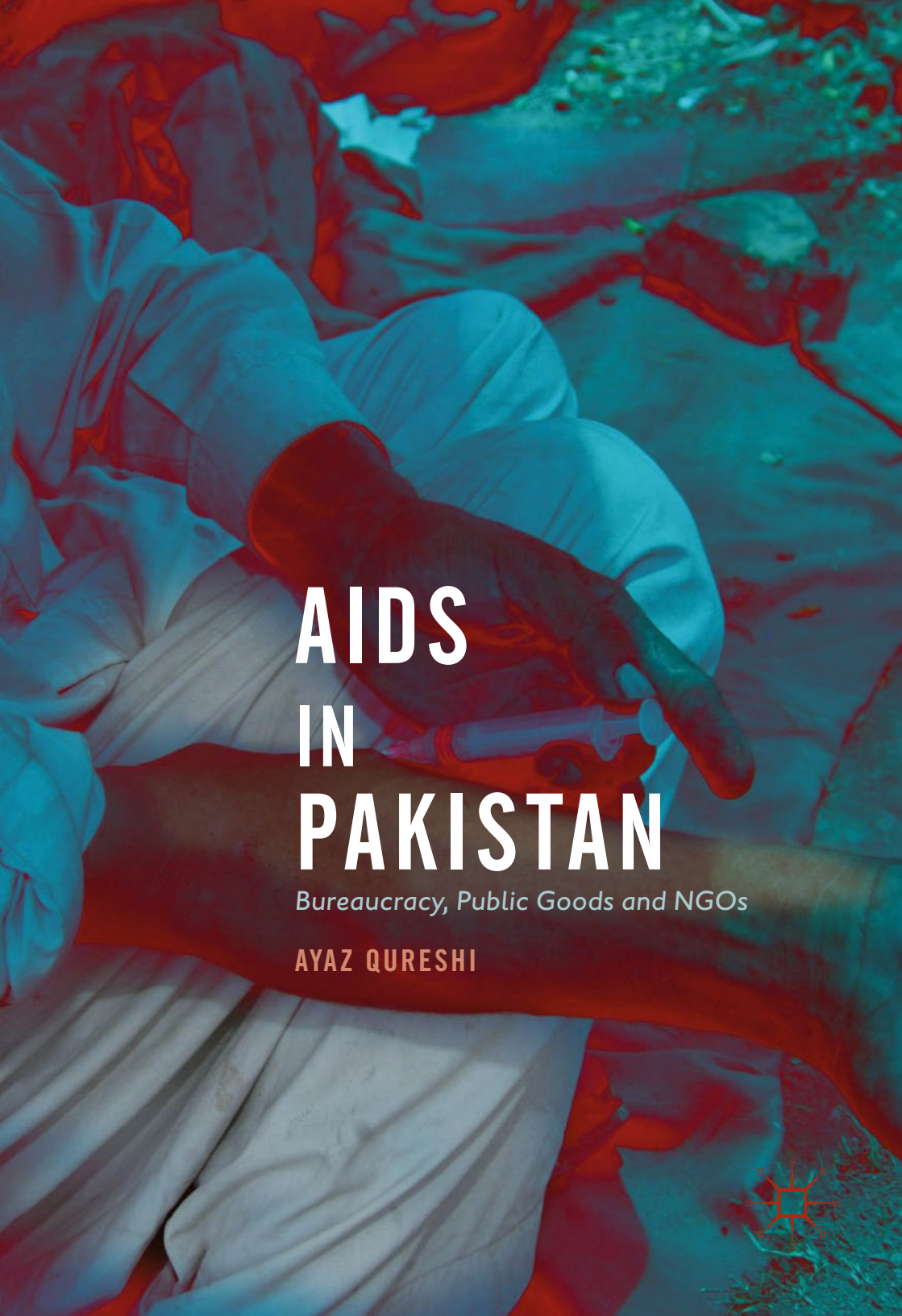

AIDS IN PAKISTAN

Bureaucracy, Public Goods and NGOs

AYAZ QURESHI

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ISBN 978-981-10-6219-3 ISBN 978-981-10-6220-9 (eBook)
https://doi.org/10.1007/978-981-10-6220-9

Library of Congress Control Number: 2017950575

Cover illustration: ton koene / Alamy Stock Photo
Cover design by Fatima Jamadar

Printed on acid-free paper

This Palgrave Macmillan imprint is published by Springer Nature
The registered company is Springer Nature Singapore Pte Ltd.
The registered company address is: 152 Beach Road, #21-01/04 Gateway East, Singapore 189721, Singapore

To my family, with love and thanks.

Acknowledgements

This book is primarily an ethnographic study of HIV/AIDS work in Pakistan at the level of government and NGOs. I will be forever indebted to those people in Pakistan who so generously allowed me to work alongside them, especially at the National AIDS Control Programme, and to all of those who shared their thoughts with me in interviews. I may not always have represented their stories in the ways that they had hoped, but I have tried to represent their situations with balance and fairness and to protect their identities as individuals. Ultimately, I hope they will understand the ethical compulsions that led me to describe their field of work in the way that I have, and perhaps they might even recognize something in my descriptions.

The book is the end result of doctoral research carried out at the School of Oriental and African Studies, London, under the supervision of Caroline Osella, who was the most supportive, kind and inspiring mentor I could have wished to have. I was lucky to benefit from insightful advice and mentoring from other faculty in the Department of Anthropology and Sociology, especially David Mosse and Kit Davis, and from the support of fellow PhD students at SOAS. Martine Collumbien at the London School of Hygiene and Tropical Medicine, who I had worked with previously on research projects related to HIV/AIDS in Pakistan, was a great support to me throughout. I am also very grateful to my PhD examiners, Ian Harper and Humeira Iqtidar, for their constructive

criticisms. Along the way, I presented this work at a number of conferences and workshops that were very influential on my thinking. I would particularly like to thank Laura Bear and Nayanika Mathur, who hosted the conference on 'flexible bureaucracy' at the University of Cambridge in March 2012 and subsequently helped to shape my paper into a contribution to the resulting special issue of *The Cambridge Journal of Anthropology*, and to the other participants at that conference. Susan Wright gave me some comments at the 'structure inside organizations' workshop at University College London in July 2012 which were very helpful. At the South Asian Anthropology Group conference in September 2013, Martin Webb, Patricia Jeffery and Filippo Osella gave me the conviction to try to voice my critical analysis more forcefully. Nora Kenworthy gave me valuable input as co-editor to a special issue on 'HIV/AIDS scale-up', to which I contributed a paper. I am very grateful to Sumeet Jain, who pointed me towards many of these opportunities for sharing my work and invited me to give a seminar in Edinburgh in June 2014. Pnina Werbner and Steve Lyon engaged positively with my work at the annual Pakistan Workshops in May 2012, 2013 and 2014 and nurtured my interest in bureaucracy.

My PhD fieldwork was funded by a scholarship from the Commonwealth. I am extremely grateful to the Commonwealth Scholarship Commission as it would have been very difficult, if not impossible, to finance a PhD as an international student otherwise. Helping us to get by in London were Kurt and Charlotte Weinberg, who so thoughtfully founded Nansen Village so as to provide affordable housing to international students and their families. It was a wonderful place to live and I learnt much from the other students I encountered there.

I rewrote the thesis as a member of faculty at the Lahore University of Management Sciences and I would like to thank my colleagues in the Anthropology and Sociology programme, particularly Ali Khan and Nida Kirmani, for their support and for pointing me towards useful literature. The students on my undergraduate courses on the anthropology of global health and political anthropology engaged me in interesting discussions, which deepened my understanding of the literatures that I draw upon. Portions of this book are partial revisions of papers that I published previously in which I developed my understanding of the people and processes

described here. I would like to acknowledge the granting of permission for this from the copyright holders. Portions of Chapter 2 are from 'The Marketization of HIV/AIDS Governance: Public-Private partnership and Bureaucratic Cultures in Pakistan', in *The Cambridge Journal of Anthropology* (volume 33, issue 1, pp. 35–48), included by permission of Berghahn Books. Portions of Chapters 3 and 4 are from 'Up-scaling expectations among Pakistan's AIDS bureaucrats: enterprising selves and precarious jobs in a hybrid bureaucracy', in *Global Public Health* (volume 9, issue 1–2, pp. 72–84), included by permission of Taylor & Francis. Portions of Chapters 6 and 7 are from 'Uncivil society: the politics of HIV activism in Pakistan', in the *Journal of the Royal Anthropological Institute* (volume 20, issue 4, pp. 694–710), included by permission of John Wiley & Sons. Thanks, too, to Holly Tyler, Joshua Pitt and Joanna O'Neill at Palgrave Macmillan, and to the anonymous reviewers to whom they sent the proposal and manuscript, who provided such insightful advice on bringing out the arguments.

My family have been a huge support. I would like to thank my parents and my siblings, my parents-in-law and Colin, George and Trisha, who have shown care and concern as well as interest in my work. Finally, thanks are due to Kaveri, who has lived very closely with this research for many years, and to Ruhi, Leila and Elahe for the happiness that they give us.

Contents

1

Introduction

'Today you give me syringes, tomorrow you might come and handcuff me', protested Kamal, the Chief Executive Officer of Naya Sewaira, the biggest NGO in Pakistan's HIV/AIDS sector. We were interviewing Kamal whilst sitting in the air-conditioned head office of Naya Sewaira in Islamabad, adjacent to the showroom where injecting drug users, their wives and children, dependent upon this NGO's detoxification units, were selling expensive leather handbags and other hand-made products. This NGO was about social enterprise rather than charitable service, since its main purpose was to give ex-drug users training in intensive farming techniques for the production of high-yield crops, which it would sell at a profit.

Gesticulating dramatically with his hands, Kamal made his designer wristwatch jangle. He was explaining how the injecting drug users would respond to attempts by the government authorities to take over HIV/AIDS prevention services, including needle exchange. Kamal was referring to the law—the 1997 Control of Narcotic Substances Act—which criminalizes non-therapeutic drug use in the country. Kamal's view was that the government could not simultaneously provide care for drug users as well as lock them up. If a government official tried to engage in HIV/AIDS prevention, argued Kamal, members of the risk populations would

A. Qureshi, *AIDS in Pakistan*, https://doi.org/10.1007/978-981-10-6220-9_1

be right to be wary. 'They'll say "is he an outreach worker, or does he work for the anti-narcotics force?"', an objection that summed up the conundrum of Pakistan's HIV/AIDS response. In Pakistan, as in other South Asian countries, the 'risk populations' amongst whom epidemics spread are not only socially and economically marginalized but also criminalized. Although injecting drug users, men who have sex with men, sex workers and transgendered people are targeted by policies and interventions, the government's hands are tied. To reach out to these criminalized populations, it must depend on NGOs.

In the early 2000s—against the counsel of some of the country's most prominent public health activists and epidemiologists—the World Bank managed to convince the government of Pakistan that HIV/AIDS should be declared an area of public health needing of urgent intervention on the grounds that if the epidemic were not contained within the risk groups, the virus would likely spread to the general population quickly. This was in the context of a growing regional HIV/AIDS epidemic in neighbouring South Asian countries (NACP 2007a, b). By 2003, only 1579 cases of HIV and 202 cases of AIDS had been diagnosed in Pakistan, but it was estimated that there were some 85,000 HIV/AIDS cases in the country—thus the vast majority of them were undiagnosed. The prevalence rate was estimated at 0.1%, a considerable percentage because of the sheer size of Pakistan's population (NACP 2007a, b). Injecting drug use was a particular concern, as drug trafficking-for-arms during the Afghan war in the 1980s had left hundreds and thousands of heroin and opium addicts as a legacy (Haq 2003). Behavioural studies in the 1990s had indicated alarmingly high levels of needle sharing and other risky practices in these populations (UNODC and UNAIDS 1999), and when bio-behavioural surveys of injecting drug users in some of Pakistan's major cities were subsequently carried out in 2004, it was found that up to 25% were infected with HIV/AIDS (NACP 2005).

As in other countries in the early 2000s, Pakistan's HIV/AIDS response was 'scaled-up' (Kenworthy and Parker 2014), that is to say, it received a 'sudden injection of new funds' (Farmer 2013, p. xvii) consistent with the tripling of development aid for health in general over the same period (Weigel et al. 2013). Accompanying these funds came a 'new technocracy' of economistic assessment techniques (Biehl and Petryna 2013,

p. 8), a sovereignty of 'metrics' identifying 'what works', and a preference for interventions that are 'scalable' and evidenced to be cost-effective in resource-poor settings (Adams 2016). As Kenworthy and Parker (2014) observe, the 'scale-up' of a HIV/AIDS response involves more than a simple expansion of services, strategies and treatments. It involves a vast assemblage of resources, manpower, expertise, strategies and technologies—'a culture of practice in which new ideological frameworks become dominant and normalised', including philosophies of efficiency, transparency, participation, capacity-building and empowerment, to name a few (p. 2).

The 'scaled-up' version of HIV/AIDS prevention in Pakistan, the Enhanced HIV and AIDS Control Program, was designed by the World Bank as a public–private partnership. Recent years had seen an upsurge in international donor interest in NGO–government partnership in global health in general, but particularly in the field of HIV/AIDS prevention (World Bank 1993, 1997a; Buse and Walt 2000; Grindle 2004; Richter 2004; Pisani 2008). In adopting policies along these lines, Pakistan was merely reproducing the wider global health orthodoxy of the time. NGOs and the private sector were deemed to have a 'comparative advantage in accessing marginalized sub-populations and providing them prevention and treatment services in a cost-effective manner' (NACP 2007a, p. 7). In Pakistan there were also, of course, the legal constraints deterring the government from working directly with the criminalized 'risk groups', of which Kamal made so much in his interview.

This book explores the consequences of contracting-out HIV/AIDS prevention and care to NGOs and Community-Based Organizations. This matter is at the heart of the emerging discipline of global health. Farmer et al. (2013), in their programmatic statement on the field, contend that in comparison with its antecedent term, 'international health'—which emphasized the nation state as the 'base unit of comparison and implied a focus on relationships among states'—'global health' encapsulates 'the role of nonstate institutions, including international NGOs, private philanthropists and community-based organizations' (p. 10). The pluralizing of the state wherein it comes to share its health governance role with civil society, international financial institutions and donors is thus a key aspect of global health. Recently, Gómez and Harris (2016)

have observed that governments across the world have 'leaned on' NGOs to reach out to the key populations that are at high risk of contracting HIV/AIDS, and that 'partnerships with civil society at a time when the disease was confined largely to "high risk groups" … [have] played an important role in stemming the spread of the epidemic and contributing to improved outcomes' (p. 57). However, they also note country-specific variations in the findings. Amongst the BRICS countries, post-military rule Brazil, with its collaborative relations between state and civil society, produced an aggressive response and successful outcomes (see Biehl 2007 for a historical narrative of the Brazilian 'activist state'). But it was democratic South Africa that had the 'worst response', where HIV/AIDS denialism and antagonistic state–civil society relations fuelled a delayed response and proved extremely costly in terms of human lives (Robins 2004, 2006; Fassin 2007; Tomer 2009; Mbali 2013). Meanwhile, authoritarian China did 'surprisingly well in spite of its repressive approach and narrow engagement with civil society' (Gómez and Harris 2016, p. 56). In India, funding from the World Bank 'led to a marked growth of AIDS-focused NGOs', many of which were later implicated in fraud and failed to live up to rights-based agendas (p. 63). Even so, Gómez and Harris appreciate that some Indian NGOs became vocal in challenging the repressive institutions of the state by organizing '"sensitization meetings" that have reformulated appropriate behavior of police towards sex workers', or by holding the state accountable; they therefore formed a 'critical new part of the Indian strategy on HIV/AIDS prevention' (pp. 62–63). Historically, then, the link between government–NGO partnership and the effectiveness of responses to the HIV/AIDS epidemic remains suggestive, but open to further debate.

Outsourcing HIV/AIDS prevention to non-government organizations is undergirded by three interlinked presuppositions: that NGOs are better at HIV/AIDS prevention than governments, due to their ability to reach the parts of society that governments often cannot; that prevention services are best provided by people who are themselves members of the affected groups; and that infected people must be involved in planning programmes and delivering services (Pisani 2008, p. 174). Pisani calls these presuppositions the 'sacred cows' of the HIV/AIDS sector. Global health funders demand approaches formed from these presuppositions,

through 'strings attached' to grants and loans, and therefore governments' hands are tied to them (Beckmann et al. 2014). But as the global HIV/AIDS epidemic evolves, are these fair assumptions? What are the real-life, on-the-ground consequences of outsourcing HIV/AIDS prevention? Is there no alternative to dependence on NGOs? What does the dogma of public–private partnership entail for the delivery of the public good? As scholars or as activists, should we agree with Kamal, the NGO boss introduced above?

Most of the slim health services literature on Pakistan's HIV/AIDS response has evaluated it in terms of its failure to implement donor-funded projects, criticizing the Pakistani government for not following 'best practices' and has therefore judged it to be in need of more 'capacity-building'. For instance, in the case of the World Bank-financed Enhanced HIV/AIDS Control Program, Zaidi et al. (2012) conclude that 'capacity gaps, delays, transparency issues and mutual wariness between NGOs and government purchasers kept contracting from being as technically smooth an exercise as envisaged'; 'capacity-building measures were poorly absorbed due to rigid overarching public sector rules and low enthusiasm for modern contracting' (p. 7, and for other examples see Karim and Zaidi 1999; AKU 2000; Hussain et al. 2007; Zaidi 2008; Mayhew et al. 2009; Zaidi et al. 2011). This book seeks to shift the debate away from the popular assumption that failures to abide by global 'best practices' have simply been the result of a lack of 'capacity' in the Pakistani state and Pakistani society, or that they can be explained by related accusations of corruption, inefficiency, red-tapism and lack of political will. As I elaborate below, bureaucracies everywhere are morally embedded and operate in ways that defy analytical separations between the formal and informal, the *ad hoc* and the procedural (Crozier 1964; Herzfeld 1992; Wright 1994; Heyman 1995; Hodgson 2004; Sennett 2012). It is not only in Pakistan, for example, that we find supposedly 'technical' procedures, such as the out-contracting of healthcare services, being rolled out in ways dependent on personal networks, or that we see 'modernizing' health reformers thwarted by civil servants' attachments to established bureaucratic structures (see e.g. Leys and Player 2011 on the UK's NHS). I contend here that the tendency to measure up a country's HIV/AIDS response against the benchmark of 'best practices' cordons off those

global norms from scrutiny. Instead of spending analytic energy thinking about departures from best practices, my interest is to understand what these global norms, such as outsourcing of HIV/AIDS prevention, actually *do* to an evolving HIV/AIDS response.

I find some resonance between Pisani's (2008) assertion about how certain global norms and practices have become 'sacred cows' in the HIV/AIDS sector and Keshavjee's (2014) more recent suggestion that the failures of development programmes, such as those of the kind associated with the health reforms of the Agha Khan Foundation in post-soviet Tajikistan, are repeatedly reenacted in health arenas because the thinking underlying them is 'hegemonic' and 'overrides both quantitative and qualitative data' (p. 148). Unlike Keshavjee, however, I do not see the repeated failures of global health orthodoxies as 'blind spots'—areas of 'programmatic blindness' where 'the original aims of projects … get lost or ignored' (p. 15). I see the ascendency of particular ways of thinking as the product of systematic erasures of welfare concerns from policy debates. When international financial institutions and donors push for a 'scaling-up' of the response to HIV/AIDS in resource-poor contexts, the philosophies of efficiency, transparency, participation, capacity-building and so on become dominant and normalized. The result is that other devastating diseases, as well as the broader social conditions of HIV infection, including the fate of survivours, tend to be ignored by the global health apparatus, as Benton (2015) observes so powerfully in her work on 'AIDS exceptionalism' in Sierra Leone.

Pisani (2008) and Keshavjee (2014), in their diagnoses of why certain failing health policies persist and proliferate, draw attention to the dominant discourses embedded within these policies, or, in other words, to the 'ways of thinking and arguing … which exclude other ways of thinking' (Shore and Wright 1997, p. 22). Anthropology, with its focus on the construction of categories and scepticism towards scientific positivism, is certainly well-placed to shed light on the social processes through which such discourses become established and on the work that they achieve. But I contend that anthropology can offer more, in apprehending the imperatives of policy not only as a form of discursive power but also as a realm of *practice*. Anthropologists of development have convincingly demonstrated that international policy regimes do not simply 'arrive' but

are *produced* by intermediary actors—bureaucrats, managers, clinicians, technicians, NGO staff, health workers, engineers and so on—whose ambitions, interests and values influence the implementation of abstract global policy in local contexts (Mosse and Lewis 2005). Mosse (2005) seeks to show us how development projects become real in the gesture of their own accomplishment. The question, from this perspective, is 'not whether but *how* development projects work; not whether a project succeeds, but how "success" is produced' (p. 8). Mosse and Lewis (2005) call this approach the 'new ethnography of aid', which seeks to scrutinize 'the systematic social effects of aid relationships, the nature of sovereignty and the state, and the workings of power inequalities built through the standardization of a neoliberal framework' (p. 1). This stands in contrast to earlier critiques of development that saw it as a mere tool for Western projects of domination (Escobar 1995). Such critiques of development, Mosse (2005) argues, have concealed the differences within development and have diverted attention from the complexity of policy as institutional practice and from the social life of development projects.

My ethnography extends this body of literature by documenting the social lives of policies, such as mandatory public–private partnership, the flexibilization of bureaucracy, participatory approaches and the GIPA (Greater Involvement of People Living with AIDS) principle, for actors such as government bureaucrats, NGO workers, AIDS activists, and HIV-positive people in Pakistan. It explores the complexity of their interpretations of global health policies and the delicate dance of balancing acts that they perform in translating them into their local contexts. I detail the perspectives of both the subjects and the instigators of HIV/AIDS policy—the donors and recipients of grants, government functionaries and civil society representatives, profiteers and philanthropists, entrepreneurs of the self and selfless AIDS activists, and so on. For them, HIV/AIDS represents many different things. It is an affliction, an epidemic, a resource, a market, a profession, a stake, a strategy, and a niche. The responses to its effects are similarly diverse: for the HIV-positive it is about 'making the best of the worst'; for career bureaucrats it is an opportunity for survival in the precarious world of employment; whilst for consultancy firms, large NGOs and their associates in governments, it offers opportunities for business extension and corporate realignment.

I will now briefly introduce the three areas of concern in scholarship with which I engage in this book—bureaucracy, public goods and civil society—and signal as to how I will develop them.

Bureaucracy

…rule by writing desk. (Hull 2012a, p. 11)

This book is largely a study of HIV/AIDS work at the level of government. Bureaucracy has long been appreciated for its importance to projects of 'organized domination' (Weber 1968). Weber, who coined this phrase, wrote of bureaucracy as the apex of rational-legal power. The model he sketched out in *Economy and Society* (1968) was of bureaucracy as impersonal, detached and rule-governed, the very opposite of the personalistic social world he saw as preceding it. By now, this depiction of bureaucracy as the apex of the rational-legal order has been critiqued in anthropological work of several generations, from the seminal studies of the 'shopfloor socialities' that animate the administrative offices of large organizations (Gardner and Whyte 1946), to the ethnographies documenting the systematic dysfunctionality of bureaucracy and self-reinforcing 'vicious circles' that rigid rule-applying produces (Crozier 1964), or from the 'social production of indifference' (Herzfeld 1992) to more recent ethnographies on 'emotional' or 'affective bureaucracy' (Graham 2002; Stoler 2004; Navaro-Yashin 2006, 2009). Like other organizations, bureaucracies are morally embedded, humane and relational (Wright 1994; Heyman 1995; Hodgson 2004).

Weber (1952) was explicit that the model of bureaucracy he was setting out was an ideal, which 'cannot be found empirically anywhere in reality' (p. 128), that is to say, the rational-legal ideal is an element of what Bourdieu (1994) later called 'state thought', or those self-representations of the state that attempt to separate it off decisively from society (see Mitchell 1991; Ferguson and Gupta 2002). But in the last two decades, the accusation that developing-country governments have repeatedly departed from this ideal has been used as a stick to beat them into submitting to the market- and private-sector logics of international

financial institutions and donors. For example, the World Bank funded a study examining the 'Weberianess' of individual governments (Evans and Rauch 1999). The International Monetary Fund and the World Bank's push towards 'good governance' and 'transparency'—virtues in respect of which, we should note, Pakistan is always found wanting in comparison with most countries—feeds nakedly on a time-honoured moral and evolutionary paradigm in which 'corruption' is 'added to the list of negative characteristics that are typically applied to the "Other", such as underdevelopment, poverty, ignorance, repression of women, fundamentalism, fanaticism and irrationality'; 'corruption here is seen as endemic to some societies (i.e. "non-Western"…), and not (or less) to others' (Haller and Shore 2005, p. 3; see also: Harrison 2010; Mkandawire 2010). Anthropologists have observed that the emphasis on 'good governance' by international financial institutions is deeply connected to neoliberalization. When the World Bank (1997b) defines corruption as 'the abuse of public office for private gain' (p. 1), it is implicit that 'since corruption is primarily a pathology of the public sector, the solution lies in reducing public spending and a rolling back the frontiers of the state' (Haller and Shore 2005, p. 18). A shrunken public sector reduces the scope for corruption because it neatly 'subjects public officials to the regulatory disciplines of the market of cost-consciousness, and to entrepreneurial business ethics' (ibid.). The solution proposed by proponents of managerialism and public choice theory is thus 'entrepreneurial governance', as du Gay (1994, 2000) has detailed.

The 'enterprise' model of government tries to address the defects of traditional bureaucracies by restructuring them in the mould of private-sector businesses. It is supposed to create more 'efficient' and 'flexible' forms of administration. The lifelong job security of cadre bureaucrats is replaced by competitive tendering and contracting-out, and the formal rules and regulations of bureaucratic conduct are replaced by individual go-getting and deal-making (see also Sennett 2006; Graeber 2010). There were certainly changes in Pakistan's AIDS bureaucracy when the World Bank required it to reorganize along the lines of an 'efficient' organization, changes that I show etched very deeply into the social relations and self-conceptions of the bureaucrats. Yet the bureaucratic field that resulted from these policies was not *above* the kinds of informal systems that so

concern the World Bank and the International Monetary Fund. Rather, that the new rules of the game created their *own* informal systems, as the government explored the possibilities created by donor-stipulated policies of subcontracting HIV/AIDS prevention services to NGOs, in conformity with its policies of subcontracting core administrative functions to freelance consultants. These informal arrangements are no doubt different from those described in Pakistan's traditional 'government of paper' (Hull 2012a), but they illustrate, too, the ways in which bureaucracies typically defy binary divisions between the formal and informal, the *ad hoc* and the procedural, public office and the private sphere.

Drawing on a host of comparative ethnographies, I show how these informal systems were enabled and produced by the 'enterprise' model of government, and thereby stress the ordinariness of the Pakistani bureaucracy, instead of casting its irregularities as the result of its pathological departure from the Weberian ideal. Crucially, I also draw out how the drive to 'efficiency' had effects that contradicted the stated objective of helping the policy subjects, namely those at risk of, or already affected by, HIV/AIDS, as I now elaborate.

Public Goods

> …the assets that the state holds in trust for the people it represents. (Roy 2001, p. 36)

My participant observation at the National AIDS Control Program (the NACP) began initially in June 2010 when it was being sponsored by the World Bank's Enhanced HIV/AIDS Control Program. Through its programme, the World Bank injected major funding into HIV/AIDS prevention in Pakistan, doing so by imposing a model of public–private partnership. The NACP was obliged to call upon a management consultancy firm to 'build capacity', which would enable it to efficiently subcontract its services to NGOs, who in turn would provide HIV/AIDS prevention services on the ground. The NGOs and management consultancy firm were paid with money that came from a World Bank loan,

meaning that the bill would eventually be repaid from public funds. The second concept I engage in this study is therefore the public good.

The literature on 'corruption' and 'good governance' again provides a useful place to start. Over the 2000s, the World Bank's definition of corruption as 'the abuse of public office for private gain' was increasingly critiqued, since it obscures our view of similar practices in the private sector. The Enron and WorldCom scandals of the early 2000s showed conclusively that corruption is not something limited to the public sector in defective, non-Western state bureaucracies, but 'can also be found in the very heart of the regulated world capitalist system' (Haller and Shore 2005, p. 2). These scandals encouraged some rethinking of the concept of corruption, and Transparency International and others now refer to public-interest definitions of corruption, or in terms of 'private gain at public expense' (Anders and Nuijten 2007, p. 7; Harrison 2010, p. 259). But regardless of the blind eye that 'anti-corruption' work has long turned to corruption in the private sector (*pace* Haller and Shore 2005, p. 18), neoliberal agendas have turned an even bigger blind eye to private gain at public expense. As Harvey (2007) has so powerfully argued, the shift from state provisioning to privatization has actually been a gigantic process of dispossession of public goods. 'Accumulation by dispossession', as Harvey calls it, has produced a huge surge in economic inequalities within and between countries. Smith-Nonini (2007) observes that 'in a perusal of literature on "the commons", it is striking how rarely medicine and health services are mentioned as potential commons' (p. 115), yet neoliberal health reform policies have led to cutbacks and privatizations, which have had decimating effects on health services (pp. 116–117). Reviewing the body of anthropological studies on the impacts of Structural Adjustment policies, Pfeiffer and Chapman (2010) conclude that privatization has severely weakened public health systems, with rising health inequalities as the result. Study after study has shown how public sector staff moonlight in the private sector to subsidize their low salaries, how the windfall of funding to NGOs has drained the public sector of resources and skilled personnel, how healthcare systems are now dominated by unregulated, fee-for-service outfits, and how healthcare costs have been passed on to poor people and communities.

I extend these arguments by asking what happens to the 'health commons' of the people who are vulnerable to HIV/AIDS in Pakistan when externally-imposed public–private partnerships create new markets for HIV/AIDS prevention services and for the administration of contracts. I describe how the 'scaling-up' of HIV/AIDS prevention in Pakistan produced a quagmire of accusations of NGO corruption, mismanagement and fraud. But even more seriously, I consider how donor policies of privatizing HIV/AIDS prevention and care and support, whereby services are subcontracted to NGOs, resulted in an expropriation of the commons of public healthcare, and thus how new public goods such as 'efficiency' may emerge as a site for 'accumulation by dispossession' (Harvey 2007). Following a recent line of argument I also show how donor policies enable private sector organizations to capitalize upon, or dispossess people of, *immaterial* public goods as well as public funds and services, such as the 'cultural difference' and social capital of marginalized groups (see Elyachar 2002, 2005, 2012) and 'utopian ideals', or 'those desirable ideals that are considered universally beneficial for everyone' (Bear and Mathur 2015, p. 21; and also Brown 2015).

Civil Society

> a counterbalance … [to] keep the state accountable and effective. (Lewis 2001, p. 2)

Consensus on the definition of the term 'civil society' is hard to find, although factors like individualism and democratic institutions are taken for granted as necessary conditions. 'If democracy has a home, it is in civil society, where a mélange of associations, clubs, guilds, syndicates, federations, unions, parties and groups come together to provide a buffer between state and citizen…The function of civil society is literally and plainly at the heart of participant political systems' (Norton 1995, p. 7). Most development agencies, by extensively funding NGOs, which are often taken as synonymous with 'civil society', enthusiastically embraced this 'neo-Tocquevillian' idea (Lewis 2001). As Chandhoke (2010) explains, the attraction of 'civil society' had much to do with its ideological

association with the end of socialist societies, as seen in the 'velvet revolutions' of Eastern Europe, which cemented the discontent of observers, from across the political spectrum, with party politics and trade unions. An effective 'civil society' came to be seen as 'a sure recipe for democracy' (Chandhoke 2010, p. 176). The idea that civil society organizations and the state should have a shared function also aligned neatly with the neoliberal agenda of rolling back the state. Today, aid flows often bypass the state completely, and are disbursed directly to these organizations. But the result has been a depoliticizing of the concept of 'civil society': 'so closely allied as they are to the agendas of donor agencies, contemporary versions of civil society have drastically emptied the sphere of any other agency, such as social movements or political struggles' (ibid., p. 177). This is the tragedy that befell proponents of the concept: 'people struggling against authoritarian regimes had demanded civil society; what they got instead was NGOs!' (ibid., p. 178). A parallel anti-politics has been observed in the related development buzzwords of 'participation' and 'capacity-building', both of which came out of emancipatory thinking—the pedagogy of Paulo Freire or the Marxist-oriented school of Participatory Action Research—but have been redeployed, or coopted, as a 'counter-paradigm' to neoliberalism, or as a 'counter-ideology that develops alongside and in harmony rather than in opposition to the official neoliberal dogma' (Leal 2010, pp. 90–91; Eade 2010).

Anthropological discussions of 'civil society' have drawn out the 'mythic' character of its opposition to the state, as with Lewis's (2004) work on Bangladesh, where state and 'civil society' are linked through family ties, contracting relationships and often overlapping dependence on foreign donors, whilst at the same time, donor-imposed policies of NGO–government partnership in service delivery have brought NGOs and the state together into a collaborative relationship (Lewis 2004, p. 313). The critique of 'civil society' in Pakistan has been no less trenchant. Not only is the overall agenda of NGOs said to be controlled by the preferences of donors, but donors are perceived to have turned NGOs into 'paid consultants' (Bano 2008a, b). This perception was expressed by a parliamentarian in Bano's (2008a) fieldwork who confronted an NGO worker: 'you do not represent civil society … you represent the views of donors on whose money you survive' (p. 103). 'Nowhere in the history of

civil society has it been conceptualized as an alternative to or as independent of the state', Chandhoke (2010) observes, as 'not only are the state and civil society a precondition for the other, but the logic of one actually constitutes the other' (p. 177). But what remains to be stressed is how the state–civil society divide may also be *leveraged* by certain actors for their own political ends, as I show here—from the creation of markets in health via outsourcing to NGOs, to the opportunistic practice of appointing supposedly 'unbiased' freelance consultants, or to the maintenance of governance mechanisms that are ostensibly 'participatory' but actually serve to exclude the marginalized.

In Pakistan, the issue of 'civil society' is, as I indicated above, particularly important in relation to HIV/AIDS. Despite their claims to a rights-based agenda, the NGOs and activist forums created by health and development funds have so far been unable to challenge the country's discriminatory legal frameworks that criminalize people for their sexuality. Ethnographies of other health arenas have been optimistic about the involvement of NGOs in HIV/AIDS sectors, documenting how AIDS activists have joined together under the common ground of their seropositivity as 'pharmaceutical citizens' (Biehl 2007), as in Brazil, or as 'therapeutic citizens' (Nguyen 2010), as in West Africa, to challenge and make claims on the state (see Rabinow 1992 on 'biosociality'; Petryna 2002; see also Rose and Novas 2008 on 'biological citizenship'). But it is unclear how stable this picture is, when dependence on donor funding and patronage politics have so often been shown to generate factionalism and in-fighting; elsewhere, HIV/AIDS sectors have been described as 'heterogeneous and fragmented' and fraught with 'competitive factions scrambling for favours' (Beckmann and Bujra 2010, p. 1061; and see also Kalofonos 2010; Boesten 2011; Marsland 2012; Prince 2012; Whyte et al. 2013). Cohen (2005) has called the politics of competing interests and ideologies in the Indian HIV/AIDS sector 'AIDS cosmopolitanism': a formation of 'dislocated agents using the economically-fortified social enterprise of AIDS prevention to support its own covert projects' (p. 271). Similarly, Kapilashrami (2010) has called the Indian NGOs funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (a major global health funder I detail in Chap. 2) 'Frankenstein's monsters' (p. 226). Once created, these NGOs break away from their core priorities and

struggle to secure their sustainability by moving activities into new fundable realms. In an attempt to survive in an intensely competitive environment, they make claims on their achievements and counter-claims on their partners' abilities to deliver.

My observations extend these studies showing that 'biosociopathies' (Kalofonos 2010), rather than the 'deep democracy' (Appadurai 2001) that many hoped for, have developed as a result of donor funding in the HIV/AIDS sector. Yet I find too that questions remain in relation to sovereignty. It has been argued that the emergence of 'AIDS exceptionalism' (Smith and Whiteside 2010; Benton 2015) has allowed for a 'government-by-exception', which requires 'the enrolment, or calling-into-being, of specific exceptional populations to be saved by foreign agents', in sites that are not bounded geographically but 'exist both within and without a national border' (Nguyen 2009, p. 212). Nguyen (2010) observes that this calling-into-being of exceptional populations involves 'an exercise of sovereignty' insofar as it constitutes the power over life and death (p. 6). He shifts the emphasis away from the state, saying that, as Ivory Coast's 'national sovereignty eroded' in the face of economic decline, Structural Adjustment, and ensuing social and political turbulence, HIV/AIDS care 'escaped the control' of the state (p. 176). HIV/AIDS governance pluralized into 'an ever-more complex assemblage of institutions and management systems, an alphabet soup of acronyms and programs that make a rendering of accountability virtually impossible' (p. 177). Yet I document the Pakistani government trying to wrest back its 'sovereign responsibility' (Brown 2015) to administrate and deliver HIV/AIDS services, and thus question whether the state really loses its relevance in the face of donor funding in the HIV/AIDS sector.

Research Setting and Methods

Between 2001 and 2009, I worked as a freelance researcher in Pakistan's health sector. As a graduate freshly trained in anthropology and field research working for the government and international agencies, I took up assignments which required me to travel far and wide to collect data for large quantitative surveys and baseline qualitative studies. I worked as an enumerator, a field supervisor, a team leader and a trainer. In preparing

research reports, my work involved interactions with the subjects of health policy, from rural households to migrant workers in cities, to members of the so-called HIV/AIDS 'risk groups'. In the course of these research projects, I contributed to many reports about the dynamics of HIV/AIDS vulnerabilities in Pakistan. In one project on HIV/AIDS 'risk groups', for example, we interviewed people from gender and sexual minorities and tried to map out the patterns of their sexual preferences and practices, eventually arguing that it was ill-advised to try and place people in boxes such as 'MSM' (men who have sex with men), 'TG' (transgender) or 'CSW' (commercial sex workers) because the salient local categories of person (such as the *malshyias* or massage workers, *bante*, supposedly the penetrating partners, and *khotki*, supposedly the penetrated partners) represented continuums of behaviours rather than discrete classes. There were blurrings between these local categories, as well as official categories, as we saw from the overlap between sex workers and injecting drug users (Collumbien et al. 2009; Mayhew et al. 2009). It was rare for us to comment in these reports on the institutional dynamics that influenced people's HIV/AIDS vulnerabilities, as our gaze was directed towards 'sexier' topics. I was involved in one report, however, in which we argued that police harassment was a crucial risk factor that needed to be addressed, particularly for injecting drug users (Mayhew et al. 2009).

In the end, it was the institutional dynamics that really held my attention. I often wondered about the organizational failures and structural violence that characterized the life histories of the migrant workers, transgendered *hijrae*, homosexual and HIV-positive people I had interviewed, and wondered why we were so rarely asked to write about these in the reports we submitted to the government and international agencies. I became more and more interested in what happened to those glossy reports after we submitted them, and by the time I had started my doctoral studies at the School of Oriental and African Studies in London, I had moved quite far away from studying the experiences of the intended beneficiaries of HIV/AIDS policy directly. Instead, I was interested in the politics of Pakistan's HIV/AIDS response itself, envisaging this study as an investigation into health policy not through analyzing policy documents but through working as an ethnographer of the Pakistani

government's HIV/AIDS bureaucracy. Schaffer's (1984) pioneering work on 'policy-as-practice', with its emphasis on material concerns such as 'zones of allocations'—budgets, control and flow of resources—was instructive to me at this stage in my mission to understand policy.

I conducted ethnographic fieldwork for this book between June 2010 and September 2011, based mostly at the government's National AIDS Control Program (the NACP) in Islamabad. It was a combination of my prior professional contacts and sheer good fortune that led me to negotiate access to this institution as an anthropologist. On returning to Pakistan I approached several former colleagues in the health sector and managed to secure a personal introduction to a senior official at the World Bank who was working closely with the NACP. She introduced me to Dr Nadir, who was one of the longest-serving employees at the NACP. I told Dr Nadir that I was a PhD student in anthropology from the University of London and that I wished to study Pakistan's policy response to the HIV/AIDS epidemic through long-term fieldwork at the NACP. I gave him a copy of my CV, documenting my earlier research in public health. It was a nerve-wracking time for me. Why should the NACP let me in to observe its work? What possible incentive was there for them to let me hang around and see what they were doing? Why should they view my request for an internship in a positive light? It must have appeared to Dr Nadir as a burdensome personal request for a favour, not unlike the requests written on handwritten *parchi* notes that citizens use to informally petition officials in Pakistan's government bureaucracy (Hull 2012a, pp. 80–86). But apparently my CV documented technical aptitudes that Dr Nadir thought could be of use, such as my experience of carrying out qualitative research, authoring reports, and good English. And I was fortunate. My introduction to Dr Nadir coincided with a World Bank mission to evaluate the Enhanced HIV/AIDS Control Program, which obliged the NACP to place one of its staff as an observer. From bringer of burdensome personal request, I was transformed into a useful, free member of staff able to assist with what Dr Nadir considered tedious work. This work was not tedious for me. It enabled me to see how 'project success' was being produced in action (Mosse 2005, p. 8). With the mission, I was able to visit government offices, NGOs and HIV/AIDS treatment and counselling facilities in Islamabad, Lahore and

Karachi to conduct discussions and interviews and to dig out archival materials. I rapidly learned who was who in the sector.

Most of my work in this 'multi-sited' ethnography (Marcus 1995) was at the NACP. As a result of my immersion in the daily life of this organization, I was given access to ethnographically revealing moments that eventually directed my research questions into the three key areas outlined above. At the NACP, I was given a desk in the same room as Dr Nadir. He was my immediate supervisor, mentor and friend, and completely central to my access to research materials, inclusion in stakeholder meetings, and later, in arranging interviews. He put me to work as a note-taker in stakeholder meetings, facilitator of workshops, convenor of seminars, proof-reader of press releases, speeches and official statements, and as an author and editor of activity reports. Later, as fieldwork progressed, he drew on me for his own personal use, to rewrite his CV and prepare his job applications.

In the second half of my fieldwork, I spent more time visiting the offices of NGOs, donor organizations, and antiretroviral therapy and counselling centres in Islamabad, Rawalpindi and Lahore, carrying out observational fieldwork and interviews so as to 'study through' the policy connections and power relations and 'trace the ways in which power creates webs and relations between actors, institutions and discourses' (Shore and Wright 1997, p. 14). Part of this was done through the auspices of my work at the NACP, which provided me with opportunities for observing the work of the Provincial AIDS Control Programmes and for interacting with provincial bureaucrats and staff at the government's partner organizations and health services. Working long-term within the NACP undoubtedly imposed constraints on my interactions with people outside the institution, some of whom seemed to regard me through the lens of their relations with the NACP. I worked to develop personal relationships that would enable me to connect with people outside as well as inside the NACP, in order to transcend what Gellner and Hirsch (2001) call the 'spatial and temporal boundaries and thresholds' facing an anthropologist working inside an organization—that is, my personal relationships with people ensured I would be 'let in' when they allowed me to be part of their activities and ethnographically revealing moments (p. 5). In the second half of my fieldwork I also carried out in-depth interviews with 39 of

the individuals whom I had encountered during the earlier part of my research, which I recorded and subsequently transcribed. I believe it was crucial to have spent time at the NACP before approaching these people for formal interviews, as they were by this stage familiar with my face and presence and I was also cognizant of many of the intricacies of their positions in the sector, enabling me to generate rich and frank interviews.

Debates about multi-sited ethnography in general, and ethnography in powerful institutions in particular, have highlighted the complexities of 'insider'–'outsider' status for ethnographers like me. 'What anthropologists know is inseparable from their relationship with those who they study: the epistemology is relational' (Mosse 2006, p. 935). As a Pakistani national who had previously carried out research on HIV/AIDS 'risk groups' in the country (see e.g. Collumbien et al. 2009; Mayhew et al. 2009), I might be positioned as an 'insider' in this fieldwork, which brings with it debatable merits. Hammersley and Atkinson (1995) argue that researchers working on their own society may find suspending preconceptions difficult, since the 'novice' role in a society, potentially beneficial for learning about it, is not available to them; as such, it may be difficult for such researchers to suspend commonsense assumptions about the 'obvious'. However, Kanaaneh (1997) stresses the perceptiveness of 'insider' researchers, their extensive field competencies and the intimacy they may introduce into their accounts. What I understood from my fieldwork was that, in practice, the categories of 'insider' and 'outsider' are ideological constructions that privilege certain connections and disconnections between these categories over others, whilst positionalities in the field are unstable and blur into one another.

In the fieldwork and in writing this book, I have tried to maintain a reflexive stance, remaining mindful of the ways in which shared understandings and misunderstandings, resulting from my shifting positionalities, could affect the research interactions and outcomes. In viewing processes rather than bounded sets of individuals as the proper object of investigation, my fieldwork and analysis are inspired by the 'extended case' method of the Manchester school of anthropology (see e.g. Gluckman 1967). This method of analysis has been variously termed 'situational' or 'processual', and lies at the heart of the approaches I outlined above, where development is viewed as a process (e.g. see Crewe and

Harrison 1998; Mosse et al. 1998; Long 2001; Mosse 2005; Lewis and Mosse 2006). Falk Moore (1987, 2006) gives a particularly insightful elaboration of this method and its paramount importance for the study of social change. She notes that Gluckman called on his successors to do more than take 'extended cases' into account; he called on them to 'treat each case as a stage in an on-going process' (Gluckman 1967, p. xv). Gluckman cites his own famous paper (1958) on the ceremonial dedication of a bridge, in which he showed how Zulus and white colonials were involved in a single social system, but criticizes himself for not having followed it up. Falk Moore observes that the case of the bridge was perhaps not an 'extended case' at all, as it was a single instance and time-limited, and suggests that it could more appropriately be called an 'event'. In her own work, she began attending to such small-scale, disparate and seemingly disconnected 'events', and argued that these may be analytically combined, by recovering the history of the present state of affairs, in order 'to reflect instability and incipient change in a larger structure' (Falk Moore 2006, p. 293). Earlier, she described them as 'diagnostic events' that are potentially revealing of 'the ongoing dismantling of structures or of attempts to create new ones' (Falk Moore 1987, p. 729), and which are singularly useful for an anthropology concerned with social transformation. Her encouragement to treat fieldwork as 'current history', or to ask 'what is the present producing' (ibid., p. 727), remains true to Gluckman, who argued that a full analysis of 'process' would 'continue to trace the relations within the specific groups involved back in time, and then forward, if possible' (1967, p. xv).

The ethnographic chapters in this book take up this idea and each follows the course of an event that I proceed to analyse within a larger historical context and in theoretical terms. These events are 'diagnostic' in just the sense that Falk Moore describes: they are 'in no sense staged for the sake of the anthropologist', and come together with extensive local commentaries; and they 'reveal ongoing contests and conflicts and competitions and the efforts to prevent, suppress, or repress these' (Falk Moore 1987, p. 730). I analyse what the rumours and controversy surrounding these events diagnose about the changes that were incipient in Pakistan's HIV/AIDS sector during the time of my fieldwork. As a result of this method, however, writing this book has brought me considerable

difficulties. One of the greatest was the tension between wanting to provide rich ethnography that is redolent of the field, whilst being mindful of the risk of reputational damage to my informants. The potential effects of my presentation of sensitive information on my informants' personal and professional well-being have been constantly on my mind. I have endeavoured to respect the relationships I built with people in the HIV/AIDS sector and uphold my responsibilities towards them as a friend, colleague and researcher. Equally, however, I feel it would be unethical to censor my observations of practices that I believe were insensitive, and in some cases inimical, to the welfare of the so-called beneficiaries of HIV/AIDS policy in Pakistan. Many colleagues I worked with, observed and interviewed were 'powerful people, with high levels of financial and cultural capital, engaged in work that, while hidden from public view, was carried out on behalf of the public' (Stevens 2011, p. 239). Treading this tightrope of contradicting imperatives, to protect them, I have anonymized my informants by giving pseudonyms to the individuals with whom I worked and by disguising additional personal details revealed to suggest context. I have also given pseudonyms to the organizations working in the HIV/AIDS sector. Readers familiar with the sector may be able to track the identities of organizations and individuals, but these strategies will at least protect my informants from internet searching.

A health warning before I begin. Acronyms were used very ubiquitously in the HIV/AIDS sector to designate government departments, official designations, NGOs, different types of 'risk groups', technical procedures, project activities, groups of experts and so on. It was a veritable 'alphabet soup' (Nguyen 2010, p. 177). Similarly, the use of development jargons, like 'civil society', 'partners' and 'stakeholders', was extensive. These terms were not simply descriptive but also performative. Their use is symptomatic of the techniques of rule of South Asian postcolonial bureaucracies, which inherited a legacy of specialized language and use of writing that distanced the civil service from vernacular cultures (Gupta 2012; Hull 2012b). They also reflect the hubris of the development sector, which has a tendency to jargnonize, rendering simple things 'technical', and requiring expert knowledge to disentangle them (Mosse et al. 1998; Lewis and Mosse 2006). Inevitability, I have used many of these acronyms and jargons whilst recounting stories from the field. I

apologize to readers who may find this jargon opaque and hope that I have succeeded in achieving intelligibility whilst retaining the *in situ* codes deployed in the field. In the analyses, I have attempted to decode these terms and see how they function as mystifying 'fuzzwords' as well as buzzwords, as Cornwall and Eade (2010) so nicely put it.

Outline of the Book

Chapter 2 gives a historical overview of the HIV/AIDS epidemic in Pakistan. It shows that HIV/AIDS was initially overlooked by successive Pakistani governments because of conservative public morality and the legal code in this Islamic Republic. It then underscores the conditions that enabled HIV/AIDS to be brought into the government policy spotlight as a development problem at the instigation of the World Bank. Treating the global AIDS epidemic as an 'epidemic of significations', after Treichler (1987), I trace how particular categories of risk groups permeated into Pakistan's HIV/AIDS response and solidified as targets of interventions. I also show how technical templates and rationalities of global health and development were transplanted into Pakistan to control and prevent HIV/AIDS, focusing on the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

In Chap. 3, I describe the World Bank mission to evaluate the Enhanced HIV/AIDS Control Program and its meetings with stakeholders, many of whom were representatives of NGOs specializing in HIV/AIDS prevention for the various risk groups. Through my participation in these meetings I discerned the emergence of a new mode of 'entrepreneurial governance' (du Gay 2000) for HIV/AIDS prevention in Pakistan, premised on the elements of cultural difference of the sex workers, injecting drug users, *hijrae*, and men who have sex with men, and the presumed inability of the state to work with these criminalized groups. I detail how the World Bank's push for public–private partnership allowed a cartel of policy elites to capitalize on these elements of cultural difference in their projects of 'dispossession', and how the Pakistani government attempted to wrest back control over its responsibility to manage resources. The ethnography shows that the new public goods proposed by theories of the new public management, such as

'efficiency' and 'transparency', emerged in the Enhanced Program as a distinct site for 'accumulation by dispossession' (Harvey 2007).

Chapters 4, 5 and 6 are where I address most directly the transformations to Pakistan's state bureaucracy brought about by the new funding regimes. In Chap. 4, I present an ethnography of the everyday life of the NACP, where a mix of career bureaucrats and market-oriented professionals were brought together under the World Bank-financed Enhanced Program. Although it was a government department, the NACP was very different from the conventional government bureaucracies that have been described in earlier ethnographies (e.g. Hull 2012a). I explore the changes this brought for bureaucrats who were empowered, under the new arrangement, to discipline themselves as 'enterprising selves' (Bröckling 2005; Miller and Rose 1990; Rose 1992, 1999). Importantly, I show how the forms of power and patronage that emerged at the NACP were produced by the 'calculatingly charismatic' (du Gay 1994) mode of management prescribed by the World Bank, and not simply by the flourishing of Pakistan's reputed cultures of corruption.

The abrupt end of the World Bank-financed Enhanced Program had the effect of proliferating anxieties amongst employees, fuelled by the entrepreneurial relations it had enabled. Chapter 5 documents these anxieties, engaging literature on flexible organizations in times of crisis (Sennett 2006). I picture the drama of the Enhanced Program's demise in 2011, when the devolution of the federal Ministry of Health to the provinces was looming. This turn of events left the NACP employees struggling to keep their employment prospects intact. The NACP became a scene of crisis, reflecting the concomitant 'insecurities' of neoliberalism (Gusterson and Besteman 2010). Many employees had to leave the organization, others were laid off, whilst the remaining staff engaged in unhealthy competition with each other. As they belatedly recognized, this turn of events raised questions about the future of HIV/AIDS prevention and treatment in the country.

Chapter 6 turns to explore the bureaucratic field that succeeded the World Bank's Enhanced Program as the major funder of HIV/AIDS-related interventions in Pakistan, namely that stipulated by the Global Fund, with its elaborate reporting mechanisms and 'participatory' governance model. I discuss ethnographic vignettes of the process of 'capacity assessment' undertaken by the project partners and of the Country Coordinating Mechanism, which oversaw project implementation.

Exploring the 'capacity assessment' that determined the inclusion or exclusion of NGOs in the grant, I draw attention to how political actions were articulated through the idiom of impartial technical procedures and the expertise of 'unbiased' international consultants. In the micro-politics of 'policy-as-practice' (Schaffer 1984), the boundaries of state and society are not only 'blurred' (Gupta 1995) but also employed to political ends, an argument I develop through my observations of the Country Coordinating Mechanism. The stated objective of the 'participatory' governance model is broad-based participation in HIV/AIDS prevention, care and support, but I show how Kamal's NGO, with its enhanced portfolio accumulated under the World Bank's Enhanced Program, emerged as a key player and stood poised to become the sole Principal Recipient of the grant.

Chapters 7 and 8 develop the focus on 'civil society'. Chapter 7 discusses the contest between the government and a Community-Based Organization of HIV positive people over the care of PLHIV or 'People Living with HIV', and traces the role of international donor funding in this conflict. I begin by recounting the story of the pioneer of AIDS activism in Pakistan who became one of the influential leaders of the HIV/AIDS sector when he set up the first CBO of PLHIV. As the role of his CBO was extended to become an 'organizational conduit' (Lyttleton et al. 2007), in order to assist in the provision of free antiretrovirals funded by international donors, the staff at local health departments saw this CBO as getting 'too big for its boots'. Resenting the CBO and its outreach workers for the resources at their disposal, and for their apparent preferential treatment by international donors, they took back their 'sovereign responsibility' (Brown 2015) to provide and administrate public resources.

Chapter 8 extends this narrative to the next CBO of HIV-positive people that emerged in Pakistan, a splinter group, which established itself with the help of competing interests within the government and donor agencies. Broadly, this chapter speaks of the relations between CBO bosses and their clients, between donor agencies and the community of beneficiaries. I bring into the discussion divergent visions for empowering HIV-positive people, or for their participation in HIV/AIDS policy, which were affected by claims and contestations over authenticity and allegations of corruption. The case of an Association of PLHIV is illustrative of how the universalizing models of 'civil society' and 'empowerment', carried in the global health and development discourse, were

appropriated by a few to advance their personal agendas. I engage critically with the literature on HIV-positive people, which posits their biological condition as foundational to their sociality to the extent that it becomes the basis of their political identity. I argue that literature embracing ideas of 'biological citizenship' has closed off discussion of the 'uncivil' acts taking place within this 'civil society'. As before, my ethnography shows that the template of intervention that was transplanted into Pakistan, devoid of broader welfare concerns as it was, turned AIDS activism into a 'market of dispossession' (Elyachar 2005).

In the concluding chapter I draw together the main arguments of the ethnography to comment on what these interventions entailed for the intermediary actors of global health policy in Pakistan, and on what my study implies for the study of public goods, bureaucracy and civil societies, specifically in the context of HIV/AIDS activism. I return to the broader questions identified above concerning the wisdom of public–private partnership as a policy orthodoxy, notably in punitive legal frameworks such as exist in Pakistan. Whilst my ethnography provides little support for the dominant policy model of public–private partnership, it also provides little ground for nostalgia about the state of public health systems in Pakistan. What might alternative arrangements look like, no matter how radical?

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2

AIDS in the Islamic Republic

In this chapter, I present a historical narrative of Pakistan's policy response to HIV/AIDS. Throughout the 1980s and 1990s, successive Pakistani governments chose to ignore the problem of HIV/AIDS because a conservative public morality attached stigma to it. However, this changed in 2003 when the World Bank extended a loan to massively scale-up and restructure HIV/AIDS governance (see Kenworthy and Parker 2014 on the global 'scale-up' decade in HIV/AIDS). In 2010, when I started my fieldwork at the NACP, bureaucrats, NGOs and activists in the HIV/AIDS sector were fully anticipating that the World Bank-financed Enhanced Program would be extended for a further five years. In the event, it was not, and the Global Fund to Fight AIDS, Tuberculosis and Malaria took over from the World Bank as the major donor for HIV/AIDS prevention in the country.

This chapter traces the origins of this scale-up, showing that Pakistan accepted the World Bank's loan due to a combination of political imperatives and expediencies. I show that, to a large extent, the policy spotlight on HIV/AIDS that developed after 2003 reflected global health policy priorities that were not echoed by public health experts in Pakistan, many of whom argued, despite the growing evidence of HIV/AIDS spreading in neighbouring countries in South Asia, that the public health threat of

A. Qureshi, *AIDS in Pakistan*, https://doi.org/10.1007/978-981-10-6220-9_2

hepatitis and of other infectious diseases was more imminent. I detail the policies that the World Bank and the Global Fund, the two major donors, stipulated for Pakistan's HIV/AIDS response. I show how the perceived immorality and criminalized status of the 'risk groups' was used as a pretext by the World Bank to justify contracting-out HIV/AIDS prevention to NGOs, whilst the Global Fund contracted NGOs and Community-Based Organizations not only to provide care and support services, but also gave them an expanded role in the governance of the grant.

In all this, the chapter lays the ground for the ethnographic material that follows, showing how the scaling-up of Pakistan's HIV/AIDS response petrified epidemiological risk categories from elsewhere and imported global templates of intervention into the country.

AIDS and Public Morality

The first case of HIV/AIDS in Pakistan was diagnosed in 1986. This resulted in the formation of a multi-sectoral Federal Committee on AIDS, with the aim of defining broad policy guidelines for HIV/AIDS control in the country. This committee was short-lived and soon became defunct (NACP 2007). It was replaced in 1988 by the National AIDS Control Program, the NACP, which was established in the Ministry of Health as a vertical disease prevention programme. Vertical programmes were promoted in other countries, too, to ensure a distinct focus on HIV/AIDS (Pisani 2000; Berer 2002; Béhague and Storeng 2008). In Pakistan, however, it is notable that the first national health policy developed after the detection of HIV—the 'People's Health Policy' of 1990—did not contain even a mention of the disease. Shehla Zaidi (2008) interviewed government officials, representatives of international agencies, public health experts and NGOs in Pakistan in 2005 as part of her evaluation of the process of contracting-out HIV/AIDS prevention services to NGOs. Her informants related that this omission in the 'People's Health Policy' was the result of 'political shyness'. The democratic government of Benazir Bhutto's Pakistan People's Party, which had come to power after the decade-long military dictatorship of Zia ul-Haq, thought of HIV/AIDS as a 'western disease' linked to the 'bad habits' of foreigners, and hesitated

to commit to a more 'in-depth involvement' (Zaidi 2008, pp. 69–70). The thinking in the government circles at that time was summed up by one of Zaidi's (2008) international agency informants: 'Benazir Bhutto['s government] had refused to take up AIDS … [because] … "democracy has come in … people will think Benazir has brought in AIDS"' (p. 69). HIV/AIDS also had little mention in each of the country's five-year development plans until 1993 (GoP 1994). Up to the late 1990s, the government's health bureaucracy had negligible involvement with HIV/AIDS and little attempt was made towards mainstreaming HIV/AIDS prevention and care in the health delivery system.

Meanwhile, the number of diagnosed HIV/AIDS-positive people increased from 56 in 1990, to 240 in 1993, and to 1021 in 1995 (Kazi et al. 1996). By 1994, therefore, the government was pushed to initiate a media campaign for HIV/AIDS awareness. Sensitive to Islamic public morality, the media messages were not explicit about the causes of the disease. Instead, they invited people to call a dedicated hotline for more detailed information. The hotline delivered pre-recorded messages about the importance of condom use for HIV/AIDS prevention and encouraged those who suspected themselves of infection to go for HIV/AIDS testing. Callers could also leave their addresses or phone numbers, or visit the NACP if they wanted more information. The hotlines received between 250 and 300 calls daily and the NACP received around 400 letters every week. Meanwhile, the NACP held sessions with Islamic leaders and journalists to obtain support for their AIDS awareness work (Lynn 1994).

A group of public health experts who were associated with Aga Khan University and Jinnah Postgraduate Medical College in Karachi worked closely with the Centre for Disease Control in Atlanta and researchers from the University of Alabama to conduct research on the 'high-risk groups' in Pakistan. The 'Karachi Working Group', as they called themselves, presented their findings in the first national conference on AIDS in 1995 in Karachi. Comprised mainly of epidemiologists, the group emphasized the central importance, to HIV/AIDS prevention, of combatting risky practices and behaviours (Kazi et al. 2000; Khan and Hyder 2001). Their epidemiological studies showed that the 'taboo Western disease' was associated with commercial sex workers, transgendered *hijrae*,

injecting drug users, men who have sex with men, and internal migrants, all of whom came to be labelled 'high-risk groups'. As Zaidi (2008) argues, their definitions of risk groups were 'guided by broad international classifications, with existing local research merely confirming risky behaviour in pre-defined groups rather than providing definitions from inductive research' (p. 68, and see further discussion below).

Between 1990 and 1995, HIV/AIDS moved from being only a disease of Westerners or foreigners (the 'other' abroad) to one of the so-called 'risk populations' (the 'other' at home); Pakistan therefore saw a 'domestication of AIDS' that had also occurred in other South Asian countries (Pigg 2002). Already marginalized and stigmatized in society, these domestic 'others' were not merely thought to be at great risk of contracting HIV/AIDS, due to their shameful lifestyles, but also a threat to the 'general population'—the innocent masses—to whom it was feared the infection might spread. Targeted interventions amongst the risk groups were therefore deemed necessary to contain the virus. However, a big challenge for the NACP was to identify and separate these 'risk groups' from the 'general population' so as to implement these interventions. Their efforts met with frustration. The NACP blamed the stigma associated with HIV/AIDS and the 'silence and denial' by members of the 'risk groups' for limiting the 'scope of awareness programmes and efforts to mobilize communities and resources'; 'cultural, social and religious taboos have inhibited public discussion of sexual behaviours' (NACP 2007, pp. 4, 12). Perhaps the Pakistani state was genuinely constrained by cultural taboos, or perhaps, as Castro and Farmer (2005) have argued elsewhere, it used stigma as 'a means of giving short shrift to powerful social inequalities that are much harder to identify and conceptualize' than cultural taboos (p. 53). Political expediency aside, the human rights literature has documented pathologically high levels of discrimination and contempt towards sex workers, injecting drug users and transgendered *hijrae* in Pakistan, and has reported of their harassment, intimidation, arrest, and incarceration, and of the demand of bribes, sexual favours and other abuses of power, by police authorities (Mane 2004; HRW 2008; Mayhew et al. 2009). On the one hand, then, the 'risk groups' continue to be the targets of government intervention and policies, and on the

other, the rights of individuals belonging to these groups are 'not specifically protected in law' (Mayhew et al. 2009, p. ii32). The abuse faced by 'high-risk groups' has been criticized as 'not only a violation of their physical and mental integrity', but also, as something that may lead to an 'increased risk of HIV/AIDS' (ibid., p. ii34).

The existing laws in Pakistan criminalize the non-therapeutic use of drugs through the 1997 Control of Narcotic Substances Act mentioned in Chap. 1; they also penalize homosexuality, prostitution and adultery (HRW 2008). Under the Pakistan Penal Code, Section 377, titled 'Unnatural offences', the punishment for anal intercourse, or 'carnal intercourse against the law of nature', is potentially 'imprisonment for life'. It reads as follows:

> 377. Unnatural offences: Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with imprisonment for life, or with imprisonment of either description for a term which shall not be less than two years nor more than ten years, and shall also be liable to fine.
>
> Explanation: Penetration is sufficient to constitute the carnal intercourse necessary to the offence described in this section.

The Penal Code was inherited from the British colonial administration of India, introduced in 1862. In recent years, scholarly critiques have concluded that it was introduced in an attempt by the colonizers to impose Victorian values on Indian polity and society (Misra 2009). With reference to Section 377, scholars have argued that homosexuality was a comfortable social reality in pre-colonial India. Of Victorian England, too, historians have drawn attention to the 'secret world' of prostitution, pornography and a strong homosexual counter-culture opposed to moral teachings about the sacrosanct nature of reproduction (see Marsh 2016). The legal historian Skuy (1998) has emphasized that the Indian Penal Code was not a straightforward replica of English law as English law did not, and in fact never has had, a criminal code, illustrating that 'imperial powers were often able to do in their colonies what they were unable to do at home' (p. 513). Laws such as Section 377 persist in many post-

colonial countries. Significantly, India recently repealed Section 377 after a long-drawn struggle by sexual minority activists (Misra 2009), but in Pakistan, this law continues to criminalize deviant forms of sexuality and produce quasi-legal populations of homosexual men. Similarly, convictions under the anti-prostitution law in Pakistan—the West Pakistan Suppression of Prostitution Ordinance of 1961—are subject to the provisions of the 1898 Criminal Procedure Code (GoP, UNDP and UN Country Team 2015, pp. 52–53).

Adding further to the severity of these laws, General Zia ul-Huq made extramarital sex (*zina*) punishable by death under the infamous Hudood Ordinances promulgated in 1979, as part of his attempt to Islamize the Pakistani state and its society during the military dictatorship (Jahangir and Jilani 1990). Even after the return to democracy in 1989, it has been argued that dominant nationalist notions, together with cultural practices around public morality and secrecy, act against the discussion of 'sexuality' in a public sphere that has been described as 'multiphrenic' (Werbner 2002, p. 189). The taboo on public discussions of sexuality thus jars with the sexually charged subcultures of young men (Walle 2004), with the explicit representations of the female body in film posters and *mujra* dance (Batool 2004), and with the titillating stock figure of the courtesan in popular culture (Asdar Ali 2005).

In 2007, the NACP initiated a piece of legislation, the HIV and AIDS Prevention and Treatment Act, premised on the claim that the 'at risk' populations and their family members 'experience a lack of human rights protection and discrimination, and are marginalized by their legal status, which may disempower them into avoiding to seek HIV tests and prevention-related measures' (NACP 2007, p. 4). Ironically, the main thrust of the proposed legislation was to guarantee protection against arrest, detention and harassment for NGO outreach staff engaged in HIV/AIDS prevention work, rather than protection for the injecting drug users, sex workers, transgendered *hijrae* and men who have sex with men, who are at risk of contracting the virus and of disenfranchizement from prevention and testing. However, even this proposed legislation could not move beyond the stage of vetting in the Ministry of Law.

The Policy Spotlight

The NACP remained a laboratory-oriented programme for five years after its establishment in 1988, supported principally by the WHO (Kazi et al. 2000; UNAIDS and MoH 2000). In 1993, the World Bank-funded Social Action Program began in Pakistan, undergirded by the World Bank's rationale for achieving poverty reduction by linking overall economic growth to sector-specific strategies (ADB 2005). In the health sector, although the primary focus of the Social Action Program was maternal and child health, and family planning, the deteriorating budgetary deficit during the 1990s led to bridge financing of all federal vertical programmes. The NACP was one of them. It was brought under the broader Social Action Program Project (UNAIDS and MoH 2000; NACP 2007), and HIV/AIDS control activities were extended by establishing Provincial Implementation Units, which later became Provincial AIDS Control Programmes (PACPs).

By 2003, donor funding constituted only 20% of the total HIV/AIDS-related outlay and was criticized for being sporadic and loosely monitored. A UN Theme Group on HIV/AIDS, which was responsible for aid coordination and technical support, brought together a large number of stakeholders to prepare Pakistan's National Strategic Framework 2001 as 'a common vision of the future' (UNAIDS and MOH 2001). Some UN agencies provided small-scale grants to the NACP, the Provincial AIDS Control Programmes, the Anti-Narcotics Control Force, the Ministry of Labour and a few large NGOs for HIV/AIDS prevention activities. In particular, the NGO Population Services International worked with a local partner, Greenstar, to carry out behavioural research and Behaviour Change Communication activities amongst female sex workers and truckers (WHO 2003). Other international NGOs funded projects with students, teachers and Afghan refugees.

This landscape of small-scale interventions changed completely after the introduction of the Enhanced Program. A major restructuring of the health sector can be traced to the aftermath of 1998, when Pakistan carried out its first nuclear explosions and faced economic sanctions as a consequence. Following the sanctions on trade and investment, bilateral

and multilateral aid decreased sharply, resulting in a crisis of foreign exchange reserves and economic instability in the country (Ravindran 2010). International lending institutions, including the World Bank, met the shortfall in donor funding by extending loans on the condition of Structural Adjustments, which included the privatization of the health sector (World Bank 2006). Also in 1998, the World Bank issued a health strategy paper for Pakistan, which recommended that the health sector should enter into partnership with the private sector in order to provide government-financed health services (World Bank 1998). After 9/11, however, when Pakistan became a key ally in the 'War on Terror', economic sanctions were lifted. USAID reopened its offices in Pakistan, and other bilateral donors followed suit, coinciding with a wider focus, amongst global health agencies, on the HIV/AIDS epidemic in Asia and the discovery of several new cases in Pakistan (NACP 2001). HIV/AIDS became a favoured area of donor funding, with the World Bank providing the overarching policy framework of contracting-out to the private sector.

The Enhanced Program

In 2003, the federal government embarked upon the World Bank-pushed agenda of public–private partnership for HIV/AIDS prevention under the Enhanced HIV and AIDS Control Program. This policy was in keeping with the broader current of international donor interest in NGO–government partnerships that had been swelling in the public health sector in general, but particularly in HIV/AIDS prevention (World Bank 1993, 1997; Buse and Walt 2000; Grindle 2004; Richter 2004; Pisani 2008; Kenworthy and Parker 2014). World Bank experts convinced the then Finance Minister to invest in 'scaling-up' the HIV/AIDS response as HIV/AIDS was, in their opinion, a development problem rather than a health problem alone, a view supported by the WHO's Commission on Macroeconomics and Health, which had recently published findings to the effect that improved health outcomes could boost economic growth (Messac and Prabhu 2013, p. 126). The Finance Minister of Pakistan, who was a former commercial banker from New York, and had recently

arrived in the country to serve with other returned expatriates in the technocratic military regime of General Musharraf, took a favourable view of the World Bank's development policies (Zaidi 2008, p. 103). The loan for the Enhanced Program was accepted at a time when the military regime of General Musharraf was in desperate need of international recognition and partnership (Zaidi 2008, p. 82). The government agreed to invest in HIV/AIDS prevention amongst the marginalized 'risk populations' at home in order to project a positive, caring and progressive image abroad (Zaidi 2008, p. 104)—a soft image of Pakistan internationally, which the government's official policy and rhetoric at that time projected.

In lobbying for the new focus on HIV/AIDS, the thrust of the World Bank's message was on the urgency of the threat of the epidemic globally; its reports on South Asian countries made repeated references to its experience in Africa. The World Bank also stressed the rapid advance of the epidemic regionally, since India's National AIDS Control Organization had estimated, in 1999, that four million Indians were HIV positive, whilst the government of Bangladesh had warned of rising rates amongst commercial sex workers and injecting drug users (World Bank 2000, 2001). In its Pakistan 'HIV/AIDS Technical Review Mission' report, the Bank warned that 'based on observations of HIV progression in South Asia, a probable scenario for Pakistan would consist of a doubling of HIV prevalence every two years or so' (World Bank 2001, p. 11). An effective response would require rapid up-scaling of commitment to match spending levels in neighbouring countries in South Asia, where the World Bank had initiated similar programmes: in India in 1999, and in Bangladesh in 2000. In the 'Technical Review Mission' report, the World Bank highlighted that whilst Pakistan, in 2000, had an annual budget of US$1.53 million for its HIV/AIDS prevention and control programme, Bangladesh, 'a country with a population slightly lower than Pakistan['s], and at about the same stage of the HIV epidemic', was 'set to spend about US$10 million/year for the next five years to carry out a somewhat narrower program than the one envisaged in the National Strategic Framework' (World Bank 2001, pp. 6, 13).

In spite of the government's willingness to avail itself of the loan opportunity, there was some scepticism in the public health community in

Pakistan about whether the World Bank's loan was needed. Anticipating Benton's (2015) critique of the 'exceptional' levels of funding for HIV/AIDS prevention in Sierra Leone, to the detriment of attention to other diseases, the public health community thought that the lack of epidemiological evidence of widespread HIV/AIDS in Pakistan made the need to address other health problems, notably hepatitis, more pressing. Against a few scattered cases of HIV/AIDS, the prevalence rate of hepatitis B and C in the adult population at the time was up to 30% in some localities (Simonsen et al. 1999). A study in 1999 of 200 injecting drug users in Lahore found that none of them were HIV/AIDS positive, but 89% were hepatitis C positive (UNODC and UNAIDS 1999). The finding was particularly stark, as these forms of hepatitis, like HIV/AIDS, are bloodborne viruses. An unnamed public health expert complained to Zaidi (2008) about HIV/AIDS funding: '…not everybody is convinced … (the) Minister says "our issue is hepatitis" … the Departments of Health in the provinces say "our issues are diarrhoea and malaria. This [HIV/AIDS] is the donors' agenda"' (p. 72). According to an unnamed official from an international donor agency, 'HIV/AIDS is in high fashion…In Pakistan [however] there are other unfinished agendas…Many would say that hepatitis is the HIV/AIDS of Pakistan' (ibid., p. 128). Even amongst the pro-HIV stakeholders there was unease with the proposed funding being disproportionate to the problem, given the rising levels of hepatitis. Another objecting public health expert complained of unfair accusations: 'we were accused, "you are not looking at the fire that is about to erupt". I replied that "I am concerned with the volcano (hepatitis infection) that is erupting"' (Zaidi 2008, p. 103). The Joint United Nations Programme on HIV/AIDS (UNAIDS) helped to lay the ground for the World Bank by sponsoring an exposure visit to India aimed at sensitizing the Health Secretary with statistics on the spread of HIV/AIDS there, so as to highlight the immediacy of the threat to Pakistan. The statistics on India's concentrated epidemic and the up-scaling of HIV/AIDS programmes in neighbouring South Asian countries served to bring home the proximity of the threat. An interviewee from an international development agency recalled that 'there came a general sense that AIDS is here in Asia … you saw alarming figures being given for India. Once India gets noticed then Pakistan is bound to get noticed too' (Zaidi 2008, p. 104).

The Ministry of Health was sidelined in the negotiations with the World Bank, and the Ministry of Finance dominated proceedings. The World Bank stipulated to the Ministry of Health that a shake-up in the NACP leadership was needed. The incumbent NACP manager was reassigned to his original post in the Ministry of Health and replaced by a younger member of staff who had represented the NACP at the initial discussions with the World Bank and had proven herself to be receptive to its guidance and expertise (Zaidi 2008, p. 108). The subsequent marriage of this new NACP manager in the following year to a World Bank official, who had been involved in designing the Enhanced Program, cemented the connection between the World Bank and the NACP. Although the marriage required a reshuffling of staff at the World Bank, for many in the health sector the addition of a personal link only strengthened the close and informal ties between these organizations that had already been apparent (Zaidi 2008, p. 109). The projected cost of the Enhanced Program was US$47.7 million, of which 15% was to be contributed by the government, whilst most of the remaining 85% was to be financed by a 'soft' loan from the World Bank, supplemented by some grant money from the UK's Department for International Development and the Canadian International Development Agency.

The policy that the World Bank stipulated for Pakistan's HIV/AIDS response was of contracting-out HIV/AIDS prevention to NGOs. The stated rationale was that 'the discriminatory setting and lack of support from the government were felt to directly impede containment of HIV infection' (Zaidi 2008, p. 228). Through the policy of public–private partnership, the Enhanced Program also sought to restructure the government's bureaucratic management of HIV/AIDS prevention along the lines of an 'efficient' business. Due to their better management systems, and greater capacity for outreach in the field—in other words, due to their reputations for 'efficiency'—the bigger, better-established NGOs and firms were to be preferred (Zaidi 2008, p. 35). The Enhanced Program therefore followed the neoliberal logic of marketizing service provision, and brought about a major shift away from traditional bureaucratic proceduralism to a 'flexible' bureaucracy (du Gay 1994, 2000; Shore and Wright 1997; Sennett 2006). Flexibilization was achieved through the reshuffling of top bureaucrats, which involved replacing

them with experts from outside the government, by filling key positions in AIDS control departments with 'market-based' employees, by awarding large province-wide contracts to a small number of influential NGOs, by obliging the government to hire a management consultancy firm to teach it the principles of business management, and by shelving the reputed 'red tape' of rules, regulations and procedures of the government bureaucracy in the name of 'efficiency'.

After hastily completed negotiations—reflecting a common 'sign first, decide later' approach in negotiating loans and grants with development partners (Anders 2005, pp. 83–84)—Zaidi found that substantial rifts had emerged amongst the stakeholders by the time she was appraising project implementation in 2005. In particular, the stakeholders of the Provincial AIDS Control Programmes were unhappy because they resented the Enhanced Program, which had caused the federal government to buy into the neoliberal rationale of the World Bank, and had overseen the awards of contracts to big firms and NGOs at the cost of neglecting the smaller ones, with whom they were already working on a smaller scale. Even though the money was loaned to the government, and was ultimately to be repaid from the public purse, many in the provinces felt the government had little control in designing or awarding the contracts (Zaidi 2008, p. 118).

The results of the exercise were that out of 36 planned contracts awarded under the Enhanced Program, only 24 materialized. The remaining 12 could not go ahead due to 'problems in procurement' (World Bank 2010, p. 35), which is to say that the government could not find NGOs or companies willing to work in troubled parts of the country. Not all of 24 contracts completed their stipulated duration. Some were terminated within months, whilst others dragged along (as Leys 2010 has identified, contracts for healthcare and health services are notoriously difficult to enforce). The large and influential NGOs that received the contracts sometimes did not have any experience of working in the health sector at all—let alone with HIV/AIDS—but were simply selected because their size ensured their financial viability (Zaidi 2008, p. 124). Small NGOs, which had demonstrated past commitment to HIV/AIDS prevention, were decimated by the contracting model, which promoted the entry of commercially motivated firms. An NGO leader Zaidi

interviewed feared that 'small NGOs are being wiped out … since the Enhanced Program has come in other donors who used to assist in the past are no longer giving funds. These contracts being given are too big' (ibid.). Paradoxically, the pooling of donor funds into the Enhanced Program presented a serious threat to the organizational survival of Pakistan's HIV/AIDS-focused NGOs. There were demands to include a capacity-building element in the grants, with calls for greater donor responsibility to continue and sustain projects. However, there was little flexibility in the proposed contracting framework, which NGOs blamed on 'a tight circle between the NACP and the World Bank'; the NGO leader complained that 'it is all connected with the commercial model of the World Bank' (Zaidi 2008, p. 125).

As Harman (2010) has observed of the World Bank's Multi-Country HIV/AIDS Program in Africa, there was little substance to the World Bank's rhetoric of government ownership and 'civil society' engagement. The agenda was of privatization and of rolling back the frontiers of the state, rather than supporting NGOs already working on HIV/AIDS prevention. The lack of data to suggest an imminent threat from HIV/AIDS only served to fuel scepticism over its motives in the face of other health problems in the country. In retrospect, a colleague of mine at the NACP regretted that the Enhanced Program was 'pushed by the World Bank to improve their own balance sheet', and that the wish to win legitimacy internationally was what motivated the military government's decision to accept its terms.

The HIV/AIDS 'scale-up decade' (Kenworthy and Parker 2014) was characterized by increasingly technocratic and top-down initiatives, which generated thousands of jobs in the new administrative apparatus. The increased spending on HIV/AIDS prevention resulted in a significant expansion of the HIV/AIDS bureaucracy and a phenomenal increase in the number of NGOs and activists in the HIV/AIDS sector. The NACP, which had been a small, laboratory-oriented programme sponsored by the World Health Organization since 1988, had been scaled-up to employ a large number of 'market-based' contractual staff, health bureaucrats, and expensive international experts and consultants. It became a government department that was run like a private firm. A large number of contractual employees were hired to work with civil servants

of the health department, combining different styles of management and bringing different logics and rationales to the work. The policy of contracting-out HIV/AIDS prevention to the private sector aimed to reduce the government's role to that of a purchaser of services. As the contracts were rolled out with borrowed money, I will suggest, the government took a back seat, undermining the development of a sustained institutional response and long-term strategy in the public sector.

The Global Fund Project

The Global Fund to Fight AIDS, Tuberculosis and Malaria is a multilateral organization funded by both public and private donations. It was established in 2002 as a response to the clamour of voices demanding to 'redefine the possible' and 'reset' institutionalized assumptions about the constraints imposed by limited resources, and the perceived impracticality of delivering antiretroviral therapy, in countries lacking adequate primary healthcare (Messac and Prabhu 2013, pp. 110, 114). In diverting funds from existing bilateral and multilateral agencies, the Global Fund claimed to be setting out a new playing field, one of 'not doing "business as usual" but rather holding itself to "new levels of fiscal accountability"' (Adams 2016, p. 41). The goal was to create new ways of evaluating not only what money was spent on, but also, what targets had been achieved.

In 2003, Pakistan obtained funding in the Global Fund Round-2 to sponsor a HIV treatment programme, which was started by setting up five antiretroviral therapy centres in major government hospitals. The number of those needing antiretroviral therapy had reached 400 in 2005. By the end of 2009, Pakistan was estimated to have some 98,000 HIV/AIDS-positive people (NACP 2012). Yet, by March 2011, only 4455 HIV/AIDS-positive people, comprising of 3399 men, 873 women and 183 children, had been registered at the 15 antiretroviral therapy centres across the country (NACP's ART centres monthly report, available from the author). Most of them were already in terminal stages of the illness because they were referred after very late diagnoses, often after spending a small fortune on different providers and treatments. The treatment centres did not categorize their beneficiaries into various types of 'risk

groups'. However, when I interviewed treatment centre staff as part of my work for the NACP, they were unanimous that the majority of the diagnosed HIV-positive cases were returned migrants from the Persian Gulf—thus they arrived via one of Pakistan's largest streams of emigration (Addleton 1992)—and their family members. Except at one antiretroviral therapy centre, there were very few injecting drug users, and there were almost no sex workers or transgendered *hijrae* amongst those registered. To address this 'data gap' concerning the 'identity' of beneficiaries, a Management Information System was therefore proposed in the Global Fund Round-9 grant, which would record information, including migration history and 'risky behaviours', so as to help the government categorize them into 'risk groups'.

The Global Fund Round-9 grant, of more than US$43 million, was accepted in June 2010. The NACP was one of the two Co-Principal Recipients: the other was Naya Sewaira, an NGO whose Chief Executive Officer, Kamal, I introduced at the start of the book (the translation of the Urdu name of this NGO is 'New Dawn'). Under the grant proposal, the NACP would channel funds to three big NGOs, termed Sub-recipients, who would then disburse those funds to a number of CBOs, dubbed 'Sub-sub-recipients', who in turn would establish Community and Home-Based Centres for HIV-positive people and their families in 30 locations. Two local NGOs would be subcontracted for the capacity-building of the community centre staff and peer outreach workers. Using this grant, the NACP would also work to strengthen the 'Association of People Living with HIV' (see Chap. 8), the Provincial AIDS Control Programmes, and NGO partners, through training and workshops. The NACP was responsible for only one-third of the grant money. The remaining two thirds would be spent by Naya Sewaira to establish a Continuum of Prevention and Care for 28,000 injecting drug users, their families and sex partners, through its own set of Sub-recipients.

The design of the Global Fund project stood in contrast to the Enhanced Program. The contracting-out in the Enhanced Program was 'output-based', or premised upon what Kamal called 'lump-sum' funding. The contracted partners were provided funds in several installments over the contract period in order to carry out agreed interventions. The implementation of these contracts was loosely monitored by a

management consultancy firm in a process that was highly contested by some partners (see Chap. 3). The overall performance of a contracting partner was inferred indirectly from the trends in HIV/AIDS prevalence in its target groups and districts, as documented by the NACP's HIV and AIDS Surveillance Project's (HASP) annual bio-behavioral surveillance. To link changes in HIV/AIDS rates to targeted interventions in this way, according to many in the HIV/AIDS sector, was an excessively vague means of measurement (see Weir et al. 2003 on the difficulties of evaluating targeted interventions). By comparison, recipients at all levels in the Global Fund project had to achieve time-bound, verifiable targets in order to meet the 'condition precedents' for the release of the next quarterly tranche of funds. These targets drew upon measures such as the numbers of Community and Home-Based Centres or Continuums of Prevention and Care that had been established, the numbers of service users registered or workshops conducted, and so on. The flow of funds from top to bottom was linked to these performance indicators and the whole process was to be rigorously monitored by the United Nations Office for Project Services, the Local Fund Agent working on behalf of the Global Fund. An official at the NACP commented to me that 'the issue with the Global Fund is that every dollar is tagged'. The Global Fund bureaucracy was criticized by NACP officials and by the Chief Executive Officer of Naya Sewaira for being too meticulous and slow, again in contrast to the 'getting-things-done' ethos of the World Bank-sponsored Enhanced Program. Frustration at the bureaucratic requirements of the Global Fund has been a consistent finding in recipient countries (see Brugha et al. 2004; Taylor and Harper 2014).

A key aspect of the Global Fund is its emphasis on a participatory mode of governance in which civil society representatives are brought centrally into the decision-making process. The formal arrangements stipulated to ensure this is brought about is the Country Coordinating Mechanism. It is a requirement of the Global Fund that a country should have a Country Coordination Mechanism, even in order for it to be eligible to submit a grant application. The Country Coordinating Mechanism for the Global Fund Round-9 grant was a forum of health bureaucrats, donors, NGO representatives and other representatives from 'civil society', whose job was to vet and submit applications for the Global

Fund's money and oversee project implementation. For each round of the Global Fund's grant application process, the NACP prepared applications with the participation of 'civil society', which in practice meant involving a few Islamabad-based NGOs and some international consultants paid for by the UNAIDS, as 'technical assistance' to the government. In her study of the Global Fund in India, Kapilashrami (2010) argues that these arrangements, ostensibly stressing 'partnership', are an instrument to extend technocratic control and advance the interests of transnational elites whilst concealing the agency of outsiders. The outsiders achieve their objectives by manipulating local elites and coopting critical discourses, and thus contribute to widening and deepening neoliberal agendas under the guise of the autonomy of the people through 'participation' in civil society.

Although their templates were different from one another's, at the core of the World Bank's and the Global Fund's policy regimes was the promotion of public–private partnership and the fostering of 'civil society'. Both used the rhetoric of 'participation' to promote a greater role for non-governmental entities under the rubric of subcontracting to NGOs, as reflected in the greatest share of funds, for both projects, going to Naya Sewaira, the main 'civil society' partner (see Chaps. 3, 4 and 6). As discussed in the introduction, these policies have become 'sacred cows' (Pisani 2008) in the global HIV/AIDS response, yet historically, the link between NGO–government partnership and the effectiveness of responses to the HIV/AIDS epidemic remains an open question, as Gómez and Harris (2016) have shown.

An Epidemic of Significations

The term 'risk groups' was completely absent from the government's policy agenda until 1996. There were no 'targeted interventions', and the NACP did not have a programme to screen 'high-risk groups'. The HIV/AIDS prevention messages in the media, which were suited to a broad spectrum of audience, were often so indirect that they were hardly intelligible. For example, one TV advert, which aimed at condom promotion, showed a sequence of shadowy outlines of people in a dark street fending

off torrential monsoon rain by using their umbrellas. This was followed by the warning 'protect yourself: AIDS is incurable'. In a follow-up evaluation, a large number of respondents reported that they had thought this advert was about using an umbrella in the rain (Arjumand and Associates 2006, p. 24). As late as 2001, Pakistan's national health policy document had everything from safe blood transfusion to mass awareness schemes for HIV/AIDS prevention, but no mention of 'risk groups' or 'targeted interventions'. How did these notions enter into policy documents and become so paramount in the subsequent response to the epidemic?

When gay men in the United States were first described as a 'risk group' associated with the medical condition that later came to be known as AIDS, it was because most of the early patients were gay. Indeed, the condition was initially defined as 'Gay Related Immunodeficiency Disease or GRID'. Some even called it a 'homosexual plague' as it was feared that it could spill over to the 'general population' (Epstein 1992). In this case, a stigma already attached to the sufferers was extended to the disease. Later on, when the virus was diagnosed amongst the young children and wives of injecting drug users, the 'risk groups' categorization was revised to include 'Intravenous Drug Users', 'Haitians' and 'Haemophiliacs'. The 'viral hypothesis'—the notion of a unifying cause that could account for all manifestations of the syndrome (Epstein 1998)—was largely accepted, yet scepticism amongst the 'lifestyle' theorists remained, who continued to talk of AIDS as a 'gay disease'. The influential *Journal of the American Medical Association* reported, in 1982, that 'it seems unlikely that a virus alone is inducing AIDS' (JAMA 1982, p. 1423). AIDS was not just another disease; it was a disease of sexual perverts. It had a baggage of meanings and significations attached to it.

This baggage of meanings and significations accompanied the virus when it was discovered in other parts of the world. Treichler (1987) called this transference the 'epidemic of significations'. Thus, for example, writing about India, Karnik (2001) draws attention to the ways in which 'studies from Africa and South East Asia set a precedent for research in nearly all "Third World" countries, where prostitutes and truck drivers would become the focus' (p. 341). A review of the emergence of 'risk groups' in India, and the percolation of disease categories and their associated meanings down through to the popular media, shows that in the

early days of the epidemic, scientists and researchers excluded 'homosexuals' from their studies because 'the category ['homosexuals'] did not exist [in India], or they were not "available" [as research subjects]' (ibid.). Similarly, Pigg (2002) has shown that in Nepal—where the efforts to control HIV/AIDS changed to reflect its shifting image, initially as a disease introduced by foreigners and migrants, later as one concentrated within internal 'risk groups'—the choices for AIDS awareness campaigns were made in the context of strong messages from donors about what an 'accurate' and 'good' HIV/AIDS prevention message should look like (p. 109).

In Pakistan, when the government undertook the National HIV/AIDS Strategic Framework exercise in 2001–2006, a large number of NGOs were invited to shape the future course of the country's HIV/AIDS response. 'Risk groups' were set as the priority beneficiaries for interventions in the light of the global discourse about their centrality to HIV/AIDS epidemics worldwide. Pakistan's National Framework read as follows: 'male and female commercial sex workers (CSWs), injecting drug users (IDUs), men who have sex with men (MSM) and migrant workers are *thought to be* at heightened risk of HIV/AIDS' (p. 15, emphasis mine). As Nguyen (2010) observes in the case of HIV/AIDS in West Africa, 'in order to govern populations by an exceptional AIDS response, the [risk] population must first exist and be available', and that the 'risk population' 'must be called into being through procedures that allow it to be identified, separated from those who are not subject of intervention, and counted' (p. 178). In Pakistan, this was accomplished in 2003 by setting up a Canadian-sponsored HASP to identify 'population subgroups' at increased risk of contracting HIV/AIDS, which would 'enable the government and its partners to plan a targeted and multi-sectoral response' (NACP 2011, p. v). This HASP not only delineated 'risk groups' from the 'general population', in accordance with transnational templates, but also found it convenient to fix the blame for HIV/AIDS on already-marginalized segments of the society. For example, although 'female sex workers' were excluded from the third round of annual surveillance in 2008 because there was not enough evidence of HIV/AIDS amongst them, they did not cease to be treated as a 'risk group'. Likewise, internal labour migrants, long-distance truck drivers and their helpers, jail inmates, youth in college hostels, and street children were excluded from

bio-behavioural surveys on the basis of low prevalence, but they remained as 'risk groups' in the epidemiological and policy imagination, since they were occasionally brought under the spotlight as 'vulnerable groups', 'affected populations' and so on. Meanwhile, the HASP surveillance results helped fix the epidemiological gaze on injecting drug users, transgendered *hijrae* and sex workers in large urban centres. It reduced homosexuality to male sex work only, and it opened the gate for typologizing female sex workers into subcategories such as 'street-based' and 'brothel-based'. The numbers and types of 'risk populations' in rural areas were estimated on the basis of assumptions derived from studies conducted in rural populations of India (Emmanuel et al. 2010, p. S83).

The 'global foreknowledge' of these international technical practices provided a pre-existing template for the government to imagine not only 'what an AIDS epidemic looks like' and 'anticipate patterns of risk', but also to 'plan interventions' (Mahajan 2008, p. 558). As Mahajan argues in the case of India, these templates were not only descriptive but also prescriptive. Not only were the definitions of 'risk groups' guided by broad international classifications, such 'global foreknowledge' also formed the basis of epidemiological modelling and the future direction of the HIV/AIDS response. Karnik (2001) argues that after beginning their existence within a temporal and spatial bounding, categories like 'risk groups' move and relocate to serve as 'scientific tools and policy making foci'. In this process of percolation, these categories are 'constructed and framed by a series of power relations that traverse the globe' (p. 344). The risk categories, like other scientific classifications, achieve hegemony or consensus to become what sociologist of science, Latour (1987) calls 'black boxed'. The term 'black box' is used by cyberneticians 'whenever a piece of machinery or a set of commands is too complex. In its place they draw a little box about which they need to know nothing but its input and output' (p. 2). We do not see the 'black box' as a site of complexity as, taken-for-granted, we stop seeing the box entirely. In Pakistan, sex workers, men who have sex with men, transgendered *hijrae* and injecting drug users became central to the epidemic not necessarily on the basis of seroprevalence tests, but because UNAIDS projection models used these categories of 'risk groups' as a default. Their 'black-boxing' was achieved through further mapping, counting and targeting.

It is my contention in this book that in this 'epidemic of significations', it is not only the HIV/AIDS virus that spreads across continents, or that the concomitant meanings of the disease transcend borders, or even that the risk categories become hegemonic, but that the technical templates for responding to the epidemic also acquire a life of their own.

Conclusion

This chapter has set the stage for the rest of the book in identifying the legal, moral and institutional context of Pakistan's HIV/AIDS response and its significance. The HIV/AIDS policy response was initially overlooked by successive Pakistani governments because of a conservative public morality and legal code in this Islamic Republic. However, HIV/AIDS was brought into the policy spotlight as a development problem by a massive 'scale-up' backed by the World Bank. This chapter has underscored the conditions that enabled this transformation, which was contested by many in the health sector. From being a neglected policy area, HIV/AIDS prevention became the foremost priority. Building on its experience in Africa and elsewhere in South Asia, the World Bank pushed for 'scaling-up' Pakistan's response and also for the policy of contracting-out to NGOs as a means of delivering HIV/AIDS prevention, which it had favoured elsewhere. The Global Fund to Fight AIDS, Tuberculosis and Malaria took forward this policy, and enhanced the additional policy of fostering connections to 'civil society' through its participatory governance mechanisms.

Treating the global AIDS epidemic as an 'epidemic of significations', after Treichler (1987), we can see how the categories of 'risk groups' permeated into Pakistan's HIV/AIDS response and solidified as blueprints for intervention. The 'global foreknowledge' (Mahajan 2008) about the epidemic was used not only to delineate HIV/AIDS risk categories but also to construct templates for HIV/AIDS prevention and control, reflecting what Mosse (2011) calls the 'travelling rationalities' of international health and development.

In the following chapter, I take the out-contracting of HIV/AIDS prevention services to NGOs under the Enhanced Program as the setting for

my first exposition of exactly how these rationalities travel. I have already sketched out some of the difficulties involved in contracting-out, but Chap. 3 takes an ethnographic entry point and examines how narratives of 'project success' (Mosse 2005) were produced.

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3

The HIV Prevention Market

At the core of the Enhanced Program was the notion of 'efficiency'. It is central to projects of 'entrepreneurial governance', which are driven not by rules and regulations, but by goals; performance is measured not by inputs, but by outputs (du Gay 2000). In the Enhanced Program, as we have seen, this was to be achieved by contracting-out HIV/AIDS prevention services to suitable NGOs and private firms, the biggest of whom were considered the most worthy of the contracts. This chapter draws from an ethnography of a World Bank mission evaluating the Enhanced Program, which was conducted in June 2010, a juncture that proved to be the instant of the Enhanced Program's demise. The mission came to be dominated by two problems that had emerged over the course of the Enhanced Program: first, a confrontation between the government of Punjab and Naya Sewaira, the NGO with the biggest contract; and second, a controversy over the role played by the management consultancy firm employed, on World Bank instructions, to build the government's capacity in overseeing the contracts. Corruption was alleged in both cases.

This chapter deploys the extended case method so as to offer scrutiny of the new public goods proposed by theories of the new public management, such as 'transparency' and 'efficiency', to show how they allow private interests to capitalize on public funding and, thus, how they

A. Qureshi, *AIDS in Pakistan*, https://doi.org/10.1007/978-981-10-6220-9_3

emerge as a site for 'accumulation by dispossession' (Harvey 2007). In so doing, it draws upon other literature observing how the models of contemporary international development and global health allow public assets to be poached. Anders' (2010) ethnography of Malawian civil servants undergoing training in 'good governance' shows, for example, how the explicit aims of audit techniques come to be transformed through the everyday life of their administrators and thus how 'what on paper initially appeared to be an all-encompassing and efficacious system of control and surveillance dissolved in the messy practice of policy implementation' (p. 7). When they succeeded in augmenting their pay by charging extra money to their allowance accounts, supposedly to allow them to attend workshops detailing civil service reform exercises, civil servants 'coopted' and 'adapted' audit measures such as 'expenditure control' and 'job evaluation' for their own ends (p. 8). Elyachar (2002, 2005, 2012) broadens the lens of the public good beyond material resources so as to take into account other assets of which the people are dispossessed. Her case is of microfinance projects for working-class people in Cairo. Supposedly, the rationale for microfinance projects is a win-win whereby poor people cease to be the hopeless beneficiaries of development aid and become agents of their own development by taking loans from banks, which are repaid out of the small wins generated by their 'informal' or 'survival economies'. As advocates of microfinance appreciate, these informal economies are constituted by the 'cultural difference' and dense social capital of poor people (Elyachar 2002). Elyachar argues that in 'financializing their social networks through relations of debt mediated by NGOs', the development machinery is doing business out of the culture and social capital of the poor (Elyachar 2005, p. 29). Their social commons, she says, are considered 'a collective resource for which recompense should be paid or rent paid for use' (Elyachar 2012, p. 121). Most recently, Bear and Mathur (2015) have added that public goods include also 'utopian ideals', or 'those desirable ideals that are considered universally beneficial for everyone', such as the covenant between the state and the people (p. 21). Particularly helpfully for us here, Brown (2015) has argued that contemporary global health funding regimes generate systematic conflicts over 'sovereign responsibility', which she defines as 'the responsibility to deliver resources and serve populations' (p. 343).

Laying the ground for what follows, this chapter thus examines how public goods—material, cultural and utopian—can become a fount for private capital accumulation. But in so doing it also brings to light conflicts over the 'proper role and work of the state' (Bear and Mathur 2015, p. 24), in the stand-offs between the government and the private organizations contracted under the Enhanced Program, which were aired so volubly before the mission.

The World Bank Mission to Evaluate the Enhanced Program

As outlined in the introduction, I became a part of a World Bank mission to evaluate the Enhanced Program, as an apprentice participant-observer, partly by stroke of luck and partly as a matter of expediency on the part of the NACP, which needed to place an observer on the mission. The three-member mission comprised of two public health experts, one Afghan and one Pakistani, and a US-based procurement specialist who had flown in from Washington. We went to government offices in Islamabad to hold meetings with high-ranking officials and travelled to Lahore and Karachi to meet provincial government officials, NGO partners, private firms and donor agency staff in lavish hotels. It was obvious from following the activities of the mission that the performance of power, prestige and munificence was central to the World Bank's encounters with its partners.

The mission summoned the representatives of Islamabad and Peshawar-based partner organizations in the Enhanced Program for interviews and group discussions at the World Bank's office in the highly securitized diplomatic quarter, or 'red zone', of Islamabad. One could enter the red zone only after negotiating security clearances at three separate police and army checkpoints along the way. Entering the World Bank's premises itself, which had a barbed boundary wall enclosing a multi-storey building and a large area of beautiful lawns and tennis courts, was by no means a small feat: there were three further security checks before one was actually admitted inside. Whilst inside, visitors had to be accompanied by a member of staff with a swipe card to open and close doors. Such security

precautions for international staff were arguably justified, due to heightened insecurity in Pakistan amidst the on-going 'War on Terror'. But to me, it appeared as if they were the bodily markers of a boundary that demonstrated the power of such institutions. The performance of ritualized, elaborate security and identification procedures was not only awe-inspiring but also humiliating. It had the effect of framing the visitor as an outsider, or as a receiver of the largesse of the World Bank's officials. Entry to this space of power was only a fleeting necessity, over which the visitor had no control.

The meeting room for the mission's interviews was small but elegantly decorated, with a blue carpet, wall-hangings and fancy ceiling lights. It had a round table in the centre with six chairs around it. On one side of the room was a set of comfortable sofas, and on the other was a wooden shelf with books, folders and reports, nicely arranged. Western-style coffee and snacks were served on two small tables in a corner beside the window. Two butlers sitting outside the room were available any time to refill coffee cups. Inviting smells of fried chicken and fish, pastries and sandwiches filled the corridors. At the end of two very busy days of meetings, interviews, and group discussions in this beautifully decorated and aromatic room, the experience felt like the latter-day equivalent of a colonial mission of olden days, or like a visit to a *darbar* (royal court) of some sort. The factions of 'stakeholders' submitted their petitions and prostrations in the presence of the Bank's lordly power, amidst their competing versions of reality and complaints against one another, in an effort to present themselves as the most trustworthy and loyal of its partners—and hence the most deserving of selection in the next round of funding. Interviewees who came on time were made to wait whilst their over-enthusiastic competitors, some interesting characters included, ran over time, or whilst we savoured fried chicken or fish in the breaks between meetings.

With this grandeur, it is perhaps unsurprising that the interviewees presented themselves through displays, as if to a powerful patron, auditor and arbitrator. Their prostrations were accompanied by a thick cloud of rumours, blame-mongering and denouncement of their partners, giving the effect of a cacophony of voices. The task for the mission was to see through the fog of accusations and counter-accusations, tune in the narrative and thereby pronounce success or failure for the Enhanced Program as a whole.

In his ethnography of an International Monetary Fund mission, Harper (2000) suggests that auditing is not merely a matter of arithmetic but the 'final stage of a social process', which enables the determination of the future, or 'divining what the future may be' (p. 24), on the basis of the determination of the present. Mattingly (1998) has similarly documented how project officers in World Bank evaluation missions became storytellers; they were 'constantly trying to construct stories to get some fix on what was going on, especially who was to blame, so that they could figure out what they ought to do and especially what they ought to say in their reports to the Bank's management on the project's progress' (p. 5).

The stakes for this process of divination or confabulation were particularly high for the mission I took part in. All stakeholders were expecting that the judgement of the mission was going to determine the prospect of the World Bank's granting of an extension to the Enhanced Program, upon which the hopes for the future of HIV/AIDS prevention funding in Pakistan, and the renewal of NGO contracts, were pinned. David Mosse (2005, p. 184) argues that the success of a project depends on socially sustained interpretations, but:

> when at one moment a project appears as the most successful DFID [Department for International Development] project of all time, and at another [it] sits on development's 'death row', we have to examine changes not just in frameworks of interpretation but also in the alliances, the mediators, the chains of translations, interests and agendas that are tied up in a project and ask what happened to them.

In the following, I ask these questions of the Enhanced Program by focusing on the dispute between the Punjab government and Naya Sewaira, which begins to show us the lay of the land concerning the alliances, interests and agendas involved.

Output-Based Contracting

'This Punjab guy should be shot dead for what he has done to Naya Sewaira', said one of the interviewees about the Provincial Health Secretary of Punjab, who had recently terminated the HIV/AIDS service

delivery contract of this NGO over allegations of corruption. This cancellation had resulted in a dispute between the NGO and the government. Although the dispute loomed large in the World Bank mission, many colleagues and partners avoided talking directly about it in our meetings. The mission itself maintained an equivocal stance on this major event in its final report. However, given the ripples it had created in the whole HIV/AIDS sector, there were occasional outbursts of anger and frustration like the one above, which was voiced by a representative of the Canadian-sponsored HIV and AIDS Surveillance Project (HASP). I explore this dispute in some detail, as it provides a window into the transformations of governance that the Enhanced Program entailed.

The contracts in the efficiency-oriented Enhanced Program were designed as 'output-based'. Every service delivery project was to be evaluated on the basis of HIV/AIDS prevalence rates in the target groups, which were collated by the HASP's annual surveillance rounds (see Chap. 2). There was no mechanism in the project design for the government to verify the effectiveness of contracted NGOs on the ground, whilst the NGOs were under no obligation to share information on their inputs, or on the identities of their beneficiaries, ostensibly because it was thought that disclosure would have had serious repercussions, on account of the beneficiaries' quasi-legal status (see Chap. 2). A weak monitoring system was built into the project design, but it came to be dominated by a management consultancy firm, which later became a problem as I discuss later in this chapter. Using traditional auditing procedures, namely record-keeping and on-the-ground verification, the government bureaucrats only managed to assert their authority over a few small NGOs. Notoriously, bureaucrats even visited the homes of the project beneficiaries in a female sex workers-related intervention. Moreover, the new flexible work culture at the national and provincial AIDS control programmes—detailed further in Chap. 4—allowed some government officials to set aside bureaucratic norms and rules in the name of 'efficiency', ostensibly to avoid lengthy government procedures, but really to enable their associates in the private sector to evade accountability.

Naya Sewaira was seen as the most obvious choice for awarding contracts for HIV/AIDS prevention services that targeted injecting drug users (IDUs) in Punjab. The other competitors at the time of bidding for

the contract were the German Agency for Technical Assistance and the Asia AIDS Network. These were both international organizations of good repute, but they lacked relevant experience on the ground. Naya Sewaira was not only local, but billed itself as an NGO ran by former drug users with unique access to, and understanding of, the problems of IDUs. The fact that Kamal and his core team members at Naya Sewaira had been drug users in the past was often emphasized as a mark of their competitive edge over other NGOs working for IDUs (thus it capitalized on the 'cultural difference' of the marginalized in a manner analogous to how the promotors of microfinance projects have done, as described by Elyachar 2002, 2005, 2012). This stance had a 'good fit' with the stated rationale of the Enhanced Program, which, as discussed in Chap. 2, claimed that 'risk groups' were stigmatized, marginalized and criminalized in Pakistan, and therefore were unsuited to receiving HIV/AIDS services from the government directly. Initially, Naya Sewaira bid for, and were offered, a contract to provide HIV/AIDS prevention to 1000 IDUs, but after they were selected, they successfully negotiated to add several thousand more IDUs and to expand the scope of service delivery from one to four cities, which made their contract the biggest in the Enhanced Program. Their contract ran smoothly for five years, during which time its scope was further scaled-up from four to twelve cities. This NGO enjoyed the good reputation and confidence of the then Provincial AIDS Control Manager, Dr Nawazish. In 2010, however, the newly appointed Health Secretary of Punjab started taking unprecedented interest in the Enhanced Program, and especially in the contract with Naya Sewaira. He demanded the NGO share its project data, and the details of its service users, to verify that public money was spent transparently. Although the Enhanced Program was funded by the World Bank, this funding came in the form of a loan, and thus the government felt justification in calling it to account. However, the NGO refused to comply with the demands, on the grounds that the contract did not oblige them to do so, and that sharing this data would breach the confidentiality of the drug users benefiting from their services. As a consequence, the Health Secretary terminated the contract, removed Dr Nawazish from his post and initiated a corruption inquiry. The line of thinking in the government was summed up before the mission by Dr Nawazish's successor, who often served as a

mouthpiece for the Health Secretary: 'we are the government, we are the policy makers. Why not disclose the identity of these IDUs to us? I can't understand the logic'. Another top government official challenged the mission by asking: 'why does the NGO not show us all the syringes that they have bought, why do they have to hide it from us? We are the clients, after all. We are giving them money to provide these services. Why can't they share with us what they have done in the field so far?' Meanwhile, Naya Sewaira stopped its services and started a media campaign against the government, which it accused of letting vulnerable IDUs die as a result of the terminated contract.

Did the insistence of the government officials on seeing the records of project inputs and service users mean that they simply could not understand or appreciate the rationale of the 'output-based' contracting system, which had been used widely in similar World Bank-financed projects worldwide? Kamal, the Chief Executive of Naya Sewaira, was not convinced. He drew an analogy with contracts for other public works:

> Every government contract … on building a bridge for example … is an output-based contract. Whether you use a Caterpillar or a Mitsubishi … ten labourers or a hundred … is never a question. The question is, 'what is the size of the bridge?' 'Have you completed that?' 'What are the specifications of the bridge?' 'Have you completed that?'…It's very common. All your roads are output-based. They [the government] come and measure, they look at the quality. They don't ask what you used. You could be bringing mortars from China or Chakwal…All your construction contracts of a house are output-based. Do you ask the architect or the contractor, 'how many labourers', how much profit he made? No! You want to measure square footage…So the easiest contract to understand is the lump-sum [output-based] contract.

The Health Secretary subsequently dropped his demand for the personal identities of the service users when he realized the centrality of the 'confidentiality principle' in the NGO sector. He came to understand the logic of 'output-based' or 'lump-sum' contracting, too, although he did not necessarily accept it. For him, survey results from the HASP, or the process of 'certification' used by the private management consultancy firm contracted under the Enhanced Program (see below), had little to do

with how the government kept track of public money or held people accountable for how it was spent. The World Bank's loan for the Enhanced Program was, after all, payable by the tax payers, so it was felt that the government must take responsibility. Playing out in this stand-off was thus the 'sovereign responsibility' (Brown 2015) of the government to verify how this money had been used. Brown defines 'sovereign responsibility' further as 'a fusion between the sovereign entitlement to define and intervene in a governmental field but…at the same time shaped by understandings of the entitlements of citizens to receive particular kinds of resources from the state or other organizational bodies' (p. 343). The way that the World Bank's template for the contracts in the Enhanced Program offended the bureaucrat's sense of the entitlements of citizens, and of the state's obligation to meet them, is elaborated further below.

Disgruntled Government Officials

On our visit to Lahore, after sifting through documents at the Punjab AIDS Control Programme and listening to the incumbent manager's list of complaints about his predecessor, I went with the World Bank mission to see the Provincial Health Secretary who was at the centre of the conflict. In one vehicle were the three members of the mission, whilst in the other I accompanied Dr Zahid, the new Provincial AIDS Control Manager, and his finance officer Intizar, who unguardedly aired their apprehensions about the upcoming meeting. Both were nervous about a meeting with their top bureaucrat. They tried to anticipate questions and rehearse their responses. For Dr Zahid, this would be his first appearance before the Health Secretary since his appointment to the new post, and for Intizar, an ambitious young man, a moment might arise in the meeting when he could dissociate himself from the wrongdoings of his former boss. They cribbed up on facts and figures concerning the Enhanced Program, trying to memorize some of them and tagging pages in the files for others.

At the Health Secretariat, we met the Special Secretary Health instead of his boss, the Health Secretary himself, because the latter was out of town. In accordance with the official protocols, Dr Zahid gave the brief

that he had rehearsed in the van on our way. 'I have told them [the mission] that basically the government did not have much leverage in these contracts … the funding mechanism needs to be revised … there should be no big NGO contracts … monitoring systems should be reviewed … bidding committees should be reformulated…', and so on. In his own presentation, the Special Secretary confined himself mainly to the parameters set out by his subordinate, Dr Zahid. He tried, at least rhetorically, to deflect the focus on Naya Sewaira alone by arguing that an overall audit of the Enhanced Program was necessary for future decisions. 'We do not want to know the identities of end users, but we want to know what was spent where. There is a lack of transparency; what we pay for should be used properly', he declared. He assured the mission that HIV/AIDS prevention was still a priority for the government, but since it was a stigmatized issue and hence not easy to spend money on, the government wanted to ensure 'transparency' as well as 'efficiency'. 'We want results from every penny we spend on it, and we want accountability'. 'We would love to build the capacity of smaller NGOs as well', he added politely but firmly, hinting at the loopholes in contracting, which had allegedly enabled Naya Sewaira and Dr Nawazish to take advantage and divert public funds into their own pockets.

The heavily fortified Punjab Health Secretariat exuded grandeur. Decorated offices with high tables, fine china crockery, turbaned butlers, and the posh English of the Special Secretary, all contributed to an awe-inspiring experience—so much so that Harry, the tall, thick-built and usually imposing procurement specialist attached to the mission, adjusted his posture in such a way that his towering figure had shrunk. His deep voice toned down, he was moved to address the Special Secretary as 'Your Excellency'. Although the kind of prostrations that I had observed at the World Bank's office in Islamabad were not *inverted* in the Health Secretary's office in favour of the government, the performance of power and money was by no means less conspicuous in the body language, choice of words and manner of exchange between this high-ranking official in the provincial government, the members of the mission, the Provincial AIDS Control Manager and his finance officer. At first, the Special Secretary appeared nonchalant about this meeting, which had been requested by the mission. He appeared to take little interest in the

mission's introduction or in the purpose of meeting and came across as someone who knew or cared very little about the Enhanced Program. However, after a few minutes into the discussion it was clear that he had done his homework. He knew a good deal about the Enhanced Program and had also anticipated the issues the mission sought to explore with him. His initial reluctance appeared to be a ritualized performance of patrician bureaucratic aloofness, due on the one hand to his level of seniority in the government, and to the need to project the omnipotence of the government whilst dealing with non-state entities, on the other.

The next meeting was with the Secretary of the Department of Planning and Development of Punjab. On our way, I was once again in the van with Dr Zahid and Intizar. They congratulated each other on their performance in the previous meeting and prepared for the next. The Planning and Development Secretary's room was big, and furnished with modern, state-of-the-art office equipment and gadgets. Curiously, there was a CCTV monitor on the side table, which showed input from many cameras at the entrance of the Secretariat and its various corridors. One of the mission members was so impressed with the office that he remarked, in a whisper, that 'these are, after all, planning and development people, they've got all the money!' Behind the visitors' chairs was an oval meeting table with seats for six. Two more chairs were placed at a couple of yards' distance from the table, close to the wall. Dr Zahid and the three members of the mission took their seats on the longer sides of the table, leaving the head chairs on either side empty. Intizar and I sat on the chairs close to the wall. For a few minutes, we were left on our own to settle down in the room before the arrival of the Chief Health, a subordinate of the Planning and Development Secretary. He greeted the mission and seated himself in one of the two empty chairs, moving it slightly to his left so that he did not sit facing the chair at the opposite end directly, which was reserved for the Secretary.

Everyone was settled when the Secretary finally entered the room. All stood up. He was a serious, bald man in his fifties wearing a grey safari suit and a chunky silver watch with a big dial. He shook hands with everyone except his Chief Health, Intizar and me (the lay-out of the room and the seats we had taken for ourselves told him that the two of us were too junior for his attention—he did not even look in our direction). His

first remark was that the mission had arrived late to the meeting. Dr Zahid, who had coordinated it, hurried to explain that we were coming straight from another at the Health Secretariat, which had run late. The Secretary was not interested in any explanations. His purpose was to make a point, which he had done. He asked the mission to proceed. All three of its representatives introduced themselves turn by turn, followed by Dr Zahid. Then the head of the mission introduced its scope and purpose and the reason for requesting the meeting. After listening to him, the Secretary looked around and asked, in a self-important and imposing manner, 'Anyone from the health department?', as if Dr Zahid had not just introduced himself as the AIDS Control Manager. 'Yes sir', replied Dr Zahid, hurriedly. Not looking in his direction, the Secretary gestured him to speak by half raising his left hand. Dr Zahid repeated the 'brief' he had presented earlier in the Health Secretariat. The Secretary asked some probing questions about the Enhanced Program. He was told that the contracts between the NGOs and government did not need vetting by the law or finance departments because the NGOs were national entities, whereas vetting was reserved for agreements with foreign governments or international entities. In the case of 'one NGO' (Naya Sewaira, which nobody actually named), Dr Zahid reported that the contract document had been tampered with by the former AIDS Control Manager to its benefit, and as a result, 'the government ended up paying Rs67 per day per IDU instead of Rs41', he said, showing the copy of tampered document as a proof. Countering Dr Zahid, the Chief Health then reported from his files that his facts and figures showed that 'the NGO under question' had 'performed more than satisfactorily'. 'It was a new field for us', he said; 'we were not fully prepared, yet the NGO managed to reach more than 14,000 against the target of 6000 IDUs'.

'Your Excellency!', interrupted Harry, drawing attention to the purpose of the mission's meeting. 'The figures are satisfactory, that means that the project worked, but we want to know your feelings about this?' The Secretary, who had shown signs of relief at the mention of overachieved figures only a moment ago, and to whom the project had appeared to be 'overwhelmingly successful', now had a second thought. He sensed that there was more to the matter than the numbers that were just quoted before him. He turned deadly serious, looked into the big

dial of his watch, and asked the Chief Health: 'Who do these figures come from?' Without wanting an answer, he turned to Dr Zahid and asked firmly: 'Do you believe in these figures?' Dr Zahid shook his head in the negative and replied that his predecessor, Dr Nawazish had colluded with the NGO to concoct them. This implied that the Secretary's Chief Health was either naïve because he had taken the figures at their face value, negligent for not verifying them, or complicit in the wrongdoings of Dr Nawazish and the 'NGO under question'. To absolve himself, the Chief Health argued that the Planning and Development Department did not have the 'capacity' to cross-check the figures: 'The Punjab AIDS Control Programme is an arm of the government, and we in the Planning and Development Department have to trust the figures that they provide us. There is no mechanism to prove these figures correct or incorrect. It's all very complicated'.

The Secretary concluded the meeting with a lecture about the need for drafting and vetting any future contracts with NGOs very carefully, so that NGOs could be held accountable. 'There is no harm in depending on NGOs', he said. 'The government cannot do it alone, but, they should be accountable to us'. At no point was Naya Sewaira named. As we left the office, Dr Zahid was held back by the Secretary and his staff for a few minutes. When he finally joined us in the van, he told Intizar and me that they had asked him to provide further information about the tampered documents and to hand over copies of the proof that his department intended to use as evidence in the on-going legal battle against Dr Nawazish, Kamal and Naya Sewaira. Dr Zahid sighed with frustration and said that he was sure that the evidence would end up in the hands of Kamal and Dr Nawazish because some of the Secretary's staff were 'in their hands'. They would then know the Punjab government's next move and would come up with something to counter it in advance.

What came out in the bureaucrats' discontented insistence on the 'accountability' of NGOs to the government was, I suggest, the affront to their sense of 'sovereign responsibility'. Brown's (2015) ethnography shows how the channelling of funds for HIV/AIDS service provision to NGOs under the US's PEPFAR initiative in Kenya (the President's Emergency Fund for AIDS Relief) gave rise to a powerful sense of 'managerial disenfranchizement' amongst health managers in the government

(ibid., p. 343). They viewed foreign donations as 'part of what has been described as the "national cake", precious resources that should be delivered to the Kenyan people under their guidance' (p. 344). They rankled at NGOs that behaved as if they, rather than the Kenyan government, were the implementing partner for HIV/AIDS treatment, and asserted the importance of the state on the basis of its role in delivering resources. Likewise, the Punjab government, sought to reinstate its vision of the state bureaucracy as upholding the collective interest, and as dispenser of the resources that it holds in trust for the people, against the logic of 'output-based' contracting that was being pressed upon it, which had encouraged NGOs to get 'too big for their boots' and had detracted from the government's managerial powers to administrate for the public good.

Playing the Victim

At Naya Sewaira, meanwhile, Kamal had hoped to reverse the termination of his NGO's contract by lobbying the World Bank, the UN agencies, bilateral donors and the federal government, using his father's political connections to do so (his father was a former senator and a federal law minister). But to his disappointment, the support from these agencies was not forthcoming. Instead, 'they tried to be diplomatic, which is ridiculous'. Kamal told the mission: 'we are strong, we stood up to the government. Imagine if it were some other NGO—what would they do?…What is the UN here for? Why did the World Bank not do anything at a higher level? The result is two months of no services and two months of people dead'. This emotional outburst in front of the mission was followed by the warning that, in future, his NGO would work with the government in donor-funded projects 'only if there is a cushion in case the government or the Secretary changed…There should be a certain percentage, say 10%, of the project budget reserved to allow NGOs to carry on in cases of crisis like these'.

Disappointed with his colleagues in the development sector for not supporting Naya Sewaira unequivocally, Kamal, as he told us, 'took the war to another front: the media'. He had news reports run on the BBC and Al-Jazeera describing the Punjab government's 'inhuman act' of

denying HIV/AIDS prevention services to drug users. Doomsday scenarios were predicted in these reports if the NGO's services were not revived by revoking the termination of the contract. Urdu and English newspapers carried stories about the government's inertia in the face of an impending HIV/AIDS epidemic, which portrayed injecting drug users as its main driver. Naya Sewaira itself produced a three-part Youtube video, which highlighted the difficulties of drug users affected by the closure of their drop-in centres. Amongst other things, the video depicted some IDUs sharing syringes in shady places with close-ups of their open wounds and torn clothes, with some of them lamenting that they had lost their bathing, first-aid and bandage facilities because the government had decided to terminate the contract. One line of attack in this politics over the lives of IDUs was that the government was planning to round up all drug users to put them behind bars. That was why, argued Kamal, the Health Secretary had tried to coerce Naya Sewaira into revealing the names and addresses of its service users. The Punjab Health Department came up with counter-stories, also published in the media, which accused the NGO of mishandling public funds, and asserted the government's responsibility to ensure transparency and accountability. Many colleagues consulted by the mission privately criticized Kamal for attacking the government and donors over the deaths of drug users, whilst at the same time not taking any practical steps to save at least some of those lives by continuing even a scaled-down version of services.

What was this dispute really about? For some, the gains made in HIV/AIDS control in the country were in jeopardy if the termination of the contract was not reversed, for the Secretary and his followers it was a question of using public money transparently, whilst for Kamal, the lives of the IDUs and their rights to confidentiality were at stake. Lying behind the dispute, however, was a conflict between the government's claim to sovereignty and the NGO's counter-claim of moral responsibility towards those it claimed to serve as a member of 'civil society'. Governments are required to 'animate and naturalize metaphors if states are to succeed in being imagined as both higher than and encompassing of society' (Ferguson and Gupta 2002, p. 984), so in a sense the government's response was the equivalent of a ritual performance (see Chap. 6, in particular, on the use of the state–'civil society' divide for political ends). For

its part, the NGO was trying to evade accountability in the name of the 'human rights' of those on whose very 'inhuman' condition it thrived. In a later interview with me, Kamal recounted several stories, which undermined its claim to a moral high ground of protecting its users from the tyranny of the state. For certain purposes, Kamal was willing to be a partner in that tyranny. He told me, for instance, that many of the beneficiaries of his NGO preferred to register with false names and addresses in order to avoid being traced, or pestered, by outreach workers. Then there was an occasion when he went to see the Health Secretary to try and get him to reconsider the government's decision. He told me he had shown the Health Secretary maps of all the IDU hotspots in the cities that his outreach workers had served during the project. He offered the Health Secretary 'a simple proof of Naya Sewaira's services on the ground': 'send a few police officers to these spots, round up a few IDUs and ask them if they were or were not provided services by Naya Sewaira'. 'When I went to his office, I had all the data on my pen drive'.

The nature of these claims will remain contested. Different people used different frames to interpret this dispute. I wish to dispute none, but one thing was obvious during the mission: over the duration of the Enhanced Program, and in fact actually because of it, Naya Sewaira had gained a monopoly over IDU-related interventions, at least in Punjab. From bio-behavioural surveillance to HIV/AIDS prevention, and from harm reduction to drug reduction, treatment and rehabilitation, this NGO was the gatekeeper for everything concerning IDUs. It was this monopoly that the Health Secretary and his followers were determined to break by promoting a 'multilogue' of smaller NGOs in place of Naya Sewaira's 'monologue', as the Special Secretary of Health put it before the mission.

When political pressure, lobbying from civil society and donors, and the media campaign against the Health Secretary and his followers failed to reverse the termination of the contract, the battle was brought into the legal arena. The dispute went into arbitration, and the text of the contract itself became the most important factor in deciding the outcome (i.e. how the clauses were phrased and what was agreed on paper). According to Dr Zahid, this had been anticipated by Kamal and his friend Dr Nawazish. They allegedly forged and tampered with the contract documents just before Dr Nawazish was deposed by the Health Secretary.

Naya Sewaira had a very strong legal team to fight its case in court. Kamal came from a very well-known family of lawyers. His brother was the barrister who now represented their NGO in this dispute. Within the government's health department, by comparison, there were many opinions and shifting loyalties. For many people, the Health Secretary remained a 'noble' and conscientious bureaucrat, but as the dispute dragged on, some started to see it less favourably as a 'war of egos' between Kamal and the Secretary—a war that was being fought on the turf of drug users' lives.

Brokerage and Primitive Accumulation

The dispute between Naya Sewaira and the Punjab government was not simply the matter of a mismatch between the old-style proceduralist bureaucracy and the new work culture of 'entrepreneurial governance' under the Enhanced Program. Something more base and opportunistic was going on, in which various private actors were taking advantage of the ambiguities created by the intersection of these two styles of working.

'We are very strong partners of the Bank. We were trained here', Babur told the mission at the World Bank. He was the Chief Executive of the management consultancy firm that was hired to 'build the capacity of the federal and provincial staff to manage [NGO] contracts and carry out procurements … (and) to provide the winning bidders [NGOs] with assistance in general management procedures and project implementation techniques' (World Bank 2003, p. 15). Babur had come to the interview with his business partner, Kazim. They were both dressed in business suits, spoke very good English and had their visiting cards ready for us as soon as they placed their Blackberry phones on the table in the meeting room. There was a well-rehearsed synchrony in their speech. Babur started a comment or responded to a query, whereas Kazim spoke only when prodded by Babur, to fill information gaps. They began with the following statement:

> It was a great experience for us to work in the Enhanced Program. This was a new area for us. We have learnt a lot of new useful skills. Many people

> who worked for us on this project are now working in UN agencies. We are now waiting for the next round of funding for this project.

During our meetings with other partners in the Enhanced Program, we had learnt that the firm had been selected primarily because it had previously worked with the World Bank for logistical procurements in Afghanistan. It did not have any prior experience in public health, let alone HIV/AIDS. These weaknesses were, apparently, overlooked initially in the rush of starting the project implementation—in the 'sign first, decide later' (Anders 2005, pp. 83–84) atmosphere that characterized many of the negotiations of the Enhanced Program. However, these weaknesses became obvious when the proposed capacity-builder came face to face with the US-trained public health experts who were also hired at the same time to work in the government sector. In their opinion, the firm's competence in business management alone was not sufficient; it had to prove its public health credentials as well. To avoid the risk of the firm losing its legitimacy as a 'capacity-builder' whilst its staff knew next to nothing about HIV/AIDS, a Washington-based firm known for consultancy services on infection control, the Futures Group, was hired to support Babur and Kazim's firm.

There had been a disconnect between the hiring of the firm and the rolling-out of the NGO contracts. Since it was a time-bound project, the contracting-out could not wait for the government employees' capacities to be built first, as had been envisaged. Therefore, the firm played a direct role in awarding contracts and in managing them. As Babur explained, 'in the first quarter we felt that it was not going to work because there was a rapid turnaround (of the government staff whose capacity was to be built), and secondly our people were doing everything for them. We literally became programme secretariat and our people were doing ten times more work than contracted for'. Initially, the staff of the firm accompanied the monitoring teams of the government to build its capacities in contract management, but within a short time they came to dominate the monitoring process and even contested with their critics the government's 'right' to monitor NGOs. Intizar, the finance officer at the Punjab AIDS Control Programme, told the mission that 'the contracted NGOs had to be certified by the consultancy firm before any payments could be

made to them'. Subsequent events show that, as the project implementation went along, the firm found it more advantageous to manage the NGO contracts themselves.

The firm might have been drawn involuntarily into doing things beyond the scope of its contract, as Babur argued, because under this new public–private partnership 'everyone was learning by doing'—a phrase that was often presented to the mission, signalling the confusion that characterized the early phase of the project. Once they found themselves in this role, however, they exploited the newly flexible work culture, which had less concern for following the rules and regulations of the government and had been more about 'efficiency' and 'output'. As put by Babur, when asked the question of whether they had overstepped their role, 'what we called monitoring, the government called it management'; 'the monitoring role [for the firm] was there in the contract but the term "monitoring" was not used'. The contracts were 'ambiguous', he claimed—a claim that did not go well with the mission.

As with the stand-off between Naya Sewaira and the government of Punjab, was this simply a matter of simple misunderstanding—of the terms 'monitoring' or 'management' in the contract—or the result of different 'frames of reference' (Mosse 2005, p. 8) between the firm, the government, and the World Bank? The firm must have spent extra money on doing more than what would have satisfied their contractual obligations. Why would they take on extra work? In a gesture intended to evoke sympathy, Babur told the mission: 'we lost our shirt in it (i.e. we became very engrossed in it), but we valued the learning and capability injection'.

As the 'sign first, decide later' phase wore off (Anders 2005, pp. 83–84), some government officials in the health department and AIDS control programmes could not condone the transfer of what they believed was their sovereign right and responsibility: the 'certification' of NGO performance and managing of NGO contracts. For instance, after recalling his experiences with the consultancy firm, a senior AIDS control official protested to the mission that 'in future, all monitoring and review powers should be given to the government's AIDS officials, because management consultancy firms know nothing about HIV and AIDS'. Smaller NGOs also maintained that the consultancy firm was unsuitable for monitoring their service delivery because 'the firm didn't know even the ABC of HIV/

AIDS or risk populations'. Even some donors regretted 'the lack of capacity of the firm'; in other words, they upheld the logic that caused the World Bank to hire a management consultancy firm, but objected to the firm chosen. The firm, on the other hand, regarded those who were against it as politically motivated. The discrediting of its work, Babur told the mission, had strong political underpinnings. 'We asked the government not to make payments to NGOs until we certified them, but they did not listen to us; this became a bone of contention between us and them'. Lack of 'transparency' was thus a charge that the firm used against the government, too. Meanwhile, the firm looked forward to working in the anticipated next phase of the Enhanced Program. Babur warned the mission that 'government intervention is the biggest demon. Sometimes even the Bank is helpless!'

Clearly, the executives at the firm had assumed more work for themselves than what they were originally contracted for. When confronted with this fact by the mission, they first tried to present their extra work as public service, but finding it was not convinced by this explanation, they cited the ambiguity of their contract and corruption in the government as the reasons. Following Latour (1996), Lewis and Mosse (2006) argue that 'there is not just a relativity of points of view on a given object (a question of perspective); rather objects appear or disappear depending upon interpretations given them by people of different standing' (p. 8). The cacophony of interpretations between actors using various frames of reference will remain as inconclusive in this shifting cloud of objects, events and actors as the stand-off between Naya Sewaira and the government. However, what is clear is that the consultancy firm tried to become a broker between the government and the NGOs in the Enhanced Program and endeavoured to develop a niche for itself in brokering the NGOs' chances for the continuation of their contracts.

Actor-oriented approaches in anthropology have studied brokers as intermediary actors at the 'interface' of different worldviews, who 'negotiate' relationships between them (e.g. see Long and Long 1992). However, these approaches have been criticized for 'compartmentalising identities' and ignoring 'various types of exchanges, strategic adaptations, or translations contained within development interventions' (Lewis and Mosse 2006, p. 10). Some scholars have located brokerage in the

fragmented politics of post-colonial states, where a 'weak state' is unable to enforce its rationality and therefore coopts patron–client relationships so as to govern and maintain its relevance (e.g. Lieven 2011; Nelson 2011 on Pakistan). Whilst actor-oriented approaches might be helpful in explaining the flourishing of intermediaries in development—not only in the post-colony but also in the translocal and transnational world of expert knowledge—Latour (1996) gives cause for circumspection about the *a priori* certainty of institutional realms that is implied in these approaches. For Lewis and Mosse (2006), riffing on Latour, 'it is the mutual enrolment and interlocking of interests that produce project realities' (p. 13). They call this the work of 'generating and translating interest, creating context by tying in supporters and sustaining interpretations' (ibid.). Let us turn to an important example of such interlocking in the Enhanced Program. Kamal explained it this way:

> There were three [main] players [in the Enhanced Program]: the Bank, the government, and the NGOs. That means you have the public sector, the private sector and the donor. Now, you needed somebody between these three to translate what the other meant. Take 'lump-sum' contracts, for example. Somebody had to explain to the government what 'lump-sum' means. It couldn't be the Bank, because they gave the money; it couldn't be us [the non-governmental/private sector] because we were getting the money…So, the management consultancy firm played a crucial role of explaining it to them…The government asked us for audit reports, but we were told not to give these reports with receipts, so somebody had to explain to us what should we submit…Same with the Bank; what is an output based contract? I mean…how would you measure the outputs?… So, I think the management firm played an important role. They were like a coordinating body, a good communication channel.

It is questionable how a firm that did not clearly understand its own contract—as admitted by Babur when he said 'what we called monitoring, the government called it management'—could make sense of others' contracts for them. Interestingly, too, the firm never reported negatively on the performance of Naya Sewaira, which was responsible for 70% of the funds allocated for HIV/AIDS prevention amongst injecting drug users. According to one senior AIDS control official's presentation to the

mission, the bosses of the management consultancy firm even reprimanded their own staff if they tried to question this particular NGO's performance. Meanwhile, Dr Nawazish, the former AIDS Control Manager of Punjab, was not obliged to cross-check Naya Sewaira's on-the-ground activities because of the 'output-based' nature of the contract. For his part, Kamal sent Dr Nawazish on international trips and helped raise his profile by featuring him in Naya Sewaira's quarterly reports.

Towards the end of my fieldwork in July 2011, although the dispute between Naya Sewaira and the Punjab government was still in arbitration, the Health Secretary who had dismissed Dr Nawazish was removed from his post, too, on political grounds. Nothing became of the corruption inquiry he had launched against Dr Nawazish. Instead, as I recount in Chap. 6, the latter got himself appointed at the NACP, on the basis of the social capital he had accumulated with Kamal, in a very senior position associated with the Global Fund Round-9 project. The dividends for Kamal's NGO were not small either. Naya Sewaira had been struggling for survival in 2003—and, in fact, it was under investigation by the European Commission due to allegations of misusing funds—but over several years of work for the Enhanced Program, the NGO's staff had grown from 50 to 500. It had set up many regional offices and was branching up and out. Meanwhile, the consultancy firm, which due to its good will from the World Bank, had its fill of 'capability injection', was all set and 'waiting for the next round of funding from the Bank'.

In its final report about the Enhanced Program, the mission kept an equivocal stance on the future of the World Bank's involvement in the HIV/AIDS sector. It gave a verdict of 'moderately unsatisfactory' for both the World Bank and the borrower. These findings only confirmed a dramatic decision that had already been taken at the World Bank, namely that that there would be no more financing of HIV/AIDS prevention—a development that dominated the setting of my fieldwork, to which I turn in Chaps. 4, 5 and 6. Thus the findings of the mission were apparently an instance of 'policy-based evidence' (Marmot 2004). But the NACP came up with a counter-claim. 'It is correctly inferred that the delayed start of the project was due to lengthy government procedures, but for many of the other instances, especially in relevance to procurement of services, delays were also observed due to lengthy procedures at World Bank'

(World Bank 2010, p. 60). The Enhanced Program thus ended in a tit for tat between the World Bank and the Pakistani government.

Conclusion

In restructuring the HIV/AIDS response in Pakistan, the Enhanced Program created a new kind of health policy field with new 'rules of the game'. As mentioned, Anders (2010) has characterized the process whereby civil servants 'coopted' and 'adapted' the audit measures of Malawi's 'good governance' reforms to their own ends (p. 8). Mosse (2011) has written about similar situations in which we see old forms of power 'recolonizing' the spaces created by external funding regimes and by turning 'new rules to different ends' (p. 6). In the Enhanced Program, however, the *new* actors were those who came to thrive in its environment. It is perhaps more fruitful to see the changed rules of the game as opening an ambiguous space, or matrix of possibilities, where vested interests could compete with the new entrants.

The triumvirate of the NGO Naya Sewaira, the discredited Provincial AIDS Control Manager and the consultancy firm came together, it seems, in response to the unprecedented funding pushed into the HIV/AIDS sector by the World Bank. These three actors exploited the ambiguities created by the transformation of HIV prevention governance under the Enhanced Program in a manner that I judge was not very different from 'primitive accumulation'. Elyachar (2005) argues 'primitive accumulation' is now a process involving not only the state and overt forms of displacement, but also 'practices carried out by diverse institutional forms such as…international organizations and NGOs' (p. 29), which hoover up not only financial public assets, but also immaterial commons, such as the 'cultural difference' and social capital of the marginalized groups that NGOs target. The partnership role of the state in the NGO–government partnership model of the Enhanced Program provided authority and legitimacy to the private sector over matters of life and death for so-called 'risk groups'. As such, the Enhanced Program involved transactions in the exercise of sovereignty between the state and NGOs (Nguyen 2010, p. 6). Yet equally, we saw that health officials from the government

contested the terms of this arrangement by dismissing Dr Nawazish, suspending the activities of Naya Sewaira, by making strong statements about 'a lack of transparency', and by insisting on 'accountability' as well as 'results'. In light of the intermediation of the management consultancy firm, AIDS control officials demanded that 'all monitoring and review powers should be given to the government's AIDS officials'. We glimpse here the contours of another commons under threat of expropriation, the 'utopian goals' that Bear and Mathur (2015) explicitly seek to put centre stage so as to push back against powerful economistic definitions of the public good. As they observe, bureaucracies are accountable to a public in ways that fit these utopian goals (pp. 18–19).

It strikes me that the World Bank's policy of contracting-out HIV/AIDS prevention to the non-governmental, private sector, following the logic of marketizing service provision, endorsed the idea of the state's inability to work with 'quasi-legal' groups, thus undermining its claim to work on their behalf. The emphasis on 'outputs' instead of scrutiny of inputs gave occasion to borrowed money ending up in the pockets of a few individuals. By allowing the private sector to spearhead HIV/AIDS prevention services, I also contend that Pakistani people were deprived of an evolving and sustainable public-sector response to the epidemic. This policy constituted a novel form of 'accumulation by dispossession' (Harvey 2007)—by dispossessing the future generations of the country. In the end, the money borrowed will be repaid by the taxpayers, so in a way, we were dispossessed of it before we even had it.

My analysis of the Enhanced Program raises the spectre of corruption as a problem of culture (Haller and Shore 2005; Anders and Nuijten 2007). The next chapter tackles this question head-on through an exploration of everyday life at the NACP, shedding light on the informal bureaucratic systems that the flexible new work culture put in place.

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4

Enterprising Bureaucrats

This chapter offers a detailed ethnographic description of the everyday life of the NACP. Departing from existing descriptions of Pakistan's bureaucracy, I explore how this 'flexible' government organization worked. Picking up the themes of the previous chapter, I demonstrate how the moral embeddedness of the restructured NACP produced opportunities for employees to 'coopt' or 'adapt' procedures to personal advantage (*pace* Anders 2010, p. 8). This opportunity was enabled by the 'calculatingly charismatic' (du Gay 1994) mode of management prescribed by the Enhanced Program. More broadly, this chapter illustrates how a neoliberal aid regime affects bureaucrats at a personal level. As mentioned previously, the 'new ethnography of aid' has emphasized the role of intermediary actors as brokers in the social life of development projects, whose ambitions, interests and values influence the implementation of global policies locally (Pigg 2002; Mosse 2005; Mosse 2006; Harper 2011). My material shows how changes in global policy regimes effect profound transformations of the social lives of these intermediary actors.

A. Qureshi, *AIDS in Pakistan*, https://doi.org/10.1007/978-981-10-6220-9_4

The New Bureaucratic Field

The Pakistani bureaucracy has often been acclaimed as the inheritor of the proceduralist bureaucracy of the *kaghazi raj*, or 'document rule', of the British colonial administration. Hull (2012), for example, engages a rich historical literature on the *kaghazi raj* to shed light on the proceduralism of the Pakistani state and its reliance on documents. The British developed an elaborate administrative regime of surveillance and control that originated in written procedures of the Mughals (Sarkar 1972), the mistrust between the East India Company in London and its overseas outposts, and the need to monitor the frequent movement of colonial officers between positions in India (Moir 1993). Normative procedures were laid down in minute detail in manuals specified for each sphere of administration (Saumarez-Smith 1985). It was common for officials transferred from Britain to note that the Indian colonial administration used written documentation far more extensively than did the British government in London (Hull 2012, p. 10). A number of studies have also highlighted the continuities between the colonial and post-colonial Pakistani bureaucracy (see Goodnow 1964; Ziring and LaPorte 1974; Kennedy 1987; Mahmood 1990; Saeed 1999). When I started working at the NACP, however, I experienced a different bureaucratic set-up. The National Manager had just been removed from his post on the behest of the powerful NGO Naya Sewaira, apparently because he had tried to negotiate a larger slice of the upcoming Global Fund Round-9 grant for the government. The restructuring under the Enhanced Program had resulted in confusion as to who was in-charge, in the absence of the National Manager, and as to what rules were to be followed. In the case of my request for an internship, for example, they first insisted on a written application, which was to reach them 'through proper channels', signed by a 'competent authority', and on a written assurance from me that I would follow government rules and regulations. Yet, when there was an opportunity, they phoned me up to ask if I could work as the NACP's representative in the World Bank mission evaluating the Enhanced Program (see Chap. 3), not minding about the status of my application, which I had not even submitted yet. Compare this with the situation of my mentor at the NACP, Dr Nadir. He was one of the

longest-serving employees at the NACP and had been playing a central role in its day-to-day running, yet he could not be officially designated as an Acting National Manager or Deputy Manager, in the absence of a National Manager, because he worked in a 'donor-supported' position. The Deputy Manager had to be someone seconded from the Ministry of Health (the various categories of employees at the NACP are discussed below). Thus, the application of the government's rules and procedures in this flexible organization was selective, as permitted by the entrepreneurial work culture created by the World Bank's funding programme.

The high salaries and incentives of the World Bank-sponsored Enhanced Program attracted civil servants from other government departments and contractual employees from the 'market'. By July 2010, when I began working at the NACP, the 68 staff members comprised of 38 'basic-pay-scale', ten 'market-based', and 20 'donor-supported' employees. The basic-pay-scale employees were permanent government servants with statutory rights and entitlements under a cadre system. They could not be removed from their jobs except in circumstances of gross misconduct. Whilst they enjoyed extra perks and privileges working on secondment at the donor-funded NACP, they had secure jobs to return to in their 'parent departments'. These employees held most of the administrative posts, were new to the HIV sector, and had little or no exposure to NGOs before joining the NACP. By comparison, the 'market-based' and 'donor-supported' employees were hired on short-term, renewable contracts with no long-term job security. Most of them had worked previously in NGOs, they considered themselves to be experts on HIV/AIDS and they filled many of the technical positions at the NACP. The salaries of the donor-supported staff came from international agencies such as UNFPA, UNICEF and Family Health International, whereas the basic-pay-scale and market-based staff were paid from the coffers of the Ministry of Health.

This was not simply a case of putting together teams of staff from the public and private sectors, as has been described in the existing ethnographies of civil service reforms. Mathur's (2015) ethnography of the 2005 National Rural Employment Guarantee Act in Uttarakhand, for example, describes tussles between permanent state employees and the subcontracted 'young professionals'—computer programmers and engineers designing

infrastructure plans—who were jointly charged with administering the programme. These two classes of bureaucrats were differentiated not only by their contracts and qualifications but also by their stages in the life course, styles of self-presentation and ways of working. The 'young professionals' came to work in jeans and t-shirts and were variously amused and bored by the long meetings and official hierarchies, whilst the permanent state employees wore sober and formal clothes and were deferential towards their superiors as well as to *sarkari* (state) procedure and custom. Anders (2005, 2010) describes similar tussles between 'old-school' officials and 'young economists' in Malawi that resulted from the 'good governance' reforms imposed there by the IMF. I will show in Chap. 5 that there were submerged tensions between the 'basic-pay-scale' employees and the rest, which emerged at a time of institutional uncertainty. In the everyday life of the NACP, however, there was a real blending of talents, despite the distinct 'legal and affectual contracts' (Bear and Mathur 2015, p. 24) of the staff, and a hybridization within the organization itself.

From the way they carried themselves in the office or performed their day-to-day duties, it was very difficult to tell who belonged to which of the above three categories of employees. For example, in what appeared to be an attempt to emulate their colleagues in the permanent government service, the contract-based employees, most of whom had previously worked in NGOs, started to wear the *shalwar-kameez* and waistcoat (the national dress) on Fridays—a practice that is commonly associated with state officials and politicians. Likewise, employees in the first category adopted the ways of their NGO-style, 'market-based' colleagues, for example in their excessive use of development sector buzzwords—'sexual minorities', 'empowerment', 'participation' and 'civil society', to name a few.

Everyday life at the NACP reflected a blending of aptitudes and work ethics, which departed from those usually associated, separately, with government bureaucracies and corporate sector organizations. As in other government offices, there was a large number of support staff, who mostly sat idle in the corridors reading Urdu newspapers, chatting about national politics, and enjoying long mid-day prayers and lunch breaks. The office environment was dominated by men in terms of absolute numbers and visibility of staff. There was a fleet of vehicles bearing the government's emblematic green number plates, some of which were off the road due to

poor maintenance. There were middle-aged clerks surrounded by dilapidated wooden furniture and stacks of dusty files in and above the tall and narrow steel cabinets lining the walls, and office desks covered in the emblematic green felt. These were but a few markers of the NACP's outlook that made it seem not very different from other government departments that I had seen and worked in. Yet this was also a government organization that offered high salaries, produced glossy reports, and shelved the rules and procedures in pursuit of achieving short-term targets—'getting things done'. The majority of the employees may have been middle-aged men, but they were obliged to work closely with NGO bosses, international experts, members of the marginalized high-risk populations and HIV-positive people, due to the imperatives of public–private partnership, which were combined with the participatory approaches favoured in global health. This masculinized office space was also therefore a place where flamboyant *hijra* (transgender) activists sat in meetings with high-ranking government officials, where the fiery leaders of women's organizations, religious minorities, and the NGOs representing men who have sex with men, sex workers and injecting drug users mingled with international health experts, civil society pundits and orthodox religious leaders, and where socially stigmatized HIV-positive activists rubbed shoulders with top bureaucrats, renowned journalists, and the country heads of aid agencies.

In this new bureaucratic field, career bureaucrats worked alongside newly hired, market-based, US-educated public health specialists, bosses of the contracted NGOs, business executives of a management consultancy firm, and experts from the Future Group and the World Bank. Technical assistance from a fleet of freelance consultants, who were called upon from time to time to build capacity or to handle logistics, was another common feature of day-to-day work at the NACP. The norms of a proceduralist bureaucracy intersected with the new 'efficiency-oriented' work culture of the contemporary neoliberal ethic. In other words, it was a hybrid, or blend, of traditional proceduralist bureaucracy, with its customs, rules and regulations reminiscent of the former British colonial administration, and the culture of a new and flexible, market-oriented organization where, as Sennett (2006) discerns, rules can be set aside in favour of expediency and short-term goals.

Entrepreneurial Reconstitution

When I started my internship in June 2010, the position of National Manager was vacant. Of the two most senior employees who looked after the day-to-day running of the NACP, one was Dr Nadir, my mentor. He was known as 'the programme guy' amongst people from its partner organizations because he often took the lead in technical discussions, whereas the other senior employee took care of its administrative side. Dr Nadir held not only the technical know-how concerning the HIV epidemic, and the response to it, but also enjoyed a reputation for unmatched charisma. Journalists seeking facts and figures about HIV/AIDS or the numbers of 'risk groups' in the country preferred to interview him rather than the NACP's designated Media Liaison Officer. Since he had also been a clinical practitioner in the past, many members of staff came to him for help, support and advice or even for free diagnosis and prescriptions for themselves or their family members. He once told me about the 'very good relations' he had enjoyed with all three of the National Managers that he had worked with over the years. They were political appointees from the Ministry of Health, whereas he was the one who was strong on the 'technical side', with his Masters degree in Public Heath from an Ivy League University in the United States. According to him, the first National Manager had treated the NACP like her own *jagir* (fiefdom), the second was 'a nepotist' and the third was 'too simple'. 'I used to prepare the presentations but Sakina would claim that she did. I prepared presentations for Farrukh too, but at least he acknowledged that. Now, I prepare presentations for Majid and he asks me to deliver them as well', said Dr Nadir with a sarcastic laugh.

I worked very closely with him during my internship. In fact, I was given a desk in the same room as him. Over this period, I realised that he was remarkably gifted at building alliances and often managed to outmanoeuvre his opponents by using his position as technical expert. Individuals from within and outside the NACP, current and former colleagues, classmates, friends and acquaintances paid visits to him and spent hours trying to convince him to consider them, or one of their relatives, for a position in the upcoming Global Fund project for which he was the focal person. He was

undoubtedly the most sought-after person at the NACP, but he was not always equally forthcoming for everyone. He would sometimes snap at colleagues for running to him for everything, but would later oblige them as well. For instance, on one occasion a junior colleague came to ask him to participate in a meeting with the UN Office on Drugs and Crime because he was the most learned expert amongst them. The request was turned down with an angry outburst. However, the junior colleague returned a few minutes later with the same request from the newly appointed National Manager, which Dr Nadir obliged instantly. He often complained about the burden of work placed on him and that everyone depended on him. 'How many things I can look into?', he would say. Yet nothing went by him unnoticed. Dr Nadir fostered dyadic senior–junior relationships with younger employees, which resembled the relationships between employees in the *oyabun-kobun* (parent–child) system in Japanese agriculture and industry, a system characterized by 'a set of diffused reciprocal obligations, duties and loyalties between a senior and a junior' (Donoghue 1957, p. 14). He called younger colleagues *bachey* (child) in a manner of imposing himself as a fatherly figure.

The NACP was 'enchanted' by many different forms of human relatedness, in sharp contrast with Weber's ideal of bureaucracy as formal and rational. As in the business corporations studied by Kanter (1990, p. 281), life in this government department had a 'romantic quality' to it. Rumour, gossip, whispering, back-biting, jokes and laughter were, of course, important means of establishing who was who in relation to whom. Bureaucratic authority was therefore not the sole arbiter, and the official rules of conduct had their limitations when it came to regulating relations between employees at the NACP. In stressing the parallels with the business world, I mean to demonstrate that relationships of patron-clientism were not unique to the NACP, and that they cannot be confined to characterizations of only certain types of organization, whether they be governmental or private, or NGOs (Haller and Shore 2005). There is certainly no dearth of literature on bureaucracies as humane and relational (Gardner and Whyte 1946; Crozier 1964; Herzfeld 1992; Wright 1994; Heyman 1995; Graham 2002; Hodgson 2016; Stoler 2004; Navaro-Yashin 2006, 2009; Sennett 2012). My purpose in this chapter is to go beyond the anti-Weberian critique and show specifically how these relations were made possible by, and were shaped by, the new

bureaucratic field at the NACP, and to what ends they were used by those who built and nurtured them—and in some cases, by those who found themselves entrapped in webs of exploitation by both the exercising of patronage and by a new emphasis on 'efficiency'.

Dr Nadir and I shared our office with a woman called Dr Sobia, who had recently joined the NACP on a contractual basis to work in a 'donor-supported' position. Before this, she had enjoyed working with a number of NGOs and had brought home a good salary to supplement her husband's income. Four months into her new job, however, she still had not received any salary, for which she was given conflicting explanations. One was that it was simply a procedural delay. Another was that a junior clerk in the accounts section had, by mistake, forgotten to submit the invoice for her salary to the United Nations Population Fund, the donor that supported Dr Sobia's position. She was not the only one affected by this mess-up; apparently, the same clerk had forgotten to send invoices for the salaries of a few other employees as well. A rumour also made the rounds that the Population Fund was re-evaluating its commitment to the NACP in the wake of a possible withdrawal of the World Bank's support for the NACP. Therefore, all fund transfers had been withheld in the intervening period. Every day she tried to find out what was happening with her salary. She rang up colleagues, paid visits to the accounts department and the office of the National Manager, and pleaded with Dr Nadir, who was also her line-manager, to do something about it. One day she told him that she had had a good job offer from an NGO and that if she was not paid her due immediately, she would leave the NACP for this new job.

It was not unusual for employees to spread false rumours about good job offers they had received, to better their bargaining stakes by inflating perceptions of their own 'market-value', or to simply show off their loyalty to the NACP. Dr Nadir himself was no exception to this trend when he said he had 'two to three job offers at any given time', but did not leave the NACP. Assuming the role of a mentor, he lectured Dr Sobia that there were long-term benefits of working in a government department, giving his own example as an illustration. But at the same time, he made it clear to her that if she decided to leave, she was easily replaceable from the market. He even gave the example of a former colleague, real or imagined, who had left the NACP and was now trying to return, but had no

chance because he was not in the 'good books' of the higher authorities, due to his disloyalty to the organization. Alternating the stick with the carrot, he told her:

> Nobody bothers you about office timings here. There is no stringent hierarchy in the office. Apart from a couple of people, everyone works as equals. Unlike other organizations, nobody is counting your working hours here. Unlike other government departments, you are not asked to give explanations.

This kind of lecturing became part of a routine in the office I shared with them, as did Dr Sobia's continued complaints. In the four months that she had worked without receiving any salary, she had already spent a lot of money on commuting to the office. Even her husband had told her off for 'wasting time and money'. This was affecting her family life. She did not 'work for leisure', she complained, nor did she come from a big 'landlord' family. She needed money to contribute to household income and thought it unwise to continue working at the NACP unpaid whilst she had the offer of one lakh rupees a month (100,000 rupees, approximately US$1000) from an international NGO. Moreover, in her assessment, the HIV/AIDS sector was not suitable for her long-term career, the international funding for HIV/AIDS prevention was 'random', and there was no guarantee that this sector would continue to employee people like her.

When she stopped coming to the office, Dr Nadir phoned her to persuade her to come back, but she replied that she preferred taking her husband's advice first. 'The problem with women', he afterwards told me and two other junior colleagues who worked at the same level as Dr Sobia, 'is that they can't take decisions. Her husband is a military man. He cannot think beyond the fact that if his wife is working, she should have her salary in her purse on the first day of every month'—as if this was not a legitimate expectation. He then asked these two junior colleagues if they were getting their salaries on time. Both replied with some hesitation, saying that sometimes they had to 'push' the accounts section for timely release. Satisfied with their reply, Dr Nadir looked towards me and said: 'Fawad and Jawad are boys [men]; they do not face the same indecisiveness as Sobia because they know what is good for them in the long run'. Dr Nadir's relations with these junior colleagues were charac-

teristic of organizations that take the 'enterprise' model, rather than the traditional, bureaucratic form of governance; this is where 'the manager and the workers are amenable to entrepreneurial reconstitution' and the former are expected to foster a spirit of enterprise amongst their subordinates (du Gay 1994, p. 644).

The calculatingly charismatic management style displayed by Dr Nadir was in contrast to the detached management style typical of a traditional bureaucratic organization. In the Weberian model, the conduct of the bureaucrats, entrepreneurs and politicians is governed by a completely different ethos and there is a certain irreducibility of these different spheres of ethical life (Weber 1968, p. 1404). At the NACP, by contrast, managers' and workers' conduct was an entanglement of a bureaucratic, entrepreneurial, and political ethos where, in the new work culture of the Enhanced Program, the formal rules, regulations and procedures were overshadowed by 'informal networks and an emphasis on individual creativity and dealmaking' (du Gay 1994, p. 671). In this way, I contend that the patron–client relationships that flourished at the NACP were not the inevitable product of a timeless culture of corruption in Pakistan, but were produced by the entrepreneurial model of working life. As du Gay (1994) continues:

> The contemporary 'entrepreneurial subjectification' of the workplace places considerable responsibility on the shoulders of individuals for their own advancement. In these circumstances—with the struggle for personal power an increasing feature of entrepreneurial conduct—it should come as no surprise to learn that forms of 'personal patronage' are far from on the wane within such organizations. (ibid.)

As I elaborate below, the landscape of power that emerged as a result of flexibilizing Pakistan's HIV/AIDS bureaucracy afforded new opportunities for its workers to forge creative alliances and occupy new spaces.

Entrepreneurial Relationships

The NACP often hired external consultants for technical and logistical support, whose tasks included the preparation of baseline studies and project evaluations as well as the undertaking of activities such as train-

ings, stakeholders' meetings, awareness seminars, workshops and dissemination events. The selection procedures for consultants varied depending on the donors, but in most cases Dr Nadir prepared the Terms of Reference (TORs) and his friend, Dr Maya, was selected without any competition. Although these consultancies were in Dr Maya's name, the actual work was carried out by her and Dr Nadir together, who split the earnings between them. Moreover, he used his influence in the HIV sector to 'get things done' for her and made his subordinates carry out the outsourced work. On her way to Dr Nadir office, which she used as a base, she would occasionally pluck a red rose or two from the National Institute of Health's gardens to surprise him. He returned the affection with a cup of coffee requested specially from the peon of the National Manager.

When they chatted with each other, the topics ranged from work gossip to preferred shopping venues and emigration to Canada. Whilst he took the lead in sharing gossip about colleagues, rumours about upcoming consultancy projects, or the twists and turns of donor funding, she was good at advising him about where to buy sofas, carpets and curtains; she had recently decorated her new house. One of her sisters lived in Canada and she had only recently given up on the idea of pursuing emigration after concluding that she could earn more money, and live a more comfortable life, in Pakistan. Dr Nadir had also considered emigrating to Canada, but had not set his mind on it, even though he researched the process and requirements of emigration very keenly. As the 'programme guy', and a genuine expert on the HIV sector in Pakistan, he was at the centre of high-profile networks of donors and NGOs; many donors depended on him to 'get things done' in the government. This provided for him a certain leverage with them. For instance, on one occasion, when Dr Maya had a writer's block over her section of a report, which was being prepared as part of one of her consultancies for the NACP, he tried to console her by saying: 'it's just a report. No one is going to read it apart from you, me and Aleem [a colleague in UNAIDS]. Just get it done, everything's fine'. He was often seen very actively promoting Dr Maya in front of expatriate staff of the donor agencies or whilst visiting international experts as the most-respected consultant on HIV/AIDS in Pakistan.

Dr Nadir was a mentor and a friend to me as well. He often lectured me on how the HIV/AIDS sector worked in Pakistan. He objected to

those critics who charged that those who work for donor-sponsored programmes make a lot of money for themselves in the name of helping the poor and at-risk populations. He called this attitude '*na khaidan gay na khaidan dian gay*' (that is, these critics 'will neither play nor let others play') and claimed that such in-fighting had a negative impact on the flow of donor money into Pakistan. He said: 'the result [of such criticism] is that nobody gets anything'. To further illustrate his point, he told me: 'look, to put it simply, two plus two equals four; but one plus three also equals four; and zero plus four is four as well'. In the donor-sponsored projects, what mattered at the end of the day was therefore not who got the bigger or smaller share of the aid money, but that 'ultimately the money comes to Pakistan and the country benefits'. He seemed to have reconciled a contradictory aspect of his life: his involvement in the 'stealthy violence' (Li 2010, p 67) of diverting aid money from its deserving recipients, on the one hand, and the urge to serve the nation by facilitating the smooth flow of aid money into the country, on the other. Such alignment of 'the modes of life that appear philosophically opposed' can be achieved, according to Nikolas Rose (1996), through 'the ethics of the autonomous, choosing, psychological self' (p. 157). Nonetheless, the promise of this 'entrepreneurial self' 'remains empty because of the unsurpassable gap between the hegemonic symbolic identities and everyday social performances' (Nadesan and Trethewey 2000, p. 245), as I now describe.

Chez Nadir

The servant who brought us cold drinks must have been around 13 years of age. He wore unclean clothes and had a look of sadness and mystery about him. Dr Nadir's elder son, who must have been of the same age as the servant, laid on a leather couch watching the Cartoon Network on a large plasma-screen television in their lounge. Dr Nadir's wife, with their younger son, had gone to her mother's folks in Karachi, who were so rich that the father had built five villas in Defence, the premium housing authority of the city; one each for a son and four daughters. Dr Nadir's brother-in-law was an importer of luxury cars, whilst his sister-in-law's

husband, he told me candidly, had run away to England after defrauding someone at the Karachi Stock Exchange. On his own family's side, by contrast, most relatives lived in inner-city Rawalpindi. He was not on good terms with them: most of them were poor craftsmen. In fact, he had not seen them since the death of his father, who had managed to pull himself out of poverty and worked as a teacher of Persian at a local college.

Dr Nadir's villa, in an upcoming neighbourhood off the airport road, was one of his big accomplishments in life. He said he had saved around one and a half lakh rupees a month (US$1500) as a clinical practitioner before going to the United States for studies, where he saved more money by working part-time. He had bought a plot of land in a suburban enclave for 13 lakh rupees a few years previously when he started working for the NACP. When he had saved enough, he started the villa's construction, which cost him around one crore rupee (US$100,000). Some of this money was borrowed from the wealthy brother-in-law.

The servant was summoned to collect the empty glasses when we finished our drinks. Upon approaching us, he was reminded to promptly wipe the water marks of the ice-cold coca cola glasses from the tinted-glass surface of the coffee table. With a duster ready on his left shoulder, he instantly obliged. Dr Nadir showed me around the villa, pointing out the plasma-screen television, the expensive woodwork, heavy furniture, decoration lights, and unopened packs of luxury accessories and expensive crockery on the kitchen shelves. He proudly asked me to feel the paint on the walls and look carefully inside the washrooms, explaining how expensive everything was and how he had personally overseen the villa's construction. A waterfall fountain in the middle of the living room, which he had designed by himself, was still a 'work in progress'—like Dr Nadir's entrepreneurial self, I thought.

In Lacanian psychoanalysis, at the heart of the subject is a 'lack' because of the realm of the Real: that which cannot be symbolized. Lacan names this lack *jouissance* or enjoyment. Struggle over and for *jouissance* constitutes the subject (Lacan 2004, 2007). Contemporary consumer capitalism has provided a 'symbolic system onto which the subject's constitutive anxieties (lack) can be transferred, creating a set of fantasies for people to believe in' (Böhm and Batta 2010, p. 354). However, according to Böhm

and Batta, 'the crucial Lacanian insight is that this enjoyment can never fully "fix" the subject; there will hence always be a lack that needs to be filled with ever new joyful content' (2010, p. 357). 'Now that the house is built, there is no thrill left in life', said Dr Nadir. He continued:

> I often feel I have nothing to do. Like today, I didn't know what to do, I watch a lot of TV, the kids have grown up and it's hard to spend time with them either, they do not like it anymore. They want to go out with their friends, not us. On the last birthday of my son, we bought meals at McDonalds for him and his friends, but we were not allowed to sit at the same table with them.

He said he had only two close friends: one had died of cancer and the other lived in a different city. These days, Dr Nadir was trying to convince his remaining close friend to build a similar villa in the same enclave as his. Sometimes, he thought of migrating to Canada for the children's education, but was put off by the thought that his career in Pakistan might come to an end if he absented himself for a long time. His decision-making was therefore influenced by a concept of personhood, closely fitting one that Kelly (2006) describes, called the 'Entrepreneurial Self', which 'sees individuals as being responsible for conducting themselves, *in the business of life*, as an enterprise, a project, a work in progress' (p. 18: original emphasis). And according to Bröckling (2005), the 'project manager of the self' is never able to finish because of the imperative of being compelled to achieve more: 'the enterprising self is not the same as a patchwork quilt, which once it has been sewn, no longer changes its pattern, but (it is) like the kaleidoscope (that) shows a new image with every turn' (p. 15). Nearly 40 years old, Dr Nadir complained that there was 'no thrill left in life', but it was obvious that he had a lot on his mind concerning his future, and there was no dearth of examples to follow:

> Does Dr Marwat himself do all 10–12 consultancies that he has at a given time? No, he uses young people, and there is no harm in that, as long as they get something and are happy with it. The important thing is that the end product should be good. Dr Gill is doing four to five consultancies…. And what about Tasleem? Has he made all this money from his salary only? So, everybody does these things; the thing is that the end product should

> be good [the reports and other deliverables]…They won't give you work [if you work] on your own. They will look to my face and they know I will supervise you and get the work done. So, you benefit, I benefit and the work is good. What is the harm in that arrangement!

Was I going to be the new Dr Maya? Did he think that I would succeed where Dr Sobia failed? Again, I do not want to criticize these arrangements by framing 'informal systems'—which evidently have a clear bearing on the 'formal systems' in organizations (Wright 1994)—as particular to Pakistani or South Asian bureaucracy. Indeed, as observed by Cullen (1992, 1994), in the context of British welfare benefit services, and by Shore (2000), in the context of the European Commission, deviations from the Weberian ideal that might be regarded, in a Western bureaucracy, as an exercise of 'personal initiative', valuable for potentially improving an organization's capacity and efficiency, might be termed corruption, nepotism or tribalism in the context of 'Third World' bureaucracies. What interests me here is the way the younger partners in such arrangements are assumed to be happy and satisfied. Behind the 'good end product', relations of inequality, exploitation and abuse are often masked. High youth unemployment in Pakistan, combined with rising educational standards in the middle classes (Haider 2016), make for just the right mix to guarantee an endless supply of clients to the patrons in the development sector. A few lucky, enterprising clients get to become patrons. Dr Sobia was not one of them. Dr Nadir, a patron at the NACP, had no hesitation in saying about himself that 'people like me who are good at leadership and management do not need to be very good at writing as well. You will find a hundred people who can do that for you'.

Conclusion

The restructuring of the NACP under the Enhanced Program led to the development of a new bureaucratic field. Departing from previous ethnographic descriptions of other government departments in Pakistan, and elsewhere in South Asia, I have pointed to a blending, or a hybridization, of bureaucratic styles and ways of working at the NACP, which began with the staffing arrangements—with their different tiers of contractual

arrangements—and permeated to all its aspects. My close-hand observations of the everyday life of this organization allow us to glimpse how changing global policy regimes may transform the personal lives of intermediary actors, their social relations and relations to the self. Drawing on a comparative literature on neoliberalism, I have suggested that what was fostered at the NACP under the Enhanced Program was an 'entrepreneurial self' (Rose 1992), a phenomenon not exclusively Western (Cullen 1992, 1994; and Shore 2000). Literature on entrepreneurship teaches us, too, that the forms of power and patronage we have observed are not exclusive to government bureaucracies either. Even in Wall Street, that hallowed summit of capitalist rationality, Ho (2009) has shown us that investment bankers' financial analyses and recommendations are not based on any logic that stands outside of their 'personal biographies…job status and workplace experiences' (p. 11).

The flexible work culture at the NACP was characterized by intense relationships and emotions and was influenced by factors such as paternalism, friendships, favours, rivalries and resentments. Informal relations of power, authority and entrepreneurialism coexisted with the formal organizational hierarchy, and with bureaucratic procedures. The result was that employees' constant concern about their value or depreciation in 'human capital' markets were manifested in forms of 'self-appreciation' (Feher 2009) through investment in others, the exploitation of junior colleagues, and the 'stealthy violence' (Li 2010, p. 67) of filling their pockets with aid money. The officials and employees at the NACP carried out their official work as 'personal enterprise' in order to make profits for themselves, increase their own clientage, seek higher patronage and build creative alliances across government, NGOs and donors. But as fieldwork progressed, I learnt that the heydays of the NACP staff were, in being produced by donor funding, also time-bound by this dependence. In the following chapter, I detail the World Bank's decision to withdraw funding of HIV/AIDS prevention in Pakistan, a turn of events which, combined with the devolution of the Ministry of Health, threatened to decimate the HIV/AIDS sector in the country. An appreciation of this turn of events nuances our understandings of the NACP, since it highlights further the significance of the NACP's donor funding, and also, therefore, its concomitant precarity.

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5

Surviving Hard Times

Only a few months after I started working there, the NACP was in crisis. In June 2010, the World Bank was still officially committed to financing a second, five-year phase of the Enhanced Program (World Bank 2010). By July, however, rumours had begun to circulate that the World Bank was going to stop financing HIV/AIDS prevention in Pakistan. The World Bank did not deny or confirm the rumour at that time. The bilateral donors also appeared non-committal, marking the end of a 'scale-up decade' in the global response to HIV/AIDS (Parker and Kenworthy 2014). This created a sense of uncertainty about the future of the NACP, further compounded by an intense national debate over the 18th Constitutional Amendment, which would result in a devolution of the federal Ministry of Health to the provinces and raised the possibility of the NACP's dissolution. What would become of the employees in this organization whose careers seemed to depend on the next phase of the Enhanced Program going ahead? Rumours bred more rumours, as they are 'intertextual by nature' (Perice 1997). In their attempts to save their current jobs and to keep their job hunts secret, former collaborators amongst colleagues at the NACP turned into competitors. Previously friendly relations soured as doubt, intrigue, and sometimes open

A. Qureshi, *AIDS in Pakistan*, https://doi.org/10.1007/978-981-10-6220-9_5

confrontation, developed. Whispers took the place of laughter, and jokes exploded into arguments.

In this chapter, I suggest that vulnerability to crisis is not coincidental to, but intrinsic to 'flexible' organizations such as the NACP. As such, I follow Sennett (2006) in pointing out contradictions in the logic of these organizations. According to theories of managerialism, flexible organizations ought to be adept at surviving crisis because the outsourcing and subcontracting of functions allows for a neat, fluid matching between fluctuating demand for the product or service they offer and organizational capacity. An organization that is not paying for unnecessary permanent members of staff will remain financially viable even in times of low demand. But Sennett observes that in old-style organizations, bureaucratic structures provide occasions for 'interpreting power, for making sense of it on the ground', and thus, that they 'give the individual a sense of agency' (p. 36). By contrast, employees in flexible organizations lack institutional loyalty, adaptive information and informal trust. As a result, ironically, and contrary to their logic, flexible organizations may actually be less predictable and less stable in times of crisis. Moreover, I follow Sennett in observing how this can have dire consequences for those who work in these organizations. Unlike in old-style organizations, which have fixed sets of functions, procedures, chains of command, codes of conduct, and sequences of activities, in flexible organizations functions can be performed in any sequence or combination. In the short time-frames that flexible organizations work within, immediate tasks become more important than long-term goals, and as a result, for Sennett, their workers are caught by demands for ever-increasing productivity. Their employees are haunted by a 'spectre of uselessness', are required to continually project their importance to the organization, and become prone to pretence and bluster. This contrasts with the situation of employees in traditional government departments, where 'climbing the steps of bureaucracy might become a way of life' and where 'unhappiness with an institution can coexist with a strong commitment to it' (p. 35). In the vein of studies on 'emotional' or 'affective bureaucracies', which counter the Weberian picture of bureaucracy as impersonal and detached (Graham 2002; Stoler 2004; Navaro-Yashin 2006, 2009; Laszczkowski and Reeves 2015), I show that there is a dysphoric aspect to bureaucratic life under flexibilization.

The Crisis

Various explanations circulated as rumours to account for the World Bank's withdrawal from funding HIV/AIDS prevention, from changing political and economic relations globally, to the mundane jealousies of individuals, which revealed the micro-politics of an externally driven intervention. According to one popular rumour, the recent approval of the Global Fund Round-9 grant for HIV/AIDS prevention meant that the World Bank's role in the HIV/AIDS sector would be pushed into the back seat. Hence, it decided to pull out altogether. Others believed that corruption and mismanagement, as exemplified in the dispute between the Punjab government and Naya Sewaira (see Chap. 3), was the real reason. One particularly intriguing rumour held that a senior staff member at the World Bank was upset with the government for having removed his spouse from the position of NACP manager, and wanted to convey the impression that 'not everyone could mobilize the Bank'.

To add to the misery of the NACP employees, by the summer of 2010, politicians were committed to dissolving the Ministry of Health, under the 18th Constitutional Amendment, and to devolve its powers, and those of the other federal ministries, to the provinces. Parliamentary debates centred on addressing long-standing tensions between the 'centralising authoritarian tendencies' of military regimes and democratic politics, which favours federalism and increased provincial autonomy (The Asia Foundation-Pakistan 2012, p. 17). Unlike previous attempts at generating greater provincial autonomy, the 18th Amendment was passed unanimously by the combined efforts of the Pakistan Muslim League (Nawaz), and Pakistan People's Party. The move was contested by a number of public health experts, who called on parliament to make an exception and retain 'health' under the control of the federal government, on grounds that smaller provinces lacked administrative capacity, and would be unable to deal with public health concerns that were of national significance. They also cited the challenges posed by the need to maintain uniform drug regulation and pricing mechanisms across all provinces, and the obligation to report on health targets to international agencies (Nishtar 2011; Malik et al. 2012). However, bureaucrats in the provincial governments were eagerly awaiting the transfer of powers.

As the devolution plan was set into motion, debates over its merits intensified, resulting in more rumours and uncertainty about the final shape that the devolved Ministry of Health would take. At the NACP, it was rumoured that bureaucrats in the Cabinet and Planning Divisions of the federal government appeared ill-inclined to salvage vertical health programmes that could not bring in money from international donors. High-ranking officials from the NACP paid visits to the Secretariat, the powerhouse of the country's government bureaucracy, for clarification about the devolution plan and what exactly it would mean for the future of the NACP. After every meeting they returned with more confusion. The rumours were contradictory. A senior colleague at the NACP told us that someone in the Cabinet Division had 'assured us that there are 99% chances that we [the NACP] are going to stay' (i.e. survive devolution), but another contended that the Cabinet Secretary was 'crystal clear that there is going to be no NACP after devolution'. Later on, the news broke that the Planning Division had issued a notification, to the effect that the NACP would not be fully dissolved, but that the notification had not yet reached the Cabinet Secretary. With only eight days left till the 30 June deadline, three junior employees, with the approval and backing of their seniors, managed to gain access to a copy of the notification from the Planning Division and pleaded with the clerks there to send it to the Cabinet Secretary in time for her to reverse her decision. As the notification reached the office of the Cabinet Secretary, staff at the NACP were on their toes, trying to keep track of every movement of the file. But, as is so often observed in bureaucratic life, the file did not move far or fast enough. Again, contradictory rumours about the fate of the file and the intentions of the federal bureaucrats gained currency at the NACP.

Rumour has been variously theorized in anthropological literature as 'a multidirectional, uncontrolled form of communication' (Sökefeld 2002, p. 299), a 'process of information dissemination as well as the product of that process' (Rosnow and Fine 1976, p. 11), a 'problem-solving strategy' (Shibutani 1966) in the face of ambiguity and uncertainty about significant matters, a 'weapon of terror' (Perice 1997, p. 2), a 'social discourse' with an 'enunciative aspect' and 'performative power' (Bhabha 1995, p. 332), an 'effective vehicle to challenge official accounts' (Gupta 1995, p. 388), and 'a necessary instrument of rebel transmission' in subaltern communication

(Guha 1983, p. 256). Rumours are not merely imperfect accounts of real events, but have a generative quality about them, which makes a real difference in the world of action. They are characterized by their indeterminacy, anonymity, contagiousness, excess, ability to impart certainty, their capacity to build solidarity, and the overwhelming urge they provoke in the listener to pass them onto others (Guha 1983; Das 1998). When rumours spread like a contagious disease, the question we must ask is not whether they are true, but why people deem them so important that they feel they should pass them on. Through their 'performative power', the rumours about the Enhanced Program were enacted as 'repositories' for justifying policy shifts, shifting blame, and predicating the future course of events. After all, they were percolating not only amongst the 'subaltern' of the HIV/AIDS sector but also amongst its elite. A senior staff member at the World Bank told me that he was not happy with the NACP's strategic shift from the focus on HIV prevention to the emphasis on the treatment, care and support of those already infected with HIV. The NACP, according to him, was 'more attuned to the Global Fund, was too ambitious and ignored high-risk groups'. Another senior member of staff talked, in a stakeholders' meeting, about a strategic shift at the World Bank. 'In the present context of resource constraints', she said, 'the Bank would prefer to invest in the wider health systems reform agenda', rather than focusing on HIV/AIDS alone. Where did the truth lie—if there was one? Rumours appeared to be as true as the official statements.

The rumours also reflected the sense of panic amongst the employees and consultants in the HIV/AIDS sector, whose livelihoods depended on the continuation of the World Bank's financing. The literature on 'emotional' and 'affective bureaucracies' redresses the stereotype of bureaucrats as devoid of emotions (or 'indifferent'; Herzfeld 1992). Mark Graham (2002), for example, has shown how taciturn Swedish welfare bureaucrats, dealing with refugees, performed delicate acts of 'emotional management' in order to contain heated public debates over the presence of immigrants and their economic burden on the state. Drawing on theories of affect—which are concerned with those 'intensities' inhering not in the individual's intentional consciousness but in the moment that precedes it, and with the relations between humans and non-human things and environments (Moore 2011, pp. 170–182)—other writers have

dwelled on the senses of belonging and attachment circulating in bureaucratic spaces. They have drawn attention to the example of colonial officers in the Dutch Indies, whose senses of belonging and attachment so worried the Dutch government (Stoler 2004), and to the 'make-believe state' of Turkish Cyprus, where a feeling of illegitimacy and decrepitude was transacted between civil servants within dilapidated office spaces (Navaro-Yashin 2006, 2012; see also Laszczkowski and Reeves 2015). To understand the sense of anxiety that circulated in the NACP at this time of crisis, however, we must go further into the comparative literature on neoliberalism. The anxiety of the staff at the NACP, and its effects on social relations and relations to the self, are elaborated below.

Emotional Encounters Between Colleagues

A delegation of international NGOs came to the NACP with a proposal about imparting HIV/AIDS awareness through dance performances amongst school-going adolescents. One of these NGOs was purported to have achieved great success in similar interventions in Africa, that fount of 'global foreknowledge' (Mahajan 2008) about HIV/AIDS and policies needed to tackle it (as I discussed in Chap. 2). However, since dance is considered un-Islamic by conservative elements in Pakistan (Batool 2004, p. 72), the translation of a dance-based information, education and communication campaign to the Pakistani context seemed problematic, even to the NGO delegation. There was a fear of a moral backlash, or even of harassment by the police, if the NGOs did not have the official backing of the government for their project. The NGO representatives were hoping to secure a Memorandum of Understanding with the NACP at this meeting, to secure legitimacy for the proposed project.

The Pakistani and the Dutch members of the visiting delegation began with Power Point presentations about their recent success in Africa. When it became clear they were driving at nothing more than a symbolic collaboration with the NACP, Dr Gill, a senior official in the research and surveillance unit, jumped into the discussion. 'Why don't we first do a baseline study of HIV awareness levels of adolescents? You're going to need that to measure the impact of your interventions'. This suggestion

was ignored by the visiting members, but Dr Gill kept returning to it. Taking his cue from him, Dr Nadir, his counterpart on the 'programme side', repeated the need for a greater role for the NACP in the proposed venture because, he argued, the NACP had better expertise in developing culturally sensitive awareness materials and guidelines. Both these senior officials tried to negotiate something for the NACP, but what they were trying to negotiate reflected their own job insecurities. Seated on either side of the NACP manager, who fell silent, they leaned forward to look at each other, frowning scornfully and asserting the greater merit of their respective plans. On the other side of the table, the members of the visiting delegation leaned back in their seats and watched the two officials talk to each other in front of their manager. Nothing formal came out of the meeting. Back in our office cabin upstairs, Dr Nadir seethed with anger. He did not like Dr Gill's 'pushing his own agenda into everything'. 'He is here only for his own survival', he fumed. I am sure that a similar scene would have been playing out in Dr Gill's cabin downstairs.

The crisis of funding and the challenge of the devolution plan became an uncertain conjuncture for the NACP; it was a moment characterized by a survival politics that precipitated heightened emotions in everyday exchange. Hitherto submerged distrust, rivalries and resentment burst out from beneath the surface of normality. In better days, when the NACP had plentiful World Bank money for its projects, they would complement each other in their roles at meetings like these. The NACP manager was usually a political appointee—therefore 'weak on the technical side'—so Dr Gill would take the lead on presenting statistical overviews of HIV prevalence, whilst Dr Nadir would explain the programmatic interventions; both would take questions and answer them. In early days of my fieldwork, Dr Gill often came to Dr Nadir's room to share gossip, laugh about colleagues and take part in a kind of 'bitching discourse' that not only constituted 'a source of pleasure at work' but also 'mark[ed] out power and status categories' (Pringle 1994, p. 120). There was a kind of symbiosis between the two. They gave each other reciprocal paid consultancies in their respective components of the NACP's activities, thanks to the flexibility of its rules and regulations (see Chap. 4). But now there was little work and money left in this organization and its dissolution loomed large. The fate of the NACP was in suspense and everyone tried to take as

much for themselves as they could, even if it sometimes meant open confrontation. Dr Nadir accused Dr Gill of stealing data from his USB stick, which Dr Gill had apparently saved on his laptop with the filename 'from Nadir's USB'. He confirmed the theft with the help of an IT person and complained about it in front of many colleagues. Other allegations about Dr Gill were that he promoted his own friends and relatives at the NACP, since he gave an internship to his wife's class fellow. His cousin Dr Iftikhar, who was also a senior NACP official, had 'appointed his girlfriend as a gender specialist', whispered Dr Nadir.

Insecurity, Distrust and Resentment

The NACP employees had prospered under a regime of generous funding for their projects and activities, regardless of which category they belonged to. But now, as the future of the NACP became uncertain, cadre bureaucrats started to call upon their contacts in other government departments so as to secure a return to previous positions, whilst the market-based and donor-sponsored employees looked for any opportunity to jump ship. If the devolution plan went ahead, it was rumoured that 'more than forty thousand people will be laid off and they will all be looking for jobs at the same time'. The job market was going to be flooded with skilled people, and not everyone was going to be lucky enough to find a job elsewhere. This dilemma was felt particularly acutely by four junior employees who had worked in the Global Fund Round-2 project at the NACP. The project had long been concluded, but a room designated 'GF office' was still maintained at the NACP. These staff came every day, despite the expiry of their contracts, and used the GF office, with its computers, printers and internet facility, as a base to apply for jobs. They tried to maintain their connections within the NACP in anticipation of the upcoming Global Fund Round-9 project. Every now and then, one of them would come to see Dr Nadir in his cabin to remind him that they were waiting to be hired for the upcoming project. Dr Nadir served as the NACP's focal person in the negotiations for the Global Fund Round-9 project and was expecting selection as the Team Leader to roll out the project from the NACP.

Dr Nadir's own situation was precarious. He worked in a UN Population Fund-sponsored position, and as we saw in the case of Dr Sobia (Chap. 4), these international donors were increasingly non-committal in sponsoring donor-funded positions at the NACP. Although Dr Nadir had been assured of selection as the Team Leader in the Global Fund Round-9 project, the government's rules required the NACP to advertise this highly paid position in newspapers, and to select the incumbent 'through proper channels', by inviting applications, going through a short-listing, and interviewing. This put him on tenterhooks for months. When he was finally confirmed as leader of the project, the first thing he did was to secure the Global Fund office at the NACP from the previous staff in order to build a new team. He told remaining staff from the previous project to stop coming to the office, and anticipated their attempts to destroy data on their computers in revenge by obtaining it beforehand; there was no place for them in the Round-9 project.

It is pertinent to note here Sennett's (2006) argument about how relations between employees in flexible organizations are coloured by anxiety and 'institutional paranoia'. In contrast to the traditional bureaucratic organization, with its clear hierarchy of positions, well-defined roles and career trajectories for individual employees, in flexible organizations the line between competitor and colleague is unclear. In times of crisis, there is a lack of trust amongst coworkers in flexible organizations because of the uncertainty attached to the future, in contrast to the predictable, laid-down courses of action often followed in traditional bureaucracies. Whilst managerialism and public choice theory seek to 'uncage' bureaucrats from the rigid application of formal procedures, promising them more control over their ways of working, Sennett argues that flexibilization has only reinstitutionalized the lack of control in new forms.

The distinctiveness of the relational dynamics that were unfolding at the NACP can be highlighted by contrasting them with those that developed in other government departments faced with these upheavals following the 18th Constitutional Amendment. The axe of devolution fell on 17 federal ministries whose functions were devolved to provincial governments. This meant a transfer of at least 182 institutions and organizations affiliated with the federal government to provincial governments, and a re-allocation of more than 60,000 employees to different

departments. Yet, crucially, none of the government employees lost their jobs or were even put in a 'reserve pool' of employees, contrary to a rumour at the time. The NACP was unique. It was a hybrid, flexible organization with three distinct categories of employees and it ran on borrowed money from the World Bank. The crisis here was not merely a crisis of devolution or of a looming restructuring, but of donor funding and hence of survival. And the crisis affected different categories of employees differently. Those in permanent government service were on surer footing to steer through, albeit standing to lose the perks associated with working in a World Bank-funded organization. Meanwhile, those who were not from the permanent civil service but had worked for the NACP for many years floundered in the midst of uncertainty. They were reminded of their status as 'temps' (Sennett 2006, p. 48), drawn from the market, or embedded by the donors.

Floundering in the Midst of Uncertainty

Dr Nadir and Dr Maya, his friend and protégé (see Chap. 4), often debated whether setting up one's own NGO was financially more rewarding than working as a consultant, or as an employee, in a government department such as the NACP. One day Dr Nadir launched into a tirade of criticism against NGOs, especially Naya Sewaira, which had received vast amounts of funds from both the Enhanced Program and the Global Fund Round-9 project (see Chaps. 3 and 6). He complained that Kamal, the owner of the NGO, had made all his private wealth from the NGO's projects on injecting drug users, and accused him of the misappropriation of public funds. Giving an example, he claimed that Naya Sewaira adopted a 'mobile drop-in centre' model for its 'syringe exchange programme' only to enable itself to purchase expensive vehicles from project money. Three years later, when the project was over, the twelve expensive vehicles, worth millions of rupees, became the permanent property the NGO. This affronted Dr Nadir's sense of the 'sovereign responsibility' (Brown 2015) of the government to manage public funds, but his resentment was mixed with envy, and Dr Maya could not agree more. He was also very critical of the NGOs that provided HIV/AIDS prevention ser-

vices for *hijra* and men who have sex with men. Millions of rupees were made by these NGOs, according to him, just for 'mobilizing a few *hijrae*, setting up a drop-in centre and distributing some condoms'. His example illustrative of this was the 'truckers project' under the Enhanced Program, which was worth six crore rupees. According to Dr Nadir, all that the NGO contracted for this project did was 'keep some condoms and few STI medicines' at 12 drop-in centres…none of which was 'bigger than the size of my office cabin'.

Dr Nadir appeared anxious and dissatisfied with his accomplishments. He had built a career for himself at the NACP. He did not leave this organization when he had offers from elsewhere. But now his prospects of continuing at the NACP were thwarted. What options did he have? Did he have enough trusted friends to help 'accommodate' him elsewhere—for instance, in a donor agency? When would be the right time to leave the government sector? What would it entail to work outside the government? These were the questions that he grappled with, mostly alone but sometime with a confidante, namely me. I helped him prepare job applications and shared his frustration about their failure as we continued our work as usual at the NACP, not letting another soul know about it. Meanwhile, like many of his colleagues hunting for new jobs, who also anxiously followed 'the latest' on the devolution process, or tried to read the minds of top World Bank officials, Dr Nadir wanted to know about every new happening at the Secretariat—the powerhouse of the government's decision-making—and rumours about those decisions. He phoned his contacts in government departments to obtain the latest news. He ended every conversation with a probe about the devolution plans, and passed on anything new he had learnt to his friends and colleagues for their comment. He spared no opportunity to gather information, solicit opinion, or to take advice. He mocked the devolution plan, lamenting what he thought would be the negative impacts on HIV/AIDS prevention in the country. He predicted that devolution would prove a big failure and would be reversed soon. These assertions were often more of self-reassurance than anything to do with the actual situation that was unfolding in late 2010.

We prepared his job applications for vacancies at DFID and a UN agency with considerable input of time and effort. Although he gave his

best in the interviews, he did not like the selection process: the candidates were made to submit a colossal amount of paperwork with their applications, to give multimedia presentations to selection panels, and even subjected to group discussions and tasks amongst themselves in order to assess their leadership skills and aptitude, before being given the chance of a final interview. He had some friends in senior positions in both DFID (Department for International Development) and the UN. However, they were helpful only to the extent that they shared some insider knowledge of what to expect in the interviews—a favour that they might have discreetly extended to other candidates as well. He was shortlisted but not selected for the vacancies. Disappointed with the outcome, he came up with the idea of setting up a joint consultancy firm with Dr Maya, offering me the opportunity to become a long-distance consultant after I went back to London. He was confident of finding work for this consultancy on the basis of his networks. To my mind, this consultancy business was a fantasy that Dr Nadir held onto in the face of his imminent failure as an 'entrepreneurial self' (Rose 1992).

Self-pity and victimhood were again evident in Dr Nadir's self-criticism when he shared with me that, in better times, he had recommended his junior colleagues for well-paid, stable jobs in international agencies and NGOs, not realizing that the NACP itself would become an organization with no money or future. If there were going to be mass lay-offs, finding a job elsewhere was going to be even more difficult. 'Why do *we* have to be the ones who are always made to sacrifice', he asked, as if pitying himself. I wondered who else he included in this 'we'. Was he pitting the technical experts versus the NGO owners, government employees versus the aid agency workers, or self-made, socially-mobile careerists versus the members of privileged classes and politically well-connected families like Kamal's? The moment of uncertain transition at the NACP, triggered by the end of World Bank financing and the devolution of the Ministry of Health, brought out all those differences that had laid hidden backstage during the grand performance of the Enhanced Program.

As he heard contradictory rumours about the future of the NACP, sometimes he would say, in despair, 'I don't like work anymore; *kya bakwas hai* (what nonsense)'. Similarly, on another occasion, he opined: 'last night, I was thinking of quitting … all this pull from all sides is unbear-

able; the provincial programmes, NGOs, civil society, Local Funding Agent…'. He did not have the heart to disengage completely from the Global Fund project, which he had spent so much time negotiating, and which he cherished as an achievement and prized as a hoped-for guarantee of future employment in similar vertical health programmes. But even if he remained there, would the Global Fund Round-9 project run its course? What would happen if he did not?

The Global Fund Round-9 project was rolled out in March 2011, just as the World Bank-financed Enhanced Program was rolled back. In the event of the NACP's rumoured shutdown, there was a possibility that the whole Global Fund project might fall into the hands of Naya Sewaira. As noted in Chap. 2, Naya Sewaira was already Co-Principal Recipient of the Round-9 grant and received two-thirds of the funding. For Dr Nadir, a Naya Sewaira take over would have been a disaster. He reassured himself and his team that

> There will be some mechanism for us … we are in the same league as the TB and Malaria grants, which are huge. The TB grant alone is close to $200 million … [so] they will sort out some future for us. Otherwise, if it was the HIV grant alone, then we would have been screwed.

Referring to the TB and Malaria funding streams, he implied that since so much money was involved in these Global Fund grants, the federal government would just not let it slip out of its hands and into the clutch of NGOs like Naya Sewaira. The staff at the NACP were not only envious of the gains their NGO colleagues were set to make from this imminent change, but belatedly, they also raised questions about the 'sovereign responsibility' of the government to administer and provide HIV/AIDS services (Brown 2015). Faced with the prospect of their replacement by NGO bosses, the NACP staff were at last moved to deliberate about the destructive consequences, for the Pakistani people, of the replacement of a government bureaucracy by an NGO. Bureaucracy as public good, as a 'utopian ideal' (Bear and Mathur 2015, p. 21), provided legitimacy to their conviction that the sustainability of Pakistan's HIV/AIDS response depended on its ability to recover from the whittling-down of its public administrative staff at the behest of donor aid.

The New Face of the NACP

Approaching the 30 June deadline for closure, when the staff were asked to prepare an inventory of the office equipment and records for a handover to the Cabinet Division, a junior clerk said to another in a fit of rage: 'I will set fire to all the records than to hand over to them'. Such was the emotional power of the 'spectre of uselessness' (Sennett 2006) for the employees. When the file with the Planning Division's notification that the NACP would not be fully dissolved did not move far or fast enough at the Cabinet Division, a trio of junior employees decided to visit this office to give the file a little push. Later that day, another junior staff member described the visit to me as follows:

> They were waiting in the room of the Joint Secretary when he entered his office. He was furious and asked them who the hell they were, what they wanted and who had let them in his room, and why none of their officers was accompanying them. They were so scared that they couldn't say a word. When the fit of rage was over, the secretary took pity on them. Sensing their nervousness, he calmed them down and allowed them to talk about their problem. They narrated the whole situation in a tone of helplessness and asked for pity. The secretary turned benevolent. He listened to them patiently. He praised their *shalwar-kameez* (national dress) and shared how he had worn *shalwar-kameez* with pride while delivering a speech in London once. He praised the work of junior people like them while complaining that most of the people in officer grades were *kamchor* (shirkers). He even insulted one of his own junior officers in front of them. In short, he showered his benevolence upon them. He gave them tea and biscuits. When they wanted to leave after making their appeal, he asked them to stay on and listen to his stories. He did not let them leave for at least two hours. In the end, he told them, he was the in-charge of dealing with the questions of the future of federally-run health programs and that his boss, the Cabinet Secretary, had never rejected a recommendation by him. Therefore, they should go home and not worry about their jobs.

There was jubilation and relief at the NACP. Of course, it is likely that this visit was not solely responsible for saving the NACP from a complete shutdown. However, its outcome gave employees at the NACP a sense of

security about the continued existence of the organization and relieved them of the anxieties that haunted them. They said that it was the 'power of the pen' of the benevolent Joint Secretary that had 'made all the difference'. The NACP was saved, albeit in a much smaller version, under the newly created Ministry of Inter-Provincial Coordination. The success of the trio at the Joint Secretary's office goes to show that, whilst faced with confusion and uncertainty in their own flexible organization when the crisis was upon them, it was the traditional bureaucratic order, with its formal procedures and hierarchical intimacies, which provided solid ground for them to stand on.

As far as Dr Nadir is concerned, on 29 June he got a phone call from the Secretary of the Country Coordinating Mechanism of the Global Fund (Chaps. 2 and 6), informing him that the federal Health Secretary had made up her mind to appoint Dr Nawazish as his deputy in the Global Fund project at the NACP. Dr Nawazish was the former AIDS control manager in Punjab who had been removed from his post as part of the corruption inquiry over Naya Sewaira's contract in the Enhanced Program, as detailed in Chap. 3. The news fell on Dr Nadir and his team like a bombshell. As everybody knew, Dr Nawazish was close to Naya Sewaira and enjoyed a personal friendship with its Chief Executive. Faced with legal proceedings, Dr Nawazish had been demoted to District Health Officer in one of the rural districts as a punishment. Now, however, using his political connections and the social capital that he had made working for the Enhanced Program, he had made a comeback to the HIV/AIDS sector.

Dr Nawazish's intentions were clear. Soon after joining Dr Nadir's team I heard him crow to one of his friends '*ab main yahan aa gaya hoon, chakkay maren gay, chakkay, Inshallah*' ('now that I'm here, God willing, we will make big money'). The word *chakkay* literally means 'six', and is used in cricket when a batsman earns a big score in a very short time rather than through a steady increase of ones and twos: a naked reference to Dr Nawazish's plan to use his office for personal enterprise in the Global Fund. With that, Dr Nadir's innings seemed to be over before he could even settle on the crease. He knew his future at the Global Fund project was doomed. He could not boss Dr Nawazish, and would soon be supplanted by him.

Conclusion

The floundering of the staff at the NACP in the culture of flexibility is confirmation that, contrary to the common perception, flexible organizations are less predictable and less stable in times of crisis. My material supports Sennett's (2006) claims about how employees in flexible organizations lack institutional loyalty, adaptive information and informal trust. The NACP as a whole also suffered due to a deficit of trust, confusion over roles, and instability. I do not wish to imply that more stable, traditional, or proceduralist bureaucracies are free of the sort of destructive competitiveness that I have described here, or that there was no competition or negative feeling amongst colleagues in the NACP before its threatened collapse. Indeed, as Graham (2002) has demonstrated, rather than being all about detachment, the rigid application of rules, or indifference, bureaucracy operates both through careful management and proper conduct, as well as through displays of emotions expressed in rivalry. The material that I have presented here adds a further dimension to the study of bureaucracy by shining a spotlight on employees' emotional life under neoliberal conditions. The emotional encounters between colleagues at the NACP that I have recounted were symptomatic of the crisis that the NACP was going through as a result of its flexible organization and dependence on external donors. Anxiety and jealousy were heightened to such ill effect precisely because of the uncertainty over the future for individuals as well as the organization.

Graeber (2010) has proposed that 'the greatest beneficiaries of neoliberal policies have been the staff of the emerging administrative apparatus itself' (p. 88). But equally, crises and instability are endemic to the neoliberal order (Harvey 2007). According to Baker (2009), in its spiritual home, the United States, working conditions are such that 'employers who desire low wage workers fuel the cycle of insecurity, inequality and instability of work, [thus] rolling back the hard-fought struggle for safe working conditions and a living wage' (p. 142). Gusterson and Besteman (2010) and their colleagues have documented how neoliberalism has created a situation where insecurities are a 'growing majority around the world in the contemporary era of globalization and high technology'

(p. 4). The ethnography I have presented here shows that at the far end of the global administrative apparatus that emerged under neoliberalization, staff in government departments modelled as flexible organizations have become more susceptible to crises. The flexibilization of state bureaucracies is one of the ways in which neoliberalism produces insecurities all over the world. Rather than superseding the traditional bureaucracy, indeed, the NACP was under the axe of devolution and threatened with a complete shutdown when it could not raise external donor funding, thus undermining the prospect of continuity in HIV prevention and treatment services in the country. If, as Parker and Kenworthy (2014) suggest, we are at the twilight of the HIV/AIDS scale-up, the donor dependency that was underlying the anxieties of Pakistan's HIV/AIDS bureaucrats implies that this ethnography may have resonances for HIV/AIDS bureaucracies elsewhere in the world.

In the next chapter, I further explore the significance of international donor money in Pakistan's HIV/AIDS sector. The ethnographic setting here will be the Global Fund, a donor consolidating the World Bank's neoliberal logic with an even stronger insistence on involving liberal 'civil society'.

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6

Participating in the Global Fund

In 2010, after its failure in six consecutive rounds of applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria, Pakistan finally managed to win the Round-9 grant. In earlier chapters, I noted that one of the Global Fund's distinct features as a donor is its emphasis on a participatory mode of governance, in which civil society representatives are brought centrally into the decision-making process, and that this goes hand in hand with extremely rigorous monitoring of the flows of funding and of each and every project partner. This chapter explores these aspects of the Global Fund through vignettes of two of its processes, the initial 'capacity assessment' of the project partners, and the Country Coordinating Mechanism, which oversaw project implementation. My analysis joins with critiques of 'participation' and 'capacity' as politically neutralized development 'fuzzwords', which disguise the cooption of local people by aid regimes (Cornwall and Eade 2010; Leal 2010; Eade 2010). But, as in earlier chapters, I suggest that there are ways in which local actors may 'coopt' or 'adapt' these policies to their own ends, or ways in which policies may open up an ambiguous space within which vested interests compete with those empowered by the new rules of the game (*pace* Anders 2010; Mosse 2011). I work towards the argument that, contrary to its claim of strengthening civil society amid public–private

A. Qureshi, *AIDS in Pakistan*, https://doi.org/10.1007/978-981-10-6220-9_6

partnership, the participatory requirements of the Global Fund weakened the possibility of broad-based participation in HIV/AIDS prevention, care and support, and strengthened an already influential NGO: Naya Sewaira.

The 'capacity assessment' process and the workings of the Country Coordinating Mechanism also speak to questions about the boundaries between the state and society that are raised by policies of strengthening civil society (see Chandhoke 2010). It has become commonplace to observe that the boundaries of state and society are 'blurred', as Gupta (1995) famously put it. Here I demonstrate, furthermore, that these boundaries are also leveraged to different political ends in different situations. I do so by exploring the politics of inclusion and exclusion in the Global Fund's governance model, which reveals that policy, as I insist, is best conceptualized as practice (Mosse 2005; Mosse and Lewis 2005; Schaffer 1984).

The Civil Society Partners

After the approval of the grant application, it took several months to sign the agreement, and several more to actually release the first tranche of funds for project implementation. In the intervening period, one of the major bureaucratic processes was the 'capacity assessment' of the project partners. First, the Global Fund did a capacity assessment of the NACP, as the Principal Recipient, then the NACP did capacity assessments of its partner NGOs (the 'Sub-recipients'), and finally, the NGOs performed capacity assessments of the Community-Based Organizations (CBOs, the 'Sub-sub-recipients'). The stated objective of the assessment was to develop appropriate 'capacity development plans' for partners before releasing money to initiate the project's activities. However, as Dr Nadir told me on many occasions, what this exercise really provided the NACP with was a convenient opportunity to get rid of some partners who had made their way into the project proposal, but who were no longer desired at the time of implementation. 'Capacity' itself was a vaguely defined concept. As Eade (2010) explains, the term originally entered the vocabulary of development through the rights-centred *capacitación* of liberation

theology, and the *conscientização* of Paulo Freire, but was redeployed to further a 'neoliberal "pull-yourself-up-by-your-own-bootstraps" kind of economic and political agenda' (p. 206). Rather than enabling development practitioners to get out of 'Project World' and realize the multifarious intellectual, organizational, social, political, cultural capacities of local people, 'capacity-building' and 'capacity assessment' processes almost invariably follow the agendas and timetables set by those in control of the money. This hugely undermines the meanings of 'capacity', Eade observes, because 'if a relationship is only as sustainable as its money supply, then power games and dependency lie at its heart' (p. 209). The undermining of the concept of capacity was particularly stark during the NACP's capacity assessment of its partner NGOs. 'Capacity' was measured by tools and templates that had been created by technocrats in Geneva, and some parts of these tools were farcically irrelevant to the local conditions of NGOs and CBOs in Pakistan. The politics affecting the exclusion and inclusion of the NGOs and CBOs in this Global Fund project was masked behind the technicality of the capacity assessment tool, yet it was all too obvious.

One of the civil society partners of the NACP in the Global Fund project proposal was an NGO I will call the Pakistan AIDS Alert Group (henceforth the Alert Group). In the early to mid 2000s, in the heydays of HIV/AIDS funding globally, the Alert Group had rivaled the NACP for the scale of its activities, the extent of its funds, and prestige and influence amongst donors. The scope of its activities included providing HIV/AIDS prevention to 'risk groups'—from sex workers in the red light district of Lahore, to seamen in the port city of Karachi, from coal miners in the deserts of Balochistan, to cross-border traders in the valleys bordering China. It was also involved in the training of trainers on sexual and reproductive health and had prepared a commendable repertoire of training manuals, guidelines, Information, Education and Communication materials, and even an Urdu glossary of HIV/AIDS-related terms and phrases translated from English. However, by the latter part of the 2000s, the Alert Group was in tatters. Soon after the withdrawal of its main donor, the European Commission, it fell into a dispute between different factions claiming its ownership. The in-fighting had resulted in a total collapse. Nevertheless, in the world of paper, the name 'Pakistan AIDS Alert

Group' survived in the proposal for the current Global Fund project, unaffected by the turf war taking place between its claimants.

Soon after the Round-9 grant was approved, one of the claimants, a former chairman of the Alert Group, showed a great deal of initiative and entrepreneurship by renting out a two-room flat on top of an auto-mechanics market in a low-priced locality in Islamabad. Shahzada set up a small office, employed a couple of young people, and had a name-board affixed at the entrance. In this new incarnation of the Alert Group, he installed himself as the Chief Executive Officer, reorganized many members of the previous Board of Governors, and convinced a powerful senator in the parliament to become the Patron-in-Chief. It was surely not a coincidence that this senator happened to be the chairperson of the senate's Standing Committee on Health. Shahzada started visiting the NACP many times a week, whilst every now and then the Patron-in-Chief phoned Dr Nadir, the focal person for this Global Fund project, to inquire about the timeframe for the release of funds to the Sub-recipients. This was a question of which Dr Nadir was weary. Both the senator and Shahzada appeared to take it for granted that the Alert Group would stand the test of its capacity assessment.

The NACP hired two international consultants from Bangladesh to carry out the capacity assessment of all of its receiving partners in the Global Fund project, including the Alert Group. These consultants were paid for by UNAIDS as technical assistants to the government. I was part of the team at the NACP, with two other junior colleagues, who were designated to facilitate the work of these consultants and support the capacity assessment process. We spent days at the offices of the partner NGOs, preparing them for their assessments by carrying out mock interviews and helping them to compile all necessary documents. When the consultants arrived, we went again to the NGO offices to assist them in their work, whilst they repeated what we had already done using same templates and tools. On our visit to the Alert Group, Shahzada gave us a multimedia presentation in the style of a marketing executive, which sometimes adopted a politician-like rhetoric whilst filling us in (addressing the international consultants, primarily) about the context in which Pakistani NGOs worked. Pausing between the slides, which showed the

apparently magnificent achievements of the Alert Group in preventing HIV/AIDS amongst sex workers, he told us:

> There are at least 20–25 major red light areas in Pakistan, and on top of that there is a red light area in every small town in the country. Then, there are considerable pockets of transgendered people all over. The government alone cannot provide [HIV/AIDS prevention] services to all these people!

Over the two days of the capacity assessment, many topics of mutual interest were discussed between Shahzada and the Bangladeshi consultants, amid niceties such as 'Bangladeshis are just like us' and 'we were once one people'. One of the consultants spoke keenly about how his father had been against the separation of Bangladesh from Pakistan in 1971. They lamented the bad politicians of the past and the role played by India in the war of 1971, agreeing that in developing countries like Pakistan and Bangladesh, Western development consultants build their own capacities instead of those of the local people because they 'take everything back in their hard drives'. Other topics included Shepla Neer, a Japanese NGO whose name has Bengali origin, which was working in Bangladesh and Kashmir, and broader issues: the state of Ismailis in Northern Pakistan, the Agha Khan, the 2005 earthquake, philanthropy and sectarianism in Pakistan, the strength of civil society and of political Islam in Bangladesh, and the commendable role of Indian televangelist Dr Zakir Naik in the projection of 'true' Islam. Shahzada appeared to impress the consultants with his knowledge of the culture of high-risk behaviours in Pakistan and his full command over the jargons, as when he spoke of the 'cognitive calendars' of migrating sex workers, the 'seasonal migration' of transgenders to popular festivals and shrines, the preference of Pakistani men for transgender over female sexual partners, the 'big problem' of homosexual activities in religious madrassas, the need for 'sugar-coating' the 'sour pill' of HIV awareness in reproductive health education, and so on. Since this was the consultants' first visit to Pakistan, like a good host, Shahzada also offered to show them the 'real' Pakistan on the outskirts of Islamabad in the afterhours.

He showed them photographs of himself taken with the big players in the HIV/AIDS sector over last ten years, many of them expatriate

workers who had long left the country. Pointing proudly towards various people in the photographs, he said that they had worked under him when the Alert Group had more funds, but had now moved to important positions in international NGOs, and in donor and UN agencies. He shared how his office used to be frequented by many European consultants and international experts on HIV/AIDS and how he had represented Pakistan's civil society at international forums in the past. He even tried to take credit for the Supreme Court's recent judgment binding the state to recognize transgendered people as a separate gender category from men and women, list them in electoral rolls, issue national identity cards to them as a third gender, and provide them with equal opportunities for employment (see Haider 2009; Redding 2012; Khan 2014). He said, 'we understand the local political context and we know how to work in it. It is not about fighting the system but working through it'. In the way he interacted with the consultants, there was more than a hint for them that no matter what they might report about his NGO's capacity, he had got all the right credentials and connections to stay put in the Global Fund project. At the end of the second day, as the consultants continued their work into the evening, he told them politely: 'actually, this very evening, I am invited as the Chief Guest at a ceremony at a law college. They have been requesting me for months but I did not have time, you know! They kept postponing it for me'. If we were to believe him, the law college might have had to postpone the ceremony once more.

'Who funds your NGO's activities now?', asked one of the consultants in an attempt to pin down what the NGO actually did these days, and how it managed to do it. Shahzada was dumbstruck. The consultant rephrased his question. 'I mean, when you don't have projects … the membership fee won't be enough to meet your expenses?' Shahzada stumbled to offer a reply, but came up with an inspired answer. 'Our board of governors, they are very rich people, some even own copper and gold mines. So that's not a problem. We get funds from … yes, philanthropists!' Later in the day, one of the consultants confided in me: 'this organization does not have core funding. They may close down any time'. Sensing that the consultants had doubts about the capacity of his NGO,

Shahzada came up with a different script, not dropping hints this time, but asserting the NGO's capacity as he saw it:

> We will move to a bigger and better place when we get project money. We used to have better office space when we had projects. NGOs, you know, are unfortunately dependent on projects…Our Patron-in-Chief has many more senators on-board as well in the support of the Alert Group…In Pakistan, as in many other countries, you need political support to survive, otherwise the files don't move, as you know…The budget for our component of the project is not final yet. I met the Health Minister the other day. He also asked about the project. We are very well connected politically. Let the NACP sign the grant agreement with the Global Fund first, and then, we will see about our budget.

As we were about to leave, one of the consultants said, whilst closing the lid of his laptop and not looking in any direction in particular: 'ok, so do you have any suggestions for the Global Fund?' Shahzada and his young Finance Manager looked towards each other as if not sure whether this was a real question, or only a comment to mark the end of the day. However, the inexperienced young man replied 'increase our budget!' He might have thought that this was an intelligent answer. But 'intelligent people', replied the consultant in a taunt, 'do not ask "give us more money". Instead, they say "give us more work!"'

Why were the international consultants involved? We, the NACP team, could have done the assessment on our own. After all, we did end up doing most of the work for them. They had very little knowledge of things that we took for granted as local members of the assessment team, such as the political history and legal constraints in which NGOs operated in Pakistan. After all, if the objective was to assess how well the NGOs could do in the project and how to improve what they could achieve, then the assessor ought to have had a good knowledge of how these NGOs 'get things done' for HIV/AIDS prevention in the existing social, legal and moral landscapes. The ability to 'get things done' was beyond the narrow confines of 'capacity-building', as indexed in the paperwork that the consultants sifted through during their week-long visit. They obviously could not fully absorb what was contained in these

documents, let alone come to grips with the complexities of the political connections and networks of NGOs, and the influential people behind them. The whole process was a masquerade. How could it be impartial when the NACP team itself prepared the NGOs for their capacity assessments by the consultants? Clearly there was more to the involvement of international consultants than met the eye. Of course, their involvement helped to counter pressure to include other NGOs, or to exclude some that were already selected as partners, which Dr Nadir had anticipated. Dr Nadir could use the opinions of the independent, impartial and unbiased international consultants to exclude, or at least discipline, some of the partners without antagonizing them or their influential supporters. If it were not for 'resource constraints', he told me, he would have preferred White American consultants over the Bangladeshi ones, who 'look like us and come at relatively cheaper rates'. The independence of the consultants was thus a veil used for political ends, as the state–society boundary was not so much 'blurred' as strategically realigned.

Shahzada had much faith in the power of his Patron-in-Chief. However, as the implementation phase of the Global Fund project approached, the Alert Group was replaced by another NGO, the Association of People Living with HIV (see Chap. 8), on the grounds that it was a controversial entity claimed by rival groups of pioneers. It was not a mere coincidence that this decision came after the capacity assessment report by international consultants had been submitted, and only a few weeks before the devolution of the Ministry of Health, after which the senate's Standing Committee on Health became defunct. Shahzada's hopes, despite the political connections and the confidence he displayed before the consultants, were therefore defeated, although his Alert Group would continue to exist, doing so under a new name, the 'Pakistan AIDS Alert Committee', whilst curiously retaining the acronym 'PAAG'. Shahzada maintained a flashy website where he continued to list the Alert Group's past achievements and provided downloadable versions of project reports, training manuals, guidelines, and the Urdu glossary of HIV/AIDS-related terms mentioned above. He regularly updated its photo gallery, which featured him with important people, receiving certificates and awards, addressing large gatherings, attending workshops with experts, and distributing goods to poor people. The caption 'Donate to PAAG in Fight against

HIV and AIDS' on the website was followed by an exclamation imploring 'Are you doing your BIT!'

In 2010, whilst he was still waiting for the Global Fund grant money and had no funds to carry out HIV/AIDS prevention, Shahzada turned the Alert Group into a 'Frankenstein's monster' (Kapilashrami 2010). Following the direction of donor funds, he guided the Alert Group into becoming an organization that provided relief activities after the devastating floods in August 2010. This was an area in which neither Shahzada nor his staff had any experience, but that did not matter because they were not the only ones who lacked experience in this new field. A large number of NGOs—big and small, new and old, 'secular' and religiously oriented—had moved into flood relief and almost every one of them got some funding in the process (Polastro et al. 2011). Shahzada also had his share of photo opportunities whilst distributing goods to the flood victims, which he showcased on the Alert Group's website. By the time we went for the capacity assessment in November 2010, the funds for flood relief were already drying up as the international assistance moved from relief to reconstruction, which was carried out by the government and big NGOs. Smaller NGOs had to look to other avenues for funds. Shahzada must have had an eye on 'the next big thing' for international donors when he jumped with excitement at the mention, by one of my colleagues, of a certain contagious skin infection, which was thought likely to spread in the country on an epidemic scale. Shahzada probed as much as he could about this new epidemic and assessed whether we thought it would be the next 'big area' for donor funding. Months later, when he was thrown out of the Global Fund project, I realized that there was every indication, given his commendable personal initiative, entrepreneurial aptitude, and ability to put up glittering performances, that he was not going to give up pursuing partnership with the government as a member of 'civil society'.

CBOs with Big and Small *Bamboo*

'We have to operate within the given environment', Dr Nadir lectured, to an international NGO representative. He was trying to convey to this partner that since the NACP was a government department, it was sus-

ceptible to political interference, and that he and his bosses in the NACP would have to 'face the music' if a Sub-sub-recipient CBO, with the 'right connections', was kicked out of the Global Fund project by any of the Sub-recipient NGOs. 'But what if a CBO does not exist on the ground?', the NGO representative responded alarmingly. 'We will request UNAIDS to carry out physical verifications if there are any doubts', replied Dr Nadir. Even if the NACP could not hire expensive international consultants for the capacity assessment of the CBOs, the *prima facie* arbitrator for their role in the Global Fund project was again an 'unbiased' international non-governmental organization: UNAIDS.

One of the Sub-recipient NGOs, an organization called Rescue Corps, faced a dilemma in specifying the roles of its partner CBOs whilst preparing for the rolling-out of the project. To find a way out of this dilemma, Dilawer, the Project Coordinator at Rescue Corps, called a meeting of stakeholders. Participation in the meeting was kept exclusive. None of the CBOs and other Sub-recipient NGOs were invited. Instead, Dilawer personally requested a close circle of friends in key positions at the NACP, UNAIDS, WHO and Naya Sewaira (which was the Co-Principal Recipient with the NACP; see Chaps. 2 and 5) to come on an informal basis. However, this meeting was not just an unofficial gathering. It had a formal, even if vague agenda and format. A multimedia presentation was given, the minutes of the meeting were documented and the participants' lunch was budgeted for. Although the meeting was intended exclusively for these five participants, Dr Nadir brought his junior staff to help find details in the project documents if needed.

The matter of concern in this meeting was a CBO called Power. Dilawer pleaded that, since this CBO did not actually exist on the ground, it could not be trusted with setting up a Community and Home-Based Centre to support HIV-positive people as per the Global Fund project proposal. Dilawer knew that it would be impossible to throw out the CBO from the project because it was owned by an influential HIV-positive activist who was also a member of the Country Coordinating Mechanism. However, he argued for dropping this CBO from the first phase and for giving its proposed site, which was in a town called Gujrat, to Shining Star, another CBO. Technically, this suggestion made sense, since Shining Star already ran a support centre for HIV-positive people,

which could be easily scaled-up into a Community and Home-Based Centre. In fact, Shining Star had discovered the HIV outbreak in Gujrat and already had hundreds of registered HIV-positive members in that city, as I recount in detail in Chap. 7. Dilawer therefore felt that it made perfect sense to up-scale Shining Star's existing services. His viewpoint was endorsed by Dr Aleem, the UNAIDS representative.

'We can't give everything to Shining Star', said Dr Nadir disapprovingly. The problem, according to him, was that Shining Star already had too much on its plate from the earlier Round-2 of the Global Fund project. On the other hand, Dilawer insisted, if a capacity assessment of Power were carried out, it stood no chance of qualifying as a partner because it had no physical presence. But the owner of this CBO was a member of the Country Coordinating Mechanism. Would he not be annoyed if his CBO was disqualified from the project? They finally decided that Dr Nadir and Dr Aleem would first meet both CBO bosses separately to convince them to accept the proposed swap of their Community and Home-Based Centre sites through a mutual compromise, and then bring them together to show their agreement in each other's presence. The stick of capacity assessment was not used in this instance, but political expediency and prudence were preferred over its use. In view of a political end, the state–society boundary may disappear, as the tool of capacity assessment is strategically withdrawn, whilst in other situations it is wielded.

When the slides were being shown on the screen during this meeting, although it was not on the agenda, Dr Aleem pointed out that all 15 Community and Home-Based Centres proposed in the first phase of the Global Fund Round-9 project were to be set up in Punjab, the largest province. This, he said, would not go well with provincial officers and other stakeholders in smaller provinces (see Chap. 5 on the emotionally heightened discussions that were taking place about inequalities between provinces in Pakistan at this time because of the upcoming devolution). 'There should be at least one in Khyber-Pakhtunkhwa and one in Balochistan'. Disagreeing with this suggestion, Dr Nadir explained that the sites chosen in the first phase were those where at least some level of service for HIV-positive people already existed, and it was a mere coincidence that most of those places happened to be in Punjab. Moreover, it

was convenient to select these sites because scaling-up services in the existing Community and Home-Based Centres was a lot easier than setting up new centres in places where no services existed at all. He continued by saying that setting up completely new centres would require a higher budget and would give lower yield on the project progress indicators (i.e. the total number of HIV-positive people registered at these centres would be fewer). By giving these technical explanations, Dr Nadir tried to explain away the disparity between Punjab and smaller provinces. However, Dr Aleem, who himself came from one of the smaller provinces, was not convinced. He said:

> You have to see the political repercussions as well. I understand that there is a need for CHBCs [Community and Home-Based Centres] in Punjab, but other provinces feel neglected and complain to us [UNAIDS] in meetings…. A number of HIV-positive people are already registered in Quetta [in Balochistan] as well! So, I am saying all this on the basis of actual need as well as the political realities.

Dr Nadir, who rarely ever differed from Dr Aleem in formal meetings, repeated his argument about the technical imperative and said, frankly, amongst this group of friends, 'we do not want to show bad results, not at least in the first reporting period!'; 'the CBOs in Punjab are capable of delivering better results', he said. Dr Aleem did not pursue his contention any further. It appeared as if the technical argument about reporting to the Global Fund took precedence over the political realities, or even over the needs of HIV-positive people in the smaller provinces. Yet in the very next moment, something happened that reversed this impression.

Dilawer mentioned in passing that only one Community and Home-Based Centre in Karachi would not be enough for the needs of all the HIV-positive people in such a huge metropolis. In response to this, Dr Nadir took everyone by surprise, when he said: 'don't worry about that. A second CHBC will be set up in Karachi to accommodate Shah Ji's CBO'. Shah Ji was a federal minister and an influential politician from Sindh province. None of us had heard this before. Surprised by the news, Dr Aleem and Dilawer asked spontaneously: 'do you have extra funds to cover the cost for setting up an additional CHBC?', and '*us ki*

CBO mein dam hai [is that CBO strong enough]?' Dr Nadir laughed and replied: '*CBO mein dam ho na ho, uska bamboo bahut bara hai, hum mein dam nahin hai* [it doesn't matter if his CBO has enough strength or not. The thing is that his *bamboo* (tool/penis) is too big for us and it's us who don't have enough strength to take it]'. Everyone laughed, and no one questioned the plan on technical or political grounds.

On a different day, a similar manoeuvre involving Dr Nadir looked completely different. The capacity assessment was in full swing when Naseem, a bulky middle-aged man, came to the NACP with a request to include his CBO in the Global Fund project. Dr Nadir explained to him that the CBO selection had already taken place and that there was nothing that he could do about it. However, Naseem, who seemed to have known Dr Nadir for quite some time, insisted on his CBO's inclusion even if it meant replacing an already selected CBO. He mentioned his friendship with several politicians whom he said were willing to put their weight behind him, if necessary. Dr Nadir warned him that, even if he made his way into the project on the basis of his political connections, his CBO would not be able to meet the targets and he might end up getting it blacklisted from future Global Fund projects. He said: 'the evaluation of targets won't be done by me or the NACP, but by UNOPS [the UN Office for Project Services]. They will neither ask nor inform me when they turn up at your CBO and ask you to produce 150 HIV-positive people. What will you do then?' Clearly, then, this man's *bamboo* was not as big as Shah Ji's. Dr Nadir advised him, on the authority of being a technical expert: 'try your luck in the Global Fund Malaria grant instead. All you have to do there is to distribute some mosquito nets'.

The Participatory Process

'How did you select partner organizations in this project?', asked a Provincial AIDS Control official, provocatively, at the end of a presentation on the Global Fund project at the NACP. This was a two-day meeting, convened to assess the situation in the country with respect to antiretroviral drugs, which had been spent predominantly in bickering

over the role of the NACP versus that of the Provincial AIDS Control Programmes. The bone of contention was not merely the selection of partners in this particular project, but, recalling the heightened awareness of provincial inequalities in the run-up to devolution, the role and relative influence of provincial and federal AIDS officials in the Country Coordinating Mechanism.

In the current Global Fund project, Naya Sewaira was designated Co-Principal Recipient with the NACP, whereas the Provincial AIDS Control Programmes had not been given a significant role. The provincial officials believed that the Country Coordinating Mechanism was dominated by a small, Islamabad-based network cutting across the NACP, influential NGOs and donor agencies. They believed that the members of this network were in cahoots with each other to keep everything to themselves, even though the scope of activities under this particular project spanned across the whole country. So much for the 'participatory' process of the Global Fund. In her study of the Global Fund in India, Kapilashrami (2010) calls the Country Coordinating Mechanism a 'forced marriage between unequal partners' (p. 192). This criticism recalls wider expositions of the use of 'participation' as a development 'fuzzword', particularly the ways in which sharing through 'participation'—as technified through packages like Participatory Rural Appraisal, Participatory Learning and Action, and Stakeholder Analysis—may stop far short of a sharing in power, and indeed serve as a means of maintaining the rule of one partner (Leal 2010). However, the timing of the disquiet over the Country Coordinating Mechanism, which left a bitterness that lingered over the next two days of the meeting, was significant. So long as the World Bank-financed Enhanced Program had been in place (between 2003 and 2009), the provincial officials had not cared much about the Country Coordinating Mechanism or the Global Fund grant applications, which had, in any case, failed in the past six consecutive rounds. But now that the World Bank was withdrawing from the HIV/AIDS sector in Pakistan, and a question mark hung over the future of the NACP in the event of devolution (see Chap. 5), the Provincial AIDS Control Programmes were concerned that Country Coordinating Mechanism would come to be further dominated by non-governmental elements: the members of 'civil society' and donors based in Islamabad. The Provincial

AIDS Control Programmes had to do something to fill the vacuum left by the anticipated departure of the NACP. Moreover, there were indications that, if the Provincial AIDS Control Programmes did not raise enough money from international donors, they too might be shut down, or merged into other vertical health programmes, by their provincial governments. Some of these provincial governments were already seen as hostile to the issue of HIV/AIDS because of the stigmas attached to it. The Global Fund therefore appeared to be the only source of funding for the foreseeable future. The provincial AIDS officials made every effort to raise their stakes at the Country Coordinating Mechanism, and to secure a piece of funding from the current Global Fund Round-9 project. They demanded a restructuring of the Country Coordinating Mechanism in favour of more representation from the provinces, and a greater role for themselves in the preparation of grant applications.

'We cannot restructure the CCM or do away with its current TORs [terms of reference]', said Dr Aleem, the UNAIDS representative at the meeting, in response to the demands of the provincial officials. This rebuttal was met with an outcry. 'Don't defend them so aggressively!', replied a Provincial AIDS Control Manager. The Provincial Manager continued: 'we are not asking to devolve the CCM to the provinces, but questioning the way it functions. We are never even told about its activities'. Attempting to cool tempers down, meanwhile, Dr Nadir cautioned them all that if Pakistan were to win any future rounds of funding from the Global Fund they must do everything to show that they did well in the current project, and that this bickering was not going to help their performance as a whole. He reminded them that, unlike the World Bank, which gave a 'soft' loan for the Enhanced Program, the Global Fund 'will give us money for the next quarter only if they are satisfied with our performance in the previous quarter'. Therefore, according to him, it was imperative that the Provincial AIDS Control officials did not create any problems in the current project by questioning how the Sub-recipient NGOs were selected, or why the provincial programmes were kept out of the project proposal. Instead, it was in their long-term interests that they extended unconditional support to him and his team.

But what about the long-term restructuring of the Country Coordinating Mechanism? 'We can include them [the Provincial AIDS

Control Managers], if they like, in the email distribution lists for the minutes of the CCM's quarterly meetings', said the Secretary of the Country Coordinating Mechanism. She argued that it could not be expanded anymore because it was already a 'crowded forum'. Someone pointed out that a former AIDS Control Manager of Punjab, Dr Nawazish, who was discredited for corruption (Chap. 3), had participated in a number of Country Coordinating Mechanism meetings in the past. The Secretary came up with a strange logic to explain this: 'he had done so on the basis of his personal connections. We had very strong objection to his participation in that manner, therefore, we had to ask the CCM chairman to officially nominate him as a permanent member'. This *ex post* validation of Dr Nawazish's participation in the Country Coordinating Mechanism shows how a forceful, well-connected individual could make his way into this supposedly participatory but exclusive forum, whereas the appeals for structural changes in favour of a greater provincial role were resisted by the Islamabad-based network. Another of the Secretary's arguments against any changes to the membership of Country Coordinating Mechanism was that the Provincial Health Secretaries were already members, although they never attended any meetings. It was therefore up to the Provincial AIDS Control Managers to convince their respective Health Secretaries to participate in the meetings and advance proposals that would benefit their provinces. After placing responsibility squarely on the provincial officials, who were obviously powerless to persuade the top bosses in their health bureaucracies to attend these meetings amidst their high-profile and busy schedules, the Secretary of the Country Coordinating Mechanism asked them, like a benevolent matriarch: 'ok … now … we have a quarterly meeting of the CCM coming up in a few weeks. I would like to hear if any of you have anything specific that I could take to this meeting on your behalf'. There was a murmur amongst the provincial officials, but no one took up the offer, as if it was pointless to pursue the matter any further. The UNAIDS Country Coordinator, Masoomi, an Egyptian expatriate, who sat quietly throughout this heated exchange, concluded the proceedings with an oft-repeated but perhaps necessary lie: 'it's important that we all have a common understanding, and the past two days have shown that we do'.

This meeting had been called to discuss the shortage of antiretroviral drugs in the country, especially in the wake of diminishing donor support, the disappearance of the World Bank from the HIV/AIDS sector, and the question mark over the future of the NACP. However, it turned into a power struggle over the Country Coordinating Mechanism and a bicker about who was going to get what out of the Global Fund project. Like the Country Coordinating Mechanism itself, this meeting was a 'participatory' forum, where the formidable Secretary, who appeared to command authority and prevail upon everyone, was not even a government employee—unlike the Provincial AIDS Control Managers. Like Dr Nadir and Dr Aleem, she was a 'market-based' employee, hired on a short-term renewable contract to convene the Country Coordinating Mechanism meetings, and to carry out other secretarial jobs on its behalf. Although this meeting took place at the NACP, the final act in the performance was carried out by Masoomi, whose statement about a 'common understanding', was obviously completely untrue. But then, the project of development cannot fail. The 'narrative of success' (Mosse 2005) has to be produced and sustained by its repetitive performance, even if that means overlooking the complexities inherent in the notion and practice of 'participation'.

Squabbling for Funds

Amongst the participants of another meeting at the NACP was a middle-aged, *dupatta*-clad woman who looked rather nervous. Her name was Razia. I had seen her at a recent workshop of NGO workers where she had been introduced as the newly elected President of the Association of People Living with HIV (henceforth, the Association). However, this meeting marked her first 'appearance' on the international stage with the likes of UN agency heads, national and international NGO bosses, government bureaucrats and public health experts. She could neither speak nor understand English, the lingua franca of the development sector and the taken-for-granted medium of exchange in meetings like these. However, she keenly observed when others spoke, perhaps ranking them in order of importance on the basis of how many heads nodded after, or

according to how much time they were allowed uninterrupted. She was important too. After the first presentation, Masoomi, the UNAIDS Country Coordinator said, looking in her direction: 'the main points of the presentation may please be repeated in Urdu for the benefit of those who don't understand English'.

Razia was accompanied by Maqbool, who was another recently elected office bearer of the Association. The other two HIV-positive people in the room were Bashir and Kiran, the former President and General Secretary of the Association and, more importantly, also one of the pioneers of AIDS activism in the country; both ran their own CBOs for HIV-positive people (Chaps. 7 and 8). Bashir and Kiran were a set-piece in forums like these. They had learnt some English and were well known amongst civil society, the donors and the government. They, Razia and Maqbool represented the necessary contingent of 'People Living with HIV' or PLHIV (as required by the UN's 'GIPA principle', or principle of Greater Involvement of People living with AIDS; UNAIDS 1999, 2007). They sat in a row next to each other in the oval-shaped seating arrangement of the conference room. This meeting was held to review the findings of a National AIDS Spending Analysis for Pakistan, which had been done by a Ukrainian consultant. Every one of the more than thirty participants present in the meeting made their presence felt by asking a question or volunteering a comment. None of the HIV-positive individuals had spoken, whilst all the other stakeholders continued the discussion on AIDS spending in the country. But all of a sudden, a dramatic moment occurred when Maqbool broke his silence in the midst of the presentation by the consultant, and said, in a rather shockingly loud voice, whilst looking at the pie chart on the screen: 'THERE SHOULD BE MORE FUNDS FOR THE PROVINCES AND LESS FOR THE NACP…'

The presenter was taken aback, speechless. Everything paused, and everyone looked in Maqbool's direction in disbelief. Razia, who sat beside him, had a look of pride on her face. They had made their presence felt too. Maqbool must have felt encouraged by this momentary attention. He cleared his throat, pointed to the pie chart on the multimedia screen and made the same point again. He struggled to come up with the correct English words and grammar, but the message was loud and clear. The pitch of his voice fluttered, his fist was clenched tightly, and his heels

pushed against the floor. He was emotionally charged and repeated his point yet again. Sitting on the other side of the table, Dr Shakir, the AIDS Control Manager of the province that Maqbool and Razia came from, asked him to calm down and to feel free to speak in Urdu. Dr Nadir, who had thus far dominated the discussion, started to look uncomfortable. He rolled his eyes, as if what Maqbool had done was ridiculous, and as if allowing him to go on with his rant would have been unreasonable. No one in the room had expected such a direct and straightforward comment in the midst of a presentation by an international consultant. Such things were to be said in a thousand words, if said at all. But Maqbool's was an in-your-face attack on the NACP, and he was not finished with it. Finally, Dr Nadir intervened and said mockingly, '*aap jaisay kehtay hai waisy he hoga, ok!* [as you say so shall be done, ok!]', implying that he should shut up.

Maqbool stopped immediately, and gave an unsure look to Dr Shakir, who had encouraged him to continue. This ridicule by Dr Nadir did not go well with the provincial officials. They rephrased what Maqbool had said and argued that a new funds distribution strategy must be developed. Encouraged by this support for his point, Maqbool took another turn to complain about the lack of HIV treatment facilities in his province, for which he blamed the NACP and UNAIDS, by accusing them of having discriminatory policies. He was now mixing English with Urdu for the benefit of Masoomi, and for the other expatriate participants of the meeting. Once again, Dr Nadir tried to cut him short, this time by suggesting to the NACP manager, who was chairing the meeting, that the concerns raised by Maqbool were 'operational issues' and not fit for discussion in a high-level meeting. 'We will discuss these issues some other time at some other forum', he said. Before the chair could say anything in agreement, Maqbool burst out against this second rebuttal. This time he was more sure-footed and forceful. He raised his voice and spoke plainly against the NACP, accusing its staff of channeling Global Fund money to those NGOs which, he said, 'keep eight out of nine rupees to themselves, and spend only one rupee on the PLHIV'.

The NGOs that he alluded to would have been none other than the CBOs ran by his fellow People Living with HIV, Bashir and Kiran, who were sitting next to him. The situation threatened to spin completely out

of control for Dr Nadir, who was usually the diplomatic interlocutor in stakeholder meetings like these, and who—together with his UNAIDS colleagues—made sure that these 'activities' were performed to perfection. He had already tried to steer the discussion by asking the chair to intervene, but Maqbool had succeeded in outmaneuvering that attempt to silence him. Now, he asked Masoomi to take the discussion back to the agenda. Masoomi leaned forward, rubbed his hands gently, took a deep breath and was about to put his foot down. But before he could open his mouth, Dr Shakir, who had earlier encouraged Maqbool to go on, said sharply:

> But you should listen to these people! I have spoken about it in the ministry [the Ministry of Health] and I talk about it now as well. You [the NACP] are the Principal Recipient [of the Global Fund], why don't you tell the Sub-recipients to give money to these people [the Association] instead of [other] CBOs?

Dr Shakir's support for the Association seemed to be based on the fact that it was a representative of PLHIV from all over Pakistan rather than only of those who were attached to Bashir and Kiran's CBOs, who were based mainly in Punjab. Moreover, the Association, unlike the other CBOs, was a democratic forum, with Razia and Maqbool as its newly elected office bearers (see Chap. 8 for how Bashir and Kiran contested the 'democratization' of the Association). Other Provincial AIDS Control officials joined in with Dr Shakir to complain that they were deliberately being kept out of the current Global Fund project by the NACP and a few NGOs. Dr Nadir gave up on his attempts to bring the discussion back to its original agenda, and Masoomi sank back even deeper into his seat. The NACP manager again tried to save face in front of the international consultants by trying to change the topic of discussion, but he was interrupted by Maqbool once more. This time, however, a deputy of Dr Shakir's gestured towards Maqbool from across the table to let the chair speak. Maqbool stopped immediately. The NACP manager assured Maqbool and everyone else that all 'matters of concern' would be discussed with Dr Shakir and other Provincial AIDS Control Managers. Perhaps he realized that Maqbool was not just a rogue participant who

could be given a shut-up call. Masoomi, who had sunk into his chair and had his nose pointing towards his navel, as if meditating, now raised his head and adjusted his posture with an unsure smile. A few more multimedia slides were shown by the consultant, and then an army of peons entered the meeting room accompanied by the rattling of tea trays and plates of *samosae*.

Razia, Maqbool, Dr Shakir and his deputy enacted, in this meeting, a script that they seemed to have agreed upon in advance. The bone of contention was, of course, the Global Fund money. Razia and Maqbool supported a redistribution of funds in favour of provinces, and the provincial officials advocated giving funds to their Association instead of to other CBOs. There was a synchrony in their performance, as they took cues from each other. But who came to these meetings without a script—often a well-rehearsed one? Regardless of the theme, agenda, timing or venue, there was a clear pattern to encounters between participants in many of the meetings that I attended, which involved more or less similar stakeholders. The NACP and UNAIDS officials never contradicted each other. Dr Nadir and Dr Aleem could pick cues from each other through even the slightest of gestures, such as the wink of an eye, to divert the discussion and allow one person to speak and shut up another, to take someone's comment seriously and laugh away someone else's, or to sympathize with one opinion and ridicule the next, and so on. Their sentences would frequently start with 'as (Dr Nadir/Dr Aleem) has said…', which would enable them to repeat their points all over again; thus their contributions felt like an oft-repeated theatrical performance of mutually agreed stances. Meanwhile, the provincial representatives came together against the NACP whenever they had a chance, especially in the anticipation of devolution. The provincial officials from Balochistan hardly ever gave an opinion, or contributed anything on their own accord in these meetings, even though they travelled a thousand miles to attend them. If they were prodded to give their province's point of view on a matter of concern, the reply would be invariably: 'in Balochistan it is the same as in Khyber-Pakhtunkhwa [the other smaller province]'. The CBO leaders, Bashir and Kiran, might have been competitors outside the meeting room (see Chaps. 7 and 8), but inside, they supported each other to the hilt in advocating for greater funds for their CBOs' 'care and support'

activities, a message that seemed timelessly relevant, whatever the official agenda of a meeting.

Towards the end of this meeting, when the floor was formally opened for a discussion on the question of 'the real challenges ahead in the response to HIV and AIDS in Pakistan', Masoomi looked around the table to encourage a brainstorm of responses. There was some silence before a Provincial AIDS Control Manager replied, in no more than three words, 'lack of funds!' He seemed to expect applause for having pinned the matter down so succinctly.

The Next Project

'The problem with us is that we start fighting over the bread before it's baked', said one senior NACP official to me whilst reflecting on Pakistan's consecutive failures in its Global Fund grant applications. In the last few months of my fieldwork, the 'participatory' consultative process for the Global Fund Round-11 grant had begun. There were many contenders for the limited resources available for HIV prevention. 'When we had money', said Dr Nadir, 'we did HIV prevention projects even for truckers'. He was referring to the golden era of the World Bank-sponsored Enhanced Program. Now, the Global Fund appeared to be the only viable source of funding for HIV/AIDS prevention. The devolution of the federal Ministry of Health had added a further dimension to the concerns related to the allocation of limited funds to address different target groups. What if, in the post-devolution period, the provincial governments declined to spend anything at all from public funds on HIV/AIDS prevention amongst certain designated risk groups—sex workers, men who have sex with men, and transgendered *hijrae* (see Chap. 2)? The case of injecting drug users was different from others, because this group was not stigmatized for sexual behavior, and thus not regarded as morally contemptible, even though it was involved in the illegal act of drug use. Moreover, spending public funds on injecting drug users would not cause uproar in the government because, as one federal official put it: 'drug users can be *seen* as a danger out there in the society. They are there and they can harm your kids, whereas providing safe heavens to sex workers

and *hijrae* might not go well with bureaucrats in the provincial governments' (by which this official meant bureaucrats in Khyber-Pakhtunkhwa and Balochistan, who are perceived as more conservative than those in Punjab and Sindh). Given this resistance to committing funds towards 'risk groups' other than the drug users, would it not have been prudent to give them a larger share in externally funded, grant-based projects like the Global Fund Round-11?

Some participants at these meetings advocated for more funds to pay for the life-saving antiretroviral drugs and 'care and support' HIV-positive people needed, whilst others argued that, since injecting drug users were 'driving the epidemic' in the country, it made more sense to spend most money on them. The 'powerful IDU lobby', as it was known, was spearheaded by Naya Sewaira, the largest beneficiary of the Enhanced Program (see Chap. 3) and the Co-Principal Recipient of the Global Fund Round-9 grant, as the 'civil society' partner, with the NACP. As we have seen, this NGO was already considered too powerful by many in the HIV/AIDS sector, and was poised to become the sole recipient of this grant in the event of the dissolution of the NACP (Chaps. 3 and 5). The spread of its reach and influence amongst its clients—donors as well as IDUs—was unparalleled. In stakeholder meetings, Kamal, the Chief Executive, quoted chapter and verse from HIV surveillance and bio-behavioural surveys, which showed rapid increases in the rate of infection amongst injecting drug users. Those who were opposed to the 'IDU lobby' cried out against the neglect of sex workers, men who have sex with men and *hijrae* in recent donor-funded projects, and expressed their anguish over the attempt to keep them on the margins, yet again, in the Global Fund Round-11 proposal. They lacked statistical support to counter Naya Sewaira's claims. However, against the backdrop of six consecutive failed applications, they put up a different kind of argument to help win the Round-11 grant. 'If we put sex workers, and *hijrae* and so on in the project proposals to international funding bodies like the Global Fund', said the Secretary of the Country Coordinating Mechanism, 'it will reflect very well upon us. It will show them that we are making good progress as a society and that we are becoming more liberal and tolerant of these people'. The othering implied by this slip of tongue—'these people'—is telling.

So much for 'participation'. If 'participation' is intended to efface the boundary between state and society, its technified performance through the Country Coordinating Mechanism resulted in the policing of this very boundary, in ways that went precisely against the stated objective of giving those on the margins the opportunity to represent and defend their interests.

Conclusion

This chapter has critically evaluated the process of 'participation' in the Global Fund, with an eye on the power of international donor money and the performativity of its governance model's templates, which instilled a particular approach to policy-making that involved paying for 'unbiased' international consultants, and was framed in the context of 'resource constraints'. Its performance was not unlike the displays of facts and figures by the 'powerful IDU lobby', or the show of a progressive, liberal and tolerant society by its opponents.

I have shown that the power relations that influence 'policy-as-practice' (Schaffer 1984)—as opposed to policy as a merely technical process—might be defined in various situated and constructed contexts: as part of the 'state' or 'civil society', of 'donors' or 'recipients/NGOs', or of 'indigenous' or 'Western' societies, and so on. Concepts like 'capacity' and 'participation' are intended to produce power sharing and dissolve the state–society boundary, but as I have detailed, in practice this boundary is leveraged by vested interests to political ends. It is disconcerting in the least to observe that civil society partners were included or excluded in the project on the basis of their connections, irrespective of their suitability or 'capacity' to carry out the project activities. The Country Coordinating Mechanism came to be dominated by a close network of friends and associates. Here, too, as with the World Bank's public–private partnership, explored in earlier chapters, not only were vested interests able to coopt donor policies, but also those enterprising elements who had been newly empowered as well. Naya Sewaira seemed poised to become the sole Principal Recipient of the current Global Fund grant in the event of taking over the government's part of the project, wherein the

government's AIDS officials, such as Dr Nadir, would become subservient to it. Naya Sewaira also dominated the 'participatory' planning for the next Global Fund project. Whilst the provincial AIDS control officials and smaller NGOs complained about their lack of inclusion in the Country Coordinating Mechanism, they were held in awe of the increasing influence of Naya Sewaira amongst the international donors.

With its enhanced funding portfolio, due to the Global Fund project and the World Bank-financed Enhanced Program, Naya Sewaira had become the major player. In the next chapter, I turn to examine the impact of the preferential treatment of the non-governmental sector on a local health department.

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7

Responsibility for Care and Support

This chapter details the animosity that ensued between Shining Star, a Community-Based Organization (CBO) of HIV-positive people, and the government's health department in district Gujrat, after the CBO had identified an outbreak of HIV/AIDS there in early 2008 and registered tens of HIV-positive people as its members. In Chap. 3, I argued that the World Bank-financed Enhanced Program, with its emphasis on contracting-out HIV/AIDS prevention to NGOs and the private sector, aimed to reduce the state to the role of a purchaser. Here, however, the stakes were even higher. On the ground, the state appeared to almost completely lose its relevance in the 'exceptional' (Smith and Whiteside 2010; Benton 2015) situation of a HIV outbreak, which required a response above and beyond the interventions it provided. The health department lacked the financial resources to provide care and support to the newly diagnosed HIV-positive people on the scale that Shining Star, enabled by international donor money, was able to deliver. Like their counterparts in HIV prevention under the Enhanced Program—the 'risk groups'—the newly diagnosed HIV-positive individuals in Shining Star's donor-supported care and support programmes were beginning to be treated as a special subgroup within an identity category separate from the 'general population': PLHIV or PLWHA (People Living With HIV

A. Qureshi, *AIDS in Pakistan*, https://doi.org/10.1007/978-981-10-6220-9_7

and AIDS, or simply *Palvey*, as they came to be known in an Urduization of the English acronym; see Chap. 2 for the coming-into-being of universal HIV templates in Pakistan). Nonetheless, CBOs like Shining Star did not become the 'moral voice of the nation' as their counterparts in South Africa had done (Robins 2004; Fassin 2007; Tomer 2009; Mbali 2013) but only gained—in the name of humanitarian intervention—situational political leverage over the local state health department, which was hamstrung by lack of funds. Nguyen (2010) argues that, in the 'exceptional response' to the 'exceptional occurrence' of an AIDS epidemic in Ivory Coast, HIV/AIDS care 'escaped the control' of the state, as the country's 'national sovereignty eroded' in the face of economic decline, Structural Adjustment, and ensuing social and political turbulence (p. 176). He argues that, as HIV/AIDS care entails 'mechanisms that decide exceptions in matters of life and death' (p. 6), these mechanisms constitute the exercise of 'therapeutic sovereignty'. In this chapter, I complicate assumptions about the receding sovereignty of the state in such circumstances by bringing to light charged debates over 'sovereign responsibility' (Brown 2015) that occurred in the new funding regimes for HIV/AIDS prevention in Pakistan.

Living Positively

'We are not aiming to prepare an army or a group of terrorists', said Bashir, the President of Shining Star AIDS Control Society. 'We are not brainwashing them against the government. The government should have some respect for NGOs like us'. He thought the government feared that his CBO, better known by its short-name, Shining Star, was becoming too powerful. In January 2012, I was copied in on a three-page email, which Bashir sent to more than 160 individuals in the government, donor organizations, UN agencies, national and international NGOs, PLHIV support networks, researchers and consultants—a list of actors in the 'transnational governmentality' of HIV and AIDS that Ferguson and Gupta (2002) might characterize as 'formidably encompassing agents of surveillance' (p. 989). Bashir began the email by reminding us that he was the first person to publically declare his HIV status in Pakistan—thus

displaying himself as the 'bearer of authenticity' (Elyachar 2002, p. 503)—and listed the achievements of his organization as the pioneer of AIDS activism in Pakistan. He then remonstrated with the government of Punjab for forcing HIV-positive people belonging to the Gujrat district to obtain HIV treatment from the newly established antiretroviral therapy centre in that district. Referring to the UN's GIPA principle (the Greater Involvement of People living with AIDS, UNAIDS 1999, 2007), he asserted that, in Pakistan, like everywhere else, HIV-positive people should be free to decide where they go to get treatment and related services. Making good use of the development jargon, he elaborated in the email:

> It is a basic human right of a patient that he or she is free to receive treatment from any place he or she feels comfortable. Shining Star was already in the process of convincing its members from Gujrat to get treatment from their own area which would reduce their travel cost and save time, and that we are no longer in a position to facilitate their trips to Lahore. But some members were still not willing to get treatment from the antiretroviral therapy centre in their own district. These were willing to come to Lahore and were ready to bear the travelling cost. Now, by moving their medical record files without notifying them or Shining Star, the Punjab AIDS Control Programme has created problems for them by forcing them to get treatment from their own area. PLHIV are afraid of being exposed and stigmatized in their area. Shining Star and I, as a PLHIV, will not accept this because it is against the basic human rights of PLHIV.

Bashir ended the email by asking the international networks of HIV-positive people: 'are you also treated in this manner in your territories?' This email, and the terms in which Bashir presented his argument, are symptomatic of the tensions that had emerged between the government and Shining Star. I will come back to Bashir's controversial email after I have introduced him in some detail and have recounted an important event involving his CBO and the government health department in Gujrat district.

The story of AIDS activism in Pakistan began with Franciscan Brother Munshi Masih at a Catholic church in Lahore, who was sent by the Catholic Church to the Philippines in 1993 on a training programme. For the first time in his life, he met AIDS patients there and heard their

stories. He was so moved that when he came back to Pakistan he set up an AIDS Awareness Group in Lahore, bringing together four HIV-positive men and their families, all of whom were Christian and belonged to a low socio-economic class. One of the men was Bashir. The four families would meet fortnightly in a private house to share their common experiences of *dukh sukh* (suffering) with each other, as Bashir told me. 'AIDS was considered a disease of non-Muslims. We were worried that we might be targeted by extremists'. Bashir had worked as a migrant labourer in the United Arab Emirates between 1977 and 1990, during which time he got married to one of his relatives in Pakistan and had three daughters and two sons. In 1990, he was required to undergo a medical examination as part of new regulations for visa renewal (see Qureshi 2013). Before his official tests, Bashir had his tests done privately and discovered that he was HIV positive. In order to avoid the humiliation of being deported on the basis of his HIV status, he returned to Pakistan where he went again for HIV testing in one of the most expensive laboratories in the country. To his surprise, he was tested negative. Doctors gave him treatment for other sexually transmitted diseases for many months before he was finally confirmed as being HIV positive in 1991, at a time when most medical professionals in Pakistan had not yet come face to face with this condition.

A health official forcibly tested Bashir's family members for HIV. A pick-up van was sent to his house to transport them to the hospital. The next day, some news reporters posing as government officials tricked Bashir and his family into posing for photographs for 'official' purposes. When these photographs appeared the next day on the front pages of major newspapers with the caption 'Pakistan's first AIDS patient', Bashir became the face of an alien and immoral disease, who captured the curiosity of the many who thronged to his street to catch a glimpse of him. After hiding for some time in his house, he finally came out and set up a bicycle repair shop, using a skill he had learnt as a boy. For five years, he and his family lived in extreme poverty and social ostracism. The group of four HIV-affected families, that had provided each other with some consolation, started to fall apart with the death of two members from AIDS. At that time there were no antiretroviral therapies available, and since they were poor, they could not afford medicine to treat their

opportunistic infections. 'If we had medicine, our diet was not good. If we had food to live on, no doctor would want to touch us when we fell sick', recalled Bashir. Whilst he braved these hardships, a major development was taking place at the international level, which would have far-reaching impact on his life.

In 1996, UNAIDS was established, with the agenda of coordinating HIV responses amongst all the UN agencies and advancing a 'rights-based approach', which would prioritize the 'Greater Involvement of People living with AIDS'(GIPA) principle (UNAIDS 1999, 2007). In Pakistan, they selected Bashir as the representative of PLHIV because he was the most familiar amongst HIV-positive people, due to the number of news stories about him and his family carried in local newspapers. They sent him to international conferences and workshops, invited him to their meetings, and introduced him as an important policy stakeholder to the government AIDS bureaucracy. Such involvement in high-level forums has often been critiqued as a gesture of 'AIDS tokenism' (NAPWA 2004), but for those affected like Bashir, who had suffered from extreme stigma and discrimination, it represented a 'making the best out of the bad situation' and an attempt at 'living positively with AIDS' (Kelly 1998, p. 210).

Shining Star

In 1999, Bashir founded the first CBO of HIV-positive people in Pakistan, Shining Star. Its first task was to find HIV-positive people and register them for food rations, school fees and assistance in buying medicines under a project funded by an international NGO, Rescue Corps (see Chap. 6). Bashir and his peers spent hundreds of hours hanging around at hospitals, laboratories and private clinics in order to get hold of newly diagnosed HIV-positive people, or their family members, and convince them of the benefits of registering with Shining Star. They built networks of information exchange with doctors, paramedics, lab technicians and other staff at health facilities to obtain the names and addresses of those testing HIV positive, and then followed them to their homes and villages to help them 'come out'. When the government started its free-of-cost

HIV diagnosis and treatment programme in 2005, the government's antiretroviral therapy centres depended on Shining Star and its splinter groups (by now there were at least three CBOs of PLHIV; see Chap. 8) to bring HIV-positive people and their family members for tests and treatment. Once these centres were fully established, they started to attract them independently. However, the range of services they provided was limited to counselling, testing and provision of antiretroviral therapy. Therefore, a reverse-referral process was started whereby the antiretroviral therapy centres now sent the newly diagnosed persons to the CBOs, like Shining Star, for care and support in the form of food, medicine and cash.

Not everyone of those diagnosed at these centres registered him or herself with a CBO, even though they were pursued by CBO outreach workers. For those who did become members, the programme of 'care and support' provided by CBOs comprised of more than food, medicine and cash support. As Bashir described, 'we speak not only to the patients but we have to get in touch with their family members as well to tell them what is coming, how to practice safe sex and how to keep themselves aware of all these things'. Those who did not become members were therefore the ones who 'did not want to change their risky behaviours and tried to hide their HIV status from their families. They know that if they register with us, one of our outreach workers would contact their family for HIV testing of them all'. The greater the number of registered members of a CBO, the greater the amount of funds it could receive from international donors, because the funds were calculated on the basis of per person need for 'care and support'.

The competition between CBOs intensified as the antiretroviral centres became the recruiting grounds for new members. Every CBO wanted the maximum number of referrals from these centres. In 2005, UNAIDS and WHO estimated that there were more than 80,000 HIV-positive people in Pakistan. However, the number of those who came to the ART centres was less than 500 (NACP 2007). The vast majority of 'hidden' HIV-positive people were yet to be discovered and registered for treatment, care and support. At this time, the global efforts to 'halt and reverse' the epidemic were at their peak. It was in this context that Bashir made the discovery of an outbreak in Gujrat, which led to a major confrontation between his CBO and a local health department.

The Discovery of the Outbreak

In early 2008, as Shining Star's outreach workers frequented antiretroviral therapy centres to register the newly diagnosed HIV-positive persons, Bashir catalogued their addresses to work out where they mostly came from. Soon, he realized that a large number of them belonged to a small town called Jalalpur in district Gujrat in Punjab. Building on his personal goodwill with the American Ambassador, and without letting anyone in the government know about his plans—let alone ask their permission—he raised some funds from USAID to carry out a rapid testing campaign in the town. This was the first time that a CBO in Pakistan had conducted rapid testing at this scale. The results were astonishing. Out of 246 individuals, 88 tested positive in this small locality. The initial reaction of the local health department, the Punjab AIDS Control Programme and the NACP, who were oblivious of the testing campaign, was to deny this discovery. The head of the local health department, the Executive District Officer, scorned Bashir's claim and questioned his credibility. The Punjab AIDS Control Programme, which had managed to find only 118 HIV-positive cases in the whole province made every effort to discredit Shining Star—after providing 35,000 screening tests over five years, using millions of dollars of the Global Fund Round-2 grant money under Dr Nawazish (see Chaps. 3 and 5 for more on the controversies over this individual). It cast doubts about Shining Star's motives and methods and, according to Bashir, even threatened him to 'back off and forget it'. Meanwhile, Bashir's discovery made headlines in the local and national media, which fuelled the anger of the local people, who felt that their area was being blamed for the spread of an immoral, taboo disease, although most news items were critical of the government's ineptitude in dealing with the epidemic.

The NACP sent a two-member 'fact-finding mission' to the District Health Office after learning about the outbreak. Bashir was also invited to the meeting. Whilst he tried to convince the fact-finding team of the results of his testing campaign, the Executive District Officer of Health maintained that they were fabricated and accused Bashir of creating a fuss for everyone. Nevertheless, as Bashir narrated to me three years later, the

meeting was still on when the Executive District Officer received a phone call from a member of his staff informing him of a dangerous situation that was unfolding in Jalalpur. A group of young men were threatening to beat up a television crew who had just arrived in the town to make a documentary about the outbreak of HIV and interview local people. The crew were accosted by an angry mob who held that they were trying to defame their town. Meanwhile, Bashir also received a phone call, separately, from his local supporters and the television crew, persuading him to go there immediately and defend himself and his findings in front of the public and the camera. Bashir invited the NACP's fact-finding team to come along but they decided to stay back and also advised him not go as the tensions were high and the local people might harm him. He acted against their advice. In Jalalpur, he found around two dozen local men, led by the local councillor, holding sticks and seething with anger. 'It was as if everything would finish that day', recalled Bashir. He recounted the scene as follows:

> The TV people asked me 'Bashir Sahib tell us how many tests you did?'. I told them the numbers. 'Is it true that there are so many HIV positive people here?' they asked. I said, 'I will show you the evidence right now'. Then, I called Taseer [a local man] to give an interview before the camera. He told them he had three children and that he didn't even know that they were all suffering from this disease. Then, there was another person in the same street. He told them that his family was completely shattered. Three had already died, he said, and he was going to be the fourth. 'What is left of me?' he said. 'What has the *doctor* [the vaccinator/quack; see below] done to me?' He cried out in front of the camera and all the people who had gathered there…I convinced the TV crew of our discovery. Then they told the councillor and his supporters sternly that it would be in everyone's interest that they backed off and 'let us do our work and let Bashir do his work'.

The councillor demanded to see the list of all those whom the CBO had diagnosed HIV positive. Bashir refused. 'It is not something to be thrown on the footpath for everyone to see', he said to the councillor. When the latter insisted on his right, as the elected leader of the area, to be appraised of the names of all those who were potentially a risk to the community, Bashir scared him off by casting doubt on his own HIV status. 'We will

have to test you and your supporters as well. God knows what diseases you people carry', he recalled telling the councillor, flamboyantly. With a little help from the TV reporters and the crowd that had gathered around them, Bashir said that he successfully countered the councillor's *chaudurahat* (his status of privileged dominance claimed traditionally by the landowning families in rural Punjab). However vehemently the councillor and his supporters argued the opposite, for Bashir these newly diagnosed HIV-positive people in Jalalpur were now part of another community: they were *Palvey* (People Living with HIV, or PLHIV).

The fact-finding officials of the NACP may have thought that the flare would die down with time, but it did not. It took the NACP five more months to send another team to Jalalpur for a 'Rapid Situation Assessment' in November 2008. The team, led by the incumbent NACP manager, prepared a report that roundly criticized Shining Star for lacking the 'foresight' of sharing with the government the information it had obtained, 'even within the bounds of medical confidentiality', for its 'unwillingness' to work with the district health authorities, and for trying to block the possibility of the Punjab AIDS Control Programme's 'close involvement and arbitration'. It highlighted the 'mistrust' of local health officials, their 'disbelief of the absolute numbers being so high', and the 'community outrage' against Shining Star. It reported allegations that the CBO 'had recruited some local people who promoted the perception about proliferation of HIV cases', and that it had made 'financial offers' to the family members of recently deceased persons to 'ascribe HIV/AIDS as the cause of the death'. The report also cast doubts on the possibility of finding so many people willing to undergo HIV testing in a 'fairly small area', and pointed out that whereas 'even in populations with intensive sensitization, the acceptance rate of HIV testing ranges from 40% to 75%'. Finally, it questioned the quality of the diagnostic tests and antiretroviral therapy provided by Shining Star. It quoted an old lady whose son had recently died after remaining ill and taking the antiretroviral therapy it provided. 'If that NGO ever shows up here, I will personally shoot them', this woman said. The report concluded that Shining Star was 'not welcome' in the locality, and 'therefore, access to or provision of care and support services for which they have been seeking funds becomes a questionable end point'. The issue of Shining Star, the report

continued, needed to be 'resolved mutually with the donors and the Punjab AIDS Control Programme as to what next'. Further on, it recommended carrying out an epidemiological investigation, in which 'the NACP should be closely involved'. It cautioned the donor community that 'at present Shining Star does not have meaningful access to this distressed community and it would not be in a position to provide the necessary support in this area irrespective of the funds availability'. The last paragraph therefore read:

> Donors should reassess and review their funding support to Shining Star and its reach to the intended HIV positive people of Jalalpur in view of the current hostile situation and poor perception of the NGO in the local community. Alternate solutions must be considered to help those in need without entitlement rights to any one NGO.

On one hand, the NACP tried to downplay the outbreak by casting doubts on Shining Star's methods of testing and the 'unbelievable' numbers, and on the other, it attempted to divert donor attention from this CBO by building a narrative of its failure, illustrated by the mistrust and hostility of the local people and health department. Donor support to Shining Star had multiplied as a result of its discovery in Jalalpur, whereas AIDS bureaucrats and health officials in the government were depicted as neglectful of a storm that had been brewing on their watch. The government had an expensive testing campaign, financed by the Global Fund, yet a small CBO had made this astonishing discovery with very little funding and only a few members of staff. As implied by the report, the NACP officials could not avert their own embarrassment or reverse the damage done to the reputation of government departments. Instead they tried to discredit this CBO by maligning its reputation amongst the people it claimed to serve, and tried to suggest ways of diverting the influx of donor money, in the wake of this outbreak, from Shining Star to the NACP and the Provincial AIDS Control Programme. Yet by this time, even more donor funding for the newly diagnosed individuals was being channeled through this CBO.

Despite the propaganda against Shining Star, its opponents could not deny it had made its discovery or dislodge it from the favoured position

it had attained with international donors. The subsequent epidemiological investigations confirmed the CBO's claim (NIH 2009). The number of CBO members increased sharply, which meant more funds from donors and more prestige in the policy corridors. As 'participatory' approaches like the GIPA principle gained currency in international development agencies, it became imperative for the government's AIDS bureaucracy to work closely with Shining Star and other CBOs. Meanwhile, Bashir told me that he had had invitations from other places to carry out similar testing campaigns to uncover the new 'concentration zones' of HIV. He told me that some of these locations were likely to yield 'promising' results where he 'hoped' to unearth similar situations that would otherwise have been hidden from the view of the authorities. Taking its lessons from Shining Star, the government had already identified some of these zones of concentration on the basis of reported cases from those areas. Since most of the newly reported cases from Jalalpur and other places came from the 'general population', as opposed to any of the designated 'risk groups' (such as sex workers, drug users, *hijrae* and men who have sex with men), the discovery of the outbreak in Jalalpur gave rise to the idea of 'risk localities' in addition to the idea of zones affected by 'behaviours' and 'groups' (see Chap. 2).

The Wailing in the Local Health Department

This was Shining Star's side of the story and its account of how the AIDS bureaucracies in Islamabad and Lahore reacted to the emerging situation. In the following I will focus on the reactions of the local health department in district Gujrat. We must bear in mind here that this department, as an arm of the district administration, worked under the provincial government and was not part of the vertical AIDS bureaucracy. As part of a multi-tiered, horizontal governance structure, the health department was an old-style, proceduralist bureaucracy concerned with its rules of conduct, quite unlike a flexible, 'efficiency'-oriented and transient vertical health organization like the NACP (see Chaps. 4 and 5).

The local health officials tried to fix the blame for the HIV outbreak on a number of causes. First it was migration. 'Around 200,000 people from

Gujrat work abroad, people have money, they are *khush haal* (well off). Therefore it's understandable', the Executive District Officer of Health told me, alluding to the stereotype that migrants spend their hard-earned money on commercial sex and drugs. Secondly, it was the injecting drug users, many of whom had been deported from abroad. Thirdly, it was 'the doctor', a rogue vaccinator/quack who had a gang of drug users around him. The Executive District Officer was of the opinion that a set of very strong laws was needed, in order to prevent people from seeking healthcare from untrained healthcare providers, because it was otherwise 'hard to change people's behaviour in an almost illiterate society like ours'. He shared that, on many occasions, the Department of Health had tried to shut down the vaccinator's clinic, but it nevertheless failed to discourage common people from going to him for healthcare. 'People are still going to him. What can I do?', he said. Echoing his boss, the Superintendent of Jalalpur Civil Hospital told me that

> The vaccinator is very popular among people because he has been working in this area for a long time. He has done all sorts of illegal things, like abortions and so on…Once, I tried to advise a woman who had gone to him for an injection before coming to me. I told her not to seek treatment from him but she replied; 'no *doctor sahib*, it is only propaganda against him, he is not an AIDS patient'… So, you know, this is the state of affairs here… Individuals like him [the vaccinator] usually have a say in their area. They are *funkar* (crafty) and do *funkarian* (crafty things) with their female patients and if these women get pregnant, they make them undergo abortions secretly. So, they are useful for dodgy people. That's why people protect them.

I could see the blame dripping down from the migrants abroad, to the deportee drug users, to the evil vaccinator, and finally to the ignorance of the people in 'our illiterate society', their 'cultural preference for injections' (Pakistan has one of the highest injection frequencies per patient per year in the world; see Janjua et al. 2006) and the alleged moral waywardness of whole neighbourhoods. There was no mention of sexual transmission of the disease amongst the so-called 'general population' (see Chap. 2 for a critique of this epidemiological category), or of possible

malpractices within the health department—for example, the reuse of syringes, transfusion of unscreened blood, and unprotected surgical procedures. Instead, the demography of the district, its high out-migration, the inhabitants' lack of literacy, 'backwardness' and moral decay, were presented as sufficient explanation. These were not causal explanations in the sense of denying the bio-medical theories of the spread of HIV/AIDS, as famously in the case of Thabo Mbeki in South Africa (see Fassin 2007), but rather a form of 'fixing the blame for the epidemic' (see Gill 2006) on the basis of 'pre-existing stigma' (Berridge 1999).

As we drove towards Jalalpur from Gujrat in his car, Dr Dilshad, my local contact in the health department, told me that 'when the news about the HIV outbreak broke in July 2008, it all became a big joke. There was confusion in the health department and among the local people about whether to own it or not, and whether it was true'. The television channels, according him, had raised such an alarm that one of his nephews in Dubai had pleaded to the family that they move to Lahore because he thought Jalalpur was no longer a safe place to live. The health department was blamed in the media reports for sleeping through the outbreak, whilst the CBO made the discovery without even informing it. Even the media was divided into two groups, he said, one supporting Bashir and the other siding with the local people, who denied the outbreak and were outraged over their town being brought into disrepute. The health officials had found themselves between a rock and a hard place. If they acknowledged Bashir's claim, it would reflect badly on them. If they tried to deny the outbreak, Bashir might have said, 'ok, I will show you the patients'. Denial was not a possibility, and acceptance would have amounted to a confession of incompetence. They tried to maintain an equivocal stance, but for this they were accused of 'shameful denial' by Shining Star's supporters, and of 'having taken a bribe from the NGO' for not speaking out against it, by those who were not willing to accept that there was an outbreak of HIV/AIDS in Jalalpur.

The Superintendent claimed that he had already identified two AIDS patients in early 2008, before Shining Star's discovery, and had informed higher authorities who had instructed him to take down the particulars of the patients and wait for further instructions. Whilst he had waited for further instructions, Shining Star created its upheaval, so it appeared as if

the Superintendent's discovery was not taken up promptly by the higher-level officials in the health bureaucracy. After the discovery was claimed by Shining Star, the Superintendent continued, local health officials, including himself, anticipated criticism from the media and scrutiny from higher authorities. But what they did not expect was that, in order to manage the outbreak, they would be required to share their authority in their district with a CBO and a non-governmental agent, who was an outsider from Lahore and a semi-literate Christian. This was unprecedented in the governance of health in their district. They envied Bashir for the attention he received from international donors and resented his CBO for the large amount of funds it received, whilst the health department had to make do with meagre annual budgets. The problem was not just that they had 'egg on their face', therefore. They were also vexed by the NGO's ability to usurp their 'sovereign responsibility' to provide and administrate services, since they saw donor aid as part of the 'national cake' (Brown 2015).

There was an interesting contrast between the Superintendent, who was a local resident, and Bashir, who was seen by the health department as an outsider. On the one hand, the Superintendent had to acknowledge the truth of the unusually high HIV/AIDS prevalence in his town, as a responsible government official. According to him, 'this was an unusual situation. The EDO [Executive District Officer] *sahib* gave orders to provide HIV tests at all public health facilities, prepare a record of all patients and make a whole set up for diagnosis and treatment'. On the other hand, as a 'son of the soil', he had to face the wrath of those local residents who denied even the possibility of there being HIV/AIDS in their town. Some local residents went to the extent of filing a police complaint against him, which alleged that he was trying to spread HIV/AIDS in their area. Bashir, by comparison, was seen as an outsider, an NGO man, who only came to the town to hold meetings for his CBO at hired venues. 'Whatever he may say now, the fact is that he was totally banned from the town but we protected him, with great wisdom, and let him continue his work', said the Superintendent.

The question of who would govern HIV/AIDS services in Jalalpur was contested between the district health department and the CBO through the micro-processes lodged in the town's transition from being 'normal'

to becoming a 'zone of HIV concentration'. Both the health department and the CBO used the time-honoured biopolitical technologies of counting HIV-positive individuals, confirmed or suspected, and of maintaining their registers for tracking HIV-positive people and their family members for tests, medicine, sexual contact, blood transfusion, injections, treatment, care and support. Both therefore employed 'confessional technologies' (Hunt 1997) in order to train people to (re)produce illness narratives and be prepared to be 'examined, prodded, discussed, and worked upon' for the 'production of a biopolitical body' (Nguyen 2010, p. 8). According to Agamben (1998), this employment of 'confessional technologies' is the 'original activity of sovereign power' (p. 6).

Three years since the initial flare-up, the district health officials maintained that they had done all the hard work of finding the HIV-positive people, by providing extensive HIV screening at all the government health facilities, but that once people were diagnosed, they ended up with Shining Star—who 'cashed' them with international donors. Ever since the outbreak in 2008, the local health department had instructions to provide HIV testing on the slightest of doubts about anyone seeking healthcare for any related illness at any government facility in the district. For three years, there had been no antiretroviral therapy centre in Gujrat. Therefore, the health department had to refer the newly diagnosed individuals to Shining Star, which provided them with free transport for visiting the antiretroviral therapy centre in Lahore, a metropolis two hours' journey away. The CBO also provided them with food rations, medicine, clothes and cash, which the health department had no means to provide because of, as one health official put it to me, 'the same old wailing for lack of money in the government sector'. He complained about losing HIV-positive people to Shining Star:

> We search for patients, disclose their HIV status to them, motivate them for confirmatory tests and counsel them to keep faith. But when we send them to the NGO, the NGO claims that they have searched them and takes all the credit. As a result, the patients are lost to us.

The staff of the health department felt that higher authorities in the government listened to 'NGO people' more than their own employees

working on the ground. 'They listen to them so attentively that it feels as if a saint (*pir sahib*) has descended from heaven to speak to them, whereas people like us, who eat the dust all the time (*khajal hotay hain*), are not even allowed to speak in front of them', complained Dr Dilshad, also native of Jalalpur.

Gujrat's New Antiretroviral Therapy Centre

Addressing HIV/AIDS as an 'exceptional disease', international humanitarian funding regimes preferred the non-government sector in the provision of prevention and care. This gave NGOs like Shining Star leverage over state institutions, and caused a shift in the balance of power that health officials like Dr Dilshad were only grudgingly reconciled to. Government officials now hoped that international donors would 'take them on-board', as Dr Dilshad put it, along with NGOs. But how long will these assemblages of transnational institutions and local NGOs, like Shining Star, 'govern by exception' (Nguyen 2009, 2010)? After all, as Bernstein and Mertz (2011) observe, 'exceptions require maintenance and administration, (and) … are negotiated on the ground' (p. 6).

Dr Dilshad served as the in-charge of a Basic Health Unit where he lived with his wife and children in a newly constructed government residence. Their children went to a nearby school at the campus of Gujrat University, which had provided a pick-and-drop service for them. He divided his week between working at the Basic Health Unit and at the Civil Hospital in Jalalpur, with a distance of no more than four kilometres between the two. This arrangement suited him very much because it meant that he was not totally cut off from his colleagues in the health department, who served at the Civil Hospital in the town, and also because he received a Rural Area Hardship Allowance from the government by virtue of being posted at a Basic Health Unit in a nearby village. Moreover, due to the close proximity of the village to the town, he could also run a private practice in Jalalpur seven days a week, in the evenings, which made some extra money on the side. Until recently, he was happy and content in his government job because of this arrangement. However, he was then made the in-charge of the newly established antiretroviral

therapy centre at the District Headquarter Hospital in Gujrat. In this new role, he would be required to work three days of the week at the Civil Hospital in Jalalpur, as before, but work the next three days at the antiretroviral therapy centre, 20 kilometres away, instead of at the Basic Health Unit. The new role forced him to commute at his own expense between Jalalpur and Gujrat and he stood to loose his Rural Area Hardship Allowance. He had no option but to take up the new assignment, but was determined to keep his posting, on paper, at the Basic Health Unit because he needed the allowance: he would loose earnings from his private practice.

His new assignment also came at a great personal cost. He would lose his preferred work routine, along with his newly-constructed and rather beautiful government residence in the Basic Health Unit on the banks of the river Jhelum, and the move meant his children would have to travel further to school. The discovery of HIV/AIDS in their district had unsettled 'life as usual' for everyone in the local health department, but what disturbed them too was what they believed was a preferential treatment, by the higher-ups in the government and the international donors, of 'NGO people' like Bashir. Giving another example of his discontent with the impact of the epidemic on his government-sector work, Dr Dilshad told me about a training workshop in Lahore, on antiretroviral therapy, that he had been sent to. Whilst attending this two week-long workshop, he was expected to spend from his pocket the cost of boarding, lodging and food, and was promised a quick reimbursement from the health department. However, two months had passed since he had submitted the invoices and there was still no sign of reimbursement. This contrasted with the 'per diem' received by the NGO workers who had attended the same workshop, who had been given an envelope with their 'TA/DA' (travel allowance/daily allowance) every day. 'Now you tell me', he said, 'will I ever go happily to any such workshop in future? Even if I went, would it concern me to learn anything whereas all the time I am worrying about whether they will reimburse me or not?' In the time of the epidemic, not only was he expected to carry out his normal government work but was also expected to attend trainings on HIV/AIDS and exposure visits hosted by these NGOs who were, he felt, better paid and better facilitated than himself.

It is in this context that we may understand the decision of the Punjab AIDS Control Programme to move the records of the patients in Gujrat to the new antiretroviral therapy centre that they established in the city without consulting Shining Star, the decision which vexed Bashir so much, as we saw. The state was wresting back its 'sovereign responsibility' (Brown 2015) and asserting its importance on the basis of its role in delivering resources. The advantages Shining Star enjoyed in providing care and support to the HIV-positive people it discovered in Gujrat proved time-bound. Like the military–humanitarian *bricolages* of international organizations that appear in geopolitical hotspots as 'mobile sovereigns' leaving in their wake 'laboratories of intervention' (Pandolfi 2007), will the 'ever-more complex assemblage of institutions' (Nguyen 2010, p. 177) that respond to the exceptional HIV/AIDS epidemic disappear once the urgency of the epidemic is over? The actions of the Punjab AIDS Control Programme underscore Brown's (2015) argument that whilst neoliberal global health regimes may aim to reduce the role of governments, the state has not become irrelevant. Indeed, the state may even attempt to wrest back its role in delivering resources such as care and support for HIV-positive people, with very real consequences for those involved.

Conclusion

The email Bashir sent in January 2012 was illustrative of the tensions that had lingered between his CBO and the government since the discovery of the epidemic in Gujrat. These tensions were, I have suggested, not only about the embarrassment of the NACP, the Punjab AIDS Control Programme and the local health department for having failed to detect the crisis that had been brewing on their watch, but were also about their 'sovereign responsibility'—the right to provide and administer services (Brown 2015). In Gujrat, as it had earlier done in Lahore, Shining Star worked as the 'organizational conduit to assist ARV provision' (Lyttleton et al. 2007, p. 49), by 'marshalling the infected to treatment' (Beckmann and Bujra 2010, p. 1046), and in order to provide care and support for its newly diagnosed HIV-positive members, it secured large amounts of

funds from international donors. For their part, however, the government's health officials faced accusations of ineptitude on the one hand, and on the other, they were hamstrung by their low budgets and lack of support from their higher authorities. Whilst the local health department fished out HIV-positive people from the general population by providing HIV testing at government health facilities, the CBO, they believed, 'hijacked' these newly diagnosed people by registering them as its members and had 'cashed' them with international donors. Meanwhile, Bashir asserted that these were 'his' people because he had discovered them, that the government was completely irresponsive to trends of HIV/AIDS in Gujrat, and that only he could understand the sufferings, and share the pain, of the newly diagnosed HIV-positive people.

The international donors put their weight behind this non-governmental agent in the time of 'AIDS exceptionalism' (Smith and Whiteside 2010; Benton 2015), whilst the local health officials hoped that they would be 'taken on-board' in the governance of HIV/AIDS in their district. But, in the long term, the 'maintenance and administration' of this 'exception' on the ground (Bernstein and Mertz 2011, p. 6) did not 'escape the control' of the state, as Nguyen (2010) has surmised of West African states (p. 177). The NACP, the Punjab AIDS Control Programme and the health department in Gujrat asserted their right to administer and provide services, insisting that the HIV-positive people of Gujrat attend the new antiretroviral therapy clinic that they had set up in the city, thus making the state distinctly relevant.

In this contest with the government over HIV-positive people, Bashir invoked the idea of a worldwide solidarity of PLHIV by asking the networks of PLHIV around the globe if they were also 'treated in this manner in their territories'. Amongst the PLHIV in Pakistan, would the fact of their shared biological condition foster some kind of belongingness and solidarity on the lines of 'biosociality' (Rabinow 1992) or 'biological citizenship' (Petryna 2002; Biehl 2007; Rose and Novas 2008)? Or, as with the field of HIV/AIDS prevention, as we saw in Chap. 3, would AIDS activism in Pakistan become one of those humanitarian 'laboratories of intervention' (Pandolfi 2007), by being turned into a key site for 'accumulation by dispossession' (Harvey 2007)? The next chapter deals explicitly with this question.

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8

AIDS Activism and 'Civil Society'

In this chapter I extend the narrative of Chap. 7 to include those CBOs and activists who emerged later and challenged Bashir's leadership of AIDS activism in Pakistan. Like him, their life histories reveal extreme suffering in a hostile surrounding, but simultaneously, they are the stories of talented, charismatic leaders and competitors. I narrate aspects of the personal and professional transformation of AIDS activists, who presented themselves to their communities as both People Living with HIV/AIDS (PLHIV), or *Palvey*, as well as transnational experts on HIV/AIDS. In their claims to authenticity, they often shifted their own 'frames of reference' (Lewis and Mosse 2006, p. 8, drawing on Latour 1996) by enacting boundaries of 'us' and 'them' along multiple axes. Some of these axes were in their histories of personal suffering, the length of their careers as activists, or the numbers of registered members in their CBOs, whilst others invoked the politics of gender, religion and morality, and their differential access to networks of power and patronage. As such, this chapter speaks to questions of authenticity, solidarity, competition, alliances, and rivalries between AIDS activists.

HIV-positive people have often been portrayed as an emerging 'community' on the basis of their shared biological condition and predicaments in society. I consider whether, in the case of Pakistan, the growth

A. Qureshi, *AIDS in Pakistan*, https://doi.org/10.1007/978-981-10-6220-9_8

in this community illustrates the emergence of a new kind of 'biological citizenship' between those afflicted with this fatal condition, as some have argued (Petryna 2004; Rose 2006; Biehl 2007; Nguyen 2009; Rose and Novas 2008). Could their membership of CBOs, through which they have engaged in and challenged authority, be seen as a sign of their 'becoming political' (Rose and Novas 2008)—a form of 'deep democracy' (Appadurai 2001) and hence worthy of international donor money? The politics of numbers, gender, class, time and liberal 'civil society' (Norton 1995) will remain central to the discussions in this chapter.

Gharailu Aurat (a Home-Maker)

'Bashir will never tell you this, but I was the one who set up Shining Star, not him!', said Kiran, a rival CBO leader. In 1998, one year before Shining Star was set up, Kiran and Bashir were taken to a district hospital to deliver a HIV awareness session to paramedical staff. Their role was to embody HIV/AIDS and share their experiences—but only within the parameters defined by their 'handlers', who had arranged the event. According to Kiran, she realized that some people were using them as 'tokens' to make money from international donors. She had this thought for quite some time. As she said, 'I was like a piece of white paper (*kora kaghaz*) on which other people had started writing. It's very painful to have someone writing on you'. That day, on their way back from the awareness session, she decided to take the reins of her life in her own hands. 'What they do is nothing that we can't', she told Bashir; 'if it's us who are required to speak in these sessions, why then, should someone else put words in our mouth and take away all the funding?' This was how she claimed she was the one who started Shining Star: it was her idea, not Bashir's. She later parted ways with Bashir and set up her own CBO, called Live Positive, in 2003. At the time of my fieldwork in 2011, she was a middle-aged, widowed mother of a teenage son and a daughter. They lived in a comfortable house in a middle-class neighbourhood of Lahore. Chandeliers, matching china dinner sets and kitchen appliances were the accoutrements of her new-found comfort.

In 1995, Kiran's husband was hospitalized for multiple illnesses. He was diagnosed with HIV. The medics shifted him from the medical ward to a store room and asked Kiran to bring herself and her children for blood tests. The next day, the hospital staff informed the media about their discovery of this HIV case, which had also announced Bashir's case (Chap. 7). Her husband died within a week and his family burnt everything that had come in contact with him. Thankfully, they spared her and the children. Kiran tested positive for HIV. She was put under immense pressure to leave her marital home. Neighbours demanded their expulsion from the area. After going through this crisis, she told me, she promised herself that she would do her best to find out as much as she could about how this disease spread and why it was so dangerous. Through a friend of her nephew, she got her HIV tests redone at the NACP to further confirm the results for herself and her children.

Kiran had twelve years of schooling but she had always remained a '*gharailu aurat*' (home-maker) with little knowledge of technical English words like 'prevention', 'transmission', 'risk groups', and other jargon of the HIV/AIDS sector, which she came across at the NACP. She started educating herself about these with the help of the available awareness material. This was Kiran's path into activism. She said it had not been easy. 'If you bring a *gharailu aurat* out in the open and ask her to run, she won't understand where to go. That's what happened to me as well. I was a typical housewife. I didn't know which path led where, what to do and how to do it'.

At the NACP, she was introduced to a group of HIV-positive people led by Bashir who, according to her, had brought this group together mainly on the basis of Christian solidarities. She joined the group as the first Muslim, the first woman, and the first person with twelve whole years of schooling. Therefore, she claimed, she had an edge over other members. Her education allowed her to 'pick up' things more quickly and imbued confidence in the rest of the group to work as a community. This was the beginning of Shining Star, according to Kiran. However, her conservative family members did not like her mingling with unrelated men. She therefore parted company with Shining Star and distanced herself from AIDS activism. Instead, she took up stitching and embroidery to earn a living. After a few years, she was rediscovered in 2001 by a group

of people she called the 'Karachi people', comprising of some officials of the Sindh AIDS Control Programme and the boss of a prominent HIV/AIDS prevention NGO. They tried to convince her to come back to the field of AIDS activism. 'I told them very clearly that I had some earnings to run my family and if I joined this sector again, I would be doing so by sacrificing my extended family's support', she recalled. The 'Karachi people' agreed to take care of her financial needs. They made her a PLHIV representative in the Country Coordination Mechanism of the Global Fund (Chaps. 2 and 6). Her detractors criticized her as a stooge of the 'Karachi people', whose job was to watch their interests in the Global Fund and to counter Bashir's influence as the leader of PLHIV.

A Big Step and 'Pulling Others' Legs'

Live Positive became a competitor for Shining Star. Both CBOs were driven by the personalities of their bosses. Bashir was the original, authentic embodiment of the pain and suffering of HIV/AIDS (see Chap. 7). Kiran was a widow, who regarded herself as an 'innocent victim' from the 'general population' (see Chap. 2 on the emergence of this epidemiological category)—as a *gharailu aurat*, pushed out into the open to run and make her own way by her marital family. By 2005, she had come a long way, measured her strengths and mapped the territory. She took what she called 'a very big step', something which she thought 'could make or break my life'. She did not tell her family about it because she knew that they would never have approved of it if she did. She also knew that if it went wrong, her children's future would have been in danger. But again, she was encouraged by the 'Karachi people', who convinced her to become the 'first drop' of hope, or example for others to follow. This first step involved agreeing to participate in a documentary about her life and work, which was aired by the TV channel CNN on World AIDS Day in 2005. It coincided with a conference in Islamabad on women's health and rights, to which she was also invited. Some UN regional officers participating in this conference had seen the documentary that morning. In the opening session of the conference, these UN officials called Kiran on stage and gave her a resounding appreciation for her courage and bravery

in openly disclosing her HIV status 'in front of the whole world', she recalled.

> It was like a bomb had exploded. The media personnel covering the conference did not yet know about my documentary. They all converged on me to speak to me about it. Even the conference organizers were worried that I was stealing their show…That evening, there was not a single TV channel that did not carry my interview.

Almost ten years before this, Bashir had given a similar performance at a Memorandum of Understanding signing ceremony between the government and UNAIDS in Islamabad when he declared himself as the first HIV-positive person in Pakistan to voluntarily 'come out' in front of cameras. Now, Kiran had done the same but on a grander scale by running a documentary on CNN and by following it up with a spectacular display at the World AIDS Day. Kiran was the first HIV-positive woman—and a *gharailu aurat*, an 'innocent victim', at that—to 'come out' in Pakistan. Nevertheless, as time passed, their narratives of suffering—that is, of 'victims' transformed into 'survivors' (Diedrich 2007)—were not persuasive enough in the scramble for funds for both these proprietors of CBOs. To transform themselves, yet again, into thrivers in the field of AIDS activism, they had to 'show numbers' in addition to embodying suffering.

Kiran became something of a celebrity in 'civil society' and amongst the international donor organizations. Television plays and even a pop music video by a famous band had been made about her achievements. Her English language skills improved considerably and she became a favourite of the international donors as a result. Already a member of the Country Coordinating Mechanism of the Global Fund, she was now made the General Secretary of the newly established Association of PLHIV. Her CBO received more funds, which enabled it to branch out to smaller towns and cities. Whilst Shining Star held fast to its main donor, international NGO Rescue Corps, Live Positive found numerous sponsors amongst the UN agencies and international sexual and reproductive health NGOs clustered in Islamabad.

This golden era ended in July 2011, when there was flurry of emails against Kiran and Live Positive in relation to alleged corruption and

financial embezzlement. She believed that these allegations were orchestrated by two individuals in one of these international NGOs, whose request for 'contribution money' from the grant that her CBO had won from them she had turned down. According to her, these individuals had also managed to 'buy out' some of her former employees to defame her and that they were also lobbying to drop her CBO from the Global Fund Round-9 project (Chaps. 2 and 6). These two, she said, were part of a 'monopoly group' that was always ready to 'pull others' legs' (i.e. ready to pull others down to prevent them from climbing up, a Pakistani idiom meaning to stop others from succeeding). She said:

> I have seen, especially in our HIV sector, that when money comes, NGOs can spring out in a single night and the money is also transferred to them in a single night, while those who can do the real work are left watching in vain. And, those who are opposed to each other start campaigns against one another's corruption … donors have their own objectives, when their objectives are achieved, they step back and go away.

The narrative that she built around the issue of corruption allegations against her started with counter-accusations against her opponents, touched upon the indifference of the donors, and ended with a portrayal of her own victimhood, on the one hand, and resilience on the other. It was 'not fair' for a big international NGO to 'discourage and torture an ill person, an HIV positive woman', who 'achieved objectives and goals for them'. If she was in the wrong (*ghalat bandi*), then why was this ignored for the past three years, she asked, and why were these two persons now threatening to send her to jail if she did not comply with their demands? 'Is that the way one should behave with a PLHIV!', she exclaimed. 'If I were after money', she told me, 'I would not have chosen this path, it wouldn't be a problem for me to raise money. Can you imagine if I stood up in a public place (*chowk*) and told people that I have this illness … do people listen more to a woman or to a man?' Her voice trembled with emotion when she said this, but these were not questions that needed replies, least of all from me. I did not even have to nod in agreement whilst she continued, getting her strength back:

> Allah Mian is the provider of *rizq* (sustenance). I have faith in Him. I came this far without any support…So, it will take them some time to push me

> back. I have learned all these things in my life. I did not receive them in a platter. I have struggled to climb this height. When I started this struggle my children were young and now they are grown up. This whole time didn't pass so easily. I have worked very hard. You think I will let them spoil all this hard work? NO.

She accounted for her predicament by framing herself as, in addition to being HIV positive, a victim of her class, gender and of her 'market relation', which had exposed her to retaliation for denying kickbacks, the so-called 'contribution money', to the unscrupulous elements amongst her former benefactors. She claimed that her contribution to the HIV/AIDS sector was enormous: she had persuaded the government to make antiretroviral drugs available and she set up a centre for free-of-cost treatment; she had provided care and support for HIV-affected women and children when they were looked over by others; she had promoted the PLHIV Association at the cost of ignoring her own CBO; she had represented Pakistan worldwide in conferences and workshops; she had lobbied for including HIV/AIDS awareness in sexual and reproductive health education, and so on. The list of services she claimed to have rendered for PLHIV was long. 'Did my children not have any rights to the time that I gave for these people?', she asked. 'Now, look what I got in return!' She felt betrayed by the very people who had welcomed her as the 'first drop'. For the fifteen years she had given to AIDS activism, she said, she had worked in the burning sun, whilst 'they' sat in their air-conditioned offices or roamed around in luxury cars. 'Kiran was not like you see her today', she exclaimed, drawing attention to the toll it had taken on her health and looks whilst working in the field. 'If I show you photographs from my past you will be stunned. I have come to look like this because I have worked hard. I didn't care about my looks or complexion or anything when I went out to work for these people'. But now, she felt that

> They used me as a token. They used me for their purpose and once that purpose was achieved they started vilifying me. I ask myself, why did I 'come out' in the first place? Why should I work for these people who are discouraging me? Why don't they do the work themselves, if they can?

She did not give up—not yet. Neither were her opponents entirely successful in having her evicted from the Global Fund project. Intriguingly, no one from the PLHIV 'community', not even Bashir, her long-standing collaborator in AIDS activism, came out to testify to her innocence in facing these corruption allegations. In fact, he told me that he had always advised her to be careful with money that was meant for her CBO members, but she 'never listened' to him. The donor organizations also kept their distance from Kiran and her CBO.

The Saviours of the HIV Positive

Both CBOs provided donor-funded handouts they called 'rations', which included medicine, food, school fees for children, cash support for funerals, counselling services, and sometimes transport for their HIV-positive members. Both were also partners in the upcoming Global Fund Round-9 project as Sub-sub-recipients (see Chap. 6). The core activity that was proposed for their CBOs under this project was to 'improve livelihoods via socioeconomic support and job creation for PLHIV'. This was in stark contrast to what these two CBOs had been doing for years, such as delivering handouts and marshalling HIV-positive people to the government's antiretroviral therapy centres. This new approach did not go well with them. 'What if the person dies of hunger?', asked Kiran in a high-level meeting in Islamabad. Bashir echoed her by sharing his observations of a recent tour of the United States where, he said, 'HIV-positive people are provided with the best food and fruit that suit their condition'. Giving his own example, he said those HIV-positive people who had benefited from the higher quality nutritional support programmes of the past had greater life expectancy than those of later generations, who were dying younger due to malnutrition. Given the side-effects of metabolizing antiretroviral drugs, such demands for nutritional support in the form of handouts for HIV-positive people have been viewed sympathetically by Kalofonos (2010), Marsland (2012) and Prince (2012).

Bashir argued that the idea of imparting technical skills or giving loans to HIV-positive people for starting a livelihood was not workable. 'They

will spend all the money on buying household accessories like a television, fridge and so on, or spend it on renovation of their houses', he proclaimed with the confidence of being one of them. One could not ask them, Bashir argued, to take a paltry sum as a loan, set up a business, earn a profit, and then use that profit to buy medicine and medical tests, hire vehicles for going to treatment centres, and meet their many other needs. If pushed any further, he feared many PLHIV would stop adhering to antiretroviral therapy. He said that when Shining Star found HIV-positive people in Gujrat, many of them were in the terminal stages of AIDS. 'We gave them ARVs, but medicines on their own were not sufficient to save their lives. These people must also have something in their stomachs'. Consequently, many had died, not because they did not have access to antiretroviral drugs, but because their medication was not supplemented with the minimum of dietary needs to cope with their condition. He stressed that if HIV-positive people are provided free-of-cost medicine, medical testing, transport and nutritional support, it has a positive impact on their care by their own families as well. The family members feel obliged to provide food and shelter and develop a hope that, if they continue to do so, the patient might recover and support himself, at the very least. 'They support him because of all the other support he receives from CBO, and not because they believe that he will fully recover and start earning like before. No!', said Bashir on the authority of his experience with hundreds of them. To further illustrate this point, he recounted that, as an AIDS activist, he had met many HIV-positive people who were thrown out of their homes because their families believed that they had become *nakara* (useless). Nevertheless, when he made them his CBO members and started providing nutritional support, the families embraced them again. These families of PLHIV, he said, realized that 'these people were at least bringing food for themselves and their dependents and that they were not completely worthless'. This 'moral economy of survival' (Prince 2012) was going to be changed by the Global Fund project, according to Bashir. The families of HIV-positive people and AIDS patients would not take any interest in keeping those affected alive, as they would become *nakara* for them once again. He argued that 'once the family members have to spend Rs10–12,000 at once on his health, they prefer to let him die and excuse themselves by

saying, "his time had come'". However, these deaths could be prevented if 'civil society treated them as humans, and tried to save them', he said.

Giving a contrast between 'civil society' and an HIV-positive person's own family, Bashir said: 'we have no greed, but his family does'. He used the English word 'civil society' and the pronoun 'we' whilst referring to himself, his CBO, other non-governmental organizations and donors—the 'community' of experts. At the same time, he was part of another 'community'—the PLHIV, whom he sought to empower by passing them handouts. 'Civil society' was thus the saviour, whereas the family members of a dying AIDS patient were greedy, or at the very least, fed up of caring for him or her. Like this, the body of the HIV-positive individual became a site for claims by 'stakeholders'. Bashir and Kiran held a unique position regarding these claims. As activists, they represented 'civil society', and as HIV-positive persons, they represented the collective 'body' of PLHIV in the country. As leaders of PLHIV, they held a claim on those HIV-positive individuals who had, they said, become *nakara* for their own family members. They salvaged those HIV-positive bodies by uniting them with the PLHIV community through CBO membership.

'Making an NGO is not a big deal in itself', said Bashir, sharing with me his scepticism about the new generation of CBO leaders. 'It's more about understanding NGOs, their philosophy, their whole purpose, what services should be provided, what is all the money about, how to use all this money. These are more important things'. He declared: 'you won't find people like us amongst those who were diagnosed after 2005. If you think you will find a Bashir amongst them, I can guarantee you won't'. This was because the new AIDS activists had not seen the hardship and human rights abuses that Bashir and Kiran had survived in the early years of HIV/AIDS in Pakistan. These newly diagnosed activists, according to Bashir, regarded AIDS as just like another disease for which doctors prescribed medicine, in this case free of cost. Bashir had lived a moment of extreme stigma facing his own imminent death (Chap. 6), which many others diagnosed after him did not have to. The amount of suffering he had gone through over these years was unmatched.

The PLHIV 'Community'

'The day they have a high-profile and educated person in their ranks, they will take over everything from us. Our work will be finished. To be honest, this is all a business', sighed Samiullah, the HIV/AIDS Focal Person at Rescue Corps, as he spoke about AIDS activists in the country. Rescue Corps was the main donor of Shining Star. Apart from their own CBOs, no national or international organization employed HIV-positive people in Pakistan, except the NACP and UNAIDS, both of which employed one each (see Qureshi 2015 for a case study of the HIV-positive representative at the NACP). A dispute was often played out between activists and experts, along lines of 'us' and 'them', which distinguished between those who were HIV positive and those who were not. The PLHIV often blamed the non-HIV positive experts for 'eating' all the money that they received in their name, whereas the experts blamed PLHIV like Bashir and Kiran for their lack of 'capacity', their habit of 'compromising the aid impact' for petty personal gains, and for the in-fighting amongst CBOs. Samiullah complained that PLHIV leaders not only lacked 'capacity', but used the idea of 'capacity' in curious ways. They insisted on being selected by international NGOs, as deserving local partners, in projects like the Global Fund's, especially when they believed their CBOs had sufficient 'capacity' to carry out certain tasks on the ground. On the other hand, if they could not prove their 'capacity', they still insisted on selection because they claimed that, since the project money was for PLHIV, it made sense to invest it in building their capacities. Some even threatened of dire consequences if the international NGOs did not 'take them onboard'. Samiullah shared a story about how a woman had once come to him and claimed that she had 20 HIV-positive women, whom she wanted to organize into a CBO, and insisted that Rescue Corps give her money from its HIV/AIDS funds to help her set it up. Otherwise, she said, she would go to the media and tell them that nobody cared for these 20 women. Samiullah had advised her to register these 20 women with one of the existing CBOs. 'But these 20 are mine', she replied. 'Why should I give them to someone else?' Such was his cynicism about the extent of the 'us' and 'them' thinking within the community of PLHIV, and its

effects on undermining the political unity of HIV-positive people. Yet, he feared that the day an educated PLHIV emerged on the scene, his own job would be in danger.

The boundaries of 'them' and 'us' and the allegations of 'eating' all the money, and of self-destructive habits of leg-pulling and in-fighting, were enacted not only between those who had HIV and those who did not. Indeed, between HIV-positive people, these boundaries and allegations were enacted out on ethnic, regional and religious lines. Rasool Baksh, for example, an HIV-positive person I interviewed from Southern Punjab, complained to me that

> The upper Punjab and Lahore-based people like Kiran and Bashir, who have dominated everything for such a long time, should now be replaced. New people should come up. Someone from South Punjab should come to the forefront, so that the world knows that there are some problems here too.

When he urged upon the 'world'—the international donors—to pay attention to the plight of HIV-positive people in areas he claimed were ignored by current leaders of CBOs, Rasool Baksh was appealing against his own 'community' members. He said this to me at a time when a movement for autonomy was growing in South Punjab—a movement fanned by the debates about provincial autonomy surrounding the upcoming devolution plan—which complained of its marginalization by wealthy and politically powerful Lahore (see Langah 2012 on ethno-nationalism in South Punjab, and Chap. 5 on devolution). At the same time, though, Rasool Baksh was also a member of one of these CBOs. Should his engagement with, and challenge of, other leaders be seen as an act of 'becoming political' (Rose and Novas 2008), and therefore a sign of the emergence of a 'deep democracy' (Appadurai 2001) amongst PLHIV, as well as of a global 'biological citizenship' wherein—according to Rabinow and Rose (2006)—'patients' groups and individuals increasingly define their *citizenship* in terms of their rights (and obligations) to life, health and cure' (p. 202)? Perhaps not. Rasool Baksh continued to complain:

> When they [the CBOs] behave the way they do, one can't keep going to them [for 'care and support'] again and again if one has any self-respect.

> Pain and suffering (*dukh aur takleef*) are part of life. We were not like this all our lives. Before this disease struck, we were also kings of our time (*ham bhi waqt kay badshah the*). A person with some self-respect left in him cannot spread his hands before others all the time. These NGOs should be shut down. They have no right to exist.

For Rasool Baksh, as well as for many others who 'came out' and registered with CBOs of PLHIV, their membership was not, it seems, an affirmation of some kind of political solidarity on the basis of their biological condition. Neither did they define their citizenship in terms of access to antiretroviral therapy—'therapeutic citizenship' (Nguyen 2010). For them, CBOs that could not relay donor-financed 'care and support' to them had no right to exist. For them, these CBOs had no other purpose but to serve as an 'organizational conduit' (Lyttleton et al. 2007, p. 49) in the delivery of food, medicine and cash support. Kalofonos (2010) has documented a similar situation of conflict and resentment in Mozambique where, as a consequence of inadequate attention to hunger in HIV/AIDS-related interventions, 'a pathological form of sociality' emerged, which 'is characterised by intense competition and disillusionment' (p. 375). Drawing from Scheper-Hughes (2004), he terms it 'biosociopathy' in contradistinction to 'biosociality', a term that resonates here as I elaborate below.

The Association of PLHIV

Like many other 'travelling rationalities' (Mosse 2011) in global health and development, the idea of a PLHIV Association was transplanted into Pakistan to bring together and empower HIV-positive people. It had wide support from all stakeholders, including the government. The advisory board of the Association included many international NGOs and bilateral aid agencies as a gesture of their approval and support. Nevertheless, it strikes me that the reification of this transnational category ignored the historical antecedents and the roots of AIDS activism in Pakistan, which leaves a question mark over the transferability of global concepts to local contexts. When they were formed, PLHIV organizations

gained publicity on the international stage for their efforts to resist marginalization, work for destigmatization, representation and community building through collective action (Kielmann and Cataldo 2010). For example, the first PLHIV association in France was described as a 'mediator' between PLHIV and wider society, whose 'active patients' created a form of 'involvement' that they successfully claimed was in the public interest (Barbot 2006).

UNAIDS set up the Association in Pakistan in 2008, a decade after the first CBO of HIV-positive people had been established in the country, during which time a number of AIDS activists and organizations had sprung up. Thousands of individuals were registered with the government's antiretroviral therapy centres, but the number of CBO members was not more than a few hundred: in other words, very few were willing to publically affirm their HIV status by becoming members of one of these CBOs. The underlying rationale for the Association was to strengthen civil society through community participation. Bashir and Kiran were the obvious choices for President and General Secretary, whilst their protégés were selected as members of the Executive Board. Being the 'brain child' of the UNAIDS Country Coordinator, the Association won widespread support and some well-funded projects from the government and the international donors. These projects were carried out in partnership with Bashir and Kiran's CBOs, which managed to save considerably on overheads and service charges. At the same time, the participation of these two CBO leaders in high-level policy forums, and their costly international trips, were legitimated by their roles as leaders of the Association representing the entire body of PLHIV in the country, not just their own factions or CBOs. The prominence of these two formerly underprivileged individuals was shaken, however, when a US-returned, university-educated HIV-positive individual, Mahmood, joined the Association and tried to 'democratize' it.

Mahmood was born and brought up in the United States, where he was educated in computer science. He had worked in the corporate sector and lived a jovial life, as he put it, which consisted of 'partying all the time, alcohol, sex, sometimes cocaine, waking up at ten in the morning and not knowing whose house I was in'. This was in the late 1990s, when he thought he would not get infected with HIV because it was 'a disease

of Mexicans and black people … [At least], that's what we saw on the TV', he said. He was diagnosed in 1999. According to him, his family had to fight a legal battle to keep him in the country. 'If you were not of American origin, you were prosecuted for being HIV positive'. This assertion was important to his narrative of how he ended up in Pakistan, the country of his forefathers. He lost the legal battle in 2004, and to avoid a forceful deportation, he came to Pakistan, where he had never been before. 'It was a shock to come here. Pakistan was a foreign country for me … a land of men with turbans, long beards, and missiles'. These were the images he had been exposed to by the same media that had led him to believe that HIV was a disease of Mexicans and blacks.

After settling in Pakistan, Mahmood flew frequently to Bangkok for chemotherapy and radiation treatment. As his health improved, he felt the need to keep himself busy in order to avoid slipping back into depression. He contacted a Local Coordinator of Bashir's CBO, who received him with great enthusiasm. Since he was educated, US-returned, and belonged to the elite, the Coordinator regarded him as an asset for the CBO. In her excitement, she even introduced him to UNAIDS officials without first consulting Bashir. In retrospect, Bashir told me that introducing Mahmood to UNAIDS directly had been a mistake for which the whole HIV/AIDS sector had been forced to pay. An even greater mistake, from his point view, occurred when UNAIDS selected Mahmood for the position of the National Coordinator of the Association. Bashir had vehemently opposed this selection because he believed that he had sensed some dissimulation in Mahmood. He told me:

> That boy told us in his interview that he came from a rich family, so he did not need any money and he wanted only to serve people. Yet, when he was told about his selection, he didn't hesitate to demand a big salary on the very same evening.

Bashir's reservations were not entertained by UNAIDS. It was thus that Mahmood was tasked with bringing to life the Association that had, as he put it to me, 'existed on paper only'. Mahmood set out to revitalize it by changing the status quo, namely by replacing the unelected Executive Board comprising of Bashir, Kiran and their 'cronies', as he called them,

with a new Executive Board elected by the entire body of PLHIV in the country.

Bashir and Kiran did not reject the notion of introducing democracy to the Association, but they proposed that the Executive Board should be elected by a select group of CBO nominees, not by every single HIV-positive person registered in the country. 'After all, who has got the numbers? It's either my CBO or Bashir's', said Kiran, asserting that the CBOs were legitimate representative bodies of people registered as HIV positive (notwithstanding the fact that many had chosen not to register with either of these CBOs, as discussed in Chap. 7). The 'numbers' that Kiran referred to were not merely a measure of quantity but had a performative value. As Maurer (2006) observes, 'quantity is simultaneously a quality of things' (p. 25). Bashir and Kiran's proposal was not acceptable to Mahmood, who was looking for ways to break the monopoly of their CBOs over the PLHIV sector as a whole, and the Association's in particular. On his insistence, UNAIDS, who had found a new ally in Mahmood, set up an Election Commission comprising of members from the NACP and the Provincial AIDS Control Programmes, donor agencies, and international NGOs. Rules were introduced to bar Bashir and Kiran from contesting the elections on the pretext that, in order to avoid clashes of interest between CBOs and the Association, no one holding office in a CBO should simultaneously be a member of Association's Executive Board. The Election Commission travelled to all four provincial capitals. It obtained the lists of HIV-positive people from the government's anti-retroviral therapy centres to use them as voter lists, it held HIV awareness seminars in local hotels, and put out ballot boxes urging participants to cast their votes. Bashir and Kiran did not go to these seminars but they did not stop their CBO members from attending them or casting their votes either.

Although some were voted for in a ballot, most of the UNAIDS-backed candidates were elected unopposed. For Mahmood, the election accomplished the ousting of Bashir and Kiran from the Association. For Bashir, it was nothing more than a sham—'a gathering of animals', he told me afterwards. Kiran called the new Executive Board a *kitchri* (a dog's breakfast/mess). 'They have no funding and are pulling each others' legs'; 'this table was built today [talking metaphorically about the

Association] and you insist on having 100 people around it, also today. We do not accept that. Why? Because it takes time! And, if we start pulling each others' legs everything will finish'. It would take time, according to Kiran, 'to break the monopoly of a few supporters of the Association' in UNAIDS and other international organizations, because there was no *itefaq* (unity) and *yakjehti* (agreement) in the ranks of the PLHIV 'community'. Unless they united amongst themselves, she thought, their survival would remain under threat from 'agencies', which had a vested interested in keeping them divided. 'When we unite we will become a pressure group and when we become a pressure group … then….'. She stopped there. I tried to probe who exactly she meant by the English word 'agencies' and whether UNAIDS, which was like a foster parent of the Association, was also one of them, even though it championed 'community building' by bringing PLHIV together under the principle of Greater Involvement of People living with AIDS (UNAIDS 1999, 2007). Kiran laughed away my question by saying that she would rather 'maintain a diplomatic silence on that'.

Ethnographies have shown that, in other contexts, dependence on donor funding and patronage politics have led to factionalism and in-fighting amongst HIV-positive people. For example, the PLHIV sectors in eastern and southern African countries have been described as 'heterogeneous and fragmented', and fraught with 'competitive factions scrambling for favours' (Beckmann and Bujra 2010, p. 1061; see Kalofonos 2010; Boesten 2011; Marsland 2012; Prince 2012; Whyte et al. 2013). However, in the case of the Association in Pakistan, it is clear that both camps espoused a sense of community of HIV-positive people, the importance of numbers, the ideal of democracy and a desire to break down monopolies.

The boundaries of this 'community' were clear. Anyone who was HIV positive was a member, regardless of whether they had 'come out' by registering with a CBO. There was a widespread belief that, although the majority of the registered CBO members were ex-migrants, their wives/widows and children, a large number were sex workers, *hijrae*, injecting drug users and men who have sex with men, who were 'hidden'. As for the numbers of those who did come out, there was no question that Bashir and Kiran had the most under their wings. These two CBO leaders could not be dislodged from their privileged position of power and

influence in the Association, even if they had been driven out from the Executive Board. 'Democracy' was a great ideal, but it was hard to practise: there was no real voting in the elections that Mahmood, in his own words, 'imposed upon the Association' with the help of UNAIDS. As for the question of monopoly, Bashir and Kiran did not appreciate the logic of why they should have to give up their leadership for appropriation by others, especially Mahmood, who they saw as an ambitious upstart, and as a protégé of powerful vested interests outside the PLHIV 'community'. Although they were ousted from the Executive Board, the old guard did not let go of their status as the pioneers, and never laid aside their claim on the Association. Kiran even warned against the attempts, as she saw them, to weaken the 'community'. Commenting on the close liaison between Mahmood and some UN officials, she told me: 'as long as non-PLHIV actors have a stake in the Association, there will always remain a *jhagra* (dispute)'. Soon after the elections, Mahmood left the Association to set up his own CBO. Even he regretted that the newly elected members of the Executive Board had failed to live up to his expectations, and that they survived merely on the 'crumbs fed to them by UNAIDS'.

Revisiting the PLHIV 'Community'

Mahmood was seen as a competitor by both Bashir and Kiran. Unlike them, however, he was from the elite, and according to Bashir, this made him unsuitable for the position of the National Coordinator of the Association, because 'he had seen nothing at the gross-root level; he was nothing, of no good repute, and no one knew him'. By comparison, Bashir observed:

> We have been here for so long but we didn't have as many connections as he developed. During his time in the Association, Mahmood made personal connections, hosted dinners, provided his car to foreign visitors for site-seeing. He was taking Rs50,000 (US$650) in salary but did nothing for the Association. He went on foreign trips every couple of months and was minting money from that too. He caused so much damage to the Association but could not raise even ten rupees for it.

Equally, Mahmood despised Bashir for his 'incompetence' and 'corruption', and for advancing the interests of his own CBO at the expense of the Association. According to Mahmood, 'even the UN agencies were frustrated with Bashir but they maintained a diplomatic stance'. Bashir accused UNAIDS for not letting him expose Mahmood: 'we tried to get rid of him many times but we were always told by UNAIDS not to take any action because he could embarrass everyone'. Before Mahmood arrived on the scene, Bashir had been the undisputed leader of the PLHIV sector, but afterwards, mistrust, as he saw it, began to grow against him. Bashir alleged that some people in UNAIDS had always wanted to 'keep everything to themselves' and that they had now found a collaborator to 'hijack' the whole sector. On the other hand, now getting personal, Mahmood said, caustically, that Bashir was 'lucky to have this disease. Otherwise, he would still be fixing punctures in his bicycle repair shop'.

Mahmood not only replaced the Executive Board by introducing democracy, but also shifted the balance of power in the Association from the Board to the post of the National Coordinator, which he held. Strangely enough, he justified this shift by arguing that 'you have to have a board as per the bylaws of the Association, but members of such boards are always different people with different ideas and backgrounds. There is too much conflict'.

Therefore, he thought that, if the Association was to become a successful organization, 'you have to entrust all powers in one person'—namely him, as the National Coordinator. From the man who championed 'breaking monopolies' and bringing 'democracy' to the Association, this sounded ironic.

In retrospect, Mahmood said, 'the idea was good but the time was not right' for setting up the Association. For him, notwithstanding the fact that both had led their own CBOs for many years, both Bashir and Kiran were incapable of leading HIV-positive people because they were uneducated, corrupt and could not speak English. Referring to the 'mistake' that UNAIDS had made by setting up the Association at a 'wrong time', he continued: 'you need to build people's capacity first and then you give them an organization'. For their part, Bashir and Kiran argued that it was not yet 'the right time' to introduce electoral democracy to the Association. As noted before, Bashir described the elections as a 'gathering of animals'

because he felt that PHLIV were incapable of choosing their leaders. Thus the field of AIDS activism was characterized by a multitude of claims about the 'right time', the 'right capacities' and the 'right people' for organizing HIV-positive individuals into a 'community'.

The AIDS activists at the core of the Association had more in common than HIV. The circumstances of their lives might have been very different, but Bashir, Kiran and Mahmood all had claims on the leadership of PLHIV. All three exhibited contempt for those HIV-positive people whom they believed to be less qualified than them. All three appealed to their own capacities and judgement about when would be the 'right time'. And all three built narratives of authenticity for themselves and narratives of suspicion for each other. They knew well which circumstances of their lives were most suitable for advancing those narratives. For Mahmood, these were his education, his international exposure, his ability to transact in the language of the 'interpretive community' (Mosse 2005, p. 9) of HIV/AIDS, to build personal friendships with donors, to hold intellectual discussions with the expatriate staff of the UN and international NGOs, to churn out well-written, well-designed reports, and above all his liberal credentials as the harbinger of democracy. Bashir's narrative centred on his status as the pioneer of AIDS activism—as the one who had to face the stigma and suffer the consequences of being discriminated against as both HIV positive and Christian, at a time when no one believed that HIV could exist in the Islamic Republic of Pakistan. He was the one who had established AIDS activism in the country, in the face of stiff opposition from moral vigilantes. He was the one who had 'come out' in front of television cameras to declare his HIV status, thus becoming the 'first drop' of hope for other HIV-positive people. His was the first CBO to set a model of how to care for HIV-positive people. He was also the one who had discovered the outbreaks of the HIV epidemic in towns and cities across the country by carrying out extensive testing amongst the 'general population' (Chap. 7). Kiran built her narrative as an innocent victim of HIV, who was widowed in her youth and thrown out of her family—an individual pushed into the open from the comfort of her house to earn a living for herself and her small children, who was forced to work with men in a gender insensitive, hostile society. Finally, all three of them were part of the networks of patronage within donor

agencies and the government, who built vertical alliances and outdid each other, but also carried, at the same time, the notions of 'participation', 'democracy' and 'community' as the imperatives of international aid.

Amid these competing claims to authenticity, the multiplicity of truths, the game of numbers, the diversity of actors, the privileges of class, gender, religion and moral authority, and the networks of power and patronage, could the field of AIDS activism be straight-jacketed into models of politics in the image of a liberal democracy? Like in Africa, HIV/AIDS in Pakistan was 'prolifically productive' as it 'gave birth to significant forms of sociality and signification, of enterprise and activism, both negative and positive' (Comaroff 2007, p. 203).

Conclusion

Following the internationally acclaimed GIPA principle, the PLHIV Association was an attempt to bring together HIV-positive people into a 'community' for their empowerment. But what this chapter has shown is that the notion of 'community'—and, its derivatives like 'community participation' and 'empowerment'—masks issues of inequality and questions of power, whilst the discourse of strengthening 'civil society' is a veil for vested interests. As Osella and Osella (2012) have noted in the context of Gulf migration, it is difficult to delineate the 'civil' from the 'uncivil' in migrant networks where the same agents play the roles of 'social workers' and 'exploiting hustlers' in different moments. It is the nature of these moments, as well as the 'other agents and particular assemblages of circumstances and actors involved', that give 'flavour to the events' (p. 130). In the field of AIDS activism, too, it is hard to establish whether implementation of the Greater Involvement of People living with AIDS principle—whether through liberal democratic principles, patronage or charismatic leadership—necessarily leads to the strengthening of 'civil society', or even whether its enactment is a 'civil' act in itself.

The attempts of the transnational HIV/AIDS assemblage to 'empower' PLHIV succeeded in accentuating cleavages of class, gender, religion and ethnicity amongst the activists. The donor money invested in setting up

and supporting the Association ended up fostering rivalry and factionalism amongst AIDS activists. In the game of maximizing headcounts, in order to qualify for more funds, they turned their CBO members into subjects of their politics—a politics that encompassed biopolitics, but also went beyond the politics of life. They guarded their 'numbers' against death by 'marshalling them to treatment' (Beckmann and Bujra 2010) and by relaying handouts in donor-supported programmes (Marsland 2012; Prince 2012; Whyte et al. 2013); in addition, they resisted any loss to rival CBOs, by alternating threats with incentives. Kalofonos (2010) has called this 'biosociopathy'. He argues for a 'broad view of social and economic citizenship' in place of the view promoted by interventions that seek to 'separate people into categories, who in this atmosphere of scarcity and competition turn on each other' (p. 375), an argument which the Pakistani case calls for too.

At the end of Chap. 7, I asked whether their shared biological condition and access to the transnational HIV/AIDS assemblage could foster belongingness and solidarity amongst HIV-positive people in Pakistan. Although courageous activist work has been accomplished in the country, the answer appears to be 'no', at least for the present. As was seen earlier in the field of HIV/AIDS prevention, we can see AIDS activism turning into a competitive 'market of dispossession' (Elyachar 2005) under the influence of new global health funding regimes. Such policies, my material suggests, may serve as a means of turning AIDS activism into an 'extractive enclave' (Ferguson 2005). In the name of democracy, they promote a politics of numbers in order to build 'creative alliances', and to 'occupy new spaces' (West 2006), in the 'exceptional' field of AIDS (Smith and Whiteside 2010; Benton 2015).

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9

Conclusion

This book has explored the impacts of neoliberal funding regimes on the HIV/AIDS sector of Pakistan. As I detailed in Chap. 2, the 'scale-up' (Kenworthy and Parker 2014) of Pakistan's HIV/AIDS response was initiated by the World Bank amid concerns about the threat of the epidemic regionally and the need to match commitment and spending levels in Pakistan with those in neighbouring India and Bangladesh. Many in the public health community in Pakistan were sceptical of the World Bank's offer because of the lack of epidemiological evidence to suggest HIV/AIDS' presence, especially when compared with hepatitis B and C, a rocketing epidemic of which was affecting up to 30% of the adult population. Yet the 'soft loan' was driven through with the enthusiasm of the Ministry of Finance, if not the Ministry of Health. A new NACP manager, who would be receptive to the World Bank's guidance, was appointed to administrate the Enhanced Program. The World Bank's sponsorship did more than increase the amount of funds available for HIV/AIDS prevention and treatment. It also introduced policies of government–NGO partnership, output-based contracting-out, and of hiring a management consultancy firm to build the government's capacity to manage the contracts. The Global Fund to Fight AIDS, Tuberculosis and Malaria, which succeeded the World Bank as the major donor for HIV/AIDS

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prevention in Pakistan, took forward the policy of public–private partnership, but with far more elaborate reporting mechanisms to monitor targets and ensure the 'condition precedents' were met for the releases of funds, which came in tranches. The Global Fund also insisted on a participatory model of governance, involving 'civil society' partners at all levels—from the vetting and submitting of applications to overseeing project implementation.

Taking up Lewis and Mosse's arguments (2006), I have shown how these new funding regimes did not simply 'arrive', but were produced by intermediary actors, including bureaucrats like Dr Nadir, the staff of UN agencies, bilateral donors and international NGOs, NGO bosses like Kamal, AIDS activists-turned-CBO dons like Bashir and Kiran, committed volunteers, and the policy subjects themselves, like HIV-positive CBO member Rasool Baksh from Southern Punjab. I have brought out the complexity of their interpretations and of the balancing acts that they performed as they sifted between opportunities for personal advantage and for disadvantage of their opponents, yet also considered the greater good. I have shown how intermediary actors translate global policy under the influence of their own ambitions, interests and values, and also how changes in global policy regimes change people at the social and subjective level.

Chap. 3, an ethnography of the 'mission' sent by the World Bank to evaluate the Enhanced Program, offered ethnographic descriptions of the hot drink and *samosa*-fuelled meetings and interviews out of which three senior World Bank staff members were supposed to see through the fog of prostrations from 'stakeholders', tune in a narrative and pronounce project success or failure. The World Bank's verdict—on which, as we saw, many hopes for future funding were pinned—was 'moderately unsatisfactory' for both the World Bank and the borrower. This was the judgement according to the technical criteria of the World Bank. But what if we take a more anthropological view? Biehl and Petryna (2013), advancing the view that 'people come first', contend that 'the focus must be on the results obtained by the patients (measured in survival rates and in the degree and sustainability of recovery) and *not* on a program's success (measured, for example, by its compliance with standardized guidelines or by the number of drugs distributed)' (p. 9; see also Adams 2016).

If such criteria had been followed, the verdict might have been considerably more damning. The latest data available at the time of writing, from a report from the Ministry of National Health Services, Regulation and Coordination, shows that there was a sharp rise in HIV prevalence in Pakistan's four main 'high-risk groups' between 2005 and 2017. The highest increase is observed in the injecting drug users, amongst whom HIV prevalence in 2016–2017 was reported at 38.4% compared to an average 10.8% in 2005. The second highest rise was amongst transgender (*hijra*) sex workers, amongst whom HIV prevalence in 2016–2017 stood at 7.6% compared with 0.8% in 2005. Meanwhile, the prevalence rate amongst male sex workers, which was 0% in 2005, is now reported at 5.2%, and amongst female sex workers, it has increased from 0.4% in 2005 to 2.2% in 2016–2017 (Wasif 2017). Similar disturbing results are given in the latest report from the NACP (NACP 2014, pp. 16–17). This leaves Pakistan amongst only four countries in Asia—along with Indonesia, Malaysia and the Philippines—where the number of new HIV infections is higher each year than the previous year, with an estimated 15,606 new infections in 2014 alone (Bergenstrom et al. 2015). A report from the National Manager of the NACP notes that the situation in Pakistan is now so grave that the Global Fund has had to increase its grant from US$10 million to US$34 million between 2014 and 2017. Pakistan's HIV/AIDS response is now entirely dependent on the Global Fund (Wasif 2017). Post-devolution, some of the provincial governments have failed to devote public funds to preventing the advance of this still-taboo disease (Ullah 2016).

Concerning the global 'scale-up' decade, Kenworthy and Parker (2014) comment that

> Writing during what appears to be the twilight hours of one of the most vast and resource-intensive health initiatives in world history … [offers] an opportunity to reflect on the politics of a passing era, while at the same time recognizing that HIV scale-up has institutionalized political dynamics that will long outlive its period of prominence. (p. 4)

In Pakistan, what did the donor-instigated 'scale-up' do to the country's response to HIV/AIDS? What do the 'diagnostic events' I have detailed

here, as Falk Moore (1987, 2006) calls them, reveal about 'current history'—the future that the present of my fieldwork was producing? My ethnography highlights profound changes in three areas: in the state bureaucracy; in the keeping of public goods; and in 'civil society', which is normatively envisaged as a counter-balance to the state. In Chap. 3, I argued that the World Bank's policy of public–private partnership resulted in a project of 'accumulation by dispossession' (Harvey 2007) on a grand scale. The policy of public–private partnership deprived the Pakistani people of an evolving, sustainable public response to the epidemic and undermined the claims on the state that members of the criminalized 'risk populations' might otherwise have pursued. The flexible bureaucracy of the Enhanced Program, which shelved rules and regulations in the name of 'efficiency', gave occasion to collusion between Naya Sewaira, the largest NGO contracted under the Enhanced Program, the management consultancy firm, and AIDS control official Dr Nawazish, who dispossessed future generations of the country. After all, the money borrowed as a 'soft loan' will eventually have to be repaid by the taxpayers.

The rationale for subcontracting HIV/AIDS prevention services to NGOs is that, especially in such punitive legal contexts as exist in Pakistan, NGOs will enjoy a 'comparative advantage' in accessing 'marginalized sub-populations' (NACP 2007, p. 10). Yet NGOs like Naya Sewaira prospered under the Enhanced Program, not necessarily due to their privileged access to the 'risk populations', but because the new aid regime advantaged those NGO bosses who—benefiting from the privileges of their class and educational backgrounds—could perform audit and reporting mechanisms with their 'eyes closed', as Kamal boasted to me in his interview, whilst projecting an image of unparalleled 'insider' access to the targets of its intervention. In all of this, I have endorsed Elyachar's (2002, 2005, 2012) critique of how NGOs may capitalize upon the social capital of marginalized groups and turn them into a resource for private gain. The health bureaucracy, meanwhile, attempted to stand up for the 'utopian ideals' (Bear and Mathur 2015, p. 21) implicit in the covenant between the citizen and the state, and contested the terms of the contracts imposed by the World Bank. When Naya Sewaira seemed to be getting 'too big for its boots', the government of Punjab asserted its 'sovereign responsibility'—its right to serve and administrate

(Brown 2015). Yet it appears that these 'utopian ideals' are another commons that neoliberal aid regimes threaten to expropriate and replace with the 'new orienting values of fiscal discipline, marketization, consensus, transparency and decentralization' (Bear and Mathur 2015, p. 20).

In Chap. 4 I suggested—departing from familiar ethnographic descriptions of the Pakistani bureaucracy that root it in the traditional *kaghazi raj* government of paper—that the influx of unprecedented funds into HIV/AIDS prevention dramatically scaled-up the expectations of the country's health bureaucrats, whilst the neoliberal policies imposed by the World Bank turned these bureaucrats into 'enterprising selves' (Miller and Rose 2006; Rose 1992, 1999). The 'calculatingly charismatic' mode of working replaced the formal rules, regulations and procedures of bureaucracy with informal networks, and an emphasis on individual initiative and go-getting (du Gay 1994). As Du Gay (1994) has observed, the 'struggle for personal power' (p. 651) is fundamental to entrepreneurial conduct in Western bureaucracies. Likewise, within the NACP, a similar struggle gave rise to new forms of patron–client relations, which exploited the opportunities for subcontracting that became abundant. Yet I have also shown that the NACP staff were more than simple opportunists. They may have carried out their official work as personal enterprise and, in some cases, made a small fortune from the 'stealthy violence' (Li 2010, p. 67) of diverting aid money into their own pockets. But, no matter how secondary it was to the strong element of personal advancement, they also sought to align their personal interests with those of the greater good. Recall the logic that Dr Nadir expressed in Chap. 4: 'two plus two plus two equals four; but one plus three also equals four; and zero plus four is four as well'; what mattered at the end of the day was not who got the bigger or smaller share of the aid money, but, as Dr Nadir put it, that 'ultimately the money comes to Pakistan and the country benefits'. As I discussed in Chap. 5, the threatened shutdown of the NACP, after the World Bank's withdrawal of funding, which coincided with the devolution of the Ministry of Health under the 18th Constitutional Amendment, made the question of the future of HIV/AIDS prevention and treatment in the country even more urgent. As a result of these dramatic changes—which I suggested, following Sennett (2006), reflect the vulnerability of 'flexible' organizations to crisis—

Pakistan's national HIV/AIDS bureaucracy was significantly whittled down, as it was reduced to sharing its role as Co-Principal Recipient of the Global Fund grant with Naya Sewaira, in a process that Chap. 6 showed bristled with politics. The Global Fund's objective of fostering broad-based participation in HIV/AIDS governance was turned on its head, as the boundaries between state and civil society were used to political ends, rather than dissolved, by its emphasis on 'participation' and 'capacity-building'. As feared by the opponents of devolution, the prospects for future public spending on HIV/AIDS prevention have been left to the political expediencies of the country's provincial governments. Subsequently, in Khyber-Pakhtunkhwa, if not in Balochistan, it seems that HIV/AIDS has indeed been judged too distasteful to commit public money towards combatting it (Ullah 2016). Chapters 6, 7 and 8 detailed the changes brought to 'civil society' by the new aid regimes. 'Civil society' is idealized in liberal thought as 'a counterbalance [to] keep the state accountable and effective' (Lewis 2001, p. 2). But NGOs in the HIV/AIDS sector in Pakistan, like other NGOs in the country (Bano 2008a, b), defy characterization in terms of voluntary associationizm. The influx of donor money produced 'Frankenstein's monsters' (Kapilashrami 2010) like the Pakistan AIDS Alert Group, discussed in Chap. 6, which moved from HIV/AIDS to flood relief and onwards, perhaps, onto eye disease or mosquito nets. Policies of subcontracting to NGOs turned HIV/AIDS prevention and care into a competitive market. The administration of contracts was also, I have shown, an intensely politicized field, with much depending on the connections and networks of the NGOs. I documented, too, the emergence of fake NGOs in the HIV/AIDS sector, or, as an international NGO worker I quoted in Chap. 6 disarmingly called them, NGOs that 'don't exist on the ground'. Turning to AIDS activism, my findings are less optimistic than those of Biehl (2007) or Nguyen (2010) on the prospects for the emergence of 'pharmaceutical' or 'therapeutic citizenship'. The organizations of HIV-positive people were divided by a 'multitude of oppressions' (Hamar 1996) deriving from their differences of class, gender, religion and ethnicity. They were also divided by the numbers game, by which they were paid per capita for the registration of new members. Whilst examples of courageous AIDS activism were by no means absent, the organizations of HIV-positive people

in Pakistan were largely limited to 'marshalling' PHLIV to treatment (Beckmann and Bujra 2010) and to relaying handouts in donor-supported programmes (Kalofonos 2010; Marsland 2012; Prince 2012; Whyte et al. 2013). Finally, the 'exceptional' situation of a HIV outbreak provided a case for studying whether, as Nguyen (2010) proposes, HIV/AIDS care 'escapes the control' of the state and comes to be lodged in a 'complex assemblage of institutions'—an 'alphabet soup of acronyms and programs' wherein supranational organizations may work directly with local NGOs and bypass the state (pp. 176–177). In the HIV outbreak in Gujrat, by contrast, I have suggested that civil society, in the form of Shining Star, acquired not a permanent form of 'therapeutic sovereignty' (Nguyen 2010), but a situational leverage, which the local health department, in the long-term, even attempted to wrest back. I have endorsed Brown's (2015) argument about the need to rethink the taken-for-granted 'failing or overwhelmed state' of humanitarian intervention as well as the 'shrinking, retreating' neoliberal state (p. 351). Whilst global policy models may seek to bypass the state, it is not by any means irrelevant.

In the last few pages of this book, I return to the broader questions with which I began, concerning the dominant policy model of government–NGO partnership in the HIV/AIDS sector and in global health more broadly (Biehl and Petryna 2013; Farmer et al. 2013; Adams 2016). As I discussed in the introduction, the rationale for this policy is that NGOs are supposed to do better at HIV/AIDS prevention than governments. Relatedly, there are assumptions that prevention services are best provided by people who are themselves members of the affected groups, and that PLHIV must be involved in planning programmes and delivering services. Pisani (2008) calls them 'sacred cows' (pp. 161, 174). But as the global HIV epidemic evolves, are these assumptions fair? My findings from Pakistan indicate that, whilst the epidemic has continued to grow unabated amongst the 'risk populations', the outsourcing of HIV/AIDS prevention to NGOs has resulted in a quagmire of problems: the marketization of the field that has undermined the voluntarism of 'civil society' has produced 'Frankenstein's monsters' (Kapilashrami 2010) and, even worse, NGOs that 'don't exist on the ground'. I have also documented numerous cases of NGOs that have been implicated in fraud and embezzlement. Meanwhile, the NGOs and activist forums, supported by

donor funds, have failed to mobilize against the country's discriminatory legal frameworks and thus have failed to live up to the liberal conception of 'civil society' as a 'counter-balance to the state' (Lewis 2001, p. 2). These problems have been documented more widely in the literature on government–civil society relationships. In Brazil, World Bank funding seems to have 'encouraged NGOs to pressure the Ministry of Health for policy reforms' (Gómez and Harris 2016, p. 59), whilst in China, funding from the World Bank and the Global Fund 'also led to the emergence of fake NGOs, intensive competition and lack of co-operation between them' (p. 61). Gómez and Harris warn similarly that, in India, 'a number of NGOs have been implicated in fraud, and some actually contributed to the stigma faced by these groups' (p. 63).

What about Gómez and Harris's (2016) argument that in countries with punitive legal frameworks, like India, or in countries with heavy-handed, authoritarian governments, like China, government–NGO partnership may be the only way to proceed? Of India, a country sharing the British colonial legal legacy with Pakistan, their verdict on the role of NGOs is largely positive; at the end of the day, 'NGOs provided the state with a venue and opportunities to meet and work with high-risk populations engaged in illegal activity' (p. 62). A similar opinion about NGOs in Pakistan was voiced by Kamal, the Chief Executive of Naya Sewaira, whom I quoted at the beginning of this book. The government's hands are tied; if it tried to take over the provision of HIV/AIDS prevention services from NGOs, drug users would be right to be wary. But my fieldwork leads me to be critical of this view. Is it not convenient to suggest that drug users would not be able to tell the difference between those who provide care and those who come out to handcuff them, or to claim that the members of risk populations regard all NGO outreach workers as benevolent and trustworthy, and all government officials as villains? After all, as Kamal admitted in an interview with me, many of the drug users served by his NGO preferred to register with false names and addresses.

In criticizing the policy model of government–NGO partnership, I do not wish to end without offering potential solutions. I would have been more convinced about the merits of policies of government–NGO partnership if NGOs in Pakistan had offered more encouraging examples of their mobilizing against the legal framework that jeopardizes the life

chances of the people they are supposed to serve (Mane 2004; HRW 2008; Mayhew et al. 2009). Rather than accepting the legal constraints that seemingly require governments to subcontract to NGOs, why not challenge them? In India, sexual minority activists succeeded in achieving a repeal of Section 377, the colonial-era law that criminalized the 'unnatural offence' of 'carnal intercourse against the order of nature' (Misra 2009). The suggestion might be radical, but I would like to see NGOs in the HIV/AIDS sector in Pakistan become similarly political and campaign to change the laws that criminalize the non-therapeutic use of drugs, prostitution, homosexuality and adultery. The recent campaign by *hijrae* in Pakistan for official state recognition of transgendered people as a separate gender category from men and women is a welcome step in that direction (Haider 2009; Redding 2012; Khan 2014). This kind of political mobilizing should not, furthermore, be the exclusive terrain of civil society. The NACP's spineless HIV and AIDS Prevention and Treatment Act, which only asked for protection for the NGO outreach staff engaged in HIV/AIDS prevention work—and not for the injecting drug users, sex workers, *hijrae* and men who have sex with men, who are at risk of police harassment—failed miserably; as noted in Chap. 2, it did not proceed beyond the initial vetting by the Ministry of Law. But I would like to see all of the HIV/AIDS 'stakeholders' in Pakistan get out of their air-conditioned offices and up their game.

Even in the existing legal framework, to go back to Kamal's argument that drug users would fear public health workers, and would ask, 'is he an outreach worker, or does he work for the anti-narcotics force?': are not all governments both benevolent and disciplining? Do they not have different organs to carry out those functions, and are they not viewed as such? Pisani (2008) offers the case of HIV/AIDS prevention in Thailand as a counter-example to the 'sacred cow' of outsourcing HIV/AIDS prevention to NGOs. It was the Thai government that shut down the HIV epidemic amongst commercial sex workers, not NGOs, even whilst prostitution was against the law. Pisani is a self-professed advocate for public-sector HIV/AIDS prevention programmes:

> To prevent an HIV epidemic we don't need perfect services for a few people. We need 'good enough' services for everyone who needs them…Look

> around. Who provides mediocre services to reach vast numbers of people? Governments. But can civil servants reach sex workers, drug injectors, gay guys? And can they provide them with adequate HIV prevention services? Yes. Or so the data say. (pp. 175–176)

The problems often documented with outsourcing to NGOs, and the 'accumulation by dispossession' (Harvey 2007) that occurred in Pakistan as a result of privatizing HIV/AIDS services, lead me to sympathize with this view. As Farmer (2013) rightly observes, 'no private entity can meet the whole range of interlocking needs of a system to support healthy human lives, and no NGO is capable of conferring *rights* to those in need of them' (p. xix, emphasis in the original). But, evidently, my ethnography has not provided compelling arguments about the capacities of Pakistan's public health system to take on the HIV/AIDS epidemic either. As I showed in Chaps. 3 and 4, government bureaucrats, whilst affronted by the usurping of their role by other institutions in the new funding regimes, were not only asserting their 'utopian ideals' (Bear and Mathur 2015) or their 'sovereign responsibility' (Brown 2015) in the interests of the greater good, but were also privately on the make. In Chap. 7, we glimpsed some of the intractable problems in Pakistan's public health system from the perspective of the local health department in Gujrat, where chronic underfunding undermined its capacity to provide care and support to HIV-positive people, and where health staff like Dr Dilshad 'worked' the system of perks and allowances to get as much money out of the government as they could, and then moonlighted in private practice. These findings are painfully familiar from other ethnographies of public health systems under the axe of neoliberal reforms (Smith-Nonini 2007; Pfeiffer and Chapman 2010). Where should we go from here?

Nishtar (2010) describes Pakistan's public health systems as 'choked pipes', whose flow is fatally blocked by their lack of capacity. She singles out problems of low public funding for health and lack of transparency in its governance, and offers a reform agenda that leads out from Pakistan's political economy, namely measures to limit debt, broaden the tax base and ensure pro-poor growth, with the goal of capacity-building in the public sector. I am reluctant to endorse all of the management reengineering that Nishtar prescribes, as she seems unaware of

the critiques of theories of public choice theory and the new public management that I have drawn on here, which might see many of her suggestions as neoliberal 'blind spots' (Keshavjee 2014). Her optimism might also be dented by ethnographic studies of public servants coopting governance reforms to their own ends (Anders 2005, 2010), of old forms of power 'recolonizing' attempts at reform (Mosse 2011, p. 6), or as I've argued here, examples of vested interests competing with the new to make use of the ambiguous possibilities produced by the changed rules of the game. But in countries like ours, it seems there is no convincing alternative other than to strengthen the public sector. Weigel et al. (2013) offer the example of Rwanda, one of the only countries in the developing world with near-to-universal access to HIV/AIDS care, as 'a model of health system strengthening by channeling tax revenues and more of its foreign assistance from public and NGO sources into a stronger public health system' (p. 301). Quoting Jeffrey Sachs, and recalling the plumbing metaphor deployed above, they note that even proponents of increased aid argue for changes to the existing systems of foreign assistance: 'if we are to get agreement by the rich world's taxpayers to put more aid through the system, we will first have to show that the plumbing will carry the aid from the rich countries right down to where the poorest countries need it most' (p. 298). Weigel et al. agree that there is a need for 'more (good) aid', and outline a programme of 'accompaniment' to assist foreign donors in 'developing country partners—public and private—until they have the capacity to deliver services … in the long term' (pp. 294–296). Pfeiffer (2013), similarly, concludes that 'the basic strengthening of public institutions, services, and safety nets requires a reinvestment in well-known fundamentals … specifically, a rejection of structural adjustment' (p. 179). He underscores the potential of a recently proposed 'NGO Code of Conduct for Health System Strengthening' as an advocacy strategy. This code advises NGOs to avoid luring public sector staff into their projects, to support local ministries in priority setting and close coordination with public sector providers, to avoid the creation of parallel services and systems, and to campaign for increased public sector spending (pp. 197–180). These kinds of principles deserve an experiment. This is the hard grist to which we need to turn.

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