# MEDICINE, MOBILITY, AND POWER
## IN
# GLOBAL AFRICA

## TRANSNATIONAL HEALTH AND HEALING

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# Targeting the Empowered Individual: Transnational Policy Making, the Global Economy of Aid, and the Limitations of Biopower in Tanzania

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In October 2001, Amelia Jacob from Tanzania was among the four awardees of the prestigious Africa Prize for Leadership, an award presented on an annual to biannual basis to outstanding African leaders whose "accomplishments have improved the lives of tens of millions of people."[1] The award—among whose previous recipients were the former South African President Nelson Mandela (1994) and the founder of the Green Belt Movement in Kenya, Wangara Muta Maathai (1991)—acknowledged Jacob's long-term engagement in the fight against HIV/AIDS in Tanzania. According to the award-giving institution, the New York–based Hunger Project, the example set by Jacob, who has lived openly with her illness since she was diagnosed as being HIV-positive in 1993, "has empowered people living with HIV/AIDS to come forth and become spokespersons. [Jacob] has demanded that the public treat people with HIV/AIDS with dignity and compassion while advocating that any effective treatment must include warmth and respect to those living with HIV/AIDS."[2]

The Africa Prize for Leadership—which in 2001 included a grant of 50,000 USD—helped to change the work and face of the Tanzanian self-help organization SHDEPHA+ (Service, Health, and Development for People Living Positively with HIV/AIDS) of which Jacob was one of the co-founders. While the award was probably not exclusively responsible for the subsequent developments, it certainly contributed to the organization's steep rise in membership, which according to SHDEPHA+ had grown to 50,000 by 2003. In the same year, the NGO opened its membership to people who are not infected with HIV but "who show solidarity with those who are." Furthermore, SHDEPHA+ expanded its services in counseling, care, and advocacy and started to implement a wide range of programs targeting the capacity-building of community groups as well as "the elimination of stigma" in Tanzanian communities. When I returned to the organization in 2003, three years after I had completed the bulk of my fieldwork, approximately 40 branches had been, or were in the process of being, established all over the country; the

new building in Dar es Salaam into which the NGO headquarters had moved was buzzing with new and old members. An external consultant had been contracted in order to help the organization to come to grips with the challenges that the growing membership presented (in addition to problems stemming from claims of embezzlement of funds that were circulating inside and outside the donor community). Finally, there were signs of a growing political consciousness within the organization itself: in 2003, the tenth anniversary of SHDEPHA+, a group of about 80 to 100 men and women, many of them living openly with HIV, marched through the streets of downtown Dar es Salaam demanding from the government the provision of free access to antiretroviral medications (ARVs).

The developments within the Tanzanian self-help organization SHDEPHA+ at the turn of the century are emblematic of the HIV/AIDS response as it evolved across wide parts of southern and eastern Africa from the early 2000s onwards. Not only was the organization among the many NGOs in the region that became involved in the fight against the epidemic during the 1990s and that received a significant boost in funding after the establishment of the Global Fund for the Fight Against AIDS, Tuberculosis, and Malaria in 2001, and the U.S. Presidential Emergency Plan for AIDS Relief (PEPFAR) in 2003. The work of SHDEPHA+ also reflects an internal shift in the world of HIV/AIDS work, which has increasingly come to integrate people living with HIV/AIDS into a holistic approach to the fight against the epidemic and which relies heavily on an internationally compatible language of empowerment, dignity, and human rights (see, e.g., UNAIDS 1999). Finally, the example of SHDEPHA+ has become emblematic of the positioning of civil society actors in a country where the formerly socialist government has had difficulties in coming to terms with the political engagement of non-governmental organizations (NGOs) (Mercer 1999), and where the face of the civil society response to HIV/AIDS has been increasingly shaped by neoliberal market forces and by the increased privatization of the health field and its dependency on international funding priorities.

## *Introduction: The Anthropology of Policy Making in the Era of AIDS*

This chapter is concerned with the field of transnational policy and program making and the implementation of health interventions in the wake of structural adjustment, the increasing transnationalization and NGO-ization of the health sector, and the HIV/AIDS epidemic in Tanzania. As in other parts of sub-Saharan Africa, HIV/AIDS policies in Tanzania over the last three

decades have been molded by country-specific epidemiological developments and the growth in mortality and morbidity rates that has entailed programmatic shifts from prevention to care and counseling to treatment—and ultimately toward a combination of these different components. Furthermore, HIV/AIDS work has been characterized by the way in which the various governmental and non-governmental authorities and organizations involved in the fight against the epidemic in Tanzania have been incorporated into a transnationalized system of health governance and funding, which in turn has affected the shape, contents, and language of specific programs. Finally, HIV/AIDS policy making in the country has been characterized by the repeated and often failed attempts of internationally funded interventions to connect to the social, economic, and moral configurations which have come to shape the ways in which people in the region are dealing with the complex challenges arising from the epidemic (for a related critique in other African regions see Heald 2003; Allen and Heald 2004; Campbell 2003; Dilger and Luig 2010).

In her book *Just One Child: Science and Policy in Deng's China*, Susan Greenhalgh (2008) draws our attention to the processes and modes of policy making as a new subject of anthropological inquiry. In the context of modern governance, Greenhalgh argues, the governance of human life is no longer an object of the state, but has shifted to a triad of governing authorities: the state bureaucracies, professional (knowledge-based) disciplines, and self-governing individuals. The forms of governance emerging in the interplay between these different levels are intimately intertwined with the formulation of policies which are regulating "virtually every domain of modern life" (Greenhalgh 2008: 7): from birth to death, school to work, and the lives and developments of populations as a whole. However, while policy can thus be understood "as the crystallization of authoritative norms" in modern systems of governance, an understanding of *the politics of these policies*—"who makes them, with what techniques and logics, through what negotiations and contests, and with what intended and unintended effects" (Greenhalgh 2008: 7f)—has hardly been achieved.

In her book, Greenhalgh continues to analyze the ways in which scientific experts in China have come to frame and interpret the growth of the Chinese population since the late 1970s and how the scientific knowledge that has been produced in this process has been translated into specific policies aimed at controlling the size and form of the population. Given the fact that HIV/AIDS is probably the best-explored epidemic in human history, in that an immense amount of data has been accumulated about the disease by a wide range of academic as well as non-academic disciplines and authorities (Treichler 1999), an epistemic approach to the analysis of HIV/AIDS-related policy making

would certainly make for an excellent challenge. In this chapter, however, I choose a different approach, focusing less on the scientific knowledge and procedures which have prepared the ground for the formulation of policy responses to HIV/AIDS, and instead on the political and economic *contexts* in which HIV/AIDS-related policies in Tanzania have been produced, as well as on the way these policies have been translated into programs and projects, and finally on how these programs and projects in turn have come to relate to the lives of people in Tanzania in the era of neoliberal reform processes and HIV/AIDS. I will argue that the transnationally embedded health responses to HIV/AIDS have led to the formulation of specific subject formations and ways of relating to one's body which are promoted by NGOs and the media, as well as by a conglomerate of peer educators, health staff, and other actors who have become incorporated into the globalized AIDS response. Ideas about the subject, gender, and the person that are implicated in these formulations are in turn appropriated by people in rural and urban Tanzania to varying degrees, and are becoming intertwined with alternative ways of thinking and acting upon health, illness, and the body in a variety of (often overlapping) situations and social constellations.

In the following I will first discuss the globalizing political and economic conditions under which policies and health care interventions in Tanzania have been designed and implemented over the last two to three decades in the context of structural adjustment, the transnationalization of the country's health sector, and HIV/AIDS. I will then describe how transnational policies and funding structures have translated into a myriad of activities in the fields of prevention, care, and treatment, which have been molded by both market-driven forces and a growing focus on human rights and empowerment. Third, I will look beyond the policy-making context and describe how the various ways in which people in Tanzania have responded to HIV/AIDS, rather than being congruent with the messages and the knowledge produced and mediated by biomedically driven health campaigns, are to be understood as part and parcel of a "moral practice and experience" that emphasizes the *social relatedness* of illness, that is, the connectedness between individual bodies and the social and moral state of kinship, community networks, and society at large.

In the formulation of my argument, I will draw strongly on my fieldwork in Tanzania, which from 1995 to 2006 has explored different aspects of the interconnection between HIV/AIDS and social relationships in the context of globalization and modernity—including issues surrounding sexuality and gender relations; relationships of care and support; the moral management of AIDS-related illnesses and deaths; and, recently, the introduction of the anti-

retroviral treatment which has shaped health policy in Tanzania since the end of 2004. What struck me during all the phases of my research was that while people in Tanzania were often well aware of how HIV is transmitted, how to protect oneself from infection, or how one should *supposedly* behave toward people with HIV/AIDS, their actual behaviors concerning sexuality or HIV/AIDS-related illnesses and deaths were often not congruent with this information—indeed, were often starkly opposed to it. Thus, while health messages about HIV/AIDS were acknowledged among wide segments of Tanzania's population even before the introduction of antiretroviral treatment, the ideas, practices, and experiences surrounding sexuality or episodes of HIV/AIDS-related illnesses and deaths were less shaped by information and knowledge drawn from governmental and/or non-governmental HIV/AIDS programs. Responses have become intimately intertwined with people's experiences of and concerns about familial, social, and economic developments in the context of modernity and globalization, and the moral and reproductive order at large (see Dilger 2005, 2008; Dilger and Luig 2010).

## Governing Health in Tanzania in the Wake of Structural Adjustment and HIV/AIDS

At the end of the 1970s, most countries in the eastern and southern African regions stood on the verge of economic and political collapse. Governments were not only confronted with the growing external debts and costs of heavily subsidized economies and overfunded welfare systems; they were also struggling with the consequences of the international oil crisis and the global economic depression. These combined factors drove many African governments to turn to the World Bank and the International Monetary Fund (IMF) for assistance. The loans that were granted to African states by the World Bank and the IMF were intended primarily for use in stabilizing economies and paying off national debts. However, they were also made contingent upon the implementation of a series of structural reforms which entailed, among other things, currency devaluation, reduction of trade barriers, and the privatization of state-owned enterprises. Structural adjustment policies (SAPs), furthermore, implied a steep reduction in governmental expenditure for health care, education, and housing programs, including a significant reduction of salary expenses for public sector employees (for Tanzania specifically, see Rösch 1995; Tripp 1997).

The effects of structural adjustment on Tanzania's heath care sector were manifold. The formerly socialist country, which had banned private medical practice in 1977 in order to eliminate "profit thinking in the face of human

suffering" (Iliffe 1998: 209), reopened its health care system to private practitioners and health institutions in 1992 (Iliffe 1998: 217). In 1999, there were already more than 500 private clinics and hospitals in Dar es Salaam alone (Boller et al. 2003: 117); in the year 2000 the government counted more than 1,270 private and/or religious dispensaries and 76 non-governmental hospitals throughout the country.[3] Cost-sharing programs—which were initially opposed by the former President Nyerere and his "socialist supporters" (see Iliffe 1998: 208)—were introduced in 1993 (Iliffe 1998: 219). These measures placed heavy burdens on patients and their families, who, in addition to hospital and clinic charges, had to cover costs for transport, food, (admission) bribes, drugs, and other medical supplies. In 2004, a report by the Women's Dignity Project stated that "health care charges [in the country] have placed an impossible financial burden on the poorest households," saying that many people were failing to access primary care when they needed it most and that many more failed to obtain the necessary referral for more skilled care (Mamdani and Bangser 2004: 151). Finally, the introduction of SAPs led to drastic cuts in state expenditures for the health care sector, and to the ever-growing reliance of Tanzania's health care system on international and private funding to make up for the growing deficit: in 1990–1991, the national budget allocation for health care in Tanzania had fallen to 5 percent from its 1970s average of 9.4 percent (Harrington 1998: 149). In 2007, 49.9 percent of capital expenditure for the health care sector was coming from external sources; private expenditure on health amounted to 34.2 percent, of which 75 percent was out-of-pocket expenditures by patients and households (World Health Statistics 2007).[4]

The growing fragmentation and privatization of Tanzania's health care system—and the concurring influx of external funding—have become especially pervasive in the field of HIV/AIDS. Since the UN Declaration of Commitment on HIV/AIDS in 2001—and the subsequent launching first of the Global Fund for the Fight Against AIDS, Tuberculosis, and Malaria (2001), and then of PEPFAR (2003)—international funding for the epidemic has mushroomed. In 2005, it amounted to more than 8 billion USD on the global level (UNAIDS 2006). In Tanzania, financial resources for the fight against the epidemic increased steeply after the country was selected as one of the PEPFAR's 15 focus countries:[5] under the Emergency Plan, Tanzania received more than 70.7 million USD in Fiscal Year (FY) 2004, nearly 108.8 million USD in FY 2005, and approximately 130 million USD in FY 2006 to support comprehensive HIV/AIDS prevention, treatment, and care programs. In the year 2007 donor funding comprised 94.6 percent of the total public expenditure for HIV/AIDS and amounted to 377.8 billion TSH (Tanzanian shillings—approximately 219.6 million USD) (TACAIDS 2008).

As in other countries in the sub-Saharan African region, the international funding for HIV/AIDS in Tanzania is channeled partly through governmental as well as non-governmental hospitals and clinics (in the case of treatment), and partly through the programs of NGOs and, increasingly, of FBOs (faith-based organizations) that have the reputation of providing transparent and accountable entry points for community-based prevention and care initiatives (Dilger 2009). In 2003, one NGO consultant in Dar es Salaam told me that HIV/AIDS had become a "hot topic" in the country: organizations that had not been involved in the topic previously were then engaging in the fight against HIV/AIDS in order to attract additional funding; new NGOs were founded on a daily basis, existing sometimes only as "briefcase NGOs" (i.e., on paper only); and, finally, there was growing competition between individual organizations aiming to develop new and innovative strategies of prevention, care, and treatment in their constant struggles to attract donor money.

While the field of HIV/AIDS work has become increasingly fragmented and also short-lived—with many AIDS organizations attracting one- or two-year funding commitments from a variety of mostly European and North American donors[6]—HIV/AIDS-related programs have gradually subscribed to a focus on human rights and empowerment. This type of programming has placed the self-reflexive individual at the center stage of HIV/AIDS-related policies and has granted the empowered actor the capacity to deal responsibly and circumspectly with the risks associated with HIV infection and AIDS illness. To phrase it in the words of Michel Foucault (1988: 18), the empowerment approach expects people to successfully apply "technologies of the self, which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality."

To be sure, such an approach is not entirely new in the history of health care and healing in the wider eastern and southern African region; however, it has in the past years gained unprecedented prominence. Subject formation was never the focus of the predominantly repressive power regime of the colonial state, which was only marginally interested in the wider transformation of its citizens' life worlds and individual and collective consciousness (Vaughan 1991), and the promotion of self-governing individuals in the immediate postcolonial setting was constrained mostly to the level of health experts (see Langwick, this volume) and did not rely on media and market forces to the extent that it has in more recent decades. Furthermore, the more recent empowerment approaches are also different from earlier, information-based



Fig. 2.1. Mural painting in Tanzania. Reads "Fear AIDS" and "AIDS is Death," 1999. PHOTO: DILGER

approaches in HIV prevention that were directed at an undifferentiated collectivity and often tried to make people fearful of possible infection with the deadly virus. This "approach of deterrence," as I would like to call it, is exemplified by a mural painting in Dar es Salaam (figure 2.1) which simply states "AIDS is Death" (Ukimwi ni kifo) and, on the left, "Fear AIDS" (Ogopa ukimwi). Today, such generalized messages of deterrence have largely given way to empowering and participatory approaches which have also gained ground in other areas of development work (see Green 2000).[7] In contrast to the earlier information-based approaches (including the "ABC approach" which relies on the tripartite message "Abstain, Be Faithful, or Use Condoms"[8]), the empowerment approach is relying on a multiplicity of media and no longer simply tells people what to do or what not to do, how HIV is transmitted, and what the consequences of risky behavior are in terms of infection and death. While such knowledge is *implicitly* contained in the "new" type of interventions, current prevention efforts are becoming increasingly pervasive with regard to *every* aspect of individual and collective life worlds and are creating differentiated positions that *may* be assumed in relation to HIV/AIDS—based on differences in age, gender, living environment, and also with regard to the professional and educational backgrounds of the respective target groups.

Fig. 2.2. "True love" according to Femina, a publication of the Health Information Project (HIP). FEMINA HIP, TANZANIA.

## Technologies of the Self in "New" Approaches to Prevention, Care, and Treatment

In Tanzania, "technologies of the self" in relation to HIV/AIDS are to be found most explicitly in prevention programs that focus on the growing urban middle class and that promote a discourse on "romantic" and "true" love among the young generation according to which partners talk openly about sexual and reproductive health, and in particular about protection from sexually transmitted diseases. This group of young people is sometimes called the "condom generation" by health planners—and in a broader sense it can indeed be understood as a reaction to the HIV/AIDS epidemic: the young men and women addressed by these interventions have become the target of a growing market of internationally funded campaigns which use different types of media interventions, including talk shows, glossy magazines, counseling sections in newspapers, call-in radio shows, etc., and which promote a view of sexuality that has become increasingly individualized and detached from family relations. All these interventions are responding to the questions

individual women and men *may* have about sexuality and HIV/AIDS. They are giving advice with regard to specific life situations that represent a risk in terms of HIV infection—and, most importantly, they talk about the pleasures and uses of sexuality. Thus, whereas earlier campaigns assumed that people know how to have sex and how to manage sexual relationships, this knowledge is no longer taken for granted and now has to be negotiated (cf. Parikh 2005). "True love," as discussed and promoted by advice columns and picture stories run by fashionable lifestyle magazines, is based not solely on sexual attraction or satisfaction—but rather on values like friendship, loyalty, trust, respect, and finally tenderness.

Such an approach is exemplified by a picture story in the lifestyle magazine *Femina*,[9] which offers a role model to young men and women who are confronted with dilemmas surrounding ideas of "true" and "romantic love"

FIG. 2.3. FEMINA HIP, TANZANIA.

as well as prevention of HIV. A picture (figure 2.2) shows a young couple that is experiencing these dilemmas of (non)communication about sex and the associated health risks. The young man on the right, who is turning his back on his partner, expects that the use of a condom is going to "harm" him (-*dhuru*) in that it will decrease his pleasure in the (obviously already agreed-upon) sexual encounter. The young woman, on the other hand, is (silently) convinced that mere "trust" (in love? in the health of one's partner?) will be even *more* harmful. The story evolves over the next few pictures, showing how the couple is starting to communicate and how they finally resolve the dilemma, until the final picture (figure 2.3) shows how they have arrived at a solution that is satisfying to both of them (iconographically represented by the physical closeness between the couple). The use of condoms in this context is seen by both partners not as a sign of "lack of trust" but as an expression of mutual esteem and of acknowledging responsibility for one's partner's health (cf. Dilger 2003).

On another level, technologies of the self have come to play a crucial role in the politics of "Living Positively" that have shaped HIV-positive identities all over southern and eastern Africa during the last 10–15 years. Originating in Uganda in the early 1990s and traveling to other countries in the region from there (see Dilger 2001), this model provides a way for people with HIV/AIDS "to take care of their mind and body" and to enter into a "healthy relationship" with the life-threatening disease through a number of regulative practices and devices. At the time of my research in Dar es Salaam (i.e., before the introduction of ARVs), these practices included adherence to dietary requirements, regular medical checkups, consistent treatment of opportunistic infections, and, finally, maintenance of social activities and regular exchanges with others on dilemmas and problems associated with an HIV infection. At the turn of the century, this open communication aspect of living positively had materialized in the form of numerous NGO support groups for people with HIV/AIDS which represented fora in which to discuss, negotiate, and form opinions about various issues related to their illness. Topics discussed in the weekly or monthly support group meetings that took place under the aegis of different NGOs in Dar es Salaam in 1999–2000 included: disclosure and stigma; the challenge of balanced nutrition; "safe sexuality" in short- and long-term relationships; the lack of material support in times of illness; the writing of a will; and the benefits and disadvantages of traditional medicine. The information and advice given with regard to problems in partnerships, families, or at the workplace was specific as well as generic and was becoming an essential part of the process of building a "positive identity" despite experiences of grief,

pia wametunzwa kushughulikia matatizo ya watu kwa usiri na faragha kubwa, hivyo huna wasiwasi wa taarifa zako kuwafikia watu wasiostahili.

**Najisikia vizuri baada ya kuzungumza na mshauri. Najua kwamba naweza kuwasiliana na mashirika yanayotoa huduma wakati wowote ninapohitaji maelezo au mtu wa kuzungumza naye.**

Fig. 2.4. "Living Positively" booklet published by HIP, a good example of the way in which public health responses have become embedded in transnational channels of funding and knowledge production. Adopted from the Soul City Institute for Health and Development Communication in South Africa, it was translated into Kiswahili and "culturally adapted to the Tanzanian setting" by HIP. The main character is confronted with an HIV-positive diagnosis and—after going through a period of internal struggling and despair—has accepted his HIV+ status. He says: "After I have talked to the counselor, I feel good. I know that I can talk to these organizations. They offer services whenever I am in need of advice or when I need a person to talk to." FEMINA, HIP, TANZANIA.

stigmatization, or despair about one's material life circumstances. For most of the support group members I interviewed in Dar es Salaam, the experiences of other HIV-positive men and women had become an essential reference in describing and initiating this healing process. It was only through the repeated counseling and identification with the suffering of others that people (ideally) adopted a self-image of being HIV-positive and translated this self-image into the context of marital and non-marital relationships, kinship networks, and the wider community.

Mama Frank[10] (f, 58) stands out as an example here. After the death of her husband in 1988, she found employment as a cleaner in one of Dar es Salaam's oldest AIDS NGOs. During the monthly group counseling sessions, she had come to function as a source of experience and knowledge for others in dealing "properly" with their illness by emphasizing how important the NGOs had become in finding one's "true [HIV-positive] self." She contrasted this in turn with the experience that her late son Frank—who had been also infected with HIV—had created for himself:

> I am living a life with hope. I got tested in 1986 and they found that I carry the virus. [My husband and I] were tested at the Aga Khan Hospital [in Dar es Salaam]. When we received the results, the doctor was hesitant, but I told him: "Just tell me, don't be worried about me." The doctor told me that there is a hint of the AIDS virus in my blood. [. . .] I went to my sister-in-law[11] and told her that I have the AIDS virus and that I may die any time. Later the counselors of these NGOs came and brought me to one of these organizations. There I found that we are many. They taught us to live with hope. I also received treatment at one of the NGOs. Today I live by praying to God. I live because of the blessing of God. I don't know if it is because of these medications[12] or because of God. What also helps is that since the time of my husband's death in 1988, I haven't known any other man. My son Frank tested HIV-positive. I told him: "Don't worry, just follow the counselors' advice." But he died five years after the test.

The "open" and "positive" approach of NGO clients to their illness was ultimately supported through programs of material and legal empowerment which predominantly represented the social and economic backgrounds of the NGO clientele. At the turn of the century the NGOs were most frequently visited by middle-aged women who had come from rural regions with relatively low education. Many of them (including Mama Frank, who had been fortunate to find employment with one of the NGOs) were widows who lived alone or with their children and earned their living on a piecemeal basis. At the time of my research, NGOs in Dar es Salaam were offering legal assistance to

widows whose hereditary entitlement was being contested by their in-laws. Others offered "home-based care," which is a service for providing care to sick family members in the home. Finally, NGOs aimed at providing financial security through granting small loans for the development of small-scale businesses, issuing food rations, or covering children's school fees.

A final issue that has shaped the politics of HIV-positive identities in more recent years is the introduction of the ARVs, which have become available in Tanzania since the end of 2004. In collaboration with the U.S.-funded PEPFAR program and the Global Fund for the Fight Against AIDS, Tuberculosis, and Malaria, newly created treatment centers have been established all over the country that connect counseling and testing procedures to the patients' enrollment in specific ARV treatment programs. Depending on the test results of their CD4 counts, patients undergo specific "adherence classes" in hospitals and clinics, where they are trained to observe their bodies carefully and to report unusual changes, symptoms, and side effects to their physicians and the health staff. The knowledge acquired in these adherence classes is carefully tested in individual "adherence panels," and patients are returned to further training if the desired effect hasn't been achieved yet (Mattes 2011).

This refined treatment apparatus that has been established around ARV provision in Tanzania and other African countries over the last years can be said to have become one of the largest public health intervention in the history of health care in Africa. ARV treatment programs now try scrutinously to regulate ARV patients' life worlds in addition to the possibility of emerging drug-resistant viral strains; and this has led to the further diversification of funding arrangements and institutional setups (Hardon and Dilger 2011). In Tanzania, ARVs are prescribed on a monthly basis and the dates of the last health clinic visit as well as of the recommended return for checkup are marked on a blue card that is used specifically for the prescription of ARVs and that allows people to visit other treatment centers around the country while traveling. A number of booklets and handouts stress the necessity of taking ARVs according to a fixed schedule and being aware of the importance of sticking to these drugs—forever: "These expensive medicines," reads one booklet which was adopted from the Soul City project in South Africa, "have to be taken every day, every month, your whole life." Finally, the health planners see it as crucial for the success of ARV treatment that families and friends establish an open dialogue about these drugs in order to create a supportive environment for consistent and continuous drug regimens: "It is good to be with someone you trust," reads one leaflet, "be it a relative or a friend—he will help you to remind you to take your medicine [as prescribed]." Thus, while people have been urged "to live positively with HIV" for more than a decade

Fig. 2.5. Leaflet emphasizing the long-term aspect of ARV treatment. Doctor: "The taking of ARVs is a life-long contract." Patient: "A life-long contract?" NATIONAL AIDS CONTROL PROGRAM, TANZANIA.

now, today they are required to "make a life-long contract" with medications that have transformed the life-threatening disease into a chronic condition (see fig. 2.5).

## Beyond NGOs and Biological Citizenship: Local Moral Worlds and the Limitations of Biopower in Tanzania

Looking at the numerous interventions that have been established in the field of HIV/AIDS over the last decades, one may wonder which particular "truths" about the disease (in the sense of Paula Treichler [1999]), or, alternatively, which type of "moral regimes and knowledge" (in the Foucauldian sense) are being promoted by health programs in Tanzania that have evolved in the context of a market-driven, mostly non-governmental and transnationalized response to the epidemic. I want to argue that the empowerment approach—and the social, cultural, and economic practices that are implied in it—are confined to specific settings; these settings can be described as *islands of biopower and self-care* that are sustained by the international AIDS industry,

which has increasingly based its activities on notions of human rights and self-responsibility and in recent years has aimed to involve "affected communities" into its manifold activities.

In medical anthropology, practices, ideals, and technologies of the self originating in the context of illness, health, and well-being have in recent years become closely related to discussions of biological citizenship, a form of citizenship that refers to the biological dimension of human life and "embodies a demand for particular protections, for the enactment or cessation of particular policies and actions [and for] access to special resources" (Rose and Novas 2005: 441). In the context of HIV/AIDS, Vinh-Kim Nguyen (2005: 126) has subsumed the various practices, values, and ideas that have emerged in the context of a globalized health response under the concept of therapeutic citizenship—a transnationalized form of biological citizenship which makes claims on the global economic and social order based on a "shared therapeutic predicament." According to Nguyen (2005: 125f), the social and cultural practices that have evolved in this context over the last 10–15 years have been organized around a complex set of confessional technologies and processes of self-fashioning which are closely interwoven with internationally acclaimed forms of HIV/AIDS activism and essentially draw their legitimacy from the economic, political, and biological inequalities existing in a globalizing world.

The practices and technologies of the self which are evolving under these circumstances can now be described with the concept of "biopower," which, according to Foucault (1977), involves the exercise of power on two mutually intertwined levels and at the center of which lies the control—and the proper conduct—of sexuality and life itself. On the individual level, the exercise of biopower presupposes a specific type of relationship with one's body, as well as a specific type of subjectivity. Thus, while the exercise of state power aims at the regulation and control of the population as a whole, the exercise of individual power aims at the disciplining of one's own body, the regulation of desire, and the refashioning of the responsible (sexual) self. In this context, the care of one's own health and body are intimately intertwined in that both are protected, cultivated, and isolated from anything that is considered undesirable and dangerous. This creation of the "healthy self" through the application of technologies of truth and knowledge seems not dissimilar to the way in which the interventions of the mostly transnationally funded AIDS NGOs in southern and eastern Africa have come to present sexuality and health. According to Deborah Posel (2005: 134), for AIDS NGOs in South Africa—and certainly to some of their clients and target groups—sexuality has become a "site of rational, individual choice and agency—an opportunity for empowerment and 'healthy positive living.'"

If we look now at rural areas of Tanzania—and also beyond NGOs and clinical settings in urban centers[13]—we find that the ways people deal with HIV/AIDS are not based *exclusively* on knowledge, discursive processes, and technologies of the self that are derived from governmental and non-governmental AIDS campaigns. While public health information has become important for how people think about and act upon health and illness in the context of HIV/AIDS, the ways they are responding to health challenges and suffering bodies have become embedded simultaneously in the wider political economies of health care in Tanzania, as well as in the social and moral priorities formulated by communities and families in relation to the disease. I want to illustrate this aspect with regard to the ways families and communities in the rural Mara Region in northwestern Tanzania—as well as in a Pentecostal congregation in Dar es Salaam—have come to deal with HIV/AIDS-related illnesses and deaths. However, while I focus on the ways in which people's responses to HIV/AIDS have been shaped in specific settings in Tanzania beyond the NGO context, it should become clear that the processes and practices I describe here are not situated *outside* the globalized AIDS response and the health sector in Tanzania. They have become inseparably intertwined with the processes described above in that they evolve *in relation to* the needs and challenges experienced in the wake of structural adjustment, privatization, and the implication of Tanzania's health system in transnationalized forms of governance. Furthermore, it has to be kept in mind that many of the HIV-positive women and men I encountered in Tanzania belong not to one neatly bounded social entity or group, but, rather, identify themselves (sometimes only temporarily) as NGO clients and/or church members in addition to emphasizing their identities as part of one or more kinship networks.

## KINSHIP, CARE, AND RELATEDNESS IN RURAL MARA

At the time of my research in the rural Mara Region in 1999–2000, governmental and non-governmental care programs were only established in rudimentary ways.[14] The expensive care and treatment provided by local private hospitals were affordable to only a few rural families, who lived primarily from agriculture and petty trade—in part from fishing and through the support of family members who were living and working in the cities. Relationships of care and welfare in this context were shifted out of necessity to the families with members with HIV/AIDS and were embedded in, among other things, family conflicts that had often begun long before the outbreak of illness. Especially with regard to sick relatives from cities like Dar es Salaam, Mwanza, or Arusha, family tensions had an effect on situations of care provision, as sick relatives who had been living in the city often returned to their

home villages unwillingly and under pressure from their (urban) relatives. On the other hand, the return of these relatives, who in some cases had paid little attention to the well-being of their rural families during preceding years, presented a significant economic, social, and emotional strain for their rural family members (Dilger 2005, 2006, 2008). This aspect was expressed in the following interview with a male farmer:

> Samson Mrungu (m, 38): Some fear [people with HIV/AIDS] because they think: "If I eat with him or touch him, I will get his disease." It has also occurred that families have chased away their sick relatives. If somebody became sick in Dar es Salaam or Mwanza and returns home people will say: "Go back to where you came from! Don't bother us with your disease! You got your disease from the town and now you bring it to us." This happens.
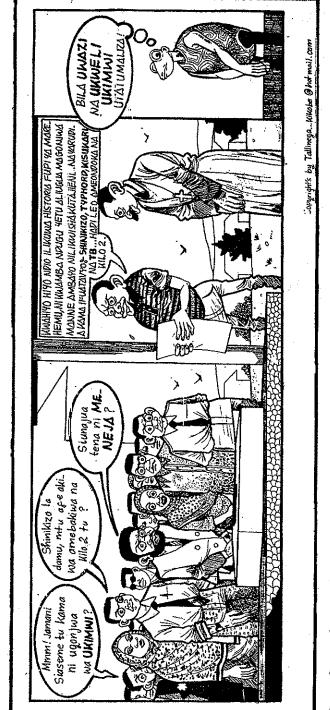>
> HD: Do these sick people return to town then?
>
> SM: No, they won't return, they say: "Where shall I go while my home is here in the village?"

In addition to the internal family conflicts and significant social and economic difficulties that the care of family members sick with AIDS implied in this rural setting, the differences in the quality of care and the availability of the care provided was determined above all by gender-specific dynamics. The latter played a particularly important role with regard to the care situations of young women. In the patrilineal family structures of the research region, women and their children were considered part of the husband's family following marriage. As such, their care in times of sickness or in the case of the death of their husbands was considered the responsibility of their husbands' relatives. In reality, however, these rules and expectations often represented the basis for tensions and discussion across family networks: in particular, questions would be raised with regard to young wives who became ill with HIV/AIDS about whether they were "properly" married and if the marriage had been "correctly" confirmed through a dowry. Discussions concerning proper marriages—and thus about the recognition of the woman's status as a wife—were especially common in regard to childless women, as well as to widows, in whose case claims on their husbands' inheritance would be shared not only with their children but with their in-laws (see Dilger 2005, 2006).

On another level, relationships of care and support were shaped by the kinship-based politics of burial and belonging, which forced people who had worked and lived outside of their villages for extended periods to return to their rural homes when death was approaching. Questions concerning care

and the subsequent burial—and especially about the place of burial—were thereby potentially conflictive and reflected again on the dynamics of age, gender, and belonging within patrilineal kinship networks (cf. Cohen and Odhiambo 1992). Thus, while the need to care for and bury male relatives raised questions concerning (unfulfilled) solidarity and kinship obligations in some cases, the situation of women routinely became more troubling to the involved families. Especially in the case of younger women who had been married to their husbands only recently and who had no or only a few children at the time of their death, the question posed was: to which family did they actually belong, and who was responsible for their care and their burial— their husband's or their father's family? Unmarried (or not formally married) women, on the other hand, were cared for mostly by their family of origin and buried on the compound of their brother-in-law, who thus provided the deceased with the status of a co-wife.[15]

Finally, the way families in rural Mara dealt with HIV / AIDS illnesses prior to the arrival of ARVs consisted of a persistent silence that surrounded the infections and deaths of family members. Prior to the arrival of ARVs, only a very few HIV-infected men and women among my informants knew about their diagnosis and almost none of them talked openly about it. Testing and counseling were carried out in the local hospitals only for those patients who were suspected by the health staff to be infected with HIV. Those patients who were found to be HIV-positive were often not informed about their diagnoses—and those who were, were sent home due to the high costs of nursing AIDS patients and as beds in the local hospitals became increasingly over-occupied. However, while for people in Mara at the turn of the century the silence on the *biological* dimensions of the disease had become an integral part of referring to illnesses and deaths in the time of AIDS, this didn't mean that there was no talk *at all* about the illnesses of dying community members or relatives. On the one hand, HIV/AIDS-related illnesses and deaths were the subject of multiple rumors that were circulating in the villages and that discussed the nature and origin of suffering—as well as the sexual relationships and networks that were its alleged root cause—in detail. As figure 2.6 shows, the targets of this talk were carefully trying to prevent these rumors from spreading—sometimes even beyond their deaths—and many people were hesitant to discuss their claims openly, especially if the person who was suspected of an HIV infection was a powerful and influential member of the community. On the other hand, many individuals and families in Mara referred to HIV / AIDS in terms of other diseases such as tuberculosis or *herpes zooster*, or associated it with witchcraft or the disease *chira*, said to be caused by the non-observance of ritual prescriptions, the symptoms of which were



Fig. 2.6. Cartoon discussing the silences—and the multiple rumors—around HIV / AIDS at funerals. From left to right: "Mmm! Why doesn't he say that it was AIDS?" "Can a person die of high blood pressure when he only weighed 2 kilos at his death?" "Don't you know that he was a MANAGER?" "This was the story of the deceased. Our relative died of the four diseases, which I have already mentioned and will now repeat: HIGH BLOOD PRESSURE, TYPHUS, DIABETES, and TB . . . In the end, he only weighed 2 kilos." "Without openness and sincerity AIDS will kill us all." MSEMAKWELI, 16—JAN, 22, 2000.

Fig. 2.7. Associations of HIV/AIDS with witchcraft have been integrated into community-based health campaigns in Mara, as is exemplified by this billboard—which, however, takes an explicitly negative approach to such interpretations of disease: "AIDS is not witchcraft," it says, "it is a disease which can not be treated / which doesn't have a cure." And below it reads: "Don't make love outside marriage. If you fail, stay with one partner." PHOTO: DILGER

described as being very similar to AIDS (Dilger 2006, 2008). While at the time of my research not all people in Mara would have argued that *all* cases of HIV/AIDS were related to *chira,* in those cases where the connection was established this had immediate effects on the way treatment was sought for patients and how care and support were being organized within family networks (this being related essentially to the fact that *chira* was said to be curable with the help of local herbs).

## HEALING, COMMUNITY, AND CARE IN A NEO-PENTECOSTAL CONGREGATION IN DAR ES SALAAM

In rural areas as in urban centers of Tanzania the daily lives of people living with HIV/AIDS are often more complex than public health programs suggest. In particular, in Dar es Salaam, Neo-Pentecostal churches, which have seen drastic increases in the number of members in large sections of sub-Saharan Africa in recent years, have played an important role in the social, economic, and religious life situations of people with HIV/AIDS (see also the quotation above by Mama Frank). The Full Gospel Bible Fellowship Church

(FGBFC) in Dar es Salaam in which I conducted fieldwork in 1999–2000 was founded in 1989 by Zachariah Kakobe, a charismatic bishop from southern Tanzania who had earned his living as a musician and meteorologist before receiving his calling in 1980. Over the last 20 years, the church has established branches in almost all regions and districts of the country and counted more than 120,000 members nationwide in the year 2000. In 1999, the FGBFC caused a stir through its public AIDS healings, which attracted 300–400 people a week and were hotly debated in the print media and among the public (see Dilger 2007).

For the members of the FGBFC I encountered during my fieldwork, the church became a source of hope mainly through its Gospel of Prosperity and, intimately related to it, the concepts of "awakening" and "salvation." According to Corten and Marshall-Fratani (2001), salvation in a Pentecostal church is "an ongoing existential project" that requires engagement in church activities and healing prayers in order to ward off attacks by diabolic forces, as well as a break with many of the obligations church followers have toward their families (especially the "cultural" and "ritual" obligations which are associated with the central phases of life, i.e., birth, marriage, and death; see also Meyer 1998). In the case of the FGBFC, the church teachings required furthermore the abandonment of sinful lifestyles such as consumption of alcohol or engagement in extramarital sexual relationships. It was only if these (admittedly difficult) conditions were fulfilled that the manifold promises of salvation began to work in multiple directions. Thus, the gospel of health and wealth in the FGBFC promised not only material success and progress for those living in poverty: salvation also meant relief from all kinds of distress, from trouble at work or with the Tanzanian bureaucratic system to diseases such as infertility, cancer, high blood pressure, or AIDS (see Dilger 2007). These promises of healing were backed up by the testimonies of members who claimed that the healings had been "proved" by scientific tests in a hospital or clinic, and these testimonies were also circulated in leaflet form. One of my interviewees recounted:

> Consolata Msemo: Before I got tested in 1998, I felt a strong heat (*moto*) in my body—as if you get burnt. Then I felt something like paralysis (*ganzi*)—I was freezing. And my head was aching. Every time I had a cold, I became critically ill. [. . .] At [the NGO] CCBRT[16] they found out that I am [HIV] positive. They told me to return for another test after three months. I told them that I am not worried because God has the power to do everything. Humans cannot heal AIDS, but if you believe in God—He can. I returned to Kakobe[17] and showed him the certificate (*cheti*). This was when we started officially (*rasmi*) with the healing prayers.

Apart from the AIDS healings—which, according to the church's bishop and his followers, have been confirmed by biomedical tests in some cases—the church has established a network of mutual solidarity that provides help and support for members in times of need and crisis. At the time of my research, the church had established a dense network of small neighborhood churches comprised of 20–30 members each, in which the idea of a "spiritual family"— defined in opposition to the worldly family—was promoted. This concept of spiritual family aimed to build a new moral community that was to disperse any doubts the church members might have about the righteousness of their path. This path to relation- and community-building was an ambiguous process that implied a high potential for intra-familial conflict, stemming both from unsaved relatives who tried to make church members depart from the path of salvation *and* from the church followers who persistently urged their families to give up their "dark" and "sinful" ways. However, the FGBFC was described to me by its members not only as a source of conflict, but also as a beneficial network of care and support that flexibly reacted to the needs of its individual followers. Especially in cases of serious illness, the charitable behaviors of other church followers went far beyond immediate acts of caring or nursing and often included arranging funerals, etc. The provision of such acts of solidarity had become particularly beneficial for the mostly female members of the church, mainly young to middle-aged women with low educational status who had migrated to Dar es Salaam in search of employment or business opportunities during the 1980s or 1990s. To these women—as well as to the fewer male members of the church, most of whom had a similar social background—the FGBFC was appealing essentially because it offered a space of hope, stability, and moral orientation in an urban context that was experienced as increasingly risky and ambivalent.

What can be drawn now from these two case studies on the FGBFC and on kinship networks in rural Mara? As I hope to have shown, there may be significant gaps between the ways in which the "empowered individuals" of transnationally designed health programs (as well as the subjects formulated predominantly on the ground of NGOs), on the one hand, and people who perceive of themselves mainly as members of kinship- and other community-based networks, on the other, conceive of illness and well-being in the time of AIDS. People in Tanzania—who may have a range of resources at their disposal and who may depend in their decisions on a variety of social and cultural settings and relationships—act not always in accordance with public health messages or with regard to the greatest benefits to their own (or others') biologically defined health. At the turn of the century, individual and

collective behaviors in the era of AIDS were constrained by the growing economic pressures and the lack of access to health care services that have been triggered by neoliberal economics and political reforms in the health sector over the last two decades. They were also rooted in the logics of community and kinship politics and in the moral, cultural, and religious priorities that people had with regard to the persistence of social relationships in and beyond the context of death and suffering. The *exclusive* focus on life worlds that are promoted and represented by state actors, non-governmental organizations, and humanitarian interventions would have revealed only a partial view of the complex social and cultural processes that have come to shape the lived experience and practice surrounding HIV/AIDS in Tanzania and other parts of sub-Saharan Africa. Consequently, I would argue that if we are to think critically about notions of citizenship and self-care in relation to HIV/AIDS, we need to take account of the complex relationships between power, experience, and practice that have shaped people's identities and subjectivities in the wake of globalization and the emerging epidemic.

## Knowledge, Experience, Power: The Making of Subjectivities in the Era of Globalization and HIV/AIDS

In contrasting the different ways in which individuals, families, communities, and a wide range of governmental and non-governmental institutions have come to deal with HIV/AIDS in rural and urban Tanzania, three things should be emphasized. All of them shed light on the way in which the relations between knowledge, practice, experience, and (bio)power have been shaped and reconfigured in the context of globalization and neoliberal reform processes over the last few decades.

First, the analysis above has made clear that the various contexts in which people have come to act on HIV/AIDS in Tanzania imply shifting understandings of the (causal) connection between knowledge and practice and the larger social contexts in which they are embedded. While earlier approaches in HIV/AIDS prevention were based on the "rational actor model," and assumed that the accessibility of knowledge (in the sense of information) translates inevitably into practice (in the sense of behavior), more recent approaches have adopted a more complex view of this relation. Thus, NGO approaches that are based on the notion of empowerment acknowledge that biomedical and public health knowledge acquire meaning only in relation to the larger contexts in which individual behavior and practice materialize. This understanding has enabled approaches to issues of the (gendered) relationships between sexual

partners; emotional states like fear, love, or hope; the challenges of disclosure, stigma, and care, and, related to this, the dynamics in (nuclear) families; and finally, albeit to a minor extent, the socioeconomic and legal conditions that shape the lives of individual actors in contemporary Tanzania. Issues that remain excluded, however, are the larger transformations in politics and health care in the country (including the issue of access to health services); alternative notions of illness, healing, and trust; and the dynamics of relatedness and belonging in relation to extended family networks and religious communities in urban and rural settings. As argued above, these latter aspects may play a crucial role in shaping individual and collective practice, knowledge, and experience in relation to HIV/AIDS in rural and urban areas.

Second, the different types of knowledge, practice, and experience that have emerged in the context of globalization and HIV/AIDS in Tanzania are inseparably intertwined with different types of subjectivities and reflexive selves, which are in turn built around shifting concepts of person and gender. Thus, in their approaches and interventions NGOs perceive their target groups and clients largely as autonomously acting individuals who, in the case of women, need to be empowered socially, economically, and legally in order to be able to make healthy and responsible decisions. Men, on the other hand, are seen as economically, socially, and legally privileged and as being largely in charge of most decisions that relate to their partnerships and families. Only in recent years have NGOs and local interest groups come to reflect critically on socially constructed modes of masculinity and male sexuality and to emphasize the need for men's "cultural empowerment" which might enable them to assume a "positive" gender role as responsible husband, son, father, and sexual partner (for the discourse on the "new men" in South Africa, see Morell 2001).

Such discourses and images contrast with the expectations, roles, and responsibilities that are formulated for the behaviors of men and women in other areas of life in Tanzania. In the patrilineal kinship networks in rural areas, the well-being of individual men and women is often closely interwoven with the fate of their—and, in the case of women, their husbands'—nuclear and extended families. Illness and suffering are often understood here as a reflection of the wider state of (gender- and age-specific) social relations which are perceived as being disturbed by globalization and migratory processes and which need to be worked upon in order to ensure individual and collective well-being. In contrast, Neo-Pentecostal churches like the FGBFC in Dar es Salaam offer new spaces of solidarity and attachment, especially for women, and thus provide an alternative to the male-centered kinship networks of rural and urban areas. Such churches often pursue a highly conservative gen-

der ideology, however, which is centered on the nuclear family and which expects decency and submissiveness from women toward their husbands. It is important to emphasize that these different types of gendered subjectivities and concepts of the person as sketched out here are not mutually exclusive. People's lives are often shaped in relation to different urban as well as rural localities and social settings through which they are exposed to shifting, and often conflicting, types of expectations, knowledge, and values.

Finally, the way knowledge, truth, and meaning are produced and reproduced in relation to HIV/AIDS in various settings in Tanzania has been shaped by the context of global development and health restructuring over the last two to three decades—as well as by the multiple iconographies and textual representations that have become part and parcel of the process of producing meaning and truth in the era of globalization. On the one hand, globally driven development precludes the integration of certain types of truth and knowledge into health interventions, a fact that is amply illustrated by the various images, texts, and statistics produced by governmental as well as nongovernmental actors in the form of flyers, booklets, and reports. In particular, the multiple moral conflicts relating to decisions concerning health and sexuality—but also people's alternative knowledges and experiences concerning illness, healing, death, and mourning—are seldom addressed by internationally funded interventions and programs. Thus, while "local knowledge" and experience are highly valued in other areas of development work in Tanzania (especially in agriculture and more recently, again, in the field of traditional medicine), HIV/AIDS interventions in the country have often engaged a modernizing approach that reproduces established dichotomies like "tradition vs. modernity," "belief vs. knowledge," and "religion vs. medicine and science." In this context, local knowledge, experience, and practice, as partially represented in local Kiswahili publications and cartoons, are often branded as "superstitious," "harmful," and "backwards."

On another level, and related to this, the production and dissemination of knowledge, meaning, and truth in the neoliberal era have been shaped by the growing disjuncture between the practices, experiences, and ideas of (internally further differentiated) families and communities, on the one hand, and the expectations and values that are promoted by the (equally differentiated) HIV/AIDS industry, on the other. Thus, this text has shown that the promises and services of NGOs have had an impact on the lives of many individuals, some of whom have benefited from the new funding arrangements that have also opened up new avenues into the globalized health order on a personal level (as exemplified by the case study of Mama Frank and the introductory

case of Amelia Jacob). Furthermore, the privatization and NGO-ization of the health care sector in Tanzania have also led to shifting understandings of rights and citizenship. While colonial and post-independent understandings of law in the country regarded the existence of legal frameworks predominantly as "constitutive of state power, not as a limitation upon it" (Harrington 1998: 151), the transition to a multi-party system and the growing influence of the international development community from the mid-1990s onwards have defined law as a code for which the state can be made liable; thus opening a space for the perception that health is a right individuals are entitled to (Harrington 1998). In Tanzanian society, such shifting perspectives have not resulted, however, in an open challenging of the state in relation to its alleged responsibility toward people with HIV/AIDS—as for instance in South Africa, where the demonstrations and activities of the Treatment Action Campaign have become symbolic for practices of health citizenship in the post-Apartheid state (Robins 2004). In Dar es Salaam, it was almost exclusively on the safe ground of the NGOs that members of the HIV/AIDS support groups expressed their critique of governmental authorities which, according to them, have failed to take care of their HIV-positive and AIDS-sick citizens (Dilger 2005). This seems understandable given the fact that during the 1990s the work of NGOs depended largely on the benevolence of the government, which often conceived of them as a threat to the social order (Mercer 1999: 250ff.).

Under these circumstance, many people in rural and urban Tanzania are relying on knowledge and relationships beyond the biomedically defined health settings, and are trying to act on their bodies and illnesses by drawing on a wide range of resources that have emerged, and have been transformed, in response to HIV/AIDS and shifting social and political-economic conditions. In conclusion, I would therefore like to argue that this disjuncture has become reflective of how the circulation of medicine and biopower in the neoliberal era has been shaped by the way global capital and development are "hopping" over sub-Saharan Africa (Ferguson 2006), thereby reconfiguring social, economic, and cultural constellations on the continent in only fragmentary ways. Thus, while the production and spreading of biopower in Tanzania have become embedded in globalized channels of funding which govern "regimes of truth and knowledge" in the context of HIV/AIDS and structural adjustment in often contradictory ways, the state and its institutions—as well as the non-governmental actors that have become complementary to them—have only a limited ability to establish and exercise biopolitical authority (also in its more beneficial form) in a *pervasive* way. Under these conditions, many Tanzanians have developed a critical sense of their government's ability to

control the living conditions of its citizens on a daily basis and turned to looking for "collective solidarity" and "moral beneficence" outside of the state altogether (Ferguson 2006: 85). In this regard, moral knowledge, practice, and experience—and the various forms of sociality and belonging that have been built around them—have remained of crucial importance to individuals, communities, and families in making sense of the transformations and challenges related to globalization and in responding actively to the suffering associated with HIV/AIDS.

## Notes

1. http://www.thp.org/what_we_do/key_initiatives/honoring_africa_leadership/laureate_list (accessed Aug. 30, 2010).

2. http://www.thp.org/what_we_do/key_initiatives/honoring_africa_leadership/laureate_list/amelia_jacob (accessed Aug. 30, 2010).

3. http://www.tanzania.go.tz/health.html (accessed Aug. 30, 2010).

4. http://apps.who.int/ghodata/?vid=20700 (accessed Sept. 14, 2010).

5. Among PEPFAR's 15 focus countries—which represent collectively approximately 50 percent of HIV infections worldwide—are five East African countries: Ethiopia, Kenya, Rwanda, Tanzania, and Uganda.

6. During my research in 1999–2000, some of the donors to AIDS NGOs in Dar es Salaam were: NORAD (Norwegian Agency for Development Cooperation), DANIDA (Danish International Development Agency), HIVOS (Humanist Institute for Co-operation with Developing Countries), UNDP (United Nations Development Programme), and UNAIDS (Joint United Nations Programme on HIV/AIDS) (see Dilger 2005).

7. "Participatory approaches" and "partnership" in development, as defined by representatives of the development complex, imply the planning and implementation of development projects as the result of a process of mutual learning and interaction that is targeted first and foremost at the "empowerment" of local populations. As Green (2000: 69) has put it,

> "Development" is not [then] simply a process of directed change leading to certain kinds of economic and social transformation, but depends on the accomplishment of a series of corresponding moral transformations in the consciousness of people participating, as change agents and changed, in the development process. Consequently, the proper task of development organizations and their personnel is to facilitate the necessary transformations in consciousness which can *empower* the poor as social actors to embark on locally managed change.

While this is not the focus of my chapter, it should be mentioned here that the ideals of "partnership" and "empowerment" are seldom translated into actual practice and that attempts at their realization have led to paradoxical relations between actors in the field who, while often being critical or even cynical about the contradictions contained in development, ultimately affirm and reproduce the overall system (Green 2000; Rottenburg 2002; Marsland 2006).

8. For a critical analysis of the ABC approach, see Heald (2002).

9. *Femina* is a publication of the Health Information Project (HIP). The HIP is a multimedia initiative which is funded by a multitude of international donors, including the German Society for Technical Cooperation (GTZ), NORAD, and SIDA. The HIP has developed a broad range of publications and activities that help young people to "get the facts and make better decisions about how to stay safe, improve [their] relationships and learn more about job opportunities." (http://www.chezasalama.com/G-Behind/view.partner.php?id=384, accessed Nov. 10, 2007).

10. All interviewees' names are pseudonyms.

11. Sister of Mama Frank's late husband.

12. During the time of our interview (2000), Mama Frank received basic treatment for opportunistic infections.

13. While my critique of concepts like "biological" or "therapeutic citizenship" in this section focuses mostly on settings and relationships situated *outside* of NGOs and biomedical institutions, the validity of these concepts has also to be questioned for the context of NGOs themselves and of the biomedical sector in general. Thus, as Whyte, Whyte, and Kyaddondo (2010) and Whyte (2009) have argued, the rollout of ARVs raises challenging questions for anthropological debates on ethics, subject formation, and understandings of biological and/or therapeutic citizenship. These questions may become even more pertinent with the current cutbacks in global funding for antiretroviral treatment and the impact this may have on the accessibility of local and national treatment programs (Médecins Sans Frontières 2010). Furthermore, the confines of this article do not allow me to elaborate on the manifold social and cultural processes influencing not only the domains of care and illness experience but also sexuality in rural Tanzania. Thus, while a discourse on "true love" is taking place even in rural areas, there are many other aspects (such as inequality between the sexes, the significance of gifts and money for sexuality, and concepts of moral integrity and sexual pleasure) that are just as essential for the shaping of sexual relationships between young men and women as the knowledge being conveyed by national and international campaigns (see Dilger 2003).

14. In the year 2001 around 9% of the region's adult population was infected with HIV. However, there was no continuous HIV/AIDS response in the villages until 2005, when an ARV treatment center was put in place by the government in collaboration with one of the private, mission-based hospitals in the area.

15. On the liminal situation of (young) women in patrilineal kinship networks in Uganda, and the challenges this liminality entails for their burials in the time of AIDS, see Whyte (2005). In western Mara, conflicts and discussions concerning the burials of men and women in the context of HIV/AIDS were also driven by the concern that the spirit of a deceased person might seek revenge if ritual prescriptions were not observed. The danger was considered especially high from women or young girls who were not married at the time of their death. If they were buried within their father's compound they were said to attract evil spirits and unleash infertility among their female relatives.

16. Comprehensive Community Based Rehabilitation, Tanzania.

17. The Bishop of the Full Gospel Bible Fellowship Church.

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