hunger and malnutrition at the international level (Janin 2010) will bring about substantial change in international commitments or national leadership. Again, the struggle over the players' respective jurisdiction takes place within the rather isolated world of international donor representatives and public officials.

⁴³⁵ Paradoxically, the TFNC's semi-autonomous status was initially conceived to address nutrition at a higher political level – a manifestly unsuccessful attempt.

⁴³⁶ For an explanation of the political neglect of nutrition, see the box "Ten reasons for weak commitment to nutrition programs" in: (World Bank 2006, p.108).

The sums allocated to AIDS control and nutrition securitisation in Tanzania reflect national and international political priorities. In comparison to the roughly USD 500 million annual budget for the struggle against HIV/AIDS, the resources available for nutrition interventions are vanishingly small. Little reliable data exist, but a World Bank report states that “even if we were to take an optimistic approach, it is hard to see how the budget for investments in nutrition could exceed \$ 5 million per annum” (2007b, p.45).⁴³⁷ If this estimate is correct,⁴³⁸ the total expenditure on HIV/AIDS in Tanzania is about one hundred times higher than that on nutrition interventions. Even the funds available for agricultural development, which can be roughly estimated at about USD 110 million in 2008 (IrishAid 2008, p.7),⁴³⁹ represent less than 25% of HIV-related expenditures. Against this background of fundamentally unequal financial support, nutrition-security players in Tanzania consider the inflow of HIV-related funding as a window of opportunity. In this context, the evidence on the interrelation between nutrition security and HIV/AIDS constitutes an important political resource.⁴⁴⁰

A-2) When biological interactions prompt policy integration

“When people are taking ARVs, they are supposed to eat. If people have nothing to eat, they will not take their ARVs. They say: ‘If I don’t eat, they are creating havoc in my stomach!’”
(NGO-3)

“There is so much contradiction: people have ARVs but no food! So they won’t take their pills... Nobody worries about that here!”
(GovSector-13)

If mobilised by policy players, knowledge about biological interrelations can decisively influence political interactions (Callon 1986; Shiffman & S. Smith 2007; Burris et al. 2011; Sumner et al. 2011). Understanding the interrelations between nutrition and HIV/AIDS is thus key in order to grasp the nature of the policy process. The multifaceted and intricate interrelationship between HIV and nutrition security has become increasingly clear over recent years. Most immediately noticeable is the negative impact of HIV infection on people’s nutritional status. People living with HIV have significantly higher energy requirements than healthy people without HIV – an additional 10 to 30% for adults and as much as 50 to 100% for children (WHO 2003, p.4; FANTA Project 2004, p.10). The virus also modifies people’s metabolic functions, altering their ability to absorb nutrients fully. Co-infections with one or several of the often co-endemic parasites (e.g. worms or malaria) additionally impair people’s ability to absorb

⁴³⁷ This figure excludes the expenditures of the World Food Programme and of several international NGOs.

⁴³⁸ When asked about this surprisingly low figure, several interviewees confirmed its plausibility. One of them responds: “It’s very possible! The situation in Tanzania is very different from, say, Uganda, where they have multi-million dollar projects on nutrition. And in Kenya and Malawi, they have more resources for nutrition as well.” (INGO-11)

⁴³⁹ This rough estimate is based on data concerning per capita expenditure.

⁴⁴⁰ That being said, and as discussed below, the main problem is certainly not the low financial support for nutrition issues, but the broader – global and national – political economy of nutrition and agricultural production, which remains largely dominated by the interests of multinational corporations and industrial large-scale producers (see: George 1978; Thébaud-Mony 1980, chap.8 + 9; Lappé et al. 1998). More recently, the development of land grabs, of agrofuels and of financial speculation on food crops (considered as a commodity) have further contributed to jeopardising the nutrition security of many African populations.

nutrients, deteriorating their nutritional status even further. Economically speaking, HIV/AIDS undermines food security and nutrition by reducing people's ability to work, leading to decreasing agricultural production and an inability to earn adequate income to purchase food. The combination of these factors leads to very high rates of malnutrition among people living with HIV in sub-Saharan Africa. De Waal and Whiteside (2003) even suggest that, by creating a new category of highly vulnerable households in sub-Saharan Africa, HIV/AIDS provokes "new variant famines" – which are less localised and thus less perceptible than 'traditional' ones.

As HIV infection worsens people's nutritional status, a vicious cycle sets in: malnutrition and household food insecurity increase the susceptibility to opportunistic infections and accelerate the progression from HIV infection to AIDS (Semba et al. 1993; Taye et al. 2010). Nutritional support for people living with HIV delays the need for ART by slowing disease progression (Paton et al. 2006; Fawzi et al. 2004). Lack of nutrition security, in contrast, undermines the body's response to therapy and jeopardises the patients' adherence to a medical regimen since taking antiretroviral drugs on an empty stomach exacerbates their side effects. Since non-adherence increases the risk of virological resistance to considerably less expensive first-line drugs, the food and nutrition security of people on ART becomes crucial in the effort to improve treatment adherence and limit the financial and clinical implications of drug resistance.⁴⁴¹ Today, it is thus widely acknowledged among scholars that the nutrition security of people living with HIV is essential to ensuring continued large-scale access to effective ARV treatment (e.g. Hardon et al. 2007; Kalofonos 2008, Chap.7; Nguyen 2010, p.182).⁴⁴²

Other advances in the evidence base, like the facilitating role of food insecurity and malnutrition in the transmission of HIV, however, did not make their way into Tanzanian HIV-prevention policies. Food insecurity and malnutrition are related but distinct phenomena with surprisingly different geographic patterns in Tanzania; several regions with cereal surpluses, for instance, have high rates of malnutrition (Leach & Kilama 2009b, p.5-6). The two conditions are also considered to affect HIV transmission very differently. Given its resonance with the dominant behavioural paradigm, it is unsurprising that by far the most common causal narrative concerning nutrition and HIV transmission is a behaviour-mediated one – illustrated by Vearey et al.'s (2009, p.20) assertion that "food insecure women are likely to engage in risky sex practices". Although plausible, the methodological weaknesses of the available studies in this respect (e.g. Miller et al. 2011; Weiser et al. 2007) considerably limit the usefulness of the data.⁴⁴³

⁴⁴¹ Even generic second-line ARVs are, on average, 2.4 times (third-line ARVs about 14.4 times) as expensive as generic first-line drugs. See: <http://utw.msfacecess.org/background>, accessed 22 November 2012.

⁴⁴² This acknowledgment was renewed in 2011 by the UN General Assembly, which acknowledged "that people die prematurely from AIDS because, inter alia, poor nutrition exacerbates the impact of HIV on the immune system and compromises its ability to respond to opportunistic infections and diseases, and that HIV treatment, including antiretroviral treatment, should be complemented with adequate food and nutrition". Consequently, its Member states "[c]ommit to take immediate action at the national and global levels to integrate food and nutritional support into programmes directed to people affected by HIV in order to ensure access to sufficient, safe and nutritious food to enable people to meet their dietary needs and food preferences, for an active and healthy life as part of a comprehensive response to HIV and AIDS" (UN General Assembly 2011, p.4 + 11).

⁴⁴³ Most importantly, all studies I am aware of relate perceived food insecurity to reported sexual behaviour, *not* HIV incidence.

Nevertheless, this behaviour-mediated narrative of HIV transmission is widely referred to as a driver of the epidemic, both in policy papers and by the interviewees. A multilateral agent, for instance, almost self-evidently underlines:

Of course, some of the exposures are due to food insecurity, to transactional sex because of people selling their bodies so that they can be able to eat. (Multilateral-16)

The 'biological' causal pathway from nutrition insecurity to HIV transmission, in turn, remains entirely undiscussed in the policy arena. The relation between people's nutritional status and their susceptibility to infection is nothing new (cf. Dubos 1980, chap.VI). Although it is obviously less straightforward than in the case of pulmonary TB (Ibid., p. 149), the relation between malnutrition and HIV is increasingly well-documented. As discussed in Chapter 1, undernutrition and micronutrient deficiency increase HIV-positive people's viral load (a chief predictor of transmission) and decrease their T-cell counts (Friis & Michaelsen 1998). While vitamin deficiencies alter the integrity of genital mucous membranes and of the placenta, anaemia weakens the general immune response and causes higher viral shedding and thus a locally higher viral burden in the vagina. These effects help explain that poor nutritional status increases the risk of both mother-to-child and sexual transmission of HIV (e.g. Semba et al. 1994; Fawzi et al. 2002). Malnutrition also lowers the immune response of HIV-negative individuals in case of viral challenge, and alters the mucous membranes' barrier function by affecting the epidermal integrity of both partners' genital parts. The resulting increased permeability of the mucous membranes adds to the risk of HIV transmission. In a nutshell, the better a person's nutritional status, the better is his or her general and genital health – both of which determine the immune system's ability to keep the virus from entering and replicating in the body (e.g. Stillwaggon 2006, chap.2□3). More generally, and as discussed in Chapter 1, the risk of HIV transmission per unprotected penile-vaginal intercourse depends on the infectivity of the person carrying the virus and the susceptibility of the HIV-negative partner. Both depend, in part, on adequate nutrition. Lastly, considering the effects of malnutrition on HIV transmission *in isolation* from other – often co-endemic – pathologies certainly only incompletely accounts for its effects on the spread of the virus (Stillwaggon 2009).

Epidemiological and bio-medical insights thus suggest a wide range of possible policy links, such as infant feeding counselling for HIV-positive mothers, the provision of nutritional support to people affected by HIV or the inclusion of both nutrition and food security concerns into HIV prevention programmes. The next sub-section describes how nutrition players in Tanzania mobilise some of these scientific rationales to argue in favour of a closer integration of nutrition and HIV-related policies, thereby presenting themselves as legitimate partners in the struggle against AIDS.

A-3) AIDS as a policy window for nutrition security in Tanzania

“HIV/AIDS funds account for 30 percent of external grants to Tanzania. [...] It makes sense to reallocate some of these resources to nutrition as HIV/AIDS and nutrition share common objectives.”

Former World Bank lead health specialist in Tanzania (quoted in: World Bank 2008)

This statement sums up the state of mind of many nutrition players in the country: AIDS has become a resource. “You could say that HIV is like a comparative advantage for nutrition”, suggests a multilateral agent, “it will support the nutritional issues” (Multilateral-10). By establishing a link between their activities and HIV/AIDS in their discourses and claims, the players involved in the field of nutrition in Tanzania aim at promoting their actions and, in some cases, at legitimising their institutional existence. In parallel, donor agencies increasingly take into account food and nutrition issues in their HIV-related programmes. Since 2009, for instance, PEPFAR explicitly considers certain nutritional aspects as part of its mandate. Despite this reciprocal interest, the uneven financial endowment of the two domains induces an asymmetric collaboration between their respective actors. It is the national and international AIDS players who decide what ‘their’ funds can legitimately be spent on. Consequently, it is up to the nutrition players either to reframe their activities according to this circumscribed framework of action or to negotiate its possible extension.

One frequently encountered framing strategy consists in arguing that every Tanzanian is *potentially* a person unconsciously living with HIV. In this sense, a World Bank report on nutrition states:

Good nutrition is particularly important for everyone, including those affected by HIV and AIDS. *Most people are unaware of their HIV status so a nutrition education campaign will have to reach all Tanzanians.* With its extensive resources and a program that is already supporting communication and behaviour change, the HIV/AIDS program is well suited to lead the implementation of the nutrition education agenda supported by TFNC with the necessary knowledge. (World Bank 2007b, p.xiv. , emphasis added)

It is not a coincidence that the World Bank draws on the behavioural narrative of malnutrition as being primarily an *educational* problem – a conception that clearly echoes dominant aetiological paradigm. Again, blaming inadequate individual behaviour (here: an insufficiently diversified nutritional intake) allows abstraction from the more structural, and fundamentally political, determinants of poor nutritional status – including agricultural intensification and trade-liberalisation policies driven – if not imposed – by the World Bank.⁴⁴⁴ Getting back to the ‘coupling’ strategy between HIV and nutrition, the Bank’s former lead health specialist in Tanzania draws on the very same strategy as the Bank report, stressing that “as better nutrition delays the onset of AIDS, food fortification to the benefit of all will support the many who are unaware of their HIV status” (in: World Bank 2008).⁴⁴⁵ Another multilateral

⁴⁴⁴ The quote in the epigraph of sub-Section A-7) underlines this contradiction quite fittingly. This suggests that not much has changed since, over thirty years ago, Thébaud-Mony denounced a report by the World Bank, whose experts had “achieved the tour de force of addressing malnutrition without ever mentioning the issue of the global market for agricultural products” (1980, p.324).

⁴⁴⁵ That being said, the World Bank’s support in favour of food fortification had only limited success. As a multilateral agent exclaims: “The World Bank is sitting there with the money to fund fortification, but it’s not happening! Why? Leadership!

agent voices a similar position concerning the possible support of food fortification by an HIV/AIDS programme:

The conclusion I have come to [...] is that the only way to push the nutrition agenda is to work with PEPFAR. [...] They could look at the use of fortified foods and they would have both: HIV [-infected] people would get better nutrition, so PEPFAR would be happy...and other people would benefit also! [...] There are lots of ways to direct HIV-earmarked money to look at nutrition issues as well. At USAID, they are open to this kind of initiative. [...] But their hands are tied [by Congress] because it has to have something to do with HIV. But then again, it's not so difficult to establish that link! (Multilateral-5)

An international NGO worker confirms the willingness of (and initial difficulty for) the PEPFAR country team to include nutrition issues into their programmes:

Look at the PEPFAR-2 Strategy and see how their language has changed on nutrition. It was a Congressional issue. All PEPFAR [implementing] partners wanted to do nutrition from the very beginning, but Congress did not authorise this under PEPFAR-1. (INGO-11)

Interestingly, the World Bank takes a rather active stand in this struggle to broaden the scope of interventions that can be financed with AIDS-earmarked funds. In the press release on its report on nutrition in Tanzania the Bank states that, “[f]or additional resources for nutrition, the analysis eyeballs HIV/AIDS funds available in Tanzania” (in: World Bank 2008). The report proposes to “[c]o-opt the HIV/AIDS program into a nutrition campaign” (World Bank 2007b, p.xiv) and the World Bank Country Director stresses that “over the next year, increased attention for nutrition needs to translate into [...] the ability to tap into HIV/AIDS resources” (in: World Bank 2008).

When asked about the Bank's proposal to use some of the AIDS money for nutritional purposes, a Tanzania AIDS official, however, clearly expresses his reservations, answering plainly: “well...that's their own problem” (GovSector-5). This attitude might explain why the World Bank Country Director underlines that, “[t]o be successful, we could use some help from our headquarters [...] by putting pressure on our global partners to allow a broader interpretation of what HIV/AIDS resources can be used for” (in: World Bank 2008). The struggle over the redefinition of the respective boundaries of the AIDS and nutrition fields in Tanzania thus takes place both at the national and the international levels. The “global partners” referred to are, in all likelihood, the Global Fund and PEPFAR. As discussed, the creation of these two initiatives in 2002 and 2003 led to a massive inflow of funding to Tanzania and rapidly side-lined the ‘traditional’ bi- and multilateral donors. Experiencing a relative loss of influence, many of these donors withdrew from the AIDS sector, an increasingly autonomous and oligopolistic field that is progressively slipping from their control. These donors decided to concentrate again on other health issues – a field where their authority is less challenged and where they feel their marginal utility (and public visibility) is higher. From their new ‘outsider’ position, some of these players – including the World Bank, whose Multi-Country AIDS Project came to an end in 2009 – now call for a broadening of

There are too many stakeholders. Concerning fortification, the evidence is there, the resources are there...so why isn't it happening? It gets down to leadership...” (Multilateral-11) – a comment that echoes with the policy process concerning HIV prevention described in Chapter 4.

the criteria of how the funds earmarked for HIV can be spent. In this sense, the struggle over the redefinition of the two fields' boundaries thus also reflects the changing broader institutional configuration of health-related international cooperation in Tanzania and globally.

Interestingly, this struggle generally is a 'bottom-up' one: the closer the players are to the implementation level, the more favourably they view an inclusion of nutritional concerns into HIV programmes. Both grass-roots organisations and in-country offices of international donor agencies call for such integration in their dialogues with the national government and international headquarters respectively. As the legitimacy of nutritional elements in HIV interventions increased over recent years, TFNC has stepped into the breach by presenting itself as an ally in the struggle against AIDS. The Centre now receives HIV-earmarked funding from the Global Fund. Despite its open criticism of TFNC in the past, the World Bank supports the Centre in this endeavour. Becoming a recipient of the Global Fund or PEPFAR could be a windfall for TFNC, which has undergone severe budget cuts over recent years. Describing the Centre's attitude following USAID's decision, in 2008, to start funding HIV-related nutrition initiatives on a larger scale, an NGO worker slightly ironically comments: "TFNC was like: 'Okay, the money is coming...this time, it is *our* turn!" (INGO-11).⁴⁴⁶

In sum, the conception of legitimate actors and rationales for action in these two increasingly overlapping fields is evolving. Nutrition players progressively take part in HIV-related projects and AIDS players increasingly consider them as partners. The boundaries of the field of HIV/AIDS, in turn, have progressively expanded into its neighbouring fields. As the following two sub-sections show, this poses a number of challenges at the implementation level and introduces a fundamental bias into nutrition policymaking.

A-4) The violence of 'segmenting' social reality

"In my last job, I was in the field. Several times I saw people in tears because they just found out they were negative in their [HIV] test. They knew they wouldn't get food, school support, etc.... Yes, quite a few of them would cry."
(Multilateral-5)

Although this statement reflects a local reality that cannot be generalised, it illustrates the pernicious real-life effects of the international AIDS players' tendency to 'think in boxes' – which is a direct consequence of the vertical design of AIDS-control programmes. The need for people living with HIV to have access to safe water and balanced nutrition, for instance, is consistently emphasised by a variety of institutions and interviewees. At the same time, both nutrition and other health players repeatedly stress that the remaining 94% of the Tanzanian population need safe water and balanced nutrition, too. Indeed, vertical disease-control programmes – all the more if predominantly formulated at the international level – can result in local situations perceived as absurd and ethically unbearable. The

⁴⁴⁶ Commenting on the closely delimited nature of these nutritional programmes, he adds: "But it is all on the PLWHA and PMTCT side...it's all 'food by prescription'" (INGO-11). On this issue, see sub-Section A-5).

challenges that arise from the imbalances due to the vertical response to HIV/AIDS in a context of generalised poverty leads the interviewee quoted in the epigraph to exclaim: “HIV has become so fashionable...it can’t *constantly* be looked at exclusively! We can’t allow it to jeopardise other development aspects!” (Multilateral-5).

A narrowly circumscribed disease-specific intervention results in what could be described as a ‘double segmentation’ of the continuum of social reality. By addressing one specific, exogenously-defined aspect of ill health, vertical programmes tend to abstract both from the plurality of people’s (health-related) needs – or ‘rights’, in a more politicised conception – and from the broader social context in which these populations live. The first aspect of this reductionism results in the fact that only specific segments of the continuum of an individual’s multifaceted needs are effectively taken into account in the delivery of health services. At the implementation level, an excessively compartmentalised vision of health leads to situations that are extremely difficult to manage. As a multilateral agent denounces at a preparatory meeting of the Global Fund Round 9 proposal, “Many people on ARVs don’t have enough to eat. So what does it mean to counsel people, but to give them nothing to eat!?”.

The second type of ‘segmenting’ of social reality stems from the fact that vertical programmes focus on individuals directly affected by one specific disease, rather than on communities within which HIV/AIDS is but one of the scourges shaping people’s everyday lives and struggle for survival. By selecting individuals based on biological criteria, AIDS-control programmes ‘create’ sub-populations for medical intervention (Nguyen 2010, chap.5). This leads to a situation where HIV-related interventions “attract a lot of interest in other patient groups” (INGO-9).⁴⁴⁷ As a multilateral agent describes:

There is a dilemma for many providers: What about the patients in the TB or paediatrics sections? They are just as much in need of nutritional support as HIV-patients. So should we give support to HIV-infected people only? (Multilateral-8)

Beyond the walls of the hospital or health centre, the HIV-focused nature of interventions disregards the broader social context of the response, both to the epidemic and to the Tanzanian population’s multiple health needs. One multilateral agent, for instance, points to the limits of nutrition-support interventions that focus on HIV-infected individuals alone and abstract them from their family context:

USAID dictates the agenda. We have to get them to steer their funds into a household approach, but they focus on individuals. [...] They push for ‘food-on-prescription’. We stress the need to work at the household level...to follow a broader approach. The ‘food-on-prescription’ approach is not sustainable at all! But then again, even our model is not very sustainable... We should look at what households can do. (Multilateral-5)

A Tanzanian official points to the difficult situations a disease-specific, individualised approach can lead to:

Sometimes people don’t realise what the reality is on the ground. Take for instance the Clinton Foundation: they wanted to provide nutritional support only to HIV-positive children. How do they imagine *that*?! You

⁴⁴⁷ See also Chapter 3.

have a group where some are positive and some are negative, but all are hungry, and you give nutritional support only to the HIV-positive kids? You can't do that! Finally, we agreed. Sometimes, the World Food Programme has similar approaches... Our fight is to say: 'We deal with malnutrition, not *only* with HIV/AIDS.' But the Clinton Foundation and the World Food Programme...their interest is people living with HIV and AIDS, not the malnourished in general. Being malnourished without being HIV-infected? No! (GovSector-8)⁴⁴⁸

This feeling is widespread among actors concerned with nutrition and, more generally, with non HIV-related aspects of health in Tanzania. As a bilateral agent puts it:

Today, people look at everything from an HIV point of view. They'll say: 'This is an HIV condom, not a reproductive health condom'. And look at PMTCT, it is not seen as part of maternal and child health! [...] People think about nutrition as...say, if you are an undernourished child with HIV, you'll get peanuts⁴⁴⁹; if you're [HIV-] negative, you'll get nothing! (Bilateral-14)

A multilateral agent sums up the paradoxes that arise from the vertical response to HIV/AIDS as follows:

The issue of nutrition is a big challenge in the domain of [HIV] care and treatment – in my previous jobs, I was there, on the ground: nutritional support is *always* an issue patients raise when you talk to them... That shows that sometimes it is so difficult to know how to address an issue in a context of generalised poverty. It is not clear what will be the best way: Should we give nutritional support to people on ARVs for one month? 6 months? Or should we rather favour income-generating activities...? (Multilateral-8)

Vertical AIDS-control programmes in a context of generalised poverty are caught in a double dilemma. The success of their HIV-specific interventions is jeopardised if they do not provide food to HIV patients, but if they do, this invariably prompts vivid tensions about eligibility (e.g. Nguyen 2010, chap.1 + 2; Kalofonos 2008). Strikingly, as an international NGO worker reports, the selective nature of food aid induced by ART programmes in Tanzania has led to a situation where "health workers and clinicians don't want to be involved in nutrition support anymore because, at the end of the day, they'll be the bad person" announcing the end of – or non-eligibility for – food aid (INGO-11).

"[P]roviding food to people on treatment as entire communities go hungry generates resentment and bitterness – and even a form of paranoia as people wonder who is getting what and imagine that others are eating while they go hungry", writes Nguyen (2010, p.182). Drawing a similar conclusion based on fieldwork in Mozambique, Kalofonos (2010, p.375) sums up this "paradox of AIDS treatment interventions" as follows:

While biomedical coverage increases, overall living conditions worsen if the basic problems of hunger and economic citizenship are not addressed. The interventions can attain their stated and measured goals, while the beneficiaries of the programs continue to suffer in an environment of weakening social solidarity. [...] [T]he technological magic bullet of ARVs alone is an insufficient intervention in the face of the increasing hunger and inequalities that continue unabated.

Kalofonos rightly underlines the insufficiencies of a narrowly treatment-oriented response and the violence caused by the segmented approach to reality such a response entails. The absurdity of people

⁴⁴⁸ The World Food Programme provides four or five additional food rations to the family of every HIV-positive person enrolled in its programme.

⁴⁴⁹ In this case, "peanuts" refers to the ready-made food supplements (which contain peanuts), not figuratively to "a trifling amount".

being ‘saved from AIDS’ and left to die from hunger echoes other debates about medicalised responses to ill health in contexts of widespread poverty.⁴⁵⁰ Beyond the obvious violence it entails, both the radical perversion of people’s incentive structure pointed to by the interviewee quoted in the epigraph (i.e. ‘You will get food, when you are HIV-positive’⁴⁵¹), and neglected the importance of effective primary health care for HIV-prevention (see Chapter 1 and sub-Section B-4, below) suggest that an excessively narrow definition of AIDS-control programmes jeopardises the attainment even of their narrowly HIV-related objectives.

A-5) When HIV/AIDS determines the institutional responses to nutrition insecurity

As discussed, HIV/AIDS holds a hegemonic position and determines the way development professionals in Tanzania think about health in general, and nutrition in particular. In a context where “it is hard to raise funds if it is not for closely HIV related actions” (Bilateral-16, quoted in Chapter 3), the resulting asymmetric relation between nutrition and HIV/AIDS is mirrored in the nature of the institutional cooperation between the two domains. TACAIDS, for instance, gave impetus and financial support to the organisation of a national conference on nutrition. A Tanzanian nutrition official points out:

In October [2008], we’ll have a big meeting with all the nutrition stakeholders in Tanzania: the [Ministry of Health], the Ministry of Agriculture... For now, some people and NGOs do some very, very small interventions on food and nutrition, but we don’t know who is doing what and where out there... We want to map these activities and coordinate them better. For the time being, we haven’t been able to do that. This meeting is organised and financed by TACAIDS. We don’t have the money to do it. And they also want that to happen...they want nutrition to be coordinated. (GovSector-8)

While this official invokes a lack of funds, several development partners blame a lack of leadership and commitment by the Tanzanian administration as the reason for the poor coordination within the sector. In any case, the inflow of HIV-related funding and TACAIDS’s broad understanding of HIV/AIDS as a cross-sectoral issue have positive spillover effects for the field of nutrition. The fact that the coordination of the Tanzanian nutrition sector is pushed for and funded by TACAIDS, however, is likely to bias nutrition policies towards HIV-related aspects.

At the sub-national levels, the PEPFAR ‘implementing partners’ are in many respects already the ‘system of reference’ for nutrition interventions. By making long-awaited resources available, the various organisations that implement PEPFAR attract nutrition specialists who, in some cases, have been struggling for years to move nutrition issues forward on the national agenda. One of them notes:

I went into HIV because it’s a fast moving agenda. And you can do a lot with one million dollars! With PEPFAR, there is an opportunity for people [working in the nutrition field] to do the things they have been thinking about for decades. Take infant feeding: for the first time in 25 years, there is a budget to go national! When we had that chance, we very much focused on the linkages between nutrition and HIV,

⁴⁵⁰ Debates over the limits to oral rehydration therapy for infants are one example. See also (Thébaud-Mony 1980, p.357-381).

⁴⁵¹ Tichtin (2006) describes a strikingly similar case, where undocumented immigrants in France inquire how they can infect themselves with HIV in order to obtain legal status.

instead of waiting for the day we'd have 10 million to take care of nutrition alone. And we had arguments on the linkages... (INGO-11).

That being said, the renewed international focus on HIV/AIDS, malaria and TB, modifies the manner in which health players from other domains conceive and present their own activities. The Tanzanian nutrition official quoted above, for instance, underlines:

We also want to look more into TB and nutrition, because there has been a lot of talk about HIV and nutrition, but nobody talks about TB. It hasn't featured adequately in nutrition policies, even though nutrition is so important for TB, too. (GovSector-8)

Similarly, a Tanzanian AIDS official suggests:

The Global Fund will accept anything – you simply have to justify it. So anything that is related to the 3 'big ones' [HIV/AIDS, malaria, and TB] is taken on board. (GovSector-9)⁴⁵²

All other health-related players are thus invited to frame their problems and solutions according to one (or several) of the 'three big' epidemics that receive the bulk of international attention and funding. While integrating the responses to different health conditions obviously makes sense, such compartmentalised framing ('AIDS and nutrition', 'TB and nutrition', etc.) increases policy fragmentation, leads to incomplete responses to other poor health conditions such as malnutrition.

This internationally defined hierarchy between different pathologies makes it difficult for nutrition players in Tanzania to raise attention to nutrition insecurity as a problem on its own right. As one of them underlines, "Nutrition is a piece of the puzzle...the overall funding goes to something else and nutrition is in there *somewhere*" (INGO-11). Similarly, a multilateral agent exclaims:

The agenda is very much looking at HIV...not even HIV prevention, just HIV. In there, nutrition is side-lined! And this in a country where 40% of the children are chronically malnourished! Alright, 7% HIV prevalence is huge but nutrition is completely side-lined! (Multilateral-5)

Short of being able to set the agenda, nutrition actors struggle to become part of the response to other pathologies that have successfully risen on the international and national agendas. The decision makers in those domains, and most prominently in HIV/AIDS, thereby indirectly contribute to defining the nutrition players' legitimate scope of action. Nevertheless, one should not have a monolithic vision of this interplay, which is not always about nutrition players 'begging their way in'. In some cases, AIDS players actually struggle to get Tanzanian nutrition officials around the table. Also in several institutions one and the same person is in charge of both HIV and nutrition. While this could be interpreted as a sign of the successful integration of the two fields, it primarily illustrates the predominant position of HIV/AIDS within the field of nutrition security in Tanzania. In sum, although the expansion of the AIDS

⁴⁵² This statement should be put into perspective. Despite the Global Fund's discursive emphasis on 'country ownership', the Fund has very precise ideas about the type of activities it wishes to support. Referring to the lack of incidence data (see Chapter 4), a multilateral agent suggests: "I guess the Global Fund could say: 'From Round 10 on, we won't entertain any proposal to a country without incidence tracking...or at least a plan to institute it! They have been very clear in other Rounds about what they were looking for – such as M+E [monitoring and evaluation], or drugs. In fact, each Round has its own 'issue', its own 'theme'..." (Multilateral-2)

policy field has opened up new funding possibilities for nutrition activities, the ensuing redefinition of the nutrition players' jurisdiction has remained limited. Indeed, the translation of biomedical insights about the HIV-nutrition nexus into effective policy measures is highly selective and places nutrition players in a subordinate position.

A-6) Nutrition players as stooges in the struggle against HIV/AIDS?

“The Government wants to talk about nutrition because it undermines the adherence to [antiretroviral treatment]. You have people crying, saying: ‘We can’t take ARVs, we have no food. With an empty stomach they give us a belly ache!’ So to improve adherence, we want to look at nutrition.”
(GovSector-5)⁴⁵³

Thanks to the increased acknowledgement of the nutritional needs of people living with HIV, food and nutrition insecurity have received increased political attention since the roll-out of ART. While nutrition-security aspects are increasingly factored into HIV documents, several interviewees notice a lack of follow-up on these commitments. Moreover, the renewed attention to nutrition security remains limited to a closely circumscribed framework of action. As the quote in the epigraph illustrates, some key players within the Tanzanian AIDS field have a narrowly utilitarian conception of the role of nutrition interventions in their programmes: food insecurity and malnutrition are primarily seen as obstacles to treatment adherence.⁴⁵⁴ Adopting an equally instrumental vision, other AIDS players consider nutrition interventions as a means to improve patient enrolment in ART programmes. An international NGO worker states:

We distribute food supplements for children. We want to put people on treatment, and there is still some stigma. So nutrition is a way of getting children [on treatment] that you wouldn't have gotten otherwise...it's a means to enrol people and improve the quality of services. (INGO-9)

Even those AIDS organisations with a broader vision limit their nutrition interventions to impact mitigation, infant-feeding counselling (to prevent mother-to-child transmission through breastfeeding) and the nutritional ‘treatment’ of people living with HIV, if not solely of ARV-patients.⁴⁵⁵ They thereby restrictively define the modalities of nutritional support and its beneficiaries.

The nature of the interventions preferred by many AIDS players is subject to debate as well. The increased acknowledgement of nutrition insecurity as a ‘problem’ in Tanzania coincided with the development, at the international level, of a ‘treatment’ response to malnutrition in the form of the distribution of ready-made therapeutic food. In the AIDS field, the very existence of this technical ‘solution’ has probably contributed to the acknowledgement of nutrition insecurity as a ‘problem’. The choice made by several international AIDS players to medicalise the response to malnutrition by

⁴⁵³ This official visibly makes no difference between food security and nutrition.

⁴⁵⁴ Kalofonos describes a similarly utilitarian conception of food aid in Mozambique, where AIDS players also consider that “food should be seen as something that will assist adherence to medications [...], not to solve social problems” (2010, p.371).

⁴⁵⁵ Some organisations have recently added people's body mass index as an eligibility criterion for food aid.

providing 'food by prescription' via their programmes is criticised by several nutrition players. One multilateral agent suggests:

Nutritional support for people living with HIV is not necessarily food. It can be support in terms of cash, regulatory changes, education on nutrition or farming issues... Development partners tend to have a very narrow conception of how one can impact on peoples' nutritional status. [...] Another option would be to conceive 'nutrition-rehabilitation' interventions at the health-centre level. These would be broader, and not only concern food supplements for people living with HIV. Nutrition gains also concern the other 93% of the population [i.e. those who are HIV-negative] . (Multilateral-11)

A Tanzanian official is more critical:

We are being donor driven! The Clinton Foundation, for instance, came here and dumped their peanuts in our health centres. They said: 'This has been researched. It's good for you!' [...] We encourage people to use local, available food of the season. And that is even the cheapest you can get. We don't like food supplements. Now they all come with their peanut food supplements... If nuts are so good, tell people to eat nuts with their rice! We have lots of nuts in Tanzania! We should use *our* nuts, not imported peanut food supplements. These are too expensive and not sustainable. If tomorrow, donors stop food supplements for [people on] ARVs, what do we do...?! (GovSector-8)

AIDS players thus not only designate the beneficiaries of nutritional support, they define the nature of the response to nutritional problems – criticised here as being unsustainable and causing dependency on AIDS funding. The fact that biomedical sciences are the dominant disciplines in the field of HIV/AIDS certainly contributes to the AIDS players' preference for health-sector responses to undernourishment and micro-nutrient deficiencies. The medical 'treatment' approach to malnutrition has a practical advantage: it allows AIDS players to propose rapid-impact turnkey solutions and to leave aside the complexities of the management of risk, as well as the conflicting interests that underlie any political regulation in favour of nutrition security (Janin 2008a). As the Tanzanian official quoted above notes,

Dependency is a challenge: In nutrition, there are huge interests of donors – the Clinton Foundation, USAID, etc. – who want to bring peanut food supplements and other products. I think that this is actually a problem, not a solution. We are not solving the problem. If you make people too dependent, they won't even think... [...] Donors look for an easy way to help, not for sustainable interventions, like planting more nutritious plants. That is more sustainable. People are used to farm, so why don't we make their plants more nutritional? [...] We should promote small-scale farming! [...] We should put the money from nutritional support into [agricultural] technology and irrigation! Nutritional support doesn't help Tanzanians. It makes matters even worse actually... [...] But it will take courage for a Tanzanian to speak out and tell them the truth... Not everybody can do that. We get all this aid and people keep quiet. (GovSector-8)

The growing importance of AIDS in the field of nutrition and food security might thus contribute to the continued dismissal of the socio-political and agro-environmental dimensions of nutrition insecurity. With the exception of food gardens for people living with HIV, the AIDS players' ambition remains limited to mainstreaming nutrition into HIV-related service delivery within the health sector.⁴⁵⁶ One nutrition player underlines a triple reductionism:

⁴⁵⁶ While food gardens improve people's nutrition and generate income, their goal is to mitigate the impact of the epidemic on people living with HIV, not to prevent HIV transmission or induce structural change for all smallholder farmers.

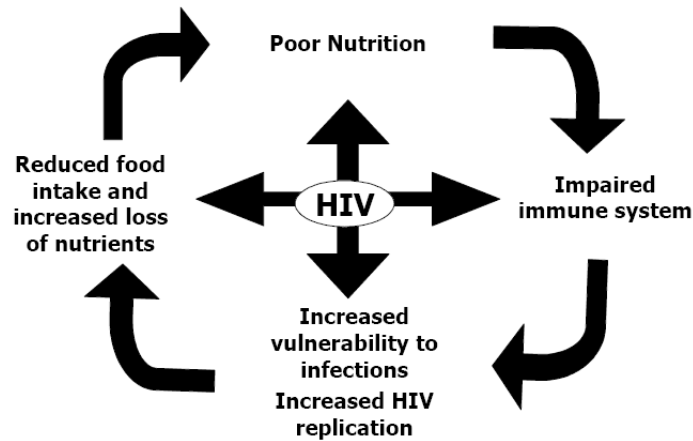
There is an over-emphasis on the health sector in the response to HIV and nutrition. Within the health sector there is an over-emphasis on cure, and within cure there is a strong focus on ARV treatment rather than on other aspects of care. (INGO-11)

As a result of the dominant framing of the nexus between HIV and nutrition security, different nutrition players are unequally prepared to establish policy links with the field of HIV/AIDS. The biomedical framework favours those players engaged in the provision of treatment-related nutritional services over players who propose a more structural, political response to nutrition insecurity by struggling for policies in favour of smallholder farmers. While health-sector interventions might be easier to implement, they are not necessarily the most effective, efficient and sustainable responses. More fundamentally, the reductionist nature of the medicalised response illustrates what several interviewees term a 'depoliticised' approach to nutrition insecurity in Tanzania, because of its insufficient articulation with agricultural development and rural livelihoods (see also: Gillespie & Kadiyala 2005; Gillespie & Drimie 2009, p.16).

The focus on health-sector interventions circumscribes the nutrition players' scope of action in another fundamental way. As discussed, biomedical and epidemiological evidence points to the deleterious effect of malnutrition on HIV infection both upstream (risk of transmission) and downstream (pathogenesis). Concerning the link between nutrition security and HIV prevention, there is a stark disconnect between evidence and policy. Interestingly, most nutrition players define their own role as being essentially downstream. The knowledge that better nutritional status reduces mother-to-child transmission of HIV and is likely to hamper its sexual transmission is not mobilised to call for a more integrated approach to nutrition and HIV-prevention.⁴⁵⁷ Even the World Bank, which actively pushes for the inclusion of nutrition-security considerations into HIV programmes, exclusively considers improved nutrition as a tool to improve treatment adherence and mitigate the impact of the epidemic, not as a contribution to HIV prevention. As the following diagram illustrates, the Tanzanian nutrition administration itself draws on an incomplete model of causation as the basis for its action and claims.

⁴⁵⁷ Interestingly, the World Bank's argument for the inclusion of a nutrition campaign into HIV programmes (see sub-Section A-3) also exclusively considers improved nutrition as a tool for impact mitigation, not HIV prevention.

Figure 4: A one-way relationship between nutrition and HIV/AIDS? [from (TFNC 2003)]



The same diagram can be found in the publications of several international organisations. HIV infection is exclusively considered as a cause, not a consequence, of malnutrition. This is all the more surprising as the causal diagram mentions an impaired immune system, increased viral replication, and an increased vulnerability to infection as consequences of poor nutrition. The model omits that these very factors also increase a population's susceptibility to HIV/AIDS – an *infectious* disease. The only acknowledged link between nutrition insecurity and HIV transmission is an indirect one: improved food security and adequate nutrition are underlined as means “to spare more mothers and children from the risk of blood transfusion” (URT 2001, p.22)⁴⁵⁸ or to prevent poverty-induced risk behaviours like prostitution, transactional sex or increased mobility (e.g. World Bank 2007a, p.40). Links between food insecurity and behaviours that put people at an increased risk of infection are well-known and certainly not specific to HIV.⁴⁵⁹ As discussed, behaviour-change programmes, however, generally omit that the very behaviours they try to change are often due to structural socio-economic factors, including nutrition insecurity, that remain unaddressed. Similarly, the fact that malnutrition is likely to favour mother-to-child and sexual HIV transmission even without any behavioural mediation is passed over in silence.⁴⁶⁰ The official version of the interrelation between HIV and nutrition insecurity is thus selective: hunger and malnutrition are exclusively acknowledged as aggravating factors in individual pathogenesis, not as determinants of populations' susceptibility to HIV. While prevention efforts based on sexual behaviour change remain a challenge, the role of malnutrition as part of a synergistic system of transmission-facilitating cofactors (see Chapter 1; Stillwaggon 2006, chap. 2+3; 2009) is consistently omitted.

While AIDS players tend to define the nature of nutrition interventions and their beneficiaries restrictively, most nutrition players do not call for a broader interpretation of their own scope of action. This limited conception of the scope of their collaboration is arguably due to the reductionist causal model both groups of players draw on. Developing upon the analyses proposed in Chapters 2 and 3, the

⁴⁵⁸ As discussed in Chapter 1, this warning is in contradiction with the government's repeated assertion that 100% of blood transfusions in Tanzania are effectively tested for HIV.

⁴⁵⁹ For a study of the impact of malnutrition and famine-induced mobility on the spread of smallpox, see: (Dawson 1992).

⁴⁶⁰ Additionally, certain types of acute malnutrition – such as severe anaemia, which is frequently treated with blood transfusions – also increase the risk of iatrogenic HIV transmission.

next sub-section argues that the incompleteness of the dominant framing of the relation between nutrition insecurity and HIV/AIDS is not politically neutral.

A-7) The limited acknowledgement of the HIV-nutrition nexus: a reciprocal political domestication?

“Why don’t [HIV] prevention policies change to take into account, say, nutrition? The problem is that it’s not enough to tell people they have to eat. It’s not that they don’t *want* to eat eggs...they don’t *have* any eggs to eat! [...] Stopping malnutrition is a more structural and more difficult problem. And if you address the issue, it means that the government is not doing enough! So maybe they are afraid of triggering something else?”
(INGO-3)

Why is available knowledge about the deleterious effects of nutrition insecurity on the spread of HIV only taken into account so incompletely? Figuratively speaking, why has the policy window for nutrition remained only tilted and what keeps it from opening wider? These questions are essentially the same as those discussed in Chapters 2 and 3 concerning the incomplete policy uptake of evidence on transmission-facilitating cofactors in general. The explanatory attempts proposed above thus also apply for the omission of nutrition insecurity from HIV-prevention schemes. Both their perceived ‘infeasibility’ and their inevitably broad beneficial spillovers hamper the uptake of nutrition interventions within HIV-prevention programmes. Perhaps the experience of HIV-denialism is particularly important in explaining the neglect of nutritional issues from HIV-prevention. The blatantly unscientific nature of the South African government’s emphasis on malnutrition as a *direct* cause of AIDS still resonates in many policymakers’ minds and continues to undermine the credibility of those who call for the acknowledgment of nutrition insecurity as an enabling cofactor in the spread of HIV.

Moreover, the omission of nutrition insecurity from HIV-prevention policies permits the maintenance of the behaviour-centred causal story and its implicit ascription of blame to individuals rather than to inadequate public policies. As long as the link between malnutrition and HIV transmission remains exclusively behaviour-mediated, structural causes of ill health and of populations’ susceptibility to infection can continue to go unaddressed, and public authorities are challenged. Quite the opposite, they save the lives of the ‘misbehaving’ by providing food. By implicating those who – through their actions or inaction – contribute to the perpetuation of poverty and nutrition insecurity, the acknowledgement of hunger and malnutrition as potential contributing factors to HIV transmission could transform ‘ordinary’ hunger into a political problem. The recognition of the essentially non-behavioural drivers of HIV transmission could turn AIDS into a greater political challenge than it is today. As the statement of the NGO worker quoted in the epigraph suggests, a more integrated framing of nutrition insecurity and HIV-prevention policies could reinforce their respective politicisation.

More generally, this raises the question of the articulation of the struggle against nutrition insecurity and the country's broader 'poverty reduction' framework. Although nutritional concerns are part of Tanzania's National Strategy for Growth and Reduction of Poverty ("Mkukuta"⁴⁶¹), the fundamental contradiction between the need to address the structural causes of nutrition insecurity and the unaltered confidence that the Poverty Reduction Strategy Papers put in market mechanisms to ensure 'optimal' (food) production and consumption outcomes remains as vivid as ever (e.g. Ziegler 2004; Lappé et al. 1998; Thébaud-Mony 1980, p.322-327; George 1978). The continued subordination of nutritional concerns to broader economic policy choices once again illustrates the limits of technical, depoliticised health action (Thébaud-Mony & Turshen 1981; Turshen 1989, chap.10). It is precisely this medicalisation of poverty that the international NGO worker quoted above denounces when criticising the formulation of health-sector responses to nutritional problems that are due to broader political orientations:

There are lots of complaints that nutrition is depoliticised, that it is kept too much in the health sector. [...] There is so much funding on biomedical interventions, not agriculture! That completely depoliticised the issue! How does the health-sector response to AIDS and to nutrition link up with agriculture and people's livelihoods?! (INGO-11)

The limits to medical action in addressing socio-economically determined health problems are nothing new. Most health-related interventions face challenges because of the inevitable tension between an indispensable narrowing-down of the reality to-be-acted-upon, and the sometimes severely progress-impairing limitations of too narrowly defined responses to health problems whose underlying causalities are considerably broader (see Chapter 8). The second section of this chapter develops upon the controversies over the design of the past AIDS response in Tanzania (Chapter 6) and the case study of AIDS and nutrition policies. It explores the tensions and contradictions that arise from disease-specific action in a context of generalised poverty and dysfunctional health systems, as well as the implications of these contradictions for the design of AIDS-control programmes in sub-Saharan Africa.

B) Limits to vertical AIDS control in a context of weak health systems and widespread poverty

"Poverty is the root cause of a lot of these social ills, HIV included. That's the greatest challenge! And improving infrastructure: hospitals, health centres, roads... If not, it will be impossible to strengthen the system! And you have to strengthen the system that will ultimately take over... In the absence of system strengthening, donors can just continue pumping money in there: it's like pissing down a rat hole!"
(INGO-7)

The case study of AIDS and nutrition insecurity illustrates the profound ambiguity of the impact of the vertical AIDS-control on other health-related issues. By making available oft long-awaited resources, this response obviously has a variety of positive effects on the field of nutrition policy in Tanzania. Yet, even though the scientific insights on the interrelations between HIV and nutrition open up a policy window for the struggle against nutrition insecurity, the collaboration between AIDS and nutrition players to

⁴⁶¹ Mkukuta is the Swahili acronym for "Mkakati wa Kukuza uchumi na Kupunguza Umaskini Tanzania".

increase the integration of policies formulated in both domains resulted in a negotiated but asymmetric redefinition of the players' respective jurisdictions. The policy field of HIV/AIDS has expanded well into that of nutrition and considerably influences the responses to nutrition insecurity. The struggle against HIV/AIDS thus places nutrition players in a subordinate position that compels them to reformulate their activities according to the requirements of AIDS control. As a US agent underlines in a self-critical assessment of PEPFAR: "The mandate during phase one was to get people on treatment – and we did that! But the emergency response skewed the whole way we are looking at these issues!" (Bilateral-24). The case study of AIDS and nutrition insecurity in Tanzania confirms this incentive for health policymakers to look at various health problems 'through an HIV-lens', be it only to access earmarked AIDS funding. Notwithstanding the positive effects of international AIDS-control programmes, their focus on one artificially singularised health problem entails a disconnect with the real-world complexity health professionals and in-country policymakers face.

The first sub-section describes the constraints that the internationally determined vertical funding structure places on in-county health players in their endeavour to respond to a population's continuum of health-related needs. Combining this assessment with the interviewees' analyses of the past design of the AIDS response in Tanzania (Chapter 6), sub-Section B-2 examines the player's mixed vision of the ongoing change in orientation towards a more comprehensive vision of health within the main international institutions involved in AIDS control in Africa. Sub-Section B-3 argues that, despite being a positive evolution, the main AIDS donors' increased attention to health-system issues is likely to introduce a considerable bias into the 'post- SAP reconstruction' of the Tanzanian health system. Confronting this assessment with the widely-omitted evidence on structural drivers of HIV transmission discussed in Chapter 1, sub-Section B-4 suggests that an excessively vertical response to HIV/AIDS hampers the formulation of a coherent national health policy and limits the effectiveness of AIDS control itself.

B-1) 'Putting the pieces back together' or making a full meal from the 'soup of the day': policy practitioners' creativity in grappling with earmarked AIDS funding

"All the vertical initiatives develop their own programmes, and then they put the pieces back together at the lower levels..."
(Multilateral-12)

"We should be clever about using Global Fund and PEPFAR money. The money can have the 'HIV-label' on it, that's okay, but we should do integrated work with it!"
(Bilateral-14)

As discussed, there is an inevitable discrepancy between the motives and timescale of (international) political mobilisation on health issues and the everyday experience of those who, at the implementation level, have to respond to a continuum of health needs. Given the partially irreducible nature of this disconnect, health players have long engaged in labelling or reframing their activities in order to access

whatever funding might be available as a consequence of changing “issue attention” (A. Downs 1972; Shiffman 2010) at ‘higher’ political levels. One bilateral agent remembers: “After Alma Ata, there was a period when everyone sold his project with a ‘primary health care’ label on it, because that’s where the money was!” (Bilateral-31). Unsurprisingly, most interviewees thus openly acknowledge a certain difference between what they receive funding for and what they actually spend it on.

Vertical disease control and child sponsorship programmes

An interesting parallel can be drawn between disease-specific initiatives and child sponsorship programmes, which also illustrate the difference between what organisations raise money for and what they spend it on. In a context of generalised poverty, it would be intolerable to support only one child in a class of fifty. NGO-run child sponsorship programmes thus generally raise money for individual children and spend it on the whole class or school. Just as with vertical disease-control programmes, their actual implementation is considerably less specific than their design ‘on paper’ suggests. Another commonality between child sponsorship programmes and vertical health initiatives is the fact that the narrowly conceived reporting mechanisms they require entail disproportionately high transaction costs – be they due to disease-specific data collection and evaluation, or to NGO fieldworkers having to spend a significant share of their time to ensure that every sponsor gets individualised feedback from ‘their’ child (e.g. letters, photos or drawings). In each case, the donors have to be pleased via costly reporting mechanisms – consisting either in a picture of the happy face of the sponsored child or in the latest project-specific HIV survey.⁴⁶² Finally, neither vertical initiatives nor child sponsorship programmes can, in any way, be expected to make up for insufficient investments in public health or education systems.

Although this need to label one’s activities strategically still exists, today’s situation is very different from the post-Alma Ata period in the late 1970s and early 1980s. Today’s predominantly disease-specific funding structure of global health initiatives reinforces, and at times exacerbates, the disconnect players at lower levels perceive between the type of funding available and the health needs they have to respond to. Many interviewees describe how they have to link their activities to one of the ‘three big’ diseases (and primarily to HIV/AIDS) in order to be able to provide basic health care. In this sense, today’s situation is diametrically opposed to the post-Alma Ata period. “There is a high level of awareness of the ‘horizontal’ of health problems and solutions in Tanzania”, says a Tanzanian official, “I met many staff members of Tanzanian institutions struggling for integration of health interventions with fragmented international funding and expertise” (GovSector-8). A bilateral agent remembers:

So much money came in vertically. That led to situations where, say, if there is a need for a bicycle in a health centre to do outreach work, the funders would say ‘That’s not an AIDS bicycle!’. But if the person writing the proposal was smart, he would change the proposal... If he was honest or didn’t know, he wouldn’t get the bicycle. [...] Today, we have to ask ourselves: ‘What is the most effective and cost-effective way to deliver health aid? Is it through vertical programmes...?’ (Bilateral-20)

A similar experience prompts a multilateral agent to underline:

⁴⁶² It should be mentioned that Tanzania has made considerable progress in this respect over the last years. Talking about the Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) (e.g.: TACAIDS 2008), a bilateral agent states: “The THMIS is a good example where we took AIDS money and did something sensible with it...PMTCT served as an ‘alibi’ in this respect.” (Bilateral-31). Interestingly, another interviewee spontaneously refers to the same example, saying: “One domain where integration is a good idea is for surveys. [...] The THMIS is a good example. It is a combination of two household surveys. Tanzania is actually the only country where this integration of the two surveys has been done successfully!” (Bilateral-22).

We have to become more industrious with how we use the earmarked money on the ground! Funding always depends on what's the 'soupe du jour', on what is 'the sexy thing this week'... How can we get away from that!? To do so, we need 'inventiveness'... It's about [in-country] donors being more inventive on how to use earmarked international funding! (Multilateral-11)

Although HIV/AIDS is certainly more than just the "sexy thing this week", the fundamental point behind this statement is well-taken and the need is real for policy practitioners and health project managers to acquire new skills in framing their activities. As one multilateral agent puts it, "the real challenge is how to harness and use these [AIDS] funds to improve the health system *in general* and to increase the availability of services *in general*" (Multilateral-2). Another multilateral agent underlines:

The funding is very much donor dependent. CDC, for instance, is saying: 'This money is for HIV!' So you really have to be creative to show that [what you are doing] is HIV-related in order to channel that money into other domains...like into a women's ward in a health centre. (Multilateral-18)

Health players progressively learn how to link their activities to a specific, internationally-valued pathology in order to allow them to address the continuum of health needs they face at the local level.⁴⁶³ As the provision of nutritional support conditioned upon seropositivity illustrates, the disconnect between vertical funding streams and people's considerably broader health needs is perceived as a form of violence not only by patients and health workers, but also by many policy practitioners. The players' increasing 'industriousness' in the use of earmarked HIV funding for activities the benefits of which go well beyond HIV/AIDS alone can be understood as a response to this perceived injustice and a deontologically motivated effort to improve the consistency of their action. Similar efforts to increase coherence at the implementation level exist *within* HIV-specific programmes. A bilateral agent, for instance, describes the use of narrowly earmarked funding in the formulation of HIV-prevention programmes as follows:

There is a big disconnect between the theoretical distinction of different prevention interventions and the earmarked funding that comes along with it, and the reality of our work. For people who work on the ground, it's like: you have your 'AB-money' and your 'C-money' and some for other prevention interventions. In reality, you co-fund your different interventions from these two sources, and you have a comprehensive programme. People do figure out ways to make it [earmarked funding] work for their epidemic. (Bilateral-24)

Interestingly, the negotiations about the use of AIDS-money take place not only between different institutions and levels of government, but also *within* agencies. When asked about the reaction of his colleagues working on HIV/AIDS concerning his department's attempt to use AIDS-funding for non immediately HIV-related health interventions, one interviewee responds: "We *do* try to tap into their resources, and they *know* we do! But they don't care about it..." (Bilateral-22). Whether it results from such explicit agreements or from more subtle arrangements, the funding of general health activities through what many interviewees call "the AIDS money" is an increasingly common phenomenon. Since

⁴⁶³ There is an awkward parallel between these health players and the HIV-positive individuals described by Nguyen (2010), who need to propose a personal narrative of suffering to access antiretroviral treatment, or the disadvantaged people described by Fassin (2010), who frame their own situation in order to correspond to an international norm defining who deserves humanitarian assistance. Each time, international norms (whether explicit or implicit) push local players to adopt their discourses and narratives strategically in order to obtain something.

it generally implies the balancing of internationally formulated priorities with local situations, this evolution of practices is certainly good news. That being said, the tensions arising from the differences between the theoretical design of AIDS programmes and their real-world implementation put into question the appropriateness of the vertical design of these programmes. As the next sub-section shows, the accumulated experience of people working at the implementation level has prompted a change in mind at the headquarter levels of international institutions involved in AIDS control. Indeed, the fairly consensual assessment concerning the side effects of the past response in terms of health inequities (see Chap. 6, Sect. B) progressively translates into a shared agreement on a reorientation of the future response towards an increased integration of HIV-related services and the strengthening of health systems.⁴⁶⁴

B-2) Putting an end to verticalism? Emerging consensus and remaining doubts

“Now donors realise that it is all linked. They say: ‘We gave you all that money, and...’. Now they realise the health system is not working! They realise that you cannot roll out ART without addressing health system issues. ART doesn’t operate in isolation of other systems; ART needs other systems to work!”
(GovSector-12)

As discussed in Chapter 6, the list of system-related requirements for an effective response to HIV/AIDS is long: care and treatment programmes require qualified and adequately distributed human resources; the fact that many Tanzanian women deliver at home rather than in health centres⁴⁶⁵ is a significant obstacle to the prevention of mother-to-child transmission; dysfunctional procurement and distribution systems for drugs and medical supplies hamper the AIDS response⁴⁶⁶, etc.. A closer look shows that the effectiveness of AIDS control and the functioning of the Tanzanian health system are intimately and reciprocally related. Beyond the contradictions that arise from an excessively vertical response in a context of widespread poverty described above, health workers and AIDS policy practitioners are sometimes confronted with a *material impossibility* to implement a vertical programme within a

⁴⁶⁴ Interestingly, the players’ opinion about what would be an appropriate design of the response in the future is partially independent from their appreciation of the appropriateness of the vertical design of AIDS programmes in the past. As discussed in Chapter 6, several interviewees consider that the urgency of the situation initially justified a narrowly circumscribed response.

⁴⁶⁵ The slow progress in preventing vertical HIV transmission in Tanzania illustrates the systemic nature of many HIV-related interventions. A bilateral agent explains: “PMTCT is an intervention that is not having the impact it could. [...] There are not enough physicians and about 50% of Tanzanian mothers deliver at home...and it is questionable if the birth assistants have the necessary equipment and the knowledge to do what it takes” (Bilateral-19). Arguing that in order to increase PMTCT coverage women need to deliver in a health facility, a multilateral agent underlines: “Women in Tanzania traditionally deliver at home. They either go to their mother’s house or to their mothers in law. If they went to deliver in a health facility, they would not be getting anything they don’t have at home anyway. The only real difference is emergency obstetric care, and most health facilities in Tanzania don’t have that...” (Multilateral-14). Safe emergency obstetric care requires qualified medical personnel as well as medical equipment and consumables...the availability and distribution of which is obviously a problem of health system management. In this sense, one interviewee suggests: “We need to go from PMTCT to a larger maternal and child health programme. If the latter is improved, PMTCT is a lot easier”(INGO-9).

⁴⁶⁶ As an interviewee from a US agency underlines: “We look into the procurement and supply process. We want to upgrade the [Medical Stores Department] information system and regional warehouse capacity. That’s another example where we can do system strengthening because we have an HIV entry point” (Bilateral-19).

dysfunctional health system. The deputy director of an international NGO involved in the provision of ART, for instance, underlines:

We didn't think we were doing infrastructure, we simply wanted to put people on treatment. But then we saw that many health centres had no power and were unable to take in charge deliveries at night... So we supported a programme installing standard solar power for health centres and integrated clinics [i.e. those with an integrated ART centre]. [...] I think there's been a process where donors increasingly see the importance of health system issues. It's no good for human-resources management or supply chain management for ARVs if the rest of the system is inoperative. (INGO-9)

A multilateral agent suggests that similar limits to the scale-up of vertical AIDS programmes arise from the human resources situation:

At this point, it is no longer enough to simply hire more people. We need to make the whole system grow. So the US government said they were willing to support the [Emergency Hiring Project], but under the condition that, instead of hiring 200 additional health workers annually – as initially planned, the programme would hire 1000 additional health workers per year! That's impossible! Materially speaking, that's simply not possible... Today, we have reached the limits in terms of human resources for health! Beyond a certain point, the vertical initiatives simply induce an internal shifting of human resources... Well, if at least that led to their increased presence in the most neglected areas, that would be a good thing, but I'm not sure about that... (Multilateral-6)

In the absence of sufficient training capacities, merely hiring more health workers for HIV-specific programmes detrimentally affects other non HIV-related activities. The zero-sum game resulting from the material difficulties to increase the throughput of health training institutions enough to keep pace with ART roll-out has been described in Chapter 6 (Section B-1). Beyond this issue of communicating vessels, some interviewees consider that the vertical design of the AIDS programme has led to a waste of resources. A Tanzanian official, for instance, considers that the lack of attention to system issues has actually *increased* the cost of the AIDS response:

It will be a challenge to move from working with programmes to working with systems...to better address issues *together*. For example, now, we have to spend a lot of money on the training of health workers for HIV-related issues. If the system was operational, HIV would be in the curriculum and we wouldn't have to train them especially for HIV! So in a way, the lack of willingness to strengthen health systems *increases* the need for additional resources for AIDS. (GovSector-12)

Pointing to comparable inefficiencies, the international NGO worker quoted above underlines:

Planning, budgeting and reporting are among the biggest threats to the system. There are so many parallel processes. I read that 2,400 reports about health were produced to donors every year by the [Government of Tanzania]⁴⁶⁷ We should improve these reports and have standardised planning and reporting tools. That would make things a lot easier and yield better information. We can use HIV-earmarked money for that. (INGO-9)

Facing major critique from other international health players, implementing organisations and from their own staff in the field offices, the two major AIDS donors – PEPFAR and the Global Fund – have progressively changed their initially very narrow definition of the activities that could be funded with

⁴⁶⁷ This figure can probably be traced back to Birdsall and Deese (2004), who wrote that “the country's Ministry of International Cooperation prepared 2,400 donor reports every quarter and hosted 1,000 meetings” – a number which does not refer to health alone. Nevertheless, since close to half of all international aid to Tanzania is for health-related issues, this figure is compatible with that given by the interviewee.

money earmarked for HIV interventions. All interviewees who address the issue positively acknowledge this change. A Tanzanian official explains this evolution within the Global Fund:

Before, it was impossible to finance health system strengthening through the Global Fund. They didn't want to double the work of WHO... Later, they realised that the health systems were so weak that it became impossible to implement the [vertical] policies decided upon! So now they encourage proposals for health system strengthening. (GovSector-3)

Concerning PEPFAR, a bilateral agent, who is very critical of the vertical design of the US response to AIDS in Tanzania in the past, notes: "There has been a lot of improvement also on the side of PEPFAR. They are now prepared to put in money for human resources on its own right...they still want to see the link with HIV, but that's a progress..." (Bilateral-23). Another interviewee confirms this evolution within PEPFAR:

Before, they were building parallel systems. Now, some way down the road, people were asking 'When are you going to stop?!' There is definitely a big shift within PEPFAR. They are thinking 'How do we transition this? How do we integrate?'. (INGO-9)

Indeed, the idea of a 'transition' is at the heart of the discourses of the players who work within PEPFAR and its implementing organisations. One of them underlines:

I guess you could say that there was a first phase of 'emergency response', where the goal was to get people on treatment, and that, now, we are entering a second phase, where we have the ability and the mandate to do 'development issues' as well...whether you believe it or not! That's how people conceptualise this. (Bilateral-24)

Another interviewee who works at one of the PEPFAR implementing institutions adopts a similar discourse:

The initial response to HIV was an emergency response. Now, the challenge is to transform it into a sustainability response. If you use a 'health system' approach and you address HIV, you *do* take care of the rest, too. (Bilateral-25)

The two examples most frequently quoted to illustrate the no longer *exclusively* HIV-focused approach of PEPFAR are human resources for health and laboratory services. One interviewee stresses:

The PEPFAR authorizing legislation of August 2008 creates more space for health system strengthening. For example, it plans to train an additional 160,000 nurses worldwide. These will be new nurses! (Bilateral-12)

As discussed, PEPFAR introduced the first centralised system of blood collection and provision in Tanzania. Having stressed that, today, PEPFAR's efforts in the domain of laboratory services go well beyond HIV alone, the above-quoted agent suggests:

We just used HIV as an entry point to build capacity and renovate lab machines across the board. [...] The first improvements on lab equipment were made to have an initial impact on [HIV] testing. Now we are more looking at the whole system. [...] Now, when we organise a training, we focus on diagnosis generally, not in a disease-specific way. (Bilateral-25)

Another interviewee involved in the blood safety programme provides the following analysis:

We know that, by strengthening the blood safety system, we are preventing more hepatitis than HIV – given their respective prevalence in voluntary donors: [...] 6 to 7% of the units are infected with hepatitis B, about 3% with HIV and less than 1% with hepatitis C. We are trying to bring the government to focus on hepatitis B...which, in many ways, is even worse than HIV...and there is a vaccine! But they only do vaccinations for children, not for health workers and other risk groups. The CDC country director brought this issue forward. But so far, we don't know what to do with them [people diagnosed with hepatitis B], because it's not a PEPFAR programme. [...] In Zanzibar, the prevalence of hepatitis B in most-at-risk populations is around 20%! But we don't have funding directed at that. Maybe for HIV-positive people it can be included in PEPFAR, but those who have 'only' hepatitis B, nobody cares about them. So you see, talking about blood safety brings up other issues also... (Bilateral-21)

This statement illustrates both the positive spillovers of the increasingly inclusive design of AIDS-control strategies and the persisting contradictions that arise from vertical initiatives in a context where any disease, however devastating, is but one among many health-related scourges.

While some significant changes in the design of the AIDS response are starting to materialise on the ground, several players remain prudent both concerning the actual degree of implementation of the broadened 'system' approach, and concerning the extent to which these evolutions announce a genuine change in orientation of international health action. One multilateral agent, for instance, considers that much of the talk about systemic approaches is lip service:

To be sure, everybody talks about health system strengthening now: the World Bank, PEPFAR, the Global Fund... But actually *doing* it is something quite a bit different! [...] For now, actions have not kept up with words...but at least people talk about it. [...] In order to actually get the results on the ground, you have to address systemic issues such as human resources for health in rural areas. People simply don't want to *live* there... [...] But that's difficult...unless you have the American ambassador knock on the door [of the Tanzanian government] and say: 'You *have to* address recruitment and retention issues, because it affects the effectiveness of our HIV/AIDS funding!' – which, by the way, it does...so he wouldn't even have to stretch reality too much. But it's not going to happen! The same is true for the MSD [Medical Stores Department]: everybody knows it's not working! But will they actually fix it or will they create a parallel structure? It's the *same* question across the board! Do we build parallel structures or integrated structures that might help improve the rest of the system also!?' (Multilateral-2)

Spontaneously referring to the same example, a Tanzanian official questions the willingness of international donors to address the underlying causes of the weakness of the Tanzanian health system:

Is health system strengthening an issue? Yes...but I don't see it being implemented! We would have to address some of the structural causes, such as 'Why are our health workers running away?' But would the Global Fund agree to give 20% to health system strengthening in order to pay for better salaries and incentives? Do you think that is going to happen? I don't think so! [...] *Nobody* from outside will make sure that your infrastructure is in good condition. They only pay for consumables! They only want short-time projects...and *if* you formulate a long-term project, they'll say: 'It's not sustainable...!' (GovSector-7)

As discussed, the Global Fund does pay for the salaries of several hundred Tanzanian health workers. Yet, this statement echoes the attitude of donors concerning the Primary Health Sector Development Programme and their accusation of 'lack of realism' discussed in Chapter 6 (Section A-2).

Importantly, beyond the sole doubts about the extent to which the AIDS agencies' discursive support for health system strengthening will translate into practice, some interviewees' scepticism concerning this evolution is due to the imbalances to which it could give rise. Beneath the calls for 'health system

strengthening' and increased integration, they argue, the disease-specific focus of the best-endowed international health agencies (primarily PEPFAR and the Global Fund) remains strong. While this focus obviously corresponds to their institutional mandate, it introduces a considerable bias into both the selection of 'systemic' issues and the manner in which they are addressed.

B-3) Strengthening health systems...vertically?

“Many of the so-called ‘vertical’ donors are open to integrated approaches. The Global Fund, for instance, actually developed guidelines for the integration of HIV/AIDS and reproductive health issues – I even believe it was the theme of Round 7. These guidelines show how possible linkages could be made...so there is increasing encouragement towards this type of integration on behalf of donors”
(Multilateral-8)

While the increasing openness of PEPFAR and the Global Fund concerning the need to (re)build functional health systems and to push towards a more integrated response to HIV/AIDS is uniformly welcomed, these two institutions' investment capacities for health system development in Tanzania exceed those of the Ministry of Health. The HIV-related Tanzanian proposal for health system strengthening (HSS) to Round 9 of the Global Fund, for instance, amounted to USD 176 million. Over the five-year period of the proposal, this equals about twice the budget of the country's Primary Health Sector Development Programme (MMAM). This difference in financial endowments favours an approach within which the financing of different elements of health system strengthening depends on their specific relevance to AIDS, malaria, or TB control (in the Tanzanian case, the HSS proposal to the Global Fund was formulated as part of the HIV proposal). In this sense, the multilateral agent's statement in the epigraph indirectly points to possible biases induced by what could paradoxically be called 'vertical health system strengthening'. Indeed, since reproductive health is widely considered as relevant to HIV/AIDS, its chances to obtain funding are reasonably good. Other less immediately HIV-, malaria- or TB-related aspects of health, in turn, have far lower chances of obtaining investments that are just as necessary. Based on this argument, several interviewees question the rationale for such a disease-specific approach to health system strengthening. “They rejected the Global Fund Round 8 proposal on health system strengthening because it was not HIV-relevant enough...”, notes a perplexed bilateral agent, exclaiming: “Try to figure!” (Bilateral-31). Commenting on the obligation to include the HSS proposal to the Global Fund into one of the disease-specific proposals, the spokesperson of a national NGO passionately states at a preparatory meeting for Global Fund Round 9:

All our complaints are related to the dysfunctioning of the health system in general. Health system strengthening should be a stand-alone proposal... It should not just be an appendix of another proposal!⁴⁶⁸

A bilateral agent shares his concerns about the operational consequences of the vertical initiatives' recent reconversion to health system strengthening in a context where the vertical mode of action itself is not fundamentally put into question:

⁴⁶⁸ Meeting held in Dar es Salaam, 3 October 2008.

Now, health system strengthening has become fashionable again, including within international agencies. [...] It's good that we have some more attention for it. But now we should watch out that we don't get enormous fragmentation in that area *again*...with one institution focusing on procurement, another one on human resources, another one on something else... Sure, some are cynical and say: 'That's only human and it's not really a problem. So let's make a huge mess...that way, at least *something* is happening. We'll clean it up later...'. (Bilateral-20)

Given the design of today's international health initiatives, a significant share of the Tanzanian agenda in terms of primary health care development directly depends not only on different issues' articulation with one of the 'three big ones', but on the uncertainties related to the funding mechanisms these initiatives propose. In a general comment on the Global Fund process by 'Rounds', a multilateral agent underlines:

Look at the Global Fund proposal-writing and -reporting process – that's huge! Just look at the waste of time and resources of a proposal fiasco! Why not just send in the existing strategies and ask funding for *them*!? (Bilateral-14)

Another multilateral agent suggests that the uncertainty arising from the Global Fund process is a major obstacle to coherent policymaking:

It's going to be the same jeopardy for the preparation of the Round 9 proposal – which, by the way, could turn into a real problem for prevention. If the Round 8 proposal [on care and treatment] is not accepted – and there are good reasons in the project for it to be refused – what will we do?! There is no plan B! Round 8 is so focussed on care and treatment...they won't drop treatment, they'll go for it again in Round 9 and prevention would be scrapped! If the Round 8 proposal is rejected, it's going to be a major crisis here! (Multilateral-6)

While the 'Round-based' mechanism of the Global Fund has been criticised for favouring massive initiatives on specific aspects at the expense of more balanced approaches, the uncertainty related to the acceptance or refusal of a Global Fund proposal also introduces considerable randomness into AIDS planning itself. While this uncertainty is considerable for HIV-related issues (here: prevention funding depending on the acceptance of the previous treatment-related proposal),⁴⁶⁹ it becomes overwhelming in the case of the various 'AIDS-and-...' issues regularly included in Global Fund proposals. The case of reproductive health is telling in this respect. Commenting on the non-acceptance of the Round 7 proposal on HIV and reproductive health, a bilateral agent involved in the process recalls:

In its response, the Global Fund basically said: 'Get your act together on the accounting for the use of past funds and on the identification of focus groups, and we give you the money for this proposal in Round 8'. So all we had to do was to clarify these issues... But no! The whole proposal was thrown away! And we wrote a completely new [proposal], starting from scratch! And this new proposal was focussed exclusively on treatment! (Bilateral-13)⁴⁷⁰

⁴⁶⁹ The Tanzanian Global Fund Round 8 proposal, for instance, asked for USD 423 million just to continue paying for the country's ART programme. USD 396 million, i.e. roughly two-thirds of the total amount requested, were approved (www.theglobalfund.org). As several interviewees suggested before the decision, the lack of any credible funding alternative would have made it very difficult for the Global Fund to reject the proposal.

⁴⁷⁰ The statement by a multilateral agent quoted in Chapter 3 (sub-Section A-3) concerning this same example proposes a very similar narrative when he concludes: "The only thing that counted for them [the Tanzanian administration] was: 'We have to find the drugs!'" (Multilateral-6)

As a result of the HIV-specific requirements concerning the Global Fund proposal process in Tanzania, the strengthening of reproductive health services dropped off the policy agenda. This experience understandably gave rise to considerable frustration among reproductive health players. Beyond the waste of time it caused, the outcome of this process suggests that, independently of the beneficial effects of successful proposals, the inclusion of individual 'system-related' health issues into HIV-specific funding mechanisms makes a coherent approach to general primary care impossible.⁴⁷¹

These different reasons explain why several players openly call for a change in the dominant approach to health system strengthening. "I don't think they should give the money to strengthen the health system through HIV" channels, exclaims a former Tanzanian official, "just give it to 'health system strengthening' as such – HIV positive people will benefit also!" (GovSector-11). Especially during the last fieldwork period, various donor agents positively commented on ongoing discussions at the headquarters level concerning the broadening of the international efforts with respect to health system strengthening:

Now there is debate about having a common 'HSS' component among GAVI⁴⁷², the Global Fund and the World Bank's health initiative. That would be a real change. [...] The health system strengthening programmes would not necessarily need to have an explicit link with the three big ones. Over the last 10 years, we have developed several coordinated initiatives in Tanzania, the Basket Fund, the SWAp...one could build on that. GAVI even said it was ready to pay into the health basket! (Bilateral-26)

Another interviewee suggests: "The Global Fund needs to evolve a little bit...it could take national strategies and fund them!" (Bilateral-29).⁴⁷³ Two bilateral agents independently propose to return to the idea of a non disease-specific Global Fund for health. "I have always felt, there should have been a Global Fund for health, not just for the three diseases", says one of them, "this way, each country could really sit down and see what its priorities are" (Bilateral-14). The other one remembers that this idea was actually on the table during the debates preceding the creation of the Global Fund:

In the very early discussions, the Global Fund was supposed to become a *health* fund. Then they introduced the priorities on the three epidemics, with the intention to increase efficiency. [...] The Global Fund should really be a Global Fund for health... Then, we should do a prioritisation, identify the 'quick wins'...and in this respect, TB, HIV and malaria would, of course, already be half the battle. (Bilateral-31)

Short of turning itself into a 'Global Fund for health', the Global Fund to Fight AIDS, Tuberculosis and Malaria has recently broadened the modalities under which countries can apply for funding for health system strengthening by including the possibility to apply for "cross-cutting HSS activities". This, however, should not be confounded with comprehensive primary health care, as the Fund specifies that

⁴⁷¹ Inversely, the selective integration of HIV/AIDS and other health services can also introduce a significant bias into AIDS-control itself. As a multilateral agent puts it: "Using sexual and reproductive health as an entry point for HIV biases treatment towards women. In Tanzania, 60 to 70% of the people on treatment are women, because they are systematically screened in ante-natal clinics and before delivery." (Multilateral-14) The latest UNAIDS report (2012b, p.51) confirms that ART coverage remains considerably higher for women than for men in low- and middle-income countries.

⁴⁷² "GAVI" refers to the GAVI Alliance, formerly The Global Alliance for Vaccines and Immunisation.

⁴⁷³ In 2011, the Global Fund started to pilot this direct funding of national strategies (which are sent in as such to the Global Fund, without any further "Round proposal") in a small number of countries. Round 11 having been cancelled, it is yet too early to draw any lessons from this experience.

the cross-cutting HSS activities for which funding is requested must have a “[c]lear and demonstrated link to improved HIV, TB, and/or malaria outcomes” (Friedman et al. 2011, p.5).

Most investments for ‘health system strengthening’ in Tanzania emanate from PEPFAR and the Global Fund. These HSS efforts must therefore strike a balance between the Government’s broad objective of improved (primary) health care, and the donors’ demand for a disease-specific relevance of the measures to be funded. To be sure, given the fundamentally ‘systemic’ obstacles to effective AIDS control described above (e.g. the human resources crisis), a wide variety of very broad measures can and do receive obviously beneficial support via these vertical, yet increasingly inclusive funding mechanisms. While welcoming the enlargement of the Global Fund’s conditions for the attribution of HSS support, one bilateral agent, however, critically comments on the ‘health system strengthening’ approach within institutions such as the Global Fund, the World Bank, and GAVI:

There will be changes in orientation within these institutions: they realise that even the best strategy cannot be built on broken or dysfunctional systems... But these institutions are not initially designed to develop a comprehensive health care approach! All of them are designed vertically. Their internal incentive structure is conceived in a way that they will probably *never* fully adopt a truly comprehensive approach to health. (Bilateral-30)

This crucial remark should be taken very seriously. Indeed, favouring comprehensive primary health care is a real challenge within an institutional landscape shaped by a successive sedimentation of past and present vertical initiatives. Nearly 30 years ago, the authors of the Antwerp Manifesto for Primary Health Care (Annys et. al 1985) already pointed to what could be called a ‘path dependence of verticality’. Criticising selective (i.e. disease-specific) health interventions, they note:

[E]xperience has taught us that selective interventions tend to become permanent even though they are presented as ‘interim’ responses only. In fact they need specific structures which a country could not easily get rid of at the moment it decided to reorientate its health policy towards comprehensive Primary Health Care.

Today’s situation in Tanzania illustrates the disconcerting topicality of this Manifesto; albeit an obvious shift in perspective, the existing vertical programmes and funding mechanisms remain the principal basis for the (re)construction of the Tanzanian health system. No doubt, non-integrated programmes make sense in certain cases (Unger et al. 2003), and it is good news that Western governments have decided to repair some of the severe damage their ‘structural adjustment programmes’ have caused to African health systems. Yet, taking vertical disease-control programmes as the main institutional basis for this reconstruction introduces a heavy, generalised bias into African health policies.

Beyond the specific biases due to different health issues’ unequal relatedness to any of the ‘three big ones’, a vertical approach to health system strengthening introduces a more diffuse bias in favour of *downstream* health action. When reading an early draft of my critique of downstream action in the field of HIV prevention (see Chapter 2), one interviewee comments:

Yes, we have to act upstream, but it is not feasible within a vertical approach! We must not believe that, if only we integrate, say, HIV and nutrition issues, we will make the right decisions... We have to stick to a comprehensive approach! The complexity of the issue is irreducible! (Bilateral-30)

The irreducible complexity to which this interviewee refers suggests that a population's continuum of health needs invariably exceeds the framework of any vertical programme or combination thereof, and that approaching 'integration' within a vertical institutional setting will inevitably fall short of bringing about comprehensive primary health care.⁴⁷⁴ Moreover, and as discussed below, the fact that international vertical initiatives are based on technocratically defined priorities and 'targets', which precludes any meaningful participation of the Tanzanian people, stands in contradiction to the concept of primary health care.

In sum, and notwithstanding the beneficial effects of the ongoing shift away from an excessively narrow definition of what disease-specific funding can be spent on, a vertical approach to health system strengthening induces a general bias into the ongoing reconstruction of African health systems. Drawing on the evidence on non-behavioural drivers of HIV transmission discussed in Chapter 1, the next subsection argues that the vertical design of AIDS-control programmes not only hampers a more comprehensive approach to health, but that, by doing so, it jeopardises the success of AIDS control itself.

B-4) The contradictions of a vertical struggle against a horizontally caused disease

“Tackling HIV alone is nonsense – it cannot be done!”
(INGO-3)

“Once again, when confronted with what they perceive as a major problem, northern donors are proposing a vertical solution, that is a set of measures designed to deal only with AIDS. [...] Yet the situation [...] demands a horizontal approach based on primary health care.”
(Turshen 1989, p.238-9)

The failure of HIV-prevention programmes in sub-Saharan Africa⁴⁷⁵ sadly echoes the critique voiced by Turshen over two decades ago – a critique at least as justified today as it was back then. In reaction to the persistently vertical design of the international AIDS response after its scale-up in the early 2000s, a variety of analysts have argued along similar lines over the last decade. Neusy, for instance, underlines:

Today, AIDS clinics in Kinshasa [...] are filled with such basic tools as sterilizers, bandages, and trained staff. But these necessities are in dangerously short supply at the General Hospital of Kinshasa on the other side of town. Consequently, a 3-year-old Congolese girl dying from pneumonia may not get the 5 cents' worth of antibiotics that could save her life. [...] Billions of international health dollars are spent fighting pandemics, while *the impotent health infrastructure that contributed to the pandemics' growth and cost* remains chronically underfunded. (2004, p.82, my italics)

⁴⁷⁴ This conclusion is confirmed by the analysis of the policy hurdles to structural HIV prevention (see Chapter 3), which illustrates the difficulties of addressing broader aspects of ill health within a vertical framework of action.

⁴⁷⁵ Although some authors are quick to claim the success of behaviour-change programmes (e.g. Halperin et al. 2011), an honest appraisal cannot but conclude that the decreases in HIV incidence in many sub-Saharan countries since the late 1990s remain not only fragile (as recent renewed increases in Uganda suggest), but widely unexplained. Although HIV-prevention programmes have undoubtedly contributed to preventing transmissions, attributing the *reversal* of HIV incidence to preventive interventions is daring, and, in most cases, incorrect.

Consequently, he concludes:

Rather than treating the symptoms of failed health systems with exclusive investment in short-term policies, longer-term investments in public health infrastructure are needed. Otherwise, humanity runs the risk of repeating the same trajectory when the next global pandemic occurs. (2004, p.84)

While his conclusions are confirmed by what is known about the specific linkages between poor health (care) and the spread of HIV, his reasoning does not explicitly draw on the available evidence. More generally, many players who stress the need for AIDS-control programmes to address broader health-system concerns primarily do so by underlining the material and organisational impossibility to implement vertical programmes in a setting of dysfunctional health systems. It makes sense, of course, to call for the integration of disease-control programmes into the general health system by pointing to the central importance of patient-centred care – with which vertical programmes interfere (Kalofonos 2010; Chabrol 2012) – and to broader organisational efficiencies to be gained from an increased coherence at the service-delivery level (e.g. Unger et al. 2003; 2006). Similarly, several interviewees – among whom people actively involved in vertical AIDS-control programmes – underline the limits of vertical disease control and point to the broader causalities of the African AIDS epidemics. Yet, many of those interviewees who mention poverty as a driving force behind the African epidemics stick to the behaviour-mediated narrative (i.e. poverty as a cause of ‘risky sex’), and draw on a vague awareness of more specific causal pathways.⁴⁷⁶

The way HIV/AIDS is framed – either as a narrowly behavioural problem, or as an epidemic with considerably broader causalities – obviously has an impact on the perceived appropriateness of a vertical approach to AIDS control. While the terms ‘vertical’ and ‘horizontal’ usually describe the more or less integrated design of health interventions, they can also be used to represent the more or less specific nature of the causal mechanism(s) at the origin of epidemics. In this sense, the ‘vertical’ aetiological framing of AIDS in Africa – i.e. the idea that specificities of ‘African’ sexual behaviour are the main causal thread of the African epidemics – fuelled a form of AIDS exceptionalism that overestimated the effectiveness of HIV-specific (and especially behaviour-specific) interventions compared to other forms of health care and promotion (see Chap. 1 + 2; and Stillwaggon 2006). More generally, and just as with any public health programme, the question of what is part of AIDS control and what is not depends to a great extent on the policymakers’ perceptions of the causes of the epidemic (cf. Tesh 1988, p.3). Beyond the question of the inclusion of specific measures (e.g. injection safety or schistosomiasis control) into AIDS-control programmes, the framing of the African epidemics as having highly specific causes (i.e. unusual patterns of sexual behavior) has encouraged the vertical design of the response. A broader understanding of the structural drivers of HIV in Africa, in turn, would have implied a reframing

⁴⁷⁶ One multilateral agent, for instance, enumerates several prevention interventions he considers important, pauses, then adds: “Of course, these are only the very immediate issues, not the underlying causes of the epidemic...such as poverty” (Multilateral-4). Several interviewees are well-aware of the reductionist nature of the vertical initiatives they work for. One bilateral agent involved in the implementation of PEPFAR, for example, spontaneously suggests: “Take HIV, TB or malaria...these diseases are one component of a population that is dealing with a lot of poverty and where the health sector has been in decline for the last 30 years” (Bilateral-19).

of the 'AIDS-in-Africa problem' within a broader public health perspective, and a response that builds upon the existing system and aims at an overall coherence of health policies.

The assertion that the vertical approach to AIDS control is inappropriate *because* the specificities of the African AIDS epidemics have been overestimated is not new. What made Turshen utter this claim over twenty years ago was a general understanding of the dynamics of infectious diseases and an acute awareness of the underlying politics of disease framing. Although those analysts familiar with classic epidemiology and the causes of population vulnerability to infection generally looked the right way, little *detailed* knowledge existed, back then, about the specific interactions between various co-infections and HIV transmission and pathogenesis. Indeed, what differentiates the recent calls for a more horizontal approach to AIDS-control from the earlier critiques is that they draw on what has become a solid body of evidence. The combination of these biological and epidemiological insights with economic analysis allows Stillwaggon (2011) to conclude:

It is possible to shift the entire distribution of risk of HIV acquisition and transmission in poor populations by focusing more on co-infections. When HIV/AIDS is isolated from other health concerns, that creates a bias against spending what are really trivial amounts to change the risk of transmission of HIV and the risk of treatment failure. [...] Efficiency requires that we stop chasing after one virus, one person at a time. We can do more with less, and we can do it better by focusing on health in integrated systems.

Indeed, the body of evidence briefly summarised in Chapter 1 provides powerful *additional* rationales for an integrated response to HIV/AIDS as part of a comprehensive approach to health. The improvement of primary health care would contribute to the control of a variety of endemic infections and other conditions of ill health that are fairly easy to prevent and treat and which have been shown to fuel the sexual and vertical transmission of HIV (e.g. malaria, intestinal worms, genital schistosomiasis, or anemia). Such an approach would probably also contribute to the reduction of iatrogenic HIV transmission by modifying the political incentive structure in favour of cross-cutting (or 'horizontal') issues such as health-care safety.⁴⁷⁷ Beyond its effects on HIV prevention, a more comprehensive approach would also facilitate medically and economically the care for and treatment of people living with HIV, improving their general health – which, in many cases, increases the effectiveness of ART. The control of these co-infections would also help limit the detrimental consequences of the *non-universal* provision of ART in the years to come (e.g. Walson, Singa, et al. 2008; Walson, Otieno, et al. 2008; Alldis 2009; Stillwaggon 2011). Concerning those people who are on ART, the treatment of co-infections would improve the toleration of and thus the adherence to antiretroviral therapy – which would allow keeping them on cheaper first-line regimens as long as possible. At the same time, maintaining in good health those HIV patients who are not on ART by treating co-infections that accelerate HIV pathogenesis allows the postponement the initiation of antiretroviral treatment. As Stillwaggon (2011) summarises, “[t]rying

⁴⁷⁷ Stressing that certain parasitic diseases that are widespread, yet easy-to-control, might limit the effectiveness of future HIV vaccination campaigns Stillwaggon (2006, p.58) underlines that “even a magic bullet for HIV, such as a vaccine, requires a broader health-promotion approach”. The common failure of BCG vaccination in settings with widespread malnutrition provides a striking historical example in this respect (see: Dubos 1980, p.150).

to roll out ART without treating widespread, easily curable conditions like worms wastes lives and squanders first-line therapy”.

In sum, because it has in many respects disregarded its broader health and institutional context, the vertical design of the international response to HIV/AIDS in Tanzania has not only introduced a fundamental bias into the Tanzanian health system as a whole, it has been counterproductive in some respects. By neglecting (or even drawing attention away from) a variety of co-infections, the vertical action against the ‘horizontally’ caused African AIDS epidemics reduced the effectiveness and efficiency of HIV treatment and prevention. Following Unger et al.’s (2003, p.S29) analysis of vertical programmes, this situation could be described as a “negative feedback loop”, i.e. a situation in which excessively narrow vertical initiatives hamper the delivery of primary health care – which, *in turn*, limits the effectiveness of vertical programmes themselves. These insights confirm de Paepe et al.’s (2007, p.S273) general assertion that “[i]ntegrating disease control with health care delivery increases the prospects for successful disease control”.

Sub-conclusion) Irreducible complexity and the recontextualisation of AIDS control

“Nobody bothers to change the background of all these interventions. If you reach people at village level with these programmes: deworm them! Give them access to bed nets, get rid of all these confounding variables...and *then* give the treatment you need to give! [...] Within the existing NTD programmes, we use village volunteers. They could also be used for TB, malaria and HIV activities! [...] The health workers we use for NTDs can deliver other services also...vitamin A, bed nets, etc. [...] Why not make it a comprehensive package?! There is a crucial need to look at all these things from the same platform. If you don’t, you risk that these underlying, pre-existing conditions will affect the effectiveness of your response to HIV/AIDS and malaria... And these conditions affect a large segment of the population and frequently the poorest of the poor. And these diseases will always be there! They will *always* be the background of the other diseases [HIV, malaria, TB] we are looking at. This background is not a clean white paper! It’s a paper that already has worms on it...and genital schistosomiasis! By addressing these issues, you can better address the other ones. If we deworm, anaemia will decrease and the impact of malaria will be lesser. [...] HIV is so multifaceted! That makes it difficult to isolate individual factors.”
(GovSector-13)

This powerful plea by a Tanzanian official against narrowly conceived vertical programmes is grounded in an acknowledgment of the interrelatedness of different health conditions. The linkages between intestinal worms, anaemia, malaria, and HIV provide an illustration of the complexity of disease control. As this interviewee underlines, worms accentuate the risk of anaemia, which affects the severity of malaria. As discussed, all three of these conditions accelerate the pathogenesis of HIV and their synergistic interaction facilitates the sexual and vertical transmission of HIV. Additionally, both severe anaemia and malaria are a major cause of blood transfusions⁴⁷⁸, which involve a risk of iatrogenic HIV transmission. This is but a simplified account of *one* of the many examples of the real-world interrelatedness of HIV/AIDS with other conditions. This awareness of the complexity of the underlying determinants of individual and population-level susceptibility to infection in a country such as Tanzania leads this Tanzanian official to conclude:

⁴⁷⁸ A bilateral agent, for instance, underlines: “in Zanzibar, we clearly see that successful malaria control leads to a decrease in the need for blood transfusions” (Bilateral-21).

The end user will not choose *only* to have malaria, just to tick the boxes in a neat way... He will have several other diseases! But if you sit in Washington, Geneva or Atlanta [the city where the CDC headquarters is located], this world looks a lot different! So when I've been there for a while, I always feel I have to go home and get a reality check. Many of the public health discussions there are totally removed from what is really happening here! (GovSector-13)

Generally speaking, this important remark underlines how the social structures of the institutional complex of 'global health' allow for the decontextualisation of public health issues that often underlies the singling-out of specific 'problems' to be 'solved' by vertical fundraising and programme implementation. More specifically, the susceptibility of populations to HIV infection depends to a considerable extent on a complex interplay of a variety of interrelated health conditions that flourish in the absence of effective primary health care. The increasing awareness of the broad causalities – or 'conditions of possibility'⁴⁷⁹ – of the African epidemics points to a fundamental contradiction of vertical AIDS control. Judging from the available evidence about how HIV spreads in sub-Saharan Africa, a narrowly focused vertical response is condemned not only to inefficiency but to a considerable lack of effectiveness, if not to partial counterproductivity.

This 'irreducibility' of health, as the interviewee quoted above puts it, implies that a common dismissal of criticism concerning the detrimental effects of vertical programmes on African health systems does not hold. Indeed, the argument that this critique is irrelevant because 'controlling HIV/AIDS, TB, and malaria is by far the most important task of African health systems anyway' is based on a reductionist and thus fundamentally flawed public health reasoning. Beyond the practical and ethical limits to disease-specific programmes in a context of widespread poverty and dysfunctional health systems, the vertical design of the AIDS response paradoxically also limits the effectiveness of AIDS control *itself*. Taking the various critiques against international AIDS-control programmes in Africa discussed in this thesis as a starting point, the last chapter reflects on the concomitant difficulty and necessity, in a context of acute dependency, to formulate a radical critique and to sketch out pathways for positive change.

⁴⁷⁹ In contrast to a linear concept of causality, the 'conditions of possibility' designate the necessary framework that make the appearance of something else (here: the African AIDS epidemics) possible.

Chapter 8) Biting the hand that treats you? Acute dependency and the challenge of radical critique

“Twenty years of people living and dying with AIDS in countries such as Tanzania, have surely earned them the right and the responsibility to direct future HIV/AIDS strategies. [...] Tanzanians should be leading the design of technical strategies, setting objectives and providing a minimum core budget. International agencies could, in turn, respond with technical assistance to support fulfillment of these strategies, rather than trying to dictate the nature of strategies.”
(Hartwig et al. 2005, p.1622)

With these words, Hartwig et al. (2005) conclude their assessment of the degree of ‘ownership’ of AIDS policymaking in Tanzania between 1987 and 2000. They show that the formulation of the Tanzanian response to HIV/AIDS has remained entirely in the hands of international donor agencies, and – comparing the Tanzanian situation to what is arguably a questionable ‘ideal’ – they conclude that “[t]he ideal of shared sovereignty failed to take root” (p. 1622). Today, over a decade after the end of their enquiry period, Tanzania’s effectively exercised political control over the country’s HIV-treatment and -prevention policies has certainly not increased. The AIDS response continues to be decisively shaped by an increasingly oligopolistic group of international agencies, and – as in all sectors with active donor involvement in Tanzania – all policy documents are discussed and formulated in English, *then* translated back into Swahili for implementation.⁴⁸⁰ The international AIDS response has become a structural element of Tanzanian politics and has durably expropriated the Tanzanian government and the Tanzanian people of their control over crucial health- and HIV-related spending priorities. The AIDS players’ ‘ownership’ discourse hardly masks the fact that a wide variety of fundamentally political decisions are made without any significant public debate by people without any democratic legitimacy within a largely *ad hoc* institutional framework that almost entirely bypasses essential components of domestic democratic structures. 85% of all external AIDS assistance is spent off budget (TACAIDS 2012), i.e. directly by donors (mostly PEPFAR) and their implementing partners, and without any significant Tanzanian contribution to priority setting. Even allocative decisions concerning *on-budget* expenditures (mainly Global Fund grants) are not discussed in Parliament but decided upon within the Tanzania National Coordination Mechanism (TNCM) – an ad-hoc forum composed of donors, government administrators and (often tokenistically selected) NGOs.⁴⁸¹ “It is highly problematic that all these agreements and arrangements completely bypass the country’s democratic process”, comments a bilateral agent, “if you look at it, the TNCM is a blatant violation of good governance principles!” (Bilateral-31). The international AIDS initiatives and their constituent donors thus openly and consistently circumvent the very democratic institutions they have insistently advocated over the last

⁴⁸⁰ Beyond the closed nature of the policy process described in the introduction to Part 2, the simple fact that all policy-relevant debates and documents are in English makes it *de facto* impossible for those Tanzanians who are not part of the urban elites to follow the debates – be it only ‘on paper’.

⁴⁸¹ As discussed, although the Global Fund process is, in principle, ‘owned’ by the Tanzanian government, the bi- and multilateral agencies involved in AIDS-control in Tanzania play a key role in the preparation (and implementation) of the proposals.

decades. As a result of the overriding importance of aid, government officials primarily report to their respective donors, not to Parliament or other representatives of the Tanzanian people. By introducing this systematic donor bias into domestic structures of political accountability, the inflow of external funding for HIV/AIDS contributes to the perpetuation of anti-emancipatory structures of domination.⁴⁸²

Most – if not all – of the fundamental critiques formulated against ‘aid’ thus apply to international AIDS-control programmes. They are the expression of the priorities of Western, not African governments, and they have exacerbated rather than attenuated dependency. Rugumamu’s general critique of an “aid industry” that “created booming parallel bureaucracies of the ‘lords of poverty’, which independently planned and designed projects for funding in Tanzania” (1997, p.156) fittingly describes the ‘AIDS industry’ as well. International assistance for AIDS control is no different from other ‘aid’ with respect to its anti-emancipatory effects on local communities and national elites, and the flaws it introduces within the ‘beneficiary’ countries’ administrative and political incentive structures (e.g. Hirschman 1967; Thébaud 1986; Rugumamu 1997; Chabal & Daloz 1999; M. Green 2003; Swidler 2006; Easterly 2007; Tandon 2008; ActionAid 2011). Just as other aid, the ‘AIDS industry’ feeds a parasitic bureaucracy and a newly emerged class of “development brokers” (Bierschenk et al. 2000) – or “interstitial elites” as Swidler and Watkins (2009) put it – who make a living by linking the international AIDS-control apparatus to its intended ‘beneficiaries’.

Beyond its fundamentally heteronomous nature, the more recent international response to AIDS in Africa has been challenged not only for its over-proportional focus on antiretroviral treatment and the relative neglect of prevention (Chapter 5), but for imposing ill-designed HIV-prevention interventions based on an epidemiological misinterpretation that over-emphasises the importance of sexual behaviour and omits the role of poverty-related co-infections that codetermine population-level susceptibility to HIV (Part 1). The vertical design of international AIDS control has been denounced for distorting and incapacitating African health systems – compromising their ability to deliver health services and even for reducing the effectiveness of AIDS-control itself (Chapter 7). Furthermore, and as discussed, the narrowly circumscribed approach adopted by the principal donors has been criticised for negating patient-centred care, for reducing individuals to biological entities, and for giving rise to donor-driven triage qualified as “a virulent mutant of earlier forms of colonial and postcolonial discrimination” (Nguyen 2010, p.176). A variety of critics have described the international AIDS response as an element of techno-economic and/or cultural imperialism (e.g. Turshen & Thébaud-Mony 1991) and underlined the analytical necessity to “locat[e] AIDS within a particular world order of ‘transnational neoliberalism’” (Lee & Zwi 1996, p.355)⁴⁸³. Ultimately, the exceptional susceptibility to HIV of many sub-Saharan

⁴⁸² “In the case of Uganda”, Tumushabe unequivocally suggests, “the positive political leadership regarding HIV/AIDS in the 1980s has translated into political capital for authoritarian rule in the twenty-first century. The Ugandan government is not using the success of the fight to ensure donor financial support as a weapon to emancipate Ugandans, but as a weapon for international deception and regime perpetuation” (2006, p.25).

⁴⁸³ See also (Comaroff 2007).

populations is the result of global (and domestic) structures of political and economic domination. As discussed below, considering AIDS-control in isolation from the broader context of oppression in which it takes place leads to implicitly considering that the end (the 'saving of lives') justifies the means (the suspension of the requirement of self-determination and democratic accountability).⁴⁸⁴ Kalofonos describes the depoliticising governance of which international AIDS control is part as follows:

The humanitarian form of governance dehumanizes as it prioritizes saving lives over granting broader access to rights and benefits of citizenship. Donors and philanthropists can congratulate themselves for their generosity and the individual lives they save, while the very structures implicated in the devastation of the AIDS epidemic remain hidden and untouched. The 'business of AIDS' currently represents a virulent form of extraction in which antiretrovirals and food baskets function as postcolonial palliatives, while the rich continue to eat the poor. (2008, p.375)⁴⁸⁵

Just as in many other domains of 'development', the argument consists in accusing the international institutions that deal with HIV/AIDS of being mainly engaged in symptom management (be it partially effective) and of eliding the structural political and economic factors that drive the disease – or, at least, of being uniquely ill-equipped to address them effectively.⁴⁸⁶ Interestingly, many AIDS policymakers and scholars consider the international AIDS response as something 'exceptional', and thus as being different from 'plain development aid' – possibly because the contrary would oblige them to ask uncomfortable questions about the political economy of aid. Nevertheless, many of the depoliticising (side-)effects of AIDS control described above are obviously common features of allegedly *technical* 'development cooperation' in general (cf. Ferguson 1994; Hibou 1998; Illy 2004).

In sum, the list of harsh criticisms of the international AIDS response is long, and the controversies over the appropriateness of its scope, content, and design are innumerable. Nevertheless, even among those critics who fundamentally question the legitimacy of international AIDS control in Africa, rare are those who conclude their critiques by calling for a withdrawal of international donor agencies. More generally, part of the scarcity of radical criticism among (even highly politicised) AIDS activists and scholars is probably due to the fear that thinking out loud about the shortcomings and contradictions of the international AIDS response could upset the donors and jeopardise future funding. That being said, the paucity of propositions for drastic change is also due to the fact that today's situation leaves no room for simple solutions. In this perspective, Section A explores the difficulty of formulating radical critique in a context of acute dependency. It does so by confronting the call for an 'end to aid' voiced by 'post-

⁴⁸⁴ This suggests that narrowly framed AIDS activism runs the risk of being counterproductive in terms of advancing a broader emancipatory agenda.

⁴⁸⁵ This analysis echoes Thébaud's question, who, two decades earlier, asked if international health aid could not be considered as "a continuation, in a new guise, of the 'civilising mission' which, in the nineteenth century, served as a humanitarian facade for the institution of the colonial order" (1986, p.46).

⁴⁸⁶ A similar power-concealing rhetoric is to be found in the increasingly consensual international discourse on the 'fight against poverty'. In passing from the 'exploitation' to the 'exclusion' of developing countries, this discourse leads to the disappearance of the actors and the underlying power relationships. As Rist (2002a, p.25) underlines, "passing from '*putting an end to exploitation*' to '*fighting poverty*' is changing the world". Man-made history and development as a process of interacting and conflicting interests have disappeared from this universe. There are no more 'bad guys' and everybody stands united to eradicate poverty, this horrible pandemic growing out of nowhere. As Baudelaire wrote in his short story *Le Joueur généreux*, "the devil's best trick is to persuade you that he doesn't exist".

development' theorists with the Tanzanian situation concerning AIDS control. Post-development theory is one of the rare theoretical approaches that propose an uncompromising critique not only of international 'aid', but of 'development' itself – which they accuse of being an ideology that reflects and perpetuates Western hegemony. Although it is not a homogenous framework, the case of post-development theory is a relevant example since many of the fundamental critiques that have been (legitimately) voiced against the donor-driven, technocratic, and 'downstream' character of the international AIDS response directly echo the analyses of many post-development authors. Developing upon the conclusion that, although fundamentally necessary, radical theory provides little practical guidance as to what should be done, Section B modestly outlines some pathways for a necessarily progressive – and inescapably contradictory – evolution in practices. It argues that the repoliticisation of AIDS-related decisions is crucial to allowing the formulation of acceptable but always temporary compromises.

A) No simple solutions: international AIDS control and the dismissal of aid by post-development theorists⁴⁸⁷

“The question of sustainability is really a difficult one...but then again, maybe we should look around us and see how many African countries really sustain themselves... [...] If there are so few, it means that it is nearly impossible! So let's deal with the easier questions first. We are a Third World country and those are the issues we have to live with.”

Tanzanian official at a preparatory meeting for a Global Fund proposal (Dar es Salaam, 3 Oct. 2008)

As mentioned, the annual budget of the AIDS response in Tanzania hovers around USD 500 million, close to 98% of which is donor-financed (TACAIDS 2012b). This external support for AIDS control represents roughly 10% of Tanzania's public expenditure and one third of all aid flowing into the country. Despite its obvious benefits, the roll-out of ART puts Tanzania in a situation where an increasing share of its population directly depends on foreign assistance for survival. This section proposes to confront this situation, which raises the issue of dependency with unprecedented acuteness, with certain elements of post-development thought. Indeed, while all post-development theorists are “explicitly not calling for a better version of [development], but dismissing it altogether” (Ziai 2007, p.3), the more radical authors among them share a resolute rejection of international aid. Rahnema and Latouche (2002), for instance, implore Western countries to “leave the poor alone!”. Esteva (1992, p.90-1), in turn, claims that “[d]evelopment aid is an instrument of colonial oppression”, that “[w]e must abolish aid organisations – indeed all of them; the national just as the international ones”, and that “we must not do things by halves”.

⁴⁸⁷ This chapter develops upon a contribution to a thematic issue on post-development theory and 'alternatives to development' of the Austrian Journal of Development Studies (Hunsmann 2012a).

Beyond the provocative and sometimes questionable verbiage of its more uncompromising proponents, who assert “the right to be underdeveloped” (Alvares 1992, p.68) and accuse development of being “another variety of AIDS” (Rahnema 1997), the post-development movement formulates a claim for genuine emancipation of the global South (Ziai 2004). In its critique of modernity and its reflections on progress and the social construction of needs, post-development theory explicitly draws on Illich’s (e.g. 1969; 1976) critique of industrial society, its over-medicalisation of illness and the “expropriation of health” it entails. Illich’s remarks concerning the limits to medicine and the blind faith Western societies put in technological solutions to control disease are highly relevant for the international AIDS response. The emphasis put on biomedical remedies (e.g. vaccines or ART), and the neglect of iatrogenic transmission and closely interwoven socio-economic and biological determinants of populations’ susceptibility to infection discussed in Part 1 certainly confirm many of Illich’s claims. Yet, the idea that the marginal utility of modern medicine becomes negative beyond a certain point of development is at the heart of his critique. Its unmediated transfer to situations where even the most basic health services are not available is thus problematic.

More fundamentally, some post-development theorists’ radical constructivist approach raises an epistemological issue. The production of knowledge about health and illness is probably one of the most telling examples of the insufficiency of both radical positivism and radical constructivism. To be sure, the perceptions of and responses to HIV/AIDS result from socially constructed visions and values and politically contested processes of knowledge production (S. Epstein 1996). Yet, HIV exists. It causes AIDS and kills people independently from the way they think and talk about it. The epistemological posture is thus analytically crucial. The radically constructivist reading of reality adopted by several post-development authors entails an affinity with value-relativist world views. Latouche (2003, p.130), for instance, claims that “there are no values that transcend the plurality of cultures because a value exists as such only in a given cultural context”. As discussed in the introduction, the pitfalls of radical constructivism are particularly obvious in the case of HIV/AIDS. Adopting a moderately constructivist perspective (e.g. Rosenberg 1988, p.14; Ziai 2004), I consider that the superiority of life over death and the ensuing ‘need’ for HIV prevention and treatment are not pure social constructions exclusively based on Western values.

That being said, the post-development theorists’ arguments concerning the general failure of aid and development are persuasive. In a nutshell, the ‘fight’ against AIDS in Africa is a top-down endeavour inspired by Western stereotypes of African sexuality, implemented by Western agencies based on their experts’ technocratic definition of African people’s needs. In this sense, the international AIDS response is ‘development’ *par excellence*; it is a stereotypical example of the type of dependency relation to which radical critics of aid want to put an end. International AIDS assistance reaches USD 8.8 billion annually (Kates et al. 2012) and HIV/AIDS is many donors’ largest single budgetary item in several African countries. Several “Millennium Development Goals” (MDGs) could not possibly be achieved in the

absence of an effective roll-back of the epidemic. Politically speaking, the success in the struggle against AIDS is thus crucial not only to the legitimacy of the Western development discourse, but to the credibility of the development endeavour itself.

Yet, despite being at the very heart of the development enterprise, AIDS has remained at the margins of the more critical theoretical debates about development and aid. This is for good reason: African AIDS epidemics are an uncomfortable ground for a radical criticism of international aid. Maybe because the question of survival is inescapable and immediately apparent in the case of HIV/AIDS, post-development theorists and other radical critics of aid have carefully avoided the issue. Indeed, the dramatic dimensions of the African AIDS epidemics and their catastrophic health, social and economic consequences make it questionable to suggest, as Matthews (2007, p.131) fittingly sums up the essence of post-development thought, that “development [is] not the medicine but the disease”. Being nearly unanimously considered as a health emergency that calls for a forceful international response, AIDS poses a serious challenge to radical critics of aid. Indeed, how can one satisfactorily analyse the international response to HIV/AIDS within an approach repeatedly criticised for its reluctance to suggest concrete political alternatives, or even explicitly accused of advocating inaction in the face of misery (Kiely 1999)? Can this theoretical approach be relevant in the context of HIV/AIDS, or are there justified concerns “that the adoption of a post-development position may amount to the abdication of responsibility” (Matthews 2007, p.141)?

While keeping in mind the heterogeneity of what is sometimes abusively referred to as a unified theoretical framework (Ziai 2006; 2004, chap. 4), this section explores the implications of a central proposal of the more uncompromising post-development authors: the claim to “radically stop aid” (Esteva 1992, p.66). As Ziai (2007, p.9) notes, post-development has “a lot of critical and constructive potential” and “needs to be further refined, explored and argued over”. In this perspective, and far from attempting to close the indispensable debate post-development theorists opened, I attempt to provide some elements of discussion concerning both the need and the genuine difficulty to formulate radical critique in a context of pronounced dependency. Because it illustrates the contradictions both of the development endeavour and of its most radical critics, the response to AIDS in Africa is a fitting empirical example for a theoretically-oriented reflection on international aid.

This section argues that AIDS control in Tanzania is highly dependent on foreign aid and that a significant increase of self-sufficiency is unlikely in the foreseeable future. Although international AIDS control illustrates the relevance of post-development theory, the call for an ‘end to aid’ voiced by its more radical proponents draws on an artificially monolithic conception of development. Indeed, far from being credulous ‘bringers of development’, international development practitioners involved in AIDS control in Tanzania radically criticise their own action in ways that overlap with post-development thought. While the predictably harmful consequences of a massive donor draw-out make it difficult to

envisage radical change, post-development appears as a theoretical refusal to adopt urgency as an exclusive framework of analysis. The section concludes by discussing the 'conditions of possibility' of critical thought in a context characterised by what the interviewees themselves perceive as an imperative for action.

A-1) Beyond metaphors: aid dependency as drug addiction

The nature of the response to HIV in Tanzania and the dependency to which it gives rise are, in many respects, grist to the mills of radical critics of aid. Although the case for HIV prevention is just as persuasive, the example of access to antiretroviral treatment is probably more immediately evident. As discussed, an estimated 1.4 million people are living with HIV in Tanzania, 660,000 of whom are currently in acute need of ART and about 275,000 of whom currently have access to the life-saving drugs (CDC 2012). This entirely donor-funded treatment programme currently costs approximately USD 340 million per year (Kates et al. 2012). AIDS control having become a structural feature of Tanzanian politics, several interviewees share their concerns about the devastating effects of a potential cut in international support. A multilateral agent envisions:

Imagine the funding for ARVs stopped drastically. People's viral loads would skyrocket! And, say, each HIV-positive person infects one other person in the following year... That would be a complete horror scenario! I don't know if anyone has already looked into that more in detail or if anyone has done some modelling on systemic breakdown, but that could be an absolute disaster! (Multilateral-13)

As mentioned, treatment interruptions lead to a rapid increase in people's viral load, thereby substantially increasing their infectiousness and the risk of spreading viral strains resistant to affordable 'first-line' drugs. A Tanzanian official passionately declares:

It is *impossible* to go back because we have incarcerated ourselves! [...] [Treatment] ties up resources forever, until these people die... For care and treatment, you incarcerate yourself, *literally*! If you don't continue, they'll die...or develop resistances. So you *have to* continue! (GovSector-12)

Beyond the individual ethical issue, there is thus a strong public health rationale for ensuring life-long access to medicines to anyone who has initiated antiretroviral therapy. The decision to roll out treatment is also perceived as being politically irreversible – a perception illustrated by the widespread use of the expression "treatment mortgage" to describe the political obligation to ensure the continued provision of ART. A bilateral agent critically reflects:

Now we have a problem: [...] Clinton said at the Mövenpick Hotel: 'We will guarantee life-long treatment'...yeah right! Of course, we can't get away from it anymore! Because if we can't pay for treatment anymore, resistances will develop and people's viral load will skyrocket. Of course, people like the WHO representative will say: 'At least, that's a couple of life years saved...' But, in a sense, we have turned the Tanzanian people into junkies! If you look at it, what actually happened is that we gave Tanzania a 'free shot'. Now, we got them hooked on ARVs! (Bilateral-30)

This comment strikingly echoes the widely-used metaphor of ‘drug addiction’ in talking of aid dependency.⁴⁸⁸ This commonality illustrates that the questions raised by international aid in the field of HIV/AIDS are essentially the same as in many other domains of ‘development cooperation’ – the main difference being that, in the case of HIV/AIDS, the ‘drug addiction’ of the dependent country is not merely metaphorical. In any case, despite the perceived political irreversibility of ART roll-out (Chapter 5), the global economic downturn has precipitated the long-feared drop in international AIDS funding, triggering what even UNAIDS (2012a) no longer hesitates to call an “AIDS dependency crisis” in Africa. This reality is further underlined by recent episodes of ARV shortages in several African countries, which illustrate that drug procurement gaps are not merely a hypothetical scenario.

A discontinuation of treatment would cause patients’ life expectancy to drop dramatically and would drastically increase their risk of spreading the virus. Although there are significant returns to scale in ART roll-out (as the number of people on the treatment rises, the marginal cost per patient declines), ART programmes will need additional resources as the number of people on therapy rises and as increasing drug resistances require more expensive ‘second-line’ drugs. The magnitude of the sums involved makes most interviewees doubt that Tanzania will be able to come up with a domestic solution to fill foreseeable future funding gaps. As a former Tanzanian AIDS official puts it:

We don’t have the ability as a government to face HIV/AIDS alone. We need external support. The problem is too massive! [...] So all we can do is hope for the external support to continue... If it doesn’t, it’s a disaster! We cannot say: ‘Sorry, we have no more money, so you get no more ARVs...’ No, we cannot say that! (GovSector-3)

At the same time, the negligible and uneven contribution of the Tanzanian government to the country’s AIDS budget implies that its financial dependency is, to some extent, a political choice. Commenting on the Tanzanian Government’s decision to cut the TACAIDS budget (see Chapter 4), a multilateral agent underlines: “There is no long term thinking and no resource mobilisation within TACAIDS for own resources. And the AIDS Trust Fund they are talking about will never reach the level of today’s funding!” (Multilateral-4). The fact that international AIDS expenditure roughly equals the rest of the country’s health budget makes it unlikely that a possible donor withdrawal from HIV/AIDS would be entirely offset by the Tanzanian government. As discussed, were the Tanzanian government to decide independently between AIDS and general health budgets, it would certainly rebalance them in favour of the broader health agenda. As a bilateral agent puts it,

If donors pull out now, will the government manage to support people who are already on ARVs? Many people might die because the Government is not going to be able to do so...or because it has other priorities. In any case, it would be either ARV patients, or those of other priority diseases who would die. (Bilateral-11)

⁴⁸⁸ Rugumamu, for instance, underlined that, “like drug addiction, the Tanzanian state gradually became hooked to aid. The more aid it received, the more it requested and the faster it eroded the self-reliance capacity of the economy, society, and its institutions.” (1997, p.156). The former President of Tanzania himself, Benjamin Mkapa, uses the same metaphor, stating that “[aid] is similar to drug addiction. Any suggestion of withdrawal from the addiction traumatises its user, and sends them [sic] into panic. The longer the addiction lasts the more difficult it becomes to escape” (in: Tandon 2008, p.vi).

Importantly, one interviewee underlines that Tanzania's dependency on international AIDS funding also concerns human resources:

If PEPFAR and the Global Fund weren't here, how many of the technical people would be here...? You'd lose three quarters of the technical staff in Tanzania...even within NGOs. That's a lot of technical capacity...and you remove it, if you remove the funding. Some say there is lots of technical ability in Tanzania...but only a tiny fraction of that will remain [should the funding decrease]! Most will go elsewhere... (Bilateral-22)

Be it because of the government's inability or unwillingness to replace donor funding, the end of external support would invariably translate into a significant decrease in AIDS financing, a considerable withdrawal of human resources, and thus into surging death rates and the social, economic and possibly even political disruption that could ensue.

As discussed, and beyond the mere issue of financial dependency, the undemocratic nature of AIDS-related decision making in Tanzania is striking. Concerning both the severity of dependency and the perverse incentives of aid, the Tanzanian example thus illustrates the relevance of the criticism voiced by post-development theorists. Yet, as the next section argues, their oft over-simplified conception of development prevents radical critics of aid from grasping the profound ambiguity of 'development cooperation'.

A-2) Omitting the ambivalence of development

Considered as its strength by some, as its weakness by others, a defining feature of post-development theory is the very generalising nature of the criticism it formulates. Some authors fail even to define development, while others circumvent the difficulty by equating it with globalisation (Latouche 2003, p.125). The result is a general critique of development as both an ideology of progress and an exploitative, neo-colonial economic and symbolic World System. No doubt, such a holistic critique is indispensable in today's world where the global intelligibility of structural processes is jeopardised by increasingly fragmented expert knowledge. This theoretical breadth of post-development, however, induces an oft artificially homogeneous conception of development (Treillet 2004). Rist's (2007, p.34-44) definition illustrates this monolithic conception:

'Development' is made up of a series of sometimes apparently contradictory practices, which make it necessary, in order to guarantee the social reproduction of the dominant group, to generalise the transformation and destruction of the natural environment and of social relationships, so as to ensure a growing production of merchandises (goods and services) meant, through exchange, for solvent demand.

Not only is international AIDS control not part of development according to this definition, as it satisfies a *non-solvent* demand, but the expression "apparently contradictory" points to the belief of many post-development theorists that development is an *ultimately coherent* undertaking. There is, however, no unifying, hidden coherence behind the apparent contradictions of development. No consistent master plan exists. Consequently, many post-development theorists miss the inherently ambiguous nature of their central object of study. They overlook the fact that 'development' describes different realities in

the WTO's so-called "Doha development agenda" and in international AIDS-control initiatives. The latter have even radically challenged WTO agreements concerning intellectual property rights on life-saving drugs. The following statement by Peter Piot, the former executive director of UNAIDS, illustrates the fact that, beyond being a watchword, 'development' is also a field of power within which conflicting interests clash. When he was still in office, Piot (2005, p.8-9) declared:

The African countries worst affected by AIDS would gain far more in financial resources from the cancellation of debts, from the ending of rich-world agricultural subsidies and trade barriers, and from truly affordable prices for pharmaceuticals. It is hypocrisy and worse when rich countries dole out aid while their remaining policies serve to undermine the capacity of poorer countries to respond to the pandemic. [...] In terms of an exceptional response to AIDS, rich countries will only have lived up to their responsibilities when they agree to reform the gross inequities of prevailing trade and financial rules. For too many years, billions of dollars annually have gone to servicing debt that African countries could have put to use investing in the AIDS response, education or other critical development fronts. [...] Public expenditure ceilings [...] restrict the levels of investment across all sectors needed to mount an exceptional AIDS response. [...] Let's not forget that the Marshall Plan for Europe required setting aside public expenditure ceilings! UNAIDS has emphasized the urgency of this point to the IMF and World Bank.

The practices of major international development agencies are contradictory and should be analysed as such.

While the artificially unequivocal conception of development is among the 'standard' criticisms of post-development that "have been raised again and again" (Ziai 2007, p.8), this conception has serious implications in the case of HIV/AIDS. Indeed, it allows post-development theorists to switch the locus of the debate to a more general level whenever confronted with what Comelieu (2003, p.121) calls the "dreadful human problems [they] do not even bother mentioning anymore". Indeed, few post-development authors have addressed social policies or international health initiatives allowing the single most dramatic 'development' problem in several African countries – HIV/AIDS – to remain conspicuously absent from their analyses. A notable exception is Rist (2007, p.416), who acknowledges that the fact that over 30 million people globally live with HIV "is part of the sad reality" – without, however, saying a word about the possible implications of this "sad reality" on post-development theory. Since radically challenging aid is more difficult in those domains where its end would directly affect people's survival, most post-development theorists focus on the spheres of 'development' where their argument is more at home (e.g. issues of general economic policy, rural development, big infrastructural projects, and discourse analysis).

Intellectually speaking, post-development theorists are in situation comparable to that of radical left-wing theorists facing the welfare state: the same entity (the state) is both the incarnation of centralised, illegitimate power, *and* the provider of social services that shelter individuals from purely market-driven mechanisms – a protective function valued by these very thinkers. Bourdieu (1998) referred to the "right hand" and the "left hand" of the state to describe its ambivalent nature as both a device of domination and coercion (right hand) and a provider of essential services and minimal social cohesion (left hand). Development in the sense of "what development agencies do" (M. Green 2003, p.123) has the same

fundamental ambiguity. Drawing on this distinction, international development agencies involved in AIDS control may be considered part of the left hand of development, which is composed of “those who are sent to the front line to fulfil so-called ‘social’ functions and to make up for the most intolerable inadequacies of the logic of the market, without being given the means to really fulfil their mission” (Bourdieu 1998, p.11). One hand repairs what the other one destroyed. Structural adjustment programmes have persistently impoverished African economies, causing substantial damage to the remnants of their health and other social systems. This push for neoliberal economic ‘reforms’ by the International Monetary Fund, the World Bank and the World Trade Organization has resulted in what Wade (2003) fittingly calls a “slow-motion Great Train Robbery” of low-income countries. At the same time, however, the UN launched its MDG-based ‘poverty reduction’ campaigns, the Global Fund was created to control three of the world’s major epidemics, and the US Government invested billions of dollars into PEPFAR. No doubt the economic coercion of the right hand of development causes more destruction than the left hand’s social policies or so-called ‘poverty reduction’ programmes could ever repair. The ‘alternative to development’ in many African countries, however, does not necessarily mean the end of oppression, or the emergence of an endogenously constructed welfare state or other forms of solidarity. In a sense, putting an end to aid in the social sectors would amount to closing the fire brigade with the pyromaniacs still on the loose.

To be sure, the inequalities induced by the global economic system are among the root causes of many of the world’s social and medical ills – including HIV/AIDS (see Part 1). The industrialised countries’ ‘fight’ against the epidemic obviously contributes to legitimising their broader ‘development’ endeavour. In this sense, Western governments’ HIV/AIDS initiatives are not completely alien to a sale of indulgences. Nevertheless, international AIDS-control efforts are not solely about the West’s attempt to improve its political image. HIV/AIDS is a partially autonomous sub-field of development, with its own rules, rationales, and practices. Its protagonists are not merely the unconscious or uncritical vassals of Western imperialism. Their strikingly self-critical discourses are omitted by post-development theorists’ (otherwise forceful) analyses of development discourse (e.g. Rist 2002b). The next section argues that, far from being monolithic institutions, development agencies are highly heterogeneous entities. It is important to take this plurality into account in the analysis of development – not in order to claim ‘mitigating circumstances’ for its protagonists but to grasp fully its complexity and ambiguity.

A-3) Development agents as radical critics

“When I started, I really didn’t want to work on AIDS. I mean, there are so many disgusting things going on in the AIDS business... I didn’t want to be associated with that.”
(Multilateral-12)

No doubt, credulous development officials exist. But rare are those among the donor agents in the field of HIV/AIDS who uncritically consider international aid and their own action as vectors of genuine

progress for Tanzania. While criticism from NGO players is less surprising, it is striking that many bi- and multilateral donor agents in Tanzania spontaneously voice far-reaching criticism of their own agencies' actions. Far from being isolated statements uttered by 'infiltrated revolutionaries', this radical critique illustrates the ability and willingness of many development agents to reflect critically on their activity in ways completely at odds with their agencies' official discourse. In a discussion about the anti-democratic implications of aid, one bilateral agent, for instance, suggests:

The fundamental question we should ask ourselves is: to what extent can a well-meaning society [i.e. a Western donor country] get away with undermining the internal priority-setting process of a country such as Tanzania by placing enormous amounts of money at its disposal? (Bilateral-17)

Another interviewee denounces the dependency induced by aid and the donor agencies' fundamental hypocrisy. Although they have a precise idea of which activities they want to fund, this bilateral agent explains, they uphold the principle of 'country ownership' to insinuate that African governments are free *not* to accept their offer:

Honestly, which country would *not* go for the money that's out there? Nobody will say: 'No, thank you very much for proposing, but given our priorities we won't apply for what you propose...' That's ridiculous! (Bilateral-14)

Similarly, PEPFAR, which represents roughly two-thirds of AIDS expenditure in Tanzania and grants funding on a five-year basis for irreversible ART roll-out, is regularly described as an imperialist endeavour, even by donor agents themselves. Pointing to the dependency induced by PEPFAR, a bilateral agent stresses: "I told [the executive chairman of TACAIDS]: 'Think carefully about what you are doing, before signing *anything* with them!'" (Bilateral-31). An even more critical multilateral agent exclaims: "*Never* would I have signed such an agreement!" (Multilateral-12). Another multilateral agent more explicitly expresses what the other two interviewees refer to:

I think it was a strategic mistake to rely so heavily on the Global Fund to ensure the procurement of drugs. It's not a sufficiently guaranteed source of funding in the long run...foreign aid can stop at any moment! Even with the Global Fund, a different pandemic...say SARS...would be enough, and the Global Fund money would be shifted to another pathology. To a certain extent, it's not a problem to use the Global Fund for drug procurement...say, if the Government of Tanzania treated 100,000 people and the Global Fund 50,000, that would be alright...but building the treatment programme *to that extent* on the Global Fund alone is very problematic! In Round 8, they ask for something like 300 million dollars just for purchasing ARVs! And PEPFAR funding is even *more* dangerous! The day they'll change their minds..." (Multilateral-6)

Addressing the dependency effect of treatment roll-out in the absence of strong prevention programmes, one multilateral agent even openly considers conspiracy:

We have to ask ourselves 'What is the interest to put people on chronic treatment without ensuring that prevention is sufficiently tackled?'. If you really think about it...I don't think these conspiracy theories are that farfetched. Even the Global Fund is not really stressing that prevention should be the number one priority. Maybe somebody is trying to drastically reduce the population of Africa? [...] So my question is: What's the *real* agenda?! [...] Say, for example, with ongoing ART roll-out, a country reaches an HIV prevalence of 40%. And you combine that with a lousy condom programme...and then, suddenly the imports of ARVs stop! There is no production of ARVs in Africa, and no condom producer either... China could cut the condoms and India could cut the drugs! [...] They are moving quickly to 'universal access' and all prevention programmes are neglected because of the push for ART roll-out. So we might be moving

towards a situation where there is a huge reservoir of viruses, with a sudden stop of ART and condom distribution. That's a holocaust, a genocide! And I don't think it is stupidity...it's deliberately designed! China just offered 500 million dollars worth of computer equipment for Tanzanian schools...to be installed by Chinese engineers. They even offered to install all the computers for the government system. That's a politically sensitive issue! They will control the infrastructure. And the Tanzanian government sells out the country... (Multilateral-13)

This statement was uttered before the preventive effect of ART was epidemiologically confirmed – which did, of course, somewhat change the argument in favour of treatment. Nevertheless, this statement not only reflects the acuteness of dependency, it also illustrates that several donor agents themselves are entirely aware of the fact that their agencies' activity is part of a political power play that by far exceeds the mere 'saving of lives'. Some donors' self-critique goes as far as to question their own *raison d'être* radically. Following a discussion about the contradictions of 'development cooperation' in the field of health, one bilateral agent with long-standing experience in Tanzania concludes after a brief moment of introspection: "Sometimes I believe that the best way to help Tanzanians would be to simply pack our stuff and get out of here..." (Bilateral-9).

In sum, many AIDS players are deeply aware of the limitations of their own actions. Although some of them are among the first to agree with the failure of development underlined by post-development theorists, they nevertheless stay where they are and continue to do their jobs. Even the most vocal critics of vertical AIDS control among the interviewees (most of whom are proponents of a comprehensive primary health care approach) continue to implement the very system they strongly criticise. Although they have an often fundamentally different vision of health action from that of the designers of vertical AIDS-control programmes, they try to make their way through the contradictions of the system in which they work and to use the little leeway they have to make a positive difference. No doubt, these people make a good living out of development. Yet, not all of them are cynics. Many are driven by strong convictions and a genuine commitment to social justice and emancipation. Indeed, the sometimes radically critical stance of many donor agents could be due to the fact that they have found their way into development agencies via a past activity as AIDS or social justice activists. They believe that it is probably a bad idea to stay, but they are convinced that leaving would be worse. The consequences of an end of aid for AIDS control make this position understandable.

A-4) Taking the proponents of an end of aid at their word?

"In theory, theory and practice are the same. In practice, they are not."

Saying attributed to Lawrence Peter Berra

A main concern of people living with HIV is not primarily to "survive development", as Latouche (2004) puts it, but to survive at all. Since it illustrates the potential effects of an end of aid in a particularly dramatic manner, HIV/AIDS raises the question to what extent the radical critics' call for putting an end to aid could actually be put into practice. As a multilateral agent underlines, "We succeeded [...] in

making [Western governments] understand that, if we don't treat, it is going to be catastrophic! It was more direct, more frightening..." (Multilateral-6). Unlike general issues of economic development, public inaction cannot possibly be accepted as an ethically tolerable alternative concerning HIV/AIDS. The victims of public inaction are, at least in part, known in advance and one could individually list those who were to die were international support for antiretroviral treatment to cease. One could put names to numbers and faces to names.

To what extent could one uphold a radical critique of aid if its conclusions are not applicable to HIV/AIDS, an empirical example of aid that is neither anecdotal nor essentially different from other domains of 'development cooperation'? Indeed, although it exacerbates contradictions by making them immediately apparent, the fact that the victims of inaction are 'identifiable' in the case of HIV/AIDS does not fundamentally change the underlying ethical argument (McKie & J. Richardson 2003). AIDS is thus not the only domain where 'leaving the poor alone' is ethically questionable: a long list of equally urgent health or nutrition issues could easily be established. Consequently, what can radical theory contribute to critical thought if the consequences of its application to real-life situations seem unbearable? Serving as a catalytic illustration of the complexities of aid, HIV/AIDS reveals a blind-spot in those theories that wish to do away with aid completely. On the one hand, the top-down design and the problematic side effects of the international AIDS response in terms of dependency, democratic accountability, and the medicalisation of poverty provide some empirical confirmation of central arguments of post-development. On the other hand, the development agents' self-critical analysis casts into doubt post-development thinkers' frequently monolithic vision of development, while the predictably catastrophic consequences of an end to international support for AIDS control pose a serious challenge to the post-development call to 'end aid'.

The following section argues that this blind-spot of post-development is due to the fact that its theorists situate their critique in a long-term perspective, which at least partially intentionally turns a blind eye to immediate operational concerns.

A-5) The refusal of urgency and the politics of permanent crisis

"[Aid is] crucial, if you have HIV and are fighting for your life. [...] But not the old, dumb, only-game-in-town aid — smart aid that aims to put itself out of business in a generation or two. 'Make aid history' is the objective. It always was. Because when we end aid, it'll mean that extreme poverty is history. But until that glorious day, smart aid can be a reforming tool [...]"
(Bono 2010)

This justification of aid by one of its most famous proponents illustrates the reasoning to which post-development theorists radically object. Since aid has not even come close to achieving its stated objectives over the last 60 years, they argue, hoping that "smart aid" will contribute to making both poverty and aid history is either incredibly naïve or a political sham. Even vague knowledge of the basic findings of the sociology of organisations is sufficient to allow one to understand that 'aid putting itself

out of business' will undoubtedly remain a vain hope. More fundamentally, by refusing the eternal priority of the 'urgent' (here: the imperative to ensure survival), post-development theories place the debate on aid in a long-term perspective. Indeed, much of the pro-aid argument draws on a short-term analysis. By asking what would happen were aid to be stopped overnight, this reasoning implicitly compares the situation 'before' to that 'directly after' a hypothetical end of aid. As a result, the 'after' scene is characterised by the lack of what is no longer there: the services the aid money paid for. This reasoning abstracts from the long-term negative effects of aid on recipient countries' socio-economic organisation, and political incentive structures.

Post-development theorists, in turn, stipulate that far from being a potential "reform tool", aid perpetuates patronising power relations and is thus an *obstacle* to change. Their long-term thinking takes into account the positive changes that dependency relations prevent from happening, such as transformations in democratic accountability and their repercussions on practices of citizenship. This ambition of long-term thinking of post-development theorists makes it all the more paradoxical that they tend to omit that significant social and political change is never instantaneous. Flouting the necessarily progressive nature of change, post-development theorists elide the inescapable period of transition between the 'development' they denounce and the 'end of development' for which they call. Thereby, they deliberately exclude time from their reasoning. While the followers of "smart aid" run the risk of getting stuck in what they erroneously believe to be a transition period, many post-development thinkers refuse to even consider its existence.

That being said, giving precedence to a reflection on 'life according to the good' – or *buen vivir*, as many post-development thinkers say – over the conservation of "bare life" (Agamben 1998) is a necessary condition for genuine critical analysis of HIV/AIDS among other issues. Indeed, global AIDS institutions generally frame their activity as an apolitical humanitarian intervention in an emergency context. As discussed throughout this work, many of the fundamentally political choices involved in HIV-prevention and -treatment policies are presented as resulting from rational compromises based on epidemiological and biomedical evidence. Reducing their role to the mere 'saving of lives' shields the protagonists of humanitarian government from critique levelled against development as a broader political project by transferring their activity from a political into either a technical or a moral framework of reference (Schmitt 1932b; Mouffe 1993; Fassin 2010). To refrain from saving lives immediately at risk, the argument goes, would amount to committing homicide by omission or outright manslaughter. "Those who are on drugs have to stay on drugs", says a multilateral agent, "it would be a *crime* not to grant them access!" (Multilateral-16).

The failure of HIV prevention efforts in sub-Saharan Africa and the increasingly chronic nature of HIV infection (thanks to ART) have progressively transformed the 'emergency response' into the normal state of affairs. Having instituted the "humanitarian exception as the rule" – an expression Fassin and

Vasquez (2005) use in a similar context – the international AIDS response is comparable to what Agamben (2005, p.2) calls a “voluntary creation of a permanent state of emergency”. Declaring such a state of exception is a fundamentally political operation in that it suspends the requirement of public accountability (Schmitt 1932b).⁴⁸⁹ On the intellectual terrain, the framing of AIDS as a humanitarian emergency, and *nothing but* a humanitarian emergency, has a comparable depoliticising effect in that it becomes difficult, if not impossible, to formulate a radical critique of ‘life rescue activities’. Importantly, although the reduction of politics to survival could be interpreted as the death of politics (i.e. the acceptance of the subordination of all non immediately ‘life-saving’ concerns to the preservation of *bare life*), the dominant humanitarian discourse simply leads to the depoliticisation of what are – and remain – fundamentally political decisions. It creates “another type of politics, even while being labelled *apolitical*” (Ticktin 2006, p.35).

It is thus the refusal to accept ‘humanitarian emergency’ as their main framework of analysis that allows post-development theorists to ask questions about the finality of life, and hence about individual autonomy and political self-determination. This ‘re-politicising’ refusal allows going beyond the logic of “suffering bodies and biological life devoid of social and political content” (Ticktin 2006, p.35), and to explore the “politics that links a not-so-bare life to a more robust practice of citizenship” (Comaroff 2007, p.215).

A-6) Radical critique and the imperative for action

“In the long run, and all other things being equal, foreign assistance dependence, like drug addiction, destroys rather than enhances the institutional capacities of the users, paralyses national initiatives [...] and erodes the very basis of national sovereignty.”
(Rugumamu 1997, p.200)

“[The] long run is a misleading guide to current affairs. In the long run we are all dead. Economists set themselves too easy, too useless a task if in tempestuous seasons they can only tell us that when the storm is long past the ocean is flat again.”
Keynes 1923, p.80)

“[T]o read post-development theory as advocating indifference or inaction is to read it uncharitably”, claims Matthews (2006, p.52). To a certain extent, it surely is: not saying what to do is not the same as saying one should not do anything. While many post-development authors, for instance, rightly point to agro-ecological practices as ‘alternatives to development’ in the agricultural sector, none of them proposes a comparably credible ‘alternative to development’ in the field of HIV/AIDS. “The call for practical solutions”, responds Nustad (2007, p.44) to this reasoning, “rests on the assumption that the apparatus now in place has the capacity for delivering a solution, and there are important reasons for doubting that premise”. Nevertheless, a paradox of post-development is that, while it (quite understandably) refuses to draw yet another blueprint for a better society, the radicalism of its position

⁴⁸⁹ As Schmitt describes, the decision of which case is exceptional (and which one is not) is a core feature of sovereignty.

is resolutely incompatible with incremental change. No doubt, given the role of demographic concentration, mobility, and modern unsafe medical practices in its spread, HIV would probably never have reached epidemic proportions in an entirely pre-industrial and pre-colonial Africa (Iliffe 2006; Pepin 2011). Yet, for an end of aid for AIDS control in Africa to be ethically acceptable, post-development would have to be instantaneously and *retroactively* put into practice on a global scale. Both imperialism and industrialisation would have to be abolished overnight along with their historical legacies.

Beyond this purely intellectual reasoning, the question AIDS players could ask post-development theorists is: 'Given the present state of affairs, what alternative strategies should we adopt?'. Putting post-development to such a 'reality test' is admittedly somewhat unfair as it confronts theories of generalised change with a demand for sector-specific solutions that could be implemented in the world *as it is*. It asks these theories to provide answers in an all-other-things-being-equal setting, although their fundamental claim is that all these 'other things' have to change drastically. While this leads to an implicit all-or-nothing approach that renders them rather inoperative with respect to HIV/AIDS, being operational is not their pretension (Rist 2007, p.445). Is asking post-development to be operational therefore a pointless endeavour? Post-development is mainly a critique of ideology (Ziai 2006) and, as such, it has revealed the erroneous premises and the impasse of 'development' as an ideology of progress based, among other things, on the devastating illusion of unlimited economic growth and the absurd belief in its desirability. It has made genuine and highly welcome contributions to critical thought and, paradoxically, to development practice. Therefore, Nustad (2007, p.35) argues that "the lack of instrumentality is not a weighty argument against the analysis itself". Consequently, the critique of development *as it is* can and should be distinguished from the call for alternatives. This reasoning raises several questions about the nature and role of critical theory. Is it intellectually satisfying to dissociate radical critique from what could be called an 'imperative for action' and the ensuing consciousness of necessarily incremental, reformist solutions? The fact that development practitioners can themselves be highly critical of their own action points to the lack of a clear-cut division of labour between 'critical' theorists and 'pragmatic' practitioners. It also suggests that critical development theorists, too, should have to grapple, at least intellectually, with the everyday reality of development practitioners and their 'beneficiaries' – in this instance, people living with HIV.

In any case, in a situation where inaction leads to extremely high mortality in the short run, the long run is "a misleading guide to current affairs", as Keynes puts it. Policymakers are constrained to formulate sub-revolutionary strategies that attempt to reconcile the diverging timescales of what 'is' and what 'should be'. For this task, post-development as a state of mind characterised by the awareness that "those engaged in [popular] struggles may want different things from us than what we are most keen to offer" (Matthews 2007, p.135) might provide some inspiration. The post-development claim for radical democracy can lead policymakers to counterbalance the authoritarian traditions of public health, and post-development theorists' critical analyses of health, illness, and Western medicine are of relevance to

AIDS control. Yet, it is doubtful that any of these changes would include doing away with international support, let alone with Western medical technology in the foreseeable future. However unsatisfactory the solutions proposed by modern medicine, the latter is an indispensable part of the answer to this inherently modern epidemic. The alternatives would thus, in a sense, be strategies for alternative development, rather than ‘alternatives to development’. Given the scale and scope of a real-life problem such as HIV/AIDS, the contribution of post-development thought will certainly – and in some cases hopefully – fall short of the stated ambitions of its more radical proponents.

As discussed, only a relativist posture grounded in radical constructivism allows one to dismiss any ethical ‘imperative for action’ concerning the African HIV epidemics. As soon as one analyses them using a moderately constructivist perspective, the ‘post’ in post-development becomes elusive. As Ziai (2004, chap. 4) notes, there is a thin line between reactionary and progressive thought within post-development theory. While the exclusive focus on ensuring survival is in fact a thought-crippling framework (a *‘reductio ad vitam’* shields against virtually all critique), genuine emancipatory theory requires a reflection upon the conditions of possibility of radical critique in a context where ‘bare life’ is massively and immediately at stake. Radical critique is vital. Yet, for it to be relevant, it must grapple with, rather than shy away from, the contradictions and tensions that arise from the confrontation with inescapable empirical problems.

B) The (re)politicisation of AIDS control as a key to its reappropriation

“The shift will come. It will come because care and treatment programmes will come to a point where they’ll be so huge! They’ll absorb the entire budget of the ministries of health. [...] So the change will come, but it will be pushed by the impossibility of what we are doing on treatment right now. Already today, ART is taking up half of the MoH’s budget. That’s terrible in a country where people are dying because of diarrhoea, or of a lack of Chloroquine, which only costs one dollar...in a country where people are dying of other diseases, which would be very cheap to treat or to control. But these are not addressed! So we don’t spend that money on care and treatment because we have it to spend, but because *that’s what the donors want to spend it on!* So much for the phase people call the ‘international success of early treatment roll-out’...”
(GovSector-12)

These concluding remarks by a Tanzanian AIDS official point to – and call for – a double shift, towards a renewed emphasis on HIV prevention and towards a more general rebalancing of the country’s health policies. Although the second aspect has slowly started to evolve since, the perspective of genuinely ‘Tanzania-owned’ AIDS-control policies formulated according to collectively expressed health needs still remains a distant mirage. This research has explored various aspects of the political economy of AIDS control in Tanzania. In trying to understand ‘why things happen the way they do’⁴⁹⁰, it has described various political obstacles to change that can help explain why many things do *not* happen the way they probably *should*. So, I will endeavour to avoid proposing yet another politically naïve blueprint for change. Critical thought nourishes political struggles that prompt change by drawing attention to

⁴⁹⁰ Cf. (Hydén 2005)

injustices or pointing to less analysed aspects of the power relations that underlie our everyday practices. Given both the relative inertia of social relations in general, and the specific path dependence that results from ART roll-out, this change is necessarily *progressive*. Although the awareness of the obstacles to change should not be an excuse for maintaining the status quo, the formulation of alternative paths must take into account today's situation and thus the path dependence it entails.

In this sense, the radical critique of aid and the critique of downstream public health action share similar difficulties. Indeed, the post-development critique has a series of commonalities with the calls for radically upstream-oriented health policies. As discussed with respect to the radical critique of aid, while focusing upstream is indispensable, focusing *too far* upstream can lead to political irrelevance.⁴⁹¹ This practical dilemma is at the very heart of public health research (and practice). On the one hand, any political economy of health should shed light on the socio-economic and political structures that cause disease, and warn against the inefficiencies and depoliticising effects arising from excessively narrow (over-medicalised) responses to health problems of which the underlying causalities are considerably broader. On the other hand, a more politicised approach focusing predominantly on the social determinants of health and disease can have a demobilising effect, if interpreted as meaning that 'you cannot do anything until you do everything'. One merit of the debate about "public health nihilism" (Fairchild & G. M. Oppenheimer 1998) is that it explicitly poses the question of the adequate level of health action. This question is also what one bilateral agent points to when commenting on the fact that the overall living conditions determine a population's susceptibility to HIV: "That is not an HIV-specific problem, it also concerns non-communicable diseases...and this problem is, *a priori*, not solvable from inside the health sector. But I'm in charge of health-sector issues!" (Bilateral-17). Gish rightly notes that taking into account the broader causalities of health and disease "means a departure from the accepted engineering and technological approach to health development, and inclusion of decision making in the health sector as part of the explicit subject matter of political economy" (1975, p.202) – an argument developed below.⁴⁹² Nevertheless, as Stillwaggon (2006) shows, effective health interventions *can* make a significant contribution to reducing African populations' susceptibility to (HIV) infection.⁴⁹³ While the health sector cannot ensure people's livelihoods or fundamentally change political and economic power relations, it could organise health-service delivery according to people's needs – which would be a good start. That being said, existing power relations obviously shape the design and content of the health service delivery.

⁴⁹¹ In a statement made to the *Société Neurochirurgicale du Québec* in 1936, Dr. Béthune, for instance, underlined that "[t]he easiest way to adequately protect people's health would be to replace the economic system that produces illness, to eliminate ignorance, unemployment and poverty" (in: Thébaud-Mony 1980, p.1). This statement, which echoes the critiques voiced by post-development authors, is as good a definition as any of radical upstream health analysis.

⁴⁹² For an interesting discussion of the determinants of health and the consequences for the appropriate level of health action, see (Gish 1975, p.202-4).

⁴⁹³ Commenting on what she calls "the argument between changing only the socioeconomic context or only the curative inputs", Stillwaggon writes in the introduction to her book that underlines the fundamental importance of the 'socioeconomic context' for the African AIDS epidemics: "[T]his book promotes a comprehensive approach to public health. But I would not squander all the wonderful, life-saving innovations that we in this era are privileged to enjoy and wait for economic change to bring about good health for the people" (2006, p.17).

Be it concerning the effects of aid or concerning the socio-economic determinants of health, it is thus possible – and necessary – both to point to the contradictions of the current situation and advocate fundamental changes, *as well as* to contribute to the formulation of what could be termed ‘sub-revolutionary’ pathways for change. Although the awareness of the contradictions at play certainly puts a break on over-enthusiastic reform proposals, it can also nourish policy change. McKinlay’s analysis that the most significant changes concerning the health of the people are to be expected “from the continued politicization of illness” (1974, p.528)⁴⁹⁴ is fundamental in this respect. Indeed, the analyses proposed throughout this work suggest that positive change in the field of AIDS-control will emerge not primarily thanks to enlightened despotism, but through public controversies and political struggles that draw on a repoliticised perception of African AIDS epidemics and AIDS-control policies. In this perspective, this section successively argues that taking the measure of the expropriations of health induced by international AIDS-control initiatives is a condition of possibility for a reappropriation of health, and that only a repoliticised conception of AIDS control allows one to envision pathways for progressive change via increased accountability and responsibility.

B-1) Looking the gift horse in the mouth: taking the measure of the expropriation of health

“The general approach to health care has been sacrificed on the altar of AIDS control.”
(Bilateral-30)

This statement, uttered as a conclusive thought by an interviewee with a longstanding experience in health and AIDS control in Africa, underlines the extent to which Tanzania has been expropriated of its health policy decisions. It points to two related consequences of the international AIDS response in many African countries: the partially irreducible contradiction between vertical disease control and comprehensive primary health care, and the heteronomous nature of health policymaking in general. Concerning the first aspect, Navario (2009) summarises a widely shared conclusion of the (still ongoing) debate over the relation between vertical disease control and a primary health care as follows:

It is overly simplistic and counterproductive [...] to frame the discussion as disease-specific programs or health system investment, positioning each as mutually exclusive approaches to global health development. This is a false choice. [...] The debate must evolve into a discussion about how best to achieve health system strengthening in the near term *with* HIV dollars in the context of these large funding initiatives.

Although the relative balance between HIV and health has been changing in favour of health over the very recent years, the structure of international health funding still remains HIV-centred. In this context, it is both possible and fundamentally desirable, as Navario and many others suggest, to integrate HIV services within PHC facilities and to invest the AIDS dollars in domains where broader systemic benefits can be expected. As discussed, vertical AIDS initiatives are starting to evolve in this sense. Nevertheless, the tensions described in Chapter 7 show that a partial ‘horizontalisation’ of vertical programmes does

⁴⁹⁴ See also Chapter 2.

not resolve the contradiction between what are ultimately two incompatible approaches to public health. It is, of course, possible and desirable, in today's context of multiple vertical initiatives, to increase the coherence of health planning. Yet, both the content (i.e. the focus on a single pathology exogenously defined as *the* major health problem to be 'solved') and the funding design (e.g. entirely off-budget for PEPFAR; haphazard for the Global Fund) of the bulk of the international AIDS response ultimately render impossible the formulation of a coherent national health policy in Tanzania.

Natrass and Gonsalves (2009, p.4) argue that "if one takes into account the way in which the fight against AIDS has broadened beyond health interventions targeted at HIV, the AIDS response looks less like 'the biggest vertical programme in history', and more like the biggest horizontal programme in history". The previous two chapters suggest that this claim is very remote from the realities of AIDS and health policymaking in Tanzania. Indeed, even the more prudent claim that vertical AIDS-control programmes and a comprehensive approach to primary health care are, although not perfectly congruent, at least *ultimately compatible* is analytically insufficient. This claim is understandable in that it results from a political compromise: considering that the money that vertical AIDS initiatives leveraged would not have been – and might not continue to be – available outside a vertical framework of action, even critical players 'pragmatically' avoid looking the gift horse in the mouth and thereby run the risk of upsetting the 'generous' donors. That being said, the 'compatibility claim' is implicitly based on a technocratic understanding of health action. This understanding is grounded in a purely technical definition of health (as the absence of disease) and the ensuing conviction that health needs can be technically (and thus exogenously) determined – a perception that abstracts from the inherently political nature of health and health policies (cf. Gish 1979; 1982b; Thébaud-Mony 1980, chap.I□III, X; Rifkin & Walt 1986; Lawn et al. 2008).⁴⁹⁵

This is precisely what one bilateral agent points to when underlining: "The primary health care approach is a political approach! Most development cooperation people conceive it far too much in a technical manner" (Bilateral-30). Far from meaning 'everything for everybody', a comprehensive PHC approach is deeply political because it requires the type of prioritisation that involves the decision *not* to provide certain services.⁴⁹⁶ Involving the provision of curative and preventive services, as well as the collective improvement of people's living conditions, primary health care is both a redistributive and an *intrinsically* participatory approach to health (Annys et. al 1985). At the TANU (Tanganyika African National Union) Conference in 1973, President Nyerere himself underlined the fundamental choice that

⁴⁹⁵ Gish (1984, p.338), for instance, underlines that the various areas of study within public health "have tended to become a set of narrowly technocratic and highly bureaucratized arrangements, often more concerned with 'Public Health' institutions *per se* than what would more generically be termed the 'health of the public'. Public health, in its conventional forms, has been virtually gutted of its social and political content to the serious detriment of its theory, study and practice."

⁴⁹⁶ One of the most frequently quoted examples of a non-priority service in low-income countries is heart surgery – a very costly and highly technical intervention. Similarly, in vitro fertilisation (IVF) is obviously a non-priority service in countries where untreated STIs are the main cause of infertility. In general, pursuing primary health care as a political priority involves renouncing costly (often hospital-based) interventions to the benefit of interventions that are cheaper, more cost-effective, less technical, and can thus be made more widely available.

underlies a primary health care approach by stating: “We must [...] not again be tempted by offers of a big new hospital, with all the running costs involved – at least until every one of our citizens has basic medical services readily available to him” (quoted in: Gish 1975, p.1). The choices involved in health policymaking are, in part, mutually exclusive.

With respect to HIV-related policies, and as discussed in the previous chapters, the ‘compatibility’ discourse abstracts from the fact that vertical AIDS-control programmes involve a variety of irreducibly political decisions such as the priority given to HIV/AIDS over other health issues, the relative focus on treatment as compared to prevention, the trade-offs *within* both treatment and prevention policies, or the multisectoral or health-sector based design of the institutional response. While all these choices can be subject to legitimate debate, they inescapably involve *political* decisions – i.e. compromises over irreducibly conflicting interests and values.⁴⁹⁷ Again, the ‘compatibility’ discourse fuels the illusion of conflict-free health policymaking, which leads to the depoliticisation of these decisions.

Let us take one example: that of the balance between HIV/AIDS and other health issues. International AIDS control has introduced what Nguyen describes as a more general form of triage: “Mass HIV interventions have taken triage to a whole new level”, he writes, “as they select out people with HIV for lifesaving treatment while others who also face illness and even death from non-HIV diseases are left behind” (2010, p.181–2). As discussed, this broader triage manifests itself in the sometimes dramatic individualised violence that can result from the sequencing of social reality by decontextualised health action, but also in more subtle asymmetries between different health players according to their success in the “coupling” (Kingdon 1984) of ‘their’ health issue with HIV-related interventions (see Chapter 7). This prioritisation of different health needs is a fundamental component of the exercise of biopolitical sovereignty. If, as in Tanzania, this broader triage results from a highly heteronomous political process, this constitutes a manifest “expropriation of health” – to use Illich’s (1976) expression in a collective sense. While several hundred thousand individual ‘lives’ are ‘saved’⁴⁹⁸, the Tanzanian people are collectively expropriated of the command over their health policies. Similarly, every one of the depoliticisation processes described throughout this work result in a comparable expropriation of crucial political decision about people’s health.

The tension between focusing on ‘sound epidemiology’ (which favours a centralised, top-down system of knowledge ‘diffusion’) and health democracy is co-constitutive of public health action. In many ways,

⁴⁹⁷ In this sense, the fact that the African AIDS epidemics did urgently require a particularly sustained response, for instance, is not particularly difficult to show. That being said, it is possible to argue, as several interviewees do, that a primary health care approach would have been more appropriate than a vertical response based on parallel institutions. Indeed, PHC obviously does not mean that one should *not* adapt national priorities in response to an epidemic of overwhelming proportions. However, the way these responses are identified and implemented is considerably different in a comprehensive approach, as compared to a vertical one.

⁴⁹⁸ The dehumanising effect of the public health rhetoric that reasons in terms of the ‘number of lives saved’ was criticised by Illich, who underlined that “[c]onceiving living beings as immune systems provides the pseudo-legitimation of reducing a human being to ‘a life’ upon which ethics committees can pass judgments. In a world made up of systems, the immune system replaces what was formerly called an individual or a person” (1976, p.xi).

the history of international AIDS control is one of the identification and standardisation of specific techniques ('ABC', PMTCT, VCT, male circumcision, etc.) and their strong (and often aggressive) promotion in sub-Saharan countries.⁴⁹⁹ The legitimacy of this vertical response implicitly draws on a conception of health as the mere absence of disease – which could be brought about by specific interventions, generally using medical technology (Rifkin & Walt 1986). The selection of these interventions being conceived as a technical process based on the sole criteria of effectiveness (and sometimes cost-effectiveness), the heteronomous nature of the international response and the closed-shop policymaking to which it gives rise in Tanzania do not diminish its political legitimacy. The legitimacy of the heteronomy of the international AIDS response thus crucially depends on the conception of health and health needs to which one refers. If one adopts Illich's (1976) definition of health as the "ability to cope", the issue of individual and collective autonomy takes centre stage in any discussion about health. If autonomy is considered as a co-constitutive element of health itself, the question of health interventions' 'efficiency' can no longer be disconnected from a *necessarily endogenous* definition of health needs (e.g. Thébaud-Mony 1980, chap.V-VII).

These considerations suggest that it is insufficient to dismiss the debate over vertical programming by saying, as Whiteside (2009, p.3) does, that "[t]he issues of vertical versus horizontal programmes for AIDS treatment are vexing", and that "[t]he hard questions we need to ask are: why we do not give more priority to prevention?; what is the cost of treatment and how it will be maintained?; and how should issues of sustainability and national sovereignty be considered?". Whiteside is absolutely right about the "hard questions" he raises. They do need to be answered and this work modestly contributes to the debates concerning the lack of focus on (structural) prevention and the question of sovereignty. Nevertheless, the issue of vertical programming and the "hard questions" Whiteside raises are *fundamentally related* and must not be analysed separately. The vertical mode of action is not only part of the explanation for the continued neglect of HIV prevention as compared to treatment, but it results from – and provides continued legitimisation for – the heteronomous definition of African countries' health priorities. The coexistence of the vertical design and the heteronomous nature of AIDS-control in Tanzania is not mere coincidence. Beyond the justifications discussed in the introduction to Part 3⁵⁰⁰, the vertical international response also results from a technocratic definition of both people's health needs and the issue-specific 'solutions' – a mode of action that considerably limits the need for (and legitimacy of) political participation, both at the national and the local levels. However, as the authors of the Antwerp Manifesto for Primary Health Care underline, "[s]ince health is only one of the concerns of people, it is self-defeating not to consider them as partners who are able to play a great part in the protection and the improvement of their own health". They add: "the selective approach [i.e. vertical

⁴⁹⁹ These characteristics are, in many ways, the essence of vertical health action (Rifkin & Walt 1986, p.563-4).

⁵⁰⁰ These include 'accountability' issues, the lacking 'absorptive capacity' of African health systems, and the nature of global agenda-setting processes.

programming] rules out the possibility of people's participation in decision making about their own health" (Annys et. al 1985).⁵⁰¹

There are acceptable arguments in favour of vertically designed AIDS initiatives in high prevalence settings, and the international response to HIV/AIDS in Tanzania has obviously allowed considerable achievements. Nevertheless, the widespread 'compatibility' discourse obscures the at least partially irreducible contradiction between vertical AIDS control and comprehensive primary health care – and thus the fundamentally political character of the choices involved. Far from being a condemnation of the past initiative or from providing a blueprint for future action, the acknowledgement of the contradictory nature of the two approaches to public health is a necessary first step in the collective formulation of the inescapable compromises their articulation involves. In other words, if (political) autonomy is considered both as an intrinsic value and as a co-constitutive element of health, it becomes impossible to dissociate entirely the question of the appropriateness of HIV-prevention and -treatment strategies from the question of *who* makes these choices and *how*.

As discussed, there are no simple solutions: the question is not whether one should put an end to aid or not. Rather, starting from today's situation in Tanzania, what are the necessarily complicated political pathways to an evolution of practices that could result in a progressive reappropriation of health and AIDS-control policies by the Tanzanian people?

B-2) From dependency to responsibility?

“As long as the Tanzanian authorities are unable to say ‘no’ when a donor comes up with his project and with the dollars in his hands, there will be no coherent health policy in this country.”
(Bilateral-7).

This bilateral agent's conclusive statement strikingly echoes that uttered by President Nyerere 35 years earlier (see above). The previous chapters have shown how true this statement really is. Yet, the fact that saying 'no' to international assistance in the form of vertical AIDS initiatives continues to be virtually impossible for the Tanzanian government suggests that the foreseeable future of AIDS control in Tanzania will continue to involve a significant presence of international donors. The medium-term goal towards which to strive is thus not the withdrawal of international aid, but a change in the practices of 'cooperation'. The recent decline in international AIDS funding, the serious difficulties in the replenishment of the Global Fund, and the meagre global economic prospects for the years to come indicate that HIV/AIDS is slowly but surely reaching the end of its "issue attention cycle" (A. Downs

⁵⁰¹ Because it is based on a heteronomous, technocratic definition of people's 'needs', the authors of the Manifesto argue, 'selective' PHC is not a variant of comprehensive primary health care, but its negation. A more recent, and more detailed, argument in favour of the democratisation of health services can be found in de Paepe et al. (2007, p.279), who underline: "Successful disease control requires integration with curative care, and both require accountable, responsive, and decently financed publicly-oriented services. These objectives can only be achieved through an attempt to make them more democratic and responsive [...]. Community participation in health services is badly needed [for public health services] to acquire the characteristics of a public interest organization".

1972). Beyond the funding decline it provokes, the ongoing 'normalisation' (or *de-exceptionalisation*) of the epidemic⁵⁰² might also be an opportunity. Indeed, once the self-proclaimed 'state of exception' of international AIDS control is over, the suspension of political accountability it manifestly entailed loses its ideological foundation. Now that the 'emergency response' is starting to enter into 'transition', it is time to hold its principal protagonists accountable, i.e. to require them to be responsible.

The multiple meanings of the word 'responsibility' are helpful in this respect. The principal AIDS donors are 'responsible' both in the sense that they 'have control and authority over' the Tanzanian AIDS response, and in the sense that they are 'liable to be called on to answer'⁵⁰³. It is telling that the multilateral agent quoted above qualifies the possible interruption of antiretroviral therapy due to insufficient funding as a "crime". Indeed, those Western governments that have pushed for and funded the enrolment of over 250,000 Tanzanians in ART programmes have the responsibility to ensure that these patients continue to receive treatment. This responsibility is very present in the minds of the in-country donor agents, including – and maybe particularly – of those who work for US agencies. On the Tanzanian side, the requirement of 'responsibility' refers to the Government's (and ultimately the people's) "ability or authority to act or decide on [it's] own, without supervision"⁵⁰⁴. That being said, breaking today's impasse is not the sole responsibility of the Tanzanian government. It requires all players to construct a transition towards a more comprehensive, integrated response to health (including HIV/AIDS) in Tanzania. Many of the analyses proposed throughout this thesis suggest that this is much easier said than done. Nevertheless, the accumulation of contradictions to which the international AIDS response gave rise in Tanzania paradoxically sparks modest hopes for change.⁵⁰⁵

In this sense, the partial autonomy of the AIDS policy field – although it is obviously part of the problem – might facilitate the emergence of different practices of cooperation between Western donors and the Tanzanian Government. The immediacy of dependency in this policy field, as well as the particularly visible long-term implications of the commitment of international donors, has already started to contribute to a progressive rebalancing of donor-government relations. Well-aware of its responsibility to continue support for HIV treatment, and manifestly intimidated by the perspective of having to pay for African ART programmes for the decades to come, the US Government is, for instance, moving away from its initial 'authoritarian' approach. Its increasing emphasis on Tanzanian 'ownership' might be progressively turning from a legitimating discourse of 'foreign presence' into a means to get out of a tight spot. Although responsibility is more diluted, a similar evolution of power relations is at play in the case of the Global Fund, which is facing increasing difficulties *not* to fund those requests that simply

⁵⁰² A striking illustration of this de-exceptionalisation of HIV is its increasingly frequent reframing as a 'chronic disease'. While this is obviously justified for those populations who have access to quality care and treatment, it still remains a euphemism for the millions who continue to die of AIDS in the absence of antiretroviral therapy.

⁵⁰³ Definitions of "responsible" from the Collins and Merriam-Webster dictionaries respectively.

⁵⁰⁴ Definition of "responsibility" from the Collins dictionary.

⁵⁰⁵ See also the statement by the Tanzanian official in the epigraph above.

consist in continuing the treatment programmes already initiated.⁵⁰⁶ Although this evolution in donor-recipient relations obviously does not represent a major shift in power, it should not be underestimated. While the fact that international donors are directly perceived as accountable can be an opportunity, it also points to the potential importance of an increased politicisation of international AIDS control within donor countries. Indeed, in many Western countries, the initial commitment to fund international AIDS-control efforts has resulted from (at times discretionary) top-down government decisions prompted by high-level advocacy, involving little public debate.⁵⁰⁷ ‘Top-down’ decisions being potentially more fragile – or more politically reversible – than decisions taken as a result of broad democratic processes, the (re)politicisation of international AIDS control within donor countries might be important in order to ensure the sustainability of international funding.

In a similarly paradoxical way, and although unfortunate as such, the recent decrease in HIV-specific funding in Tanzania – in combination with the continued increase of the general health budget – contributes to the attenuation of some of the most glaring contradictions that resulted from the disease hierarchies induced by vertical AIDS control. This rebalancing could further facilitate the integration of HIV-related planning processes and service delivery within the more general health system. By favouring a more comprehensive policy design and more integrated implementation processes, such an evolution makes the AIDS response *a priori* more compatible with genuine political control by the Tanzanian Government. That being said, the ‘ownership’ implications of increasingly integrated (or general) donor support are ambiguous. On the one hand, the lack of donor coordination clearly creates an incentive structure that disfavors national ‘ownership’ (see Chapter 4), and the Tanzanian experiences of the Health Basket and the Sector-wide Approach certainly point in the right direction. On the other hand, the adoption, by international agencies, of a more comprehensive approach to health action would not necessarily solve the problem of ‘expropriation’. Commenting on the possible evolution of international institutions’ willingness to fund entire national health plans, one bilateral agent, for instance, warns: “There could be some positive changes in this sense...but then the conditionalities come in: African countries will be expropriated of their health policy decisions if the three big institutions [i.e. World Bank, Global Fund, and GAVI] will have to decide if this is a ‘good’ or a ‘bad’ national strategy”. Drawing on his past experience with non earmarked international support, he adds: “Every time, they [the donor headquarters] want to re-evaluate the health-sector plans at the international level, even though they have all been reviewed and approved by the in-country donor representatives! They, *again*, want to do another assessment...so that’s expropriating the countries even further!” (Bilateral-30). Indeed, although they reduce the possibility for individual donor countries to exert direct political pressure⁵⁰⁸, highly integrated approaches to international health funding can amount to granting donors a right to

⁵⁰⁶ Although four countries – the US, UK, France and Germany – represent the bulk of the contributions to the Global Fund, the existence of an autonomous institutional entity certainly provides additional ‘political cover’ for those countries who lower their financial commitment to international AIDS control.

⁵⁰⁷ PEPFAR, for instance, stands for “The *President’s* Emergency Plan for AIDS Relief”. In France, too, the successive *President’s* have tended (and continue) to consider international AIDS control (and Global Fund commitments in general) as a ‘*fait du prince*’.

⁵⁰⁸ The Global Fund, for instance, represents a considerable progress in this respect.

examine – and thus to reject or modify – not only specific projects or programmes, but entire national health policies. Again, there are obviously no easy solutions.

The major difficulties encountered by the ART programme point to the fact that another change in practices can emerge from the level of service delivery. The figures clearly show that the treatment programme fails to reach the majority of the patients in need of antiretroviral therapy.⁵⁰⁹ From there, two questions need to be answered: How can treatment access be organised in a more efficient manner, and how do treatment programmes need to be modified in order to minimise drop-outs? The case of HIV prevention raises similar questions. In any case, the responses can only emerge from the experience at the implementation level – and thus come from Tanzanians themselves. Although this would, of course, require increased leeway in the use of international funding according to an endogenous assessment of the situation, such a bottom-up process could provide a path towards a progressive reappropriation of the national AIDS response by Tanzanian health players. Such a process necessarily involves a change in mentality on behalf of the Tanzanian Government. Although the ‘lack of ownership’ can be a strategic means to maximise donor funding (see Chapter 4), Tanzania’s history of the concomitance of affirmative self-reliance *and* considerable donor support, as well as some donor agents’ genuine exasperation with the lack of government leadership suggest that a more active form of ‘ownership’ is not necessarily an obstacle to sustained international support for AIDS-control – if maximising aid remains a political objective, as it is likely to be the case. For such a process not to remain a high-sounding promise, however, the repoliticisation of decisions related to HIV prevention and treatment within the *Tanzanian* political arena is essential. Importantly, and beyond ‘government ownership’, what is at stake is the redefinition – or even the establishment – of the ‘responsibility’ of the Tanzanian government vis-à-vis the Tanzanian people with respect to AIDS control. As discussed, Tanzania’s more general political context of patronage and the parasitic bureaucracy to which it gives rise are serious obstacles to such an evolution – both internally and because they do not encourage donors to shift towards less directly-controlled modalities of aid. Rather than interpreting this situation as a political deadlock, it seems important to stress that the expropriation that results from heteronomous AIDS and health policymaking *de facto* precludes any enhancement of government accountability. To be sure, various members of the Tanzanian administration have no interest in the greater transparency to which an increased politicisation of AIDS-control policies would inevitably give rise (see Parts 1 + 2). The nature of the ‘political issue’ of HIV/AIDS, however, suggests that it is probably overly simplistic to conclude that the Tanzanian Government as an institution has everything to lose and nothing to gain from such a process. Irrespective of one’s assessment of their national responses, the cases of Botswana (Chabrol 2012) and Uganda (Putzel et al. 2006; Tumushabe 2006) illustrate that AIDS control can be a significant source of government legitimacy. Consequently, its increased presence in public debate does not necessarily run counter the government’s interests.

⁵⁰⁹ As discussed, even if half of the patients considered as ‘in need’ of ART receive treatment at any given moment, the significant ‘turnover’ among those patients who are ‘in need’ of therapy but do not access it (before dying), means that, over time, the proportion of patients ‘in need’ who access therapy is far below 50%.

No doubt, there is something fundamentally unsatisfying about these conclusions. It remains unclear, for instance, where precisely the impetus for such a politicisation of AIDS control could come from in Tanzania. Yet, does calling for an increased politicisation of the national AIDS response amount to fighting a losing battle? Much in the preceding analyses suggests that it might. At the same time, these very analyses also point to the fact that the only viable medium- and long-term option is to (re)open the political debate about AIDS-control policies within a broader framework that includes the overall coherence of the health system as well as the social determinants of health in general and of the susceptibility to HIV in particular. More generally, and despite the depoliticization processes described throughout this work, the magnitude of the underlying stakes suggests that political struggles can emerge at any time and in unpredictable ways.

Conclusion

In a sense, HIV/AIDS is everywhere, but nowhere to be found in Tanzanian politics. Claiming that the world's most publicised – and in many ways most politicised – epidemic is being depoliticised seems paradoxical. Yet this research has shown that HIV/AIDS in Tanzania is subject to multiple interrelated processes of depoliticization concerning both the causes of the epidemic and the responses to it. The high stakes of the societal compromises involved in the formulation of national AIDS-control strategies contrast with the absence of public debate on the trade-offs between irreducibly conflicting interests and incommensurable values these strategies imply. The consistent omission of the inherently political nature of HIV-treatment and -prevention policies contributes to making invisible the inequalities that result from non public and often implicit decisions about AIDS control. The circumvention of public debate it entails jeopardises the development of adequate responses by precluding the collective formulation of temporarily acceptable compromises via a political process.

Based on an empirical enquiry into the formulation of national HIV-prevention and -treatment policies in Tanzania, this work has explored different facets of the political economy of AIDS control in Africa. Each of the three parts has analysed how different aspects of the epidemic and the responses to it are framed and managed politically in Tanzania. Part 1 has addressed the political economy both of the causal narratives of the African AIDS epidemics and of the agenda-setting process concerning HIV-prevention interventions. Developing upon a critical scrutiny of today's dominant aetiological framing of HIV/AIDS in sub-Saharan Africa, it has argued that, by overlooking the non behaviour-related drivers of sexual HIV transmission and by turning a blind eye to the role of unsafe medical practices in the transmission of the virus, the behaviour-centred explanatory approach contributes to the political domestication of the epidemic. It exonerates governments and donor agencies and shifts blame and the responsibility to act to individuals. Not only is the uneven political resonance of different explanatory approaches not random, but the translation of the available biomedical and epidemiological evidence into actual HIV-prevention measures is politically mediated. Tanzanian HIV-prevention policies result from a politically negotiated aggregation of competing and frequently non-optimizing rationalities. The incentive structures entailed by vertical AIDS programming and project-based 'development cooperation' hamper the consideration of more structural determinants of health. That being said, the very idea of purely 'evidence-based' health policies is an illusion. Indeed, the study of the multiple rationalities at play in HIV-prevention planning illustrates that these policies require a political prioritisation of conflicting interests and a just as political establishment of hierarchies of values. It is impossible to bypass these irreducibly political struggles through a technical process – be it via a technocratic definition of 'optimal' solutions based on bio-epidemiological evidence or via decision tools meant to allow the formulation of 'rational consensus'.

Adopting a slightly different perspective, Part 2 has focused on those interventions that have successfully reached the national AIDS policy agenda. In a context in which the prioritization of interventions and beneficiaries has a direct impact on the lives and survival of a significant share of the population, chapters 4 and 5 have analysed how AIDS policymakers in Tanzania collectively deal with the inescapable rationing decisions that underlie HIV prevention and treatment. Crucial choices are neither publicly discussed nor explicitly decided upon within the relatively closed political arena of donor-government discussions. Many priority-setting decisions result from implicit choices conditioned by an institutional configuration that gives precedence to the maximisation of aid flows over a genuinely strategic approach, and that effectively avoids public debate to escape political responsibility for unpopular rationing decisions. Consequently, HIV-prevention and -treatment policies in Tanzania are shaped by a non-confrontational mode of politics that results in a depoliticisation by non-decision, or a 'circumvention of the political'. This aversion to prioritise explicitly via a political process makes it difficult, if not impossible, to engage in more inclusive debates and decisions over the organisation of *de facto* non-universal access to treatment and prevention services. Beyond these detrimental implications for democratic process, the empirical analysis of HIV-related decision processes shows that aid dependency is a *relation*, rather than a *bias* that distorts a hypothetical pre-existing 'national' strategy. This *consubstantially* heteronomous nature of AIDS policymaking in Tanzania in many ways explains the confined character of the debate over HIV treatment and prevention.

The last part of this thesis focused more specifically on the donor-driven nature of the response to HIV/AIDS in Tanzania. It analysed the opportunities, as well as the tensions and contradictions that arise from the presence of international AIDS-control initiatives. Drawing on the players own reading of the situation, Chapter 6 looked at the ambiguous effects of the vertical AIDS response on the Tanzanian health system and the broader coherence of national health policies. Based on a case study of the interaction between the players of the AIDS and nutrition fields, Chapter 7 explored the limits to vertical AIDS control in a context of weak health systems and poor general population health. This last part argued that, irrespective of its obviously beneficial effects, the international AIDS response bypasses domestic administrative and representative structures and dispossesses the Tanzanian people of a variety of political decisions related to HIV/AIDS and to health in general. Arguing that this situation makes a radical critique of global AIDS initiatives indispensable, Chapter 8 confronted the international AIDS response with fundamental criticisms of aid. It concluded that, although the acuteness of dependency makes a genuinely radical critique difficult, a conceptual and procedural repoliticisation of AIDS-control can provide the conditions and pathways for a necessarily progressive reappropriation of health by the Tanzanian people.

In sum, the successive chapters of this work explored a multifaceted political process in which, at various stages, policymakers choose the 'path of least resistance'. Analytically speaking, one can distinguish six interrelated and closely interwoven aspects – or modalities – of depoliticisation within this process. The first aspect is the *causal* depoliticisation of the structural drivers of the spread of HIV in sub-Saharan

Africa via the obscuring of the broader power relations that condition the high susceptibility of African populations to infection. The other five aspects relate to depoliticisation of the responses to the epidemic. One consists in the artificial deconflictualisation of AIDS control via an allegedly technical definition of 'optimal' solutions, another one in the 'circumvention of politics' via implicit choice (i.e. 'non-decision'). A fourth modality of depoliticisation consists in the limitation of political participation via the confinement of the decision process to closely circumscribed (ad hoc) institutional fora. All of these aspects are intimately related to the fundamentally donor-dependent character of the AIDS response in Tanzania. The depoliticising effect of this heteronomy itself is twofold: beyond its immediate dispossessing consequence (i.e. the exercise of core attributes of biopolitical sovereignty by Western governments and non-governmental agencies), the international intervention indirectly shields itself from political critique by adopting a humanitarian framework of action based on 'institutionalised emergency'. This entails an implicit reduction of politics to the preservation of 'bare life', which has obvious depoliticising consequences as it transforms collective reflections about the desirable modalities of 'living together' into a secondary question.

As a result of this multifaceted political process, the Tanzanian AIDS epidemic and the responses to it are quite consistently 'organised out of politics'. Consequently, the Tanzanian people are dispossessed of many crucial decisions involved in the formulation of AIDS-control policies. As discussed throughout this work, the analysis of the political configurations that result in this protean depoliticisation suggest that there are many 'good reasons' why this might not change. The international and national structures of political and economic domination, the individualistic paradigm among doctors and epidemiologists, the technocratic conception of health action among international agencies, as well as the genuine difficulty to make explicit rationing choices via inclusive decision processes are but some among many of these reasons. These factors will continue to fuel the negation or political circumvention of the irreducible conflicts of interests and values that underlie the formulation of AIDS-control policies.

No doubt, looking at international health initiatives over the long run can prompt considerable disillusion. Nevertheless, the history of public health points to the importance of *progressive* change. It does not teach us that 'you cannot do anything unless you do everything'; nor does it provide too many examples of genuinely revolutionary processes that have radically improved population health. In this perspective, the criticism expressed in this work not only fully acknowledges the indisputable positive effects of international AIDS initiatives, it in no way precludes the possibility of positive, progressive change. Indeed, it is from the contradictions of today's situation that such change can emerge. As described, many donor agents themselves denounce the dispossession brought about by their agencies' interventions, various NGO players actively call for more inclusive decision processes, and some Tanzanian AIDS and health officials struggle to give 'ownership' a meaning. All these people carry with them values that do not reflect today's dominant visions. They are 'countervailing powers' through which change can come about. Significant transformations, and the shift in the balances of power they

require, can emerge via people who adopt different positions and practices, even *within* the existing institutional framework. If things have slowly started to change within PEPFAR and the Global Fund, for instance, this is not least due to persistent critiques from the players on the ground, who, by holding these institutions internally and publicly accountable, have contributed to shifting the lines progressively. Much remains to be done in Tanzania. Yet, underestimating the potential for change would not only be a confession of failure but an analytical mistake.

This research has obviously several limitations. The general ones that derive from this study's methodological approach and research design (which allow some insights and foreclose others) have been discussed in Appendix 1 and in Part 3. Another, at least partially inevitable, limitation stems from my willingness to position this research within the thematic field of HIV/AIDS and to engage in a dialogue with its protagonists. Since health policies are far from being interchangeable, this choice made it necessary to take into account fully the specificities of both HIV/AIDS itself and of the AIDS policy field, the relative autonomy of whose players, rules and practices has been underlined throughout this work. This attempt to explore the politics of AIDS control in Tanzania by drawing on various tools of political economy analysis might not fully do justice to the more generalist literature in fields such as the sociology of health and illness, African political anthropology and sociology, and even public policy analysis. A related limitation is an indirect consequence of this choice to position my work within the field of HIV/AIDS. Since the overwhelming majority of HIV-related research on sub-Saharan Africa is published in English, I probably have neglected relevant literature written in German and French (the two other languages I have a good enough mastery of to read scientific publications).

Importantly, the specificities of time and place should be kept in mind when reflecting on the results of this enquiry. The analyses developed in Parts 2 and 3, for instance, are certainly co-determined by the specificities of the Tanzanian case. Although the involvement of various international organisations in the formulation and implementation of AIDS-control policies is not a Tanzanian specificity, the phenomenon is particularly pronounced in Tanzania. The jeopardising effects of this multitude of players on the coordination and coherence of AIDS and health policies are compounded by the fact that Tanzania is among those African countries that have attracted the most international AIDS funding. The massive donor presence in conjunction with low government involvement has rendered the Tanzanian response particularly heteronomous and turned Tanzania into one of the most aid-dependent countries with respect to HIV/AIDS. This, combined with the fact that Tanzania is among the countries where the over-proportionality of AIDS funding (if compared to its share in the overall burden of disease) is most pronounced, undoubtedly exacerbated the tensions to which international AIDS initiatives gave rise. Moreover, and as discussed, the period of enquiry coincided with a rather specific moment of international AIDS and health action. It was precisely during the years in which I conducted fieldwork that the budget for AIDS control temporarily exceeded the general health budget – a proportion that has reversed since. This specific configuration allowed defining the existing contradictions by making them

particularly visible. No doubt, many of the problems, ideas, and institutions described in the Tanzanian context are common or comparable to those at play in other AIDS-control programmes in sub-Saharan Africa. The relative specificity of the Tanzanian case, however, suggests that one should be careful when extrapolating the findings in space and time.

This specificity points to the usefulness of similar empirical research on the political economy of AIDS-control in other sub-Saharan countries. Such a comparative approach would allow us to corroborate or put into perspective the findings of this study. More generally, the recent evolutions in the field of international health initiatives raise a variety of serious questions. Some of the contradictions to which vertical AIDS control gave rise within the Tanzanian health system are starting to be absorbed as a result of the rebalancing of health expenditures. At the same time, many of the tensions and political trade-offs that underlie the formulation of HIV-treatment and -prevention policies are further accentuated by the recent decrease in international AIDS funding. This twofold reality points to at least three avenues for future research. Importantly, our collective ability to address them *together* will be essential in allowing the formulation of more coherent, and thus more viable political compromises concerning health policies.

A first field of enquiry that emerges from this research concerns the interactions and synergistic effects between the various cofactors (nutritional deficiencies, and bacterial, parasitic, and viral co-infections) on the transmission and pathogenesis of HIV. While examining these effects individually, i.e. cofactor by cofactor, is insufficient (Stillwaggon 2009; 2012), it also seems important to move beyond the purely biological aspects of these interactions and to explore fully the bio-social complexities that co-determine the exceptional efficiency of the spread of HIV on the continent, as well as the possibilities of adequate treatment and care. Indeed, the distribution of most 'biological' cofactors reflects broader socio-economic inequalities in terms of living conditions and unequal access to care. The irreducible entanglement of the biological and social dynamics that underlie HIV epidemics makes it indispensable to strengthen the dialogue between the biomedical and epidemiological aspects of HIV transmission and pathogenesis on the one hand, and social science research that takes up these findings within a renewed approach to the social determinants of health on the other. While such an approach would certainly yield important insights, the existing evidence is already largely sufficient to take significant action. As Stillwaggon (2012) underlines, the "[l]ack of full scientific certainty is not a reason for postponing safe, cost-effective measures to prevent irreversible damage".

As discussed, the various difficulties many vertical AIDS programmes in Africa currently encounter point to the need to re-embed the AIDS response within a more general approach to health and health care. A second field of enquiry, which is closely related to the first one, thus concerns the modalities of what could be described as the 'non-predatory integration' of HIV prevention, treatment, and care within

African health systems – both at the planning and service-delivery levels.⁵¹⁰ Indeed, although the decline in AIDS funding poses serious threats, the end of AIDS exceptionalism it announces could become an important opportunity – provided the practical aspects of the ‘normalisation’ of the AIDS response is thought out properly. This essentially comparative, operational research would thus explore appropriate modalities of a ‘reciprocal integration’: i.e. the inclusion of cofactor management into HIV-related programmes, *and* the inclusion of these programmes into the general health system. These two apparently opposed trends constitute a mutually reinforcing double movement through which greater coherency can progressively emerge. The social sciences are well equipped to contribute to this endeavour. Indeed, there certainly is some truth to Bernard Taverne’s observation that “the main issue in the struggle against AIDS in Africa today is not primarily the development of new sophisticated techno-scientific tools, but in the implementation of insights that have already been gained”⁵¹¹. Beyond their contribution to disciplinary bodies of knowledge, research on HIV/AIDS in the social and political sciences can help identify the obstacles and barriers to collectively putting these insights into practice in order to increase health-policy coherence at all levels.

That being said, it remains crucial, of course, for social science scholars working on HIV/AIDS not to let their research be confined to operational concerns alone. Research in the social and political sciences that is not immediately operational can provide crucial input into the general debates by analysing the economic, ethical and political consequences of the choices that underlie the formulation of health strategies. In this sense, a third important field of enquiry concerns the specifically political aspects of the epidemic, and the biopolitics that have emerged in response to it. The (geo)political stakes of the new forms of humanitarian government of which international AIDS control is a part, for instance, are still only incompletely explored with respect to the new health inequalities to which they give rise and their effects in terms of dependency and sovereignty. More specifically, the fact that HIV/AIDS is slowly but surely sliding off the international policy agenda, combined with the ongoing trend towards the re-embedding of AIDS-control, will inevitably modify the manner in which allocative decisions are asked and answered. The new phase opened up by these concomitant evolutions poses a variety of unique political challenges, including the management of non-universal access to antiretroviral treatment and the increased prioritisation of HIV-prevention interventions. What are, for instance, the domestic political consequences of global health initiatives that have set their ‘beneficiary countries’ on a partially irreversible trajectory of ‘universal’ access to ART without ensuring sustainable funding? How does a highly aid-dependent country such as Tanzania cope with the decline in international support? What are the strategies put in place to mitigate the risk of treatment discontinuation and can these alternative solutions contribute to increasing genuine national ownership of the response? Many of the questions

⁵¹⁰ This obviously does *not* mean that HIV prevention should be limited to health-sector interventions. Simply, the health-sector based interventions should be integrated, as much as possible, into the general system of health care.

⁵¹¹ Contribution to a follow-up discussion concerning the workshop "Nouveaux enjeux de la lutte contre le VIH/Sida: quelles questions pour la recherche en sciences sociales?", organised by the French National Agency for Research on AIDS and Viral Hepatitis (ANRS), 28 November 2011, Paris (unpublished document).

discussed in this thesis thus remain as relevant as ever. This situation calls for empirical studies that would analyse the political economy of rationing at the various decisional levels. These studies should be particularly attentive to the manner in which the political nature of the choices involved is perceived and presented as such or, on the contrary, obscured throughout the policymaking and implementation processes.

Generally speaking, both the improved understanding of the causal mechanisms at the origin of the African HIV epidemics and the insights concerning the fundamentally political trade-offs involved in the formulation of national responses to them illustrate the need to resituate thinking about AIDS control in Africa within a considerably broader analytical and operational framework. Indeed, while health was consistently addressed as a fundamentally political matter during the 1970s (e.g. Mahler 1978), the debate on African health has in many respects narrowed down over the last decades. Today, even those players on the ground who attempt to broaden the debate frequently continue to reason within a technical, programme-based framework and only rarely draw on a more global vision of health. One of the tasks of scholars concerned with the political economy of health and AIDS control in Africa is certainly to contribute to widen this debate again. A key challenge in doing so is to explore these very general, yet crucial questions via empirical enquiry that is solidly anchored in localised fieldwork. Decontextualised analysis has done much harm.

As one interviewee underlines in a concluding remark that points to a common difficulty of low- and high-income countries: “A fundamental problem is that you don’t get money for health or for maintaining people’s good health; you get money for illness. So the problem to solve – and it’s an intellectual one – is how can we collect money for illness and spend it on health?” (Bilateral-31). Collecting money for illness has worked fairly well over the last decade. Actually spending it on health, however, has proved to be a considerable challenge. Doing so not only requires a renewed attention to the broader social determinants of health and illness; it presupposes taking people seriously. This implies acknowledging the fundamental importance of autonomy, self-determination, and people’s individual and collective ability to cope – not merely as tools for enhancing adherence to antiretroviral therapy but as elements of improved individual and population health. Having a say, individually and collectively, in the decisions that affect one’s own health and that of one’s community is co-constitutive of health itself. The collective formulation of health policies via political process is thus not a luxury; it is a *sine qua non* condition for promoting good health. The dispossession induced by the depoliticisation of AIDS control in Tanzania is thus inherently counterproductive. Yet, the re-embedding of HIV programming within the broader politics of health in Tanzania presents opportunities both for improved AIDS control and for a collective reappropriation of health policies via a repoliticised management of the difficult trade-offs they involve.

Appendix 1) Methodology and methods of analysis: the progressive research framing

This study draws on four different types of data: scientific literature, policy documents, semi-structured interviews, and the observation of policy meetings. Data gathering and analysis are at least partially parallel processes in the grounded theory approach, which proceeds via an iterative procedure where partial (or preliminary) research findings are critically analysed and where the results of this analysis lead to a refinement of research questions and thus feed back into the adjustment of the data collection strategy.

One of the consequences of this approach for the bibliographic analysis is that I limited the literature research conducted *before* the first fieldwork to very broad domains such as the general epidemiology of HIV/AIDS, the history of the African AIDS epidemics, or the political economy of health on the continent. Since health was a new field of enquiry to me, I also read a variety of general publications on the sociology of health and illness, on social determinants of health, and the history of public health. It is only after my first fieldwork, once I had refined my research questions and more clearly defined the issues I decided to focus on, that I engaged in a more systematic review of the literature concerning the various aspects of this work. The first important task consisted in gaining familiarity with the abundant scientific literature on the biological and epidemiological aspects of HIV transmission and pathogenesis, as well as with the literature that assembles these insights into competing, yet not necessarily contradictory causal narratives of the African HIV epidemics.⁵¹² Other fields of bibliographic research concerned the various aspects addressed in the different chapters of this thesis, including public policy analysis and (de)politicisation processes, the framing of diseases, 'evidence-based' health policymaking, triage and prioritisation in health-related decision processes, primary health care and vertical disease-control in resource-limited settings, or critical analyses of aid relations and dependency.

The second group of written documents I drew on consists in a wide variety of policy documents (co)produced by international organizations, bilateral donor agencies, and the Tanzanian health and AIDS administrations. Since my initial attempt to conduct systematic research based on the Tanzanian administrations' document data base was inconclusive, I asked the interviewees about the relevant policy documents to be aware of and asked them for copies of these documents. For those documents referred to during the meetings or in the literature, I either relied on online research or directly asked some of my past interviewees to send me electronic versions.

The most important source of data for this study stems from a series of 92 key informant interviews conducted during three fieldwork periods (of approximately six weeks each) in March and April 2007,

⁵¹² As it is obvious throughout this work, this important aspect of my bibliographic research was prompted and decisively influenced by my 'discovery' of Stillwaggon's (2006) seminal book *AIDS and the Ecology of Poverty*.

September and October 2008, as well as September and October 2009.⁵¹³ Given my interest in the political economy of AIDS control, I identified a number of individuals who held relevant positions within institutions that were actively involved in the AIDS policymaking process in Tanzania. In order to get an ‘outside’ perspective on this process as well, I also identified several of researchers and people working in Tanzanian and international NGOs.⁵¹⁴ About one third of the interviewees were selected *a priori* in this manner. The remaining participants were identified through respondent-driven chain referral sampling. At the end of each interview, I asked the respondents “Given our discussion, who do you think are other relevant players I should talk to?”. Although I did not intend to produce a ‘representative sample’ of the people actively involved in AIDS policymaking in Tanzania, this combined sampling method allowed me to reduce bias (Marshall 1996) and resulted in a satisfactory representation of the key players of the Tanzanian AIDS policy process at the time of the study.⁵¹⁵

Researchers and consultants excepted, about half of the interviewees worked at a senior level (as heads of agencies, departments or NGOs), the other half as project managers or higher-level technicians. Concerning the terminology adopted, I use the term “policymakers” to designate those players *directly* involved in the formulation of policies on a regular basis: i.e. donor agents and public officials. If used with reference to the interviewees, this term thus excludes researchers, consultants and NGO workers. The terms “players” or “protagonists”, when used with respect to the interviewees, includes all respondents. The vast majority of the interviewees have worked in Tanzania for years (if not decades) and are well aware of the political challenges in the fields of health and AIDS control. All freely chose to participate, have been granted anonymity, and are therefore quoted with reference to their category of institutional affiliation.⁵¹⁶ The interview conduct is described in more detail in the following sub-section.

The interview data were controlled, amended and contextualized through the observation of 8 national-level policy discussions (or workshops), including meetings of the Prevention Technical Working Group, donor-government policy reviews, and a Global Fund stakeholder meeting. I chose to observe these meetings in order to complement the information obtained from the interviews by comparing it with actual policies in the making. Confronting the interviewees’ individual narratives with their face-to-face interaction in negotiation-like settings improves the grasp of existing power relations and allows identifying controversial issues and their relative importance in priority-setting processes. While

⁵¹³ The fieldwork study received a research clearance by the Tanzania Commission for Science and Technology (COSTECH).

⁵¹⁴ I generally identified these players either because I knew they were actively involved in the response to HIV/AIDS in Tanzania, or because colleagues who had worked in Tanzania before recommended that I meet them.

⁵¹⁵ This is confirmed by the saturation observed towards the end of fieldwork: more than half of the newly suggested potential interviewees had already been interviewed. This also suggests that, despite the impressive number of stakeholders in the Tanzanian AIDS arena, the group of *key* policymakers is not that large after all (cf. introduction to Part 2). While this selection of interviewees was obviously influenced by the existing social networks (P. Murphy 1999), it ‘biased’ the sample precisely towards the ‘social network’ of AIDS policymakers in which I was most interested.

⁵¹⁶ The only exception in this respect concerns interviewees from US agencies. Indeed, the predominant role of the US in the Tanzanian AIDS response entails that, in some instances, analytical considerations make it necessary to distinguish them from other bilateral donors. That being said, the health-related US agencies (e.g. USAID, PEPFAR, CDC, and PMI) probably have more staff than the health offices of all other bilateral donor agencies in Tanzania combined. The US government is thus a large enough institutional entity to ensure anonymity.

attending the meetings, I more specifically paid attention to what the players' formal and informal interactions suggested about their (unequal) ability to influence agendas and discussion outcomes. The questions I had in mind included: To what extent do the players and groups of players have clearly identifiable agendas? To what extent and how are these agendas 'pushed' by specific players? How much time is spent on the different issues on the meeting's agenda? Whose statements are considered as relevant and shape the outcome of the meetings and/or the elaborated policy documents? Moreover, attending these meetings provided the occasion for informal discussions, which often turned out to be very informative.

I took extensive – if possible verbatim – notes during all observed meetings. Both the type and the number of meetings attended was, however, limited by the haphazard possibility to negotiate my presence in these non-public discussions. As described in more detail below, my presence at these meetings was made possible by the fact that, during all three fieldwork periods, I was 'situated' within the health coordination office of what was then the German Agency for Technical Cooperation (GTZ). Although I did not participate in any of the agency's activities, being physically present in its office provided the opportunity for many informal discussions with a variety of people involved in Tanzanian health policies. It also gave me a reasonably good overview of the every-day life of a bilateral donor agency and of how it interacts with the 'rest of the world' (its projects in the districts, its headquarters, the Tanzanian administration, other 'development partners', external consultants, etc.).

Both the interview notes and the notes from the observations of meetings were analysed using a qualitative data analysis software (*MAXQDA*). This tool facilitates data triangulation, helps limit selectivity in its use, and allows for the iterative generation of concepts, categories and theory through successive stages of coding and memo-writing according to the principles of grounded theory. The phases of data analysis (which partially overlapped with data collection) included open coding, selective coding and sorting of text excerpts (interview notes and meeting protocols), theoretical memo-writing, as well as the writing and rewriting of the manuscript itself. In some instances, I sent draft versions of different sections of this study to interviewees who expressed a particular interest in the results of my research. Beyond the unavoidable differences between a general political economy analysis and individual experience, their comments and the fruitful discussions to which they gave rise suggest that many of the findings reflect their experience as policymakers.⁵¹⁷

⁵¹⁷ I do not resist the temptation to tell one anecdote of such a feedback, which illustrates the tensions between many social science researchers' double ambition to contribute to the production of knowledge and to stimulate social change: I had passed a draft paper I wrote after my second fieldwork to one of my key informants. Having read the paper and reading over his own notes, he made some factual remarks and pointed out a few passages where he considered the argument could have been slightly more differentiated or looked at from a different angle. When he finished, he paused for a second, handed the annotated version of my paper over to me and said: "Well, I'm telling you to add this and to develop or slightly qualify that, but...you probably shouldn't change anything! It could water down your argument and you really want to get this message out there...". An analysis that would fully take into account real-world complexity, he feared, would run the risk of losing the principal message on the way. I did take most of his comments into account and do not think I abandoned the ambition to produce a differentiated analysis. Yet, this interviewee's idea that, beyond a certain point, analytical complexity becomes

The interview enquiries were formulated via e-mail, by phone, or orally, in person (during policy meetings). Both in the interview enquiry and at the beginning of each interview, I presented myself as a PhD student and described the study initially as a “PhD research on HIV prevention policymaking in Tanzania” and – as I decided to include certain treatment-related aspects as well – as being “on the politics of AIDS control in Tanzania”. The choice to conduct semi-structured interviews was made for several reasons.⁵¹⁸ They allow a deeper understanding of the interviewees’ responses by leaving room to ask for more detail or clarifications. They also provide interviewees with the opportunity to discuss what they consider most important and to express their own analyses of the policy process, its insufficiencies and challenges – which is the basis of grounded theory research. Practically speaking, semi-structured interviews are closer to natural two-way conversations than structured interviews and their loose structure allows progressively building rapport and gaining respondents’ trust – an aspect that turned out to be of crucial importance for the quality of the data collected during the interviews.

While most interviewees were welcoming, the relatively open nature of the interview schedule generally allowed me to build rapport progressively with those initially prudent. As the discussions unfolded, quite a few manifestly perceived the interview as an opportunity to speak out and make themselves heard⁵¹⁹, or as a moment of self-critical introspection. Towards the end of the interview, several of my interlocutors explicitly expressed their (often high) expectations concerning my research.⁵²⁰ In a sense, the demand expressed by my interviewees made explicit the aforementioned tension between the social utility of research and its contribution to a body of scientific knowledge. Quite naturally, there was thus a temptation to adapt my research questions to the questions expressed by the policy protagonists themselves and to let my research evolve along the lines of the numerous ‘hot’ debates within the Tanzanian AIDS policy field. Although I obviously hope that my analyses can be helpful to policy players, research on the political economy of health – just as medical sociology⁵²¹ – loses part of its relevance if the questions it seeks to answer are too close to the day-to-day questions policymakers ask themselves.

politically paralysing points to the existence of *strategic* decisions in scientific writing. If the rigour of a study depends to any extent on the degree to which it allows real-world complexity to penetrate the analysis, there can be trade-offs between the scientific status and the (political) relevance of knowledge.

⁵¹⁸ For a detailed discussion of the advantages and pitfalls of the use of interviews, as well as the different interactive and transactional aspects of this data collection method, see (Olivier de Sardan 2008, p.54-65; Blanchet & Gotman 1992; Kaufmann 1996).

⁵¹⁹ Despite the initial distrust, this was, for instance, the case with the interviewee quoted in the epigraph.

⁵²⁰ Several interviewees were explicitly hoping for my research to help them ‘bridge a gap’ – between the international and the national policy levels, between epidemiological evidence and policies, or between theory and practice more generally. One bilateral agent put things slightly less ambitiously, saying: “We don’t have the time to think critically about what we are doing every day, so we need people like you...”. Some interviewees asked me to share my results – which I did in several cases, and which provided occasions for highly interesting feedback. In a sense, it is probably also this combination of the (at least initial) mistrust or circumspection of some interlocutors and the social demand for critical analysis that contributes to what Murphy (1999) fittingly calls the “productive discomfort of the field encounter”, or to what de la Soudière’s (1988) describes as “*l’inconfort du terrain*”. For an account of how and why social science researchers are not always warmly welcomed during their fieldwork on HIV/AIDS, see (Mbaye 2010; Achilli 2010).

⁵²¹ Maslow describes how medical sociology loses its practical value if medical sociologists exclusively and directly dedicate their research to improving people’s health. As he puts it: “Medicine has the goal of discovering, through scientific methods, data that bear on questions of health...how to keep people well and how to restore them to health when they are ill. This value, placed on health, is shared, quite rightly, by medical sociologists. But if sociologists relinquish their goal of building a body of knowledge about social structures and process or subordinate this goal to any other, the result, paradoxically, is a lessening of the practical value of sociology.” (Maslow 1954; quoted in: McKinlay 1971)

Paradoxically, its relevance is precisely due to the shift in focus it introduces compared to the players' operational preoccupations. Consequently, although the players' questions and concerns guided my analysis (they are clearly the principal 'raw material' of this study), they did not determine the questions I asked, or the 'answers' I give – which, therefore, might not correspond to the questions these players consider as being the most immediately important ones.⁵²²

That being said, during the interviews, I chose to be very open about the topic of my research and the manner in which I presented my interests and main questions. With the notable exception of the aetiological framing of the African HIV epidemics (see Part 1), I did not always make a clear difference between “the questions I asked myself” and “the questions I asked the interviewees”. This intentional confusion of research questions and interview questions did allow fairly open conversations about the issues at the heart of my research, and sometimes prompted spontaneous reflections by the interviewees concerning questions they might not have asked themselves before. The choice of openness was also influenced by the fact that most of my interviewees were highly educated individuals, many of whom had themselves conducted research in social sciences or public health before.⁵²³ On several occasions, my interlocutors questioned me about my research goals, or the theoretical framework and methods of my study at the beginning of the interviews. Some generously shared their thoughts about my research design. Others, hearing that I was a political scientist, spontaneously focused their discourse on decision processes, anticipating that that was probably what I was most interested in.

Although the generally 1- to 3-hour interviews were based on a loosely organized interview guide, I tried, whenever possible, to engage in an open conversation about the issues raised and to “forget the canvas” (Kaufmann 1996, p. 44). Aiming at understanding both the interviewees' representations and practices, this guide included narrative questions (e.g. “How did the issue of xy come up?”) and interpretative ones (e.g. “What is your impression concerning the role of xy...?”). Being aware of the internal heterogeneity of institutions and convinced of its heuristic value, I told all interviewees that I was interested in their *personal* analysis, not in their organisation's official standpoint.

Following a first round of analysis of 2007 fieldwork data through open and selective coding, the interview guide used during the second and third fieldwork periods was amended to address more specifically the major themes (based on recurrence and perceived relevance) that emerged from the first

⁵²² As Roth writes with respect to medical sociology, “the values and questions of medical educators or the problems of medicine [...] should be treated in the same way that a physician treats the patient's statement, 'I have a pain in the back of my leg.' The symptom of immediate distress gives us some clues about what directions we might look in, they do *not* define the problem” (Roth 1962; quoted in McKinlay 1971).

⁵²³ Having identified my first question (“Maybe you could start by telling me a bit more about how long you have been working here for and about what your work consists in?”) as a classical ‘interview starter’, one respondent, for instance, replied: “Yeah, alright...that's children's stuff. So, let's get to point one...”.

fieldwork.⁵²⁴ The different groups of players (donor agents, government officials, NGO workers, researchers and consultants) play different roles in the policy process. The questions I asked thus varied according to the interviewees' institutional affiliation. Nevertheless, the core of the interview guide was similar. All interviews included introductory questions about the respondents' professional background, current missions, the main challenges they face in their work, and how these challenges had evolved over recent years. I also asked all interviewees what they currently considered to be the 'hot issues' on the Tanzanian AIDS-policy agenda and, again, how they felt these had changed over time. I asked them about their personal impression concerning the problems and/or solutions that had not received sufficient attention up until now, and how they explained the difficulty of these issues to reach the decision agenda. From 2008 on, I specifically asked the interviewees for their opinion concerning the ongoing formulation process of the National Prevention Policy and their perception of both the content of the document and the policy process itself.

If the question of prioritisation did not come up spontaneously – which it did, in most cases – I asked the interviewees about their views on the degree of prioritisation of the Tanzanian response and the existence of (and policy arenas for) strategic debate on priorities. A last group of questions common to all interviewees concerned the interactions between (and coordination of) the various players involved in AIDS and health policymaking in Tanzania. More specifically, I asked the interviewees about their impressions of the effects of vertical AIDS initiatives on health policymaking and general health service delivery in the country, as well as about their analysis concerning the sustainability of the international AIDS response and its consequences in terms of dependency. That being said, most interviewees spontaneously raised most of these questions in one way or another, in which case I merely had to ask them to develop upon their initial remarks.

One issue that most interviewees did not raise spontaneously is that of the non-behavioural drivers of HIV transmission (see Chapter 1). I consistently brought up the issue if they did not mention it in their response to the question about the neglected problems and solutions. Once all thematic issues were raised and exhausted, I asked the following two questions: "If you were to look down the road a bit, which issues and problems do you think will be prominent three or four years from now?"⁵²⁵ and "Is there anything else you would like to add or mention?". These open questions were particularly fruitful as they allowed the interviewees to re-insist on (and sometimes bring up) issues to which they attached particular importance. In some cases, these questions prompted another long, more personal discussion about what mattered most to the interviewees.

⁵²⁴ Similarly, I also slightly narrowed the interview guide towards the beginning of the second fieldwork period. The mainly exploratory nature of the 21 interviews conducted during the first fieldwork period explains why excerpts from the early interviews (i.e. those at the beginning of each category, such as "Bilateral 1", "INGO-2", etc.) are much less frequent throughout the text than those from the later interviews (e.g. "Multilateral-13" or "GovSector-12") – which include questions that were more relevant to the progressively defined research focus.

⁵²⁵ This question is taken from (Kingdon 1984).

I conducted and analysed all interviews and observations myself. I began by tape-recording the interviews. Given the interviewees' reservations, repeated refusals, and the manifest bias taping (or the mere request for it) introduced in the first interviews, I decided to abandon tape-recording in the middle of the first fieldwork.⁵²⁶ To compensate the subsequent loss of data density⁵²⁷, I proceeded as follows: 1) take as many word-to-word notes as possible during the interviews, while paying special attention to the correctness of verbatim quotes considered as particularly relevant; 2) conduct systematic review and completion of interview notes immediately after the interview; 3) complete full 'transcription' of all notes (meeting protocols included) in order to process them with the qualitative data analysis software. By the end of fieldwork, most constructed categories had reached relative theoretical saturation, i.e. about the last ten interviews did not add fundamentally new viewpoints and confirmed, rather than challenged, the iteratively developed analytical framework.

All but four interviews were conducted in Tanzania. One interview with a bilateral agent took place in the agency's regional office in Nairobi. Three interviews with researchers took place in Kenya, the United States, and France respectively. Five interviewees were interviewed more than once (two of whom three times), at one- or two-year intervals. 82 interviews were conducted in English, 6 in German and 4 in French. I translated the non-English interviews into English. Interestingly, the fact that these interviews were made in another language than English – the official language of HIV/AIDS concerns in Tanzania – appeared to encourage the interviewees to distance themselves from their institution's official viewpoint and to express their own thoughts and doubts. In several cases, as soon as I proposed to switch to the interviewees' mother tongue, they switched to a more personal, less inhibited discursive register. Inversely, my inability to conduct interviews with Tanzanians in Swahili probably did not encourage them to express more personal views.

Table 3: Number of interviews conducted, according to the interviewees' institutional affiliations

Interviewees' institutional affiliation	Number of interviews	Interview codes
Tanzanian administration / public agencies	15	GovSector-1 to 15
Bilateral donor agencies	31	Bilateral-1 to 31
Multilateral organisations	18	Multilateral-1 to 18
International NGOs	11	INGO-1 to 11
Tanzanian NGOs at national or local level	6	NGO-1 to 6
Researchers or independent consultants	11	Research-1 to 11
Total	92	

People working in the AIDS field in Tanzania frequently shift employers, both within and between these institutional categories. In case of doubt, interviewees are classified with respect to the institutional

⁵²⁶ My discussions with two scholars who previously conducted research on AIDS policies in Tanzania suggest that this difficulty with tape recording was a common problem and was thus not due to the way I presented the study.

⁵²⁷ While Glaser (1998, chap.7) argues against taping and transcribing interviews word by word, not doing so certainly does entail a loss of data.

affiliation that contributed most to them being identified as relevant interlocutors. In this sense, the former head of a multilateral agency who was an independent consultant at the time of the interview is, for instance, classified as a multilateral agent; the former head of a national agency who was working in a Tanzanian NGO at the time of the interview is considered as a Tanzanian official.⁵²⁸ That being said, this mobility also has obvious consequences for the policy process itself. While it contributes to what is arguably a beneficial permeability between institutions, this predominantly one-way mobility from national administrations (or NGOs) to international agencies (or INGOs) is an important source of brain-drain. As a bilateral agent underlines: “For those working within the ministry the WHO is a great opportunity...they can participate in their workshops and, later on, get a job there. And those who go from the Ministry of Health to WHO are the best...and there are a lot of them! So that’s quite an important cause of brain drain.” (Bilateral-26) This is not a new phenomenon. During the 1990s already, Tanzanian AIDS administrations repeatedly expressed frustration at losing their staff to bilateral and multilateral AIDS agencies (Hartwig et al. 2005, p.1616-17). Roughly one third of the interviewees working at an international organisation (i.e. a bilateral or multilateral donor agency, or an international NGO) for instance, are Tanzanian nationals – many of whom had worked within the Tanzanian health or AIDS administration before.⁵²⁹

In addition to the policymakers' high mobility between institutions, the permeability of thematic areas and missions within organisations makes it sometimes difficult to identify the interviewees’ main thematic focus. The title of the interviewees’ function is not always a clear indicator, as people working in smaller organisations tend to have less differentiated functions. Notwithstanding these limitations, Table 2 gives a rough idea of the interviewees’ main thematic focus – based on their official function (or main research focus) and/or on the dominant viewpoint they adopted during the interviews. It is according to this admittedly imperfect classification that I, in some instances, differentiate “AIDS players” from “health” or “nutrition players”.

Table 4: Number of interviewees, according to their main field of concern

Interviewees’ main thematic focus	Number of interviews
HIV/AIDS	51
Health system issues / primary health care	22
Nutrition and parasitic diseases	9
Governance issues (accountability, transparency, etc.)	10
Total	92

Among the bilateral donor agencies whose employees participated in this study are the Canadian International Development Agency (CIDA), the French Embassy, the German Agency for Technical

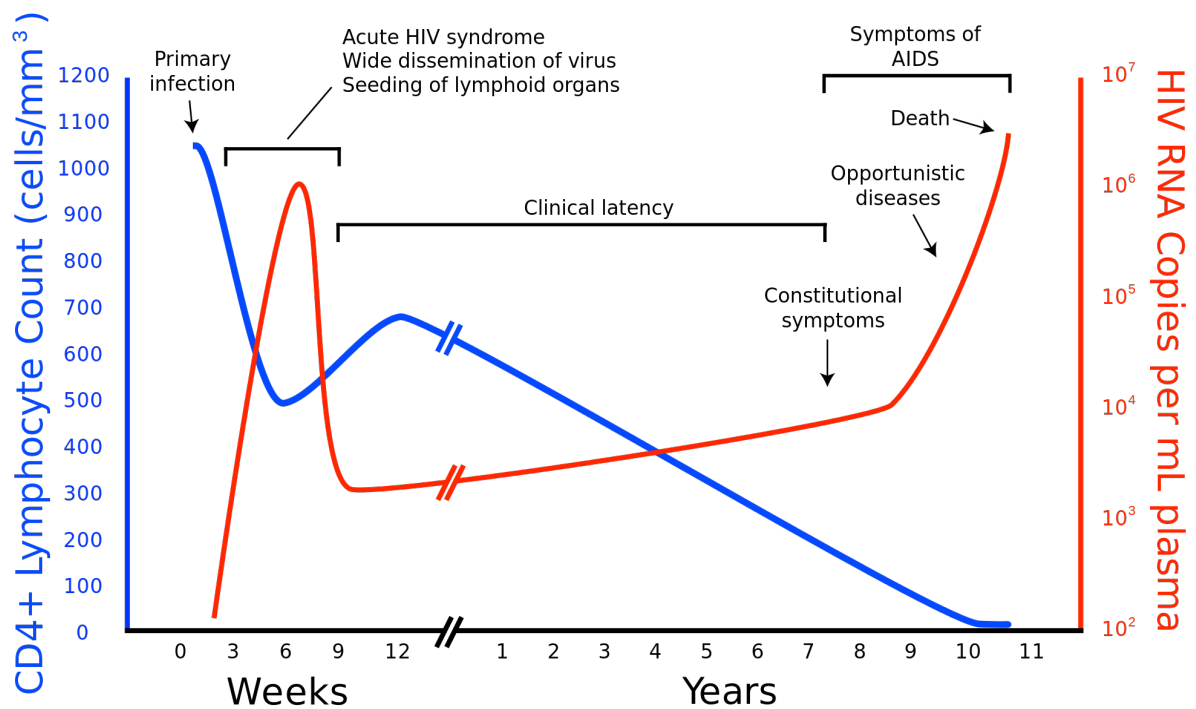
⁵²⁸ The difference in the figures in comparison to a previously published description of this data set (15 rather than 14 interviews with Tanzanian officials, and 6 rather than 7 with Tanzanian NGO workers) stems from the initial misclassification of one interview with a former Tanzanian AIDS official. I interviewed this person once he worked for a Tanzanian NGO, but I contacted him because of his former appointment as a Tanzanian official.

⁵²⁹ I asked the interviewees about their professional background, but did not ask for their nationality in most cases.

Cooperation (GTZ, today GIZ), Irish Aid, the Japan International Cooperation Agency (JICA), the Dutch development cooperation, the Swiss Agency for Development and Cooperation (SDC), and the US agencies involved in AIDS control (i.e. CDC, PEPFAR, and USAID). The multilateral agencies include: FAO, UNAIDS, UNDP, UNFPA, UNICEF, WFP, WHO, and the World Bank. The Tanzanian administrations are: the Ministry of Health, the National AIDS Control Programme (NACP), the Tanzania Commission for AIDS (TACAIDS), the National Institute for Medical Research (NIMR)⁵³⁰, and the Tanzania Food and Nutrition Centre (TFNC). Researchers were from the University of Dar es Salaam, the Muhimbili University of Health and Allied Sciences (MUHAS), REPOA (an independent research institution on socio-economic development issues), a Paris hospital, or worked as independent consultants. Given both the relatively small number of NGO employees interviewed, and their often very small (at times single-person) teams, giving the names of the organizations would, in many cases, amount to identifying individual people. To ensure anonymity, I therefore chose not to do name the NGOs of which members or employees participated in the study.

⁵³⁰ Although a research institution, the NIMR is part of the Ministry of Health and actively involved in operational research and policy design.

Appendix 2) HIV viral load in relation to CD4+ lymphocyte count⁵³¹



Importantly, this chart shows the average evolution of viral load and CD4+ lymphocyte count in HIV-infected individuals *without* antiretroviral treatment and in the absence of the poor health conditions widespread in much of sub-Saharan Africa, which accelerate HIV replication and disease progression.

⁵³¹ by Jurema Oliveira, based on (Pantaleo et al. 1993), available at <http://en.wikipedia.org/wiki/File:Hiv-timecourse.png> (Accessed April 6, 2013)

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