AIDS Activism in Pakistan

AIDS Activism in Pakistan: Diminishing Funds, Evasive State

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ABSTRACT

A year of ethnographic fieldwork was conducted in the HIV/AIDS sector of Pakistan at the moment of rolling back a World Bank-financed Enhanced Programme. Classified by UN agencies as at 'high risk' of a generalised HIV epidemic, Pakistan has an epidemiology driven by injecting drug use, and a Penal Code and Islamist legislation which make non-therapeutic drug use and extra-marital sex illegal. In recent years, a sharp increase in the numbers of registered HIV positive people required a shift from HIV prevention among 'high risk groups' to the provision of care to those living with HIV/AIDS. The rolling back of external funding, which was further compounded by the devolution of the Ministry of Health (MoH), created challenges for AIDS activism in Pakistan, as reflected in the everyday lives – and deaths – of the patient-activists and their Community-Based Organisations (CBOs). This paper recounts one such story of an aspiring AIDS activist caught in multiple dilemmas emanating from these macro-processes. I draw out what the story of this activist tells us about the limitations of the complex agency of actors in development and how the shifting loci of power from the state to non-state entities in the global neoliberal order impacts the provision of vital services like HIV prevention and AIDS control.

INTRODUCTION

International aid to countries like Pakistan has been the subject of intense academic debate for past several decades. 'Development' has been condemned as an insidious and failed chapter of western modernity (Escobar 1995), an 'anti-politics machine' (Ferguson 2006), 'orientalism transformed into a science for action' (Gupta 1998: 37), and a tool for the western project of domination – 'a destructive and self-serving discourse propagated by bureaucrats and aid professionals intended to entrap the poor in a vicious circle of passivity and misery' (Edelman and Haugerud 2005: 2). Such criticisms of the development industry have held sway among intellectuals within and outside the academia. These scholars have taken from Michel Foucault's understanding of power/knowledge to signify that power is constituted through accepted forms of knowledge, scientific understanding and 'truth'; 'What is needed is a study of power in its external visage, at the point where it is in direct and immediate relationship with[...]its object, its field of application, [...]where it installs itself and produces its real effect'(Foucault 1980:97). However, this critique of development and subsequent call for 'post-development' (Escobar 1995) have themselves also come under strong criticism as 'rhetorical ploys' that are far removed from the ethnographic ground and conceal the differences within development by homogenizing it and misrepresenting 'modernity' as one-dimensional (Pieterse 1998).

A growing number of anthropologists, under the banner of a 'new ethnography of aid', have argued that international policy regimes do not simply 'arrive', but are *produced* by intermediary actors – bureaucrats, clinicians, technicians, NGO staff, health workers and so on – who translate abstract global policy into their own ambitions, interests and values (see e.g. Pigg 2002, Mosse 2005, Harper 2006, Mosse and Lewis 2006). Drawing on Bruno Latour's Actor Network Theory (1996), Mosse and Lewis (2006)call for scholarly attention to the 'complex agency of actors' at every level of development. They assert that 'actors assume identities in relation to their strategies of interaction, and political representations inform the negotiations that take place between actors' (p.13). Therefore, the 'new ethnography of aid' argues that the notion of all-powerful western development institutions needs to be critiqued.

In this paper, I will examine a crisis in Pakistan's HIV response in 2010, when the World Bank rolled back its funding for a major programme of interventions, the 'Enhanced HIV and AIDS Control Programme' (henceforth, the Enhanced Programme). I sketch the scene at the

demise of this programme and what it entailed for activist-patients and employees who depended on this sector for their survival and livelihoods. Recent anthropological literature on the 'ethnography of aid' has emphasised the need to appreciate the agency of intermediary actors in the 'social life' of projects, their ability to put development goals to different ends. I turn to a telling story of an AIDS activist in the midst of the crisis in the aid industry to exemplify the material and psychological consequences of the withdrawal of external funding and the apathy of the state. I will argue that whilst we bring to light the agency of individuals to carve their own paths in the matrix of development policy, we should not overlook the broader structural forces of the state apparatuses and planetary institutions like the World Bank, for it is these structural forces that delimit the field of action and limit the lives of actors to a precarity that seems characteristic of the neoliberal order.

By centring on one particular actor and exploring his complex agency, as well as vulnerable situation in the fast-changing world of international funding and national policy frameworks, the ethnographic material that I present here points to the power of the institutional changes to affect everyday lives of actors despite their strategies of interaction. I agree that the truism of all-powerful development institutions as structures of western domination needs to be revisited ethnographically. However, I show in this paper that acknowledging the agency of actors does not reveal that the effects of these institutions on the ethnographic ground are any less powerful. Hence, I argue for a continuing engagement with, and for the relevance of macro-level institutional changes in the analysis of the 'social life' of projects.

I carried out fifteen months of multi-sited organisational ethnography in Pakistan's HIV/AIDS sector, interviewing health bureaucrats, NGO workers, donor officials and HIV positive people – the intermediary actors in the field of HIV prevention and control. A large part of this fieldwork consisted of participant observation at the ACP, where I worked as an internee, sharing the everyday work and life of the organisation with many of my colleagues. One of these colleagues, Assef, worked as the PLHIV Coordinator and was the only HI positive member of staff in this organisation. The material on Assef's life that I present here was collected over many months of informal exchanges with him, which I followed up with an in-depth interview in the final phase of my fieldwork. By presenting an extended case study of a single individual, with regards to his relations with colleagues, his position in AIDS activism, the course of his involvement in the HIV sector and his reflections on the past experiences and future anxieties, I deploy participant observation 'to locate everyday life in its extra local and historical context' (Burawoy 1998:4), to illuminate some of the

dilemmas that the changes to external funding regimes and the government policies bring about for individuals caught in an everyday battle of survival with HIV.

The scale of investment under the Enhanced Programme was unprecedented in Pakistan's HIV/AIDS control. The first democratic government of Benazir Bhutto (1988-90) did not want to be associated with a 'taboo western disease' linked to the 'bad habits' of foreigners, after the detection of the virus in the country. The 1990's National Health Policy did not even mention HIV or AIDS (MOH 1990, Lashari 2003, Zaidi 2008) and there was no allocation of funds for HIV prevention in the five-year development plans until 1993 (GoP 1994, GoP 1999, World Bank 2001). Even today, senior bureaucrats and politicians shy away from legislating to end the discrimination against HI positive people. Over the last seven years a proposed 'HIV and AIDS Prevention and Treatment Act 2007' could not be tabled in the parliament because of delays in the vetting at the Ministry of Law. Instead, the existing Hudood laws and the Penal Code criminalise drug users and sex workers - the primary victims of HIV. On one hand, the state considers sex outside marriage and the non-therapeutic use of drugs as an offence against the state- punishable with up to the death penalty (Jahangir and Jilani 1990, HRW 2008)).On the other, HIV and AIDS are misconstrued in the popular nationalist media as a disease of foreigners, sexual perverts and 'dirty' drug users.

However, in early 2000s, when the military regime of General Musharaf was in desperate need for international recognition and partnership, the government agreed to invest big money in HIV prevention among the marginalised 'risk populations' at home in order to project a positive, soft and progressive image abroad. A 'soft loan' for the Enhanced Programme – 'pushed by the World Bank to improve their own balance sheet', as a colleague of mine at the government's AIDS Control Programme (ACP) put it- was accepted mainly as an incentive to win legitimacy for the military regime, as it transpired later when the continuation of the Enhanced Programme was linked to the continuation of external funding when the rumours about the Bank's withdrawal emerged in 2010

A major restructuring of the health sector can be traced to 1998, when Pakistan carried out its nuclear expulsions and had to face economic sanctions as a consequence. Following the sanctions on trade and investment, bilateral and multilateral aid sharply decreased, resulting in a crisis of foreign exchange reserves and economic instability (Ravindran 2010). International lending institutions, including the World Bank, exploited this gap in donor

funding by extending loans on the condition of structural adjustments, which included privatisation of health sector (World Bank 2006). In the same year, the World Bank issued a health strategy paper for Pakistan, which recommended that the health sector should enter into partnership with private sector for provision of government-financed health services (World Bank 1998). After 9/11, when Pakistan became an ally in the 'war on terror' economic sanctions were lifted. USAID reopened its offices in Pakistan, and other bilateral donors followed suit. This coincided with a focus in global health and development on the emerging HIV epidemic in Asia and the discovery of several new cases in Pakistan (NACP 2001). HIV became a favoured area of funding for the new and returning external donors, with the World Bank providing the policy framework of contracting-out to private sector. As with reproductive health services in Pakistan (see Ravindran 2010), the increased spending on HIV/AIDS was accompanied by massive restructuring of the government's AIDS control, resulting in a significant expansion of the AIDS bureaucracy and a phenomenal increase in the number of NGOs and activists in the HIV/AIDS sector. The recent 'HIV scale-up decade' (Kenworthy and Parker 2014) has been characterized by increasingly technocratic and top-down initiatives, which have generated thousands of jobs in the emerging administrative apparatus (see Pisani 2008, Rowden 2009). The ACP, which had been a WHO-sponsored, small and laboratory-oriented programme since 1988, was now scaled-up to employ a large number of 'market-based' contractual staff, health bureaucrats, and expensive international experts and consultants -'bands of hunters and gathers', as Jock Stirrat (2000: 35) has called them, or in Richard Sennett's(2006: 105)words, the 'essential ingredients' of modern bureaucracies in the culture of new capitalism (those 'who swoop in and out but never nest'). This 'new managerialism of international development' (Mosse 2005) turned Pakistan's AIDS control into a 'hybrid bureaucracy' (see [removed for anonymisation]) that promoted a 'flexible' work culture, characteristic of new forms of 'entrepreneurial governance' (du Gay 2000) in contrast to Pakistan's proceduralist, bureaucratic 'government of paper' (Hull 2012).

The ACP became a government department that was run like a private firm. The incumbent national manager, a seasoned health bureaucrat, was replaced by a relatively junior employee who was more receptive of the World Bank's policy models and had shown eagerness to implement public-private partnership programme (Zaidi 2008). A large number of 'market-based' contractual employees were hired to work with mandarins of the health department, combining different styles of management and bringing different logics and rationales to the everyday work. The policy of contracting-out HIV prevention to the private sector under the

World Bank's guidance reduced the role of the government to that of a purchaser of services. There was little substance in the Bank's rhetoric of government ownership, civil society engagement, transparency, and multi-agency working, as has also been found in the context of Bank-sponsored Multi-Country HIV/AIDS Programme in Africa (Harman 2010). Most of the service delivery contracts were given to a small number of large and influential NGOs, some which did not have any experience of working in the health sector, let alone HIV, but were selected because their size was taken as an indicator of financial viability (Zaidi 2008). As the contracts were rolled out with borrowed money, the state took a back seat in responding to the epidemic, thus undermining the development of a sustained institutional response and long-term strategy in the public sector - beyond contracting-out to private sector. The Enhanced Programme transformed government offices into flexible bureaucracies, and the denizens of those offices into the enterprising but anxious subjects of neoliberalism (see [removed for anonymisation]).

ARVs, CBOs and Handouts

Assef was diagnosed accidently at a military base in 2006 when he volunteered to donate blood for the thalassemic child of a friend of the commanding officer. As the news of his infection spread among his fellow servicemen, he recalled that they teased him for his HIV status, suspecting him of *'japhian'* (hugging/cuddling, implying homosexuality). He tried in vain to convince them that he must have acquired the infection through a blood transfusion (this is what he maintained in his interview with me, too). Instead, he was ordered to give back his military uniform and stay in his barrack. Upset by accusations of homosexuality and fed up with being confined to his barrack, he planned to run away, but the barbed boundary walls were not easy to break. With no institutional guidelines or precedent, Assef said that the commanding officer at the base was not sure about what to do with him. He was finally sent to a military hospital after eight months of near solitary confinement.

He received hardly any care in the military hospital; 'the nurses wouldn't give me even painkillers unless the doctors said so, and the doctors were undecided about what to do with me'. At one point, he was even shifted out of the medical ward and into a storeroom for fear of contamination. He did not have a personal attendant in the hospital because he chose not to disclose his HIV status to his widowed mother and younger siblings due to the widespread

stigma(see APLHIV 2010 on stigma and discrimination against HIV positive people in Paksitan).A turning point in his ordeal was when a curious doctor, who had been internet-searching HIV, took pity on Assef. In his words, the doctor had 'honoured' him by having him shifted back to the medical ward. His HIV status was reconfirmed and his file was moved to a medical board for him to be formally discharged from the military service. As his personal belongings, which were left behind at the base, arrived home a few days later, he told his family that he suffered from Hepatitis-C. At the hospital, the doctor signposted him to an Antiretroviral Therapy (ART) centre in Islamabad.

The ART centres were set up in Pakistan in 2004-5 with the support of the Global Fund for AIDS, TB and Malaria (henceforth the Global Fund). By June 2004, only 100 individuals were receiving antiretroviral medicine (ARVs) whereas more than 10,000 were estimated to be in need of the treatment(UNAIDS/WHO 2004). A decade on, the most recent estimates suggest that there are more than 130,000 HI positive people in Pakistan but still only 6000 are registered with treatment facilities (MNHSRC 2012, UNAIDS 2013). The vast majority remain undiagnosed due to extreme stigmatization in health services and the wider society. The UN agencies have classified Pakistan as at 'high risk' of a generalized HIV epidemic (MoH 2010).The country has among the highest numbers of Injecting Drug Users (IDUs) in the world (UNODC and MNC 2013) and surveys have indicated that in some cities up to 50 percent of them are HIV positive(HASP 2011).

By the time Assef started on ARVs, his CD4 count, which is a measure of the strength of immune system, had fallen close to the critical number for immune function, 200 cells; 'there was no severe condition, but since I was in depression my CD4 count was falling down very rapidly'. With the free-of-cost ARVs, his immunity improved and his 'depression' declined. Assef now faced another challenge– joblessness. One of his relatives got him a low paid office assistant's job in a telecom company but very soon, he said; 'I was caught eating loads of strange medicines [ARVs]' and forced to resign. The boss of the company told him to walk away quietly or face the disclosure of his HIV status to everyone in the office and to the relative who had referred him. He walked away quietly. With no regular income, his savings were diminishing fast and he was frustrated. The councillors at the ART centre advised him that becoming a member of an HIV positive people's CBO might bring him much needed emotional and financial support. He joined a local CBO after some hesitation.

The effectiveness of 'handouts 'for HIV positive people delivered through their CBOs has been debated among scholars for their impact on AIDS activism and the wellbeing of those suffering from HIV. For Beckmann and Bujra(2010:1062), the most important role that local

groups of PLHIV in Tanzania have managed to achieve is to 'marshal people into queues for treatment and monitor that treatment so that their members can live', and that 'this activity affords little political leverage' to the vast majority of CBO members. Boesten(2011:785)has shown that the 'poor and positive' people in Tanzania have to navigate a disjointed landscape of competing, unsustainable and donor-dependent outlets to gain access to rations of food and medication that they need to survive. This, according to Boesten 'undermines, rather than strengthens political action and voice' of AIDS activist. Marsland (2012)has noted that HIV positive people in Kenya associate on the basis of the pre-existing relations of family rather than the biological condition of HIV infection, and Prince (2012) argues that their needs are not articulated as a political force to challenge the state but deflected through a rapacious NGO economy. Tomor (2009), on the other hand, argues that the local organisations of PLHIV have become the 'moral voice of the nation' in South Africa. Similarly Nguyen(2009) has proposed, from his fieldwork in West Africa, thatin the alliances between local groups of HIV positive people and transnational institutions is an emergent 'therapeutic citizenship' heralding a worldwide 'biosociality' (Rabinow 1992) among them which could play a pivotal role in AIDS activism. Whilst this universalistic claim faces the test of evidence as it traverses the globe, meeting very different ethnographic terrains along its way (see Livingston 2012) ([removed for anonymisation]), the story of Assef, and of AIDS activism in Pakistan, does not offer much sustenance for Nguyen and other's optimism -especially in an atmosphere of insecurity of funding for the HIV/AIDS sector and uncertainty of the state (in)action, as I will explore below.

Battling Stigma: The PLHIV Coordinator

Following the international donors' emphasis on the globally acclaimed GIPA (Greater Involvement of People living with AIDS) Principle (Piot and Aggleton 1998), a group of HIV positive people was brought together at the ACP to prepare them for a sensitisation meeting with parliamentarians. Assef was nominated from his CBO. He was chosen because of his unique military background and impressive communication skills. He was keen on narrating his experiences at the military base and the hospital. As Robins (2006:1)has argued, it is the retelling and mediation of traumatic experiences that facilitates activists' commitment and the 'profound negativity of social death that animates the activist's new positive HIV-positive identity'. For Assef, action in this new world of AIDS activism was 'in quest of a narrative'

(see Ricoeur 1984).Mattingly (1998)has argued that storytelling involves far more than retrospective glances at past events. Stories are not just told *after* experience but are constructed while people are still very much in the midst of action, with implications for how stories come to be 'emplotted' and unfold. As the stories of pioneering AIDS activists inspired Aseff, he had begun to emplot his own.

In only his mid twenties, equipped with intermediate level of education, military experience and good communication skills, Assef stood out among most other HIV positive people and was valued as a volunteer by NGOs and donor agencies. The group of PLHIV selected for the meeting with parliamentarians was given a preparatory training at the ACP. Acting on his own initiative, Assef slipped out this training to see the ACP manager. 'I was unemployed. It was a big problem for me. Someone suggested that I should meet Dr Rafay. He is a good man', he recalled to me. Despite his many attempts, he had not been able to find employment outside the HIV sector. Dr Rafay gave him a sympathetic ear and had the new position of 'PLHIV Coordinator' created for him at the ACP. UNFPA agreed to support the salary for this position. Within weeks Assef had a contractual employment on a salary of Rs. 15000 per month (approximately $150, i.e. a modest salary). He had his own desk, a computer, a telephone and unlimited access to internet. He did not have to hide his HIV status at his workplace and now had the means to connect with HIV positive people globally.

The ACP, as the nerve-centre of Pakistan's HIV response, was supposed to be the most PLHIV-friendly place in Pakistan. However, Assef faced stigma and discrimination at the hands of even those who were charged with countering this stigma. Initially, he was given a three month probationary contract and tasked with developing the 'terms of reference' for his own position. He was then told to develop 'workable' proposals for the HIV positive people's welfare. He developed many such proposals including one he was particularly proud of, titled 'The needs of PLHIV'. Some of these proposals were rejected out-rightly, and others were accepted but none was considered for implementation. The best use that the ACP could put him to was as a 'token' to show that the government and its partners in donor agencies cared for the GIPA Principle. But Aseff, by his own admission, was not a very useful token for the ACP. He was not completely 'out'; 'where I thought it was suitable, I did disclose that I am HIV positive but where I didn't think that it was suitable, I didn't disclose my status'. He was strategic about disclosing his HIV status due to the widespread stigma.

This selective 'coming out' did not go well with the bosses at the ACP. If their numbers about the spread of HIV were to be believed, the ACP must put a face, or rather many faces, to this deadly disease. On every big public occasion, like the annual World AIDS Day

ceremonies, the ACP officials and their colleagues in donor agencies would come under intense pressure to prove to the journalists and the civil society that an AIDS epidemic was imminent. One of Assef's jobs as the PLHIV Coordinator was to bring HIV-positive volunteers to these big events for on-stage testimonials. These ritualised public performances of HIV positive narratives would sometimes be followed by individual interviews with journalists. After a few big events, Assef ran out of options to bring volunteers because they were demanding more and more money for their role in these performances. On World AIDS Day 2010, when Aseff could not bring any volunteers at all, senior ACP colleagues were furious. One of them disclosed his HIV status, against his wishes, by telling a television crew to interview him as a PLHIV. Aseff refused to identify himself on TV as HIV positive, but the reporters threatened him that they already had his footage and could run a story on him even if he did not agree to an interview. Apparently, they already had the senior official's permission to do that.

Because of the insensitivity and discrimination, he felt at the hands of senior members of staff at the ACP, Assef's every move was now tentative. He revived links with his CBO and became even more careful about disclosing his HIV status. He told me; 'where my heart and mind are satisfied, I give an interview, and where they are not, I don't. I've started to give interviews openly. I have given interviews as a PLHIV to *The News* and *The Nation*. I have given many interviews in English as well'. Assef's mention of *The News* and *The Nation* is significant. These are English language dailies with an upper and middleclass readership including donor officials and high civil society, as compared with the more widely read and easily accessible Urdu newspapers, which he felt would be more exposing of HIV status. He became a member of global networks of HIV positive people by using online resources and benefited from them in the form of exposure trips to Amsterdam, Vienna and Paris.

The World Bank Rollback: a crisis of resource constraints

In July 2010 a rumour circulated in the HIV/AIDS sector that the World Bank was going to withdraw its support for the Enhanced Programme. On its website the Bank maintained that it was 'committed to supporting the government programme over the next phase […] focusing particularly on increasing service coverage of most at risk groups in all major urban centres, improving access and quality of treatment and care, [and] strengthening the monitoring and evaluation' (World Bank 2010). However, in their meetings with the ACP, high-ranking

Bank officials hinted their unhappiness with a 'strategic shift' at the ACP, which they saw as more aligned to the perspective of the Global Fund on the epidemic. They also spoke about a shift of policy within the Bank where, according to one official, 'in the present context of resource constraints, the Bank would prefer to invest in the wider health systems reforms agenda'. This reflected the drawing to an end of the decade of global HIV scale-up (see Kenworthy and Parker 2014).

The 'context of resource constraints' was compounded by another series of political changes. In April 2010, Pakistani parliament passed the 18th constitutional amendment for devolution of powers from federal government to provinces. A three-phased devolution process was set into motion to transfer 17 federal ministries, including the Ministry of Health to the provinces. Following the passage of amendment, an intense debate had ensued on the merits of transferring health governance to the provinces. Many reputable public health experts called for an exception in the devolution plan to retain 'health' as a federal subject, arguing that the provincial governments were incapable of providing this crucial public service(see Nishtar 2011, Malik, Khalil et al. 2012)Nishtar, 2011).

In the intense dissonance of rhetoric, rumour and the circulation of various conspiracy theories following the withdrawal of the World Bank and the contentions over the devolution plan, it was hard to predict what would become of the Ministry of Health and its affiliated donor-sponsored vertical health programmes, which included the ACP. Some experts in the HIV sector speculated that the government might salvage those vertical health programmes that could still raise funds from external donors. Colleagues at the ACP joked about their predicament of working in an organisation which, in the words of one of my senior colleagues, had 'neither money nor future' and was possibly going to be shut down within weeks. They saw their organisation's survival vested in a strong commitment by the World Bank to continue financing the Enhanced Programme. However, this was not forthcoming. Meanwhile, the Global Fund also delayed grant negotiations with the ACP for the much-anticipated round-9 project. Paradoxically, it appeared that before committing any further funding, the donors were waiting for the government's final move to save or discard the ACP in the post-devolution Pakistan, whilst the government appeared to evaluate its options in light of the donors' commitment to the HIV sector.

The uncertainty about the future gripped the entire HIV sector. Concerns were raised about the continuity of the country-wide provision of free-of-cost ARVs in the absence of donor funding and central coordination of the ACP. The numbers of those needing ARVs was increasing sharply, as a senior official noted in an advocacy meeting with local journalists;

‘people are now sensitised, they are coming forward for diagnoses and are willing to disclose their HIV status’. ‘But’, he said ironically, ‘instead of scaling-up our efforts, we [as a country] are saying that we don’t have money for HIV!’. Another official debated, in a high-level meeting on the eve of preparing for the Global Fund grant application, that Pakistan’s reliance on the donor-supported free-of-cost ARVs programme should be replaced with ARV provision by the state from its own resources. ‘The interventions that we think are vital for our survival should come from our own resources because when we rely on external sources and if the source collapses, we are left with nothing, we despair… I mean, we make atomic bombs in this country, why can’t we make ARVs!’. Such emotional outbursts reflecting the frustration of the ACP officials were insufficient to impact the changing national policy framework and donor support. As the situation of resource constraint intensified, many contractual employees were told that the ACP could not extend their contracts anymore. Assef, whose contract had been extending after every six months, was among them. With a near impossibility of finding a job outside the HIV/AIDS sector and a funding recession within it, Assef had nowhere else to go; ‘I kept coming here for eight months without pay’, he told me disconsolately. His salary had been paid by UNFPA and UNAIDS, but now, even these ‘PLHIV-friendly’ organisations, as he put it, were turning their backs on HIV positive people. He was once again without an income. As the Enhanced Programme rolled back, the increasing likelihood of having to pay out-of-pocket for the ARVs in the future further enhanced Assef’s tottering on a thin line between life and death.

The Global Fund Project: ‘Our People, Our Money’

It was now becoming clear that if the ACP survived the devolution it would be because of the Global Fund round-9 grant. Dr Alamgir, a senior official at the ACP, was the leader of the team that successfully negotiated the implementation plan for the grant. He was made the project leader when the implementation phase started in early 2011.A number of employees from the previous round of the Global Fund suspected that they might be replaced by newcomers. Therefore, many of them started to pay regular visits to Dr Alamgir requesting him to re-employ them in the new project. In their displays of loyalty, they not only made themselves visible around him, running errands for him, but also praised him in his absence for his kindness, skills and expertise as an HIV technical expert who had almost single-handedly won the Global Fund grant for the ACP. Dr Alamgir, who had only just overcome

his own job insecurity after securing the top position in the project because of his considerable contribution in the negotiation phase, did not turn away any of these aspirant colleagues until very late when he got his new team of contractual employees in place. All but one contractual employee from the previous project were made redundant. The one who was retained was an office boy who knew how to navigate the corpus of manually indexed files and folders from the previous project. Dr Alamgir suspected that the laid-off staff would create nuisance for the new project team. Therefore, he very tactfully got copied all the data from their computers before informing them that they were not needed anymore.

Aseff also paid many visits to Dr Alimgir and made himself 'visible' by being in and around Dr Alamgir's cabin. Assef was confident of his selection in the new project team because he believed that he had developed the right credentials by working at the ACP. He explained to me how his 'capacity building' had been taking place since he joined the HIV sector, boasting that he could now draft excellent project proposals and reports. Most importantly for him, he was from within the 'PLHIV community': 'suppose you need someone (an HIV positive person), I can make 10-15 phone calls and bring you these people any time', he said confidently -although similar claims had failed him only a few months previously, on World AIDS Day 2010.

Like others Assef was also kept in anticipation regarding his prospects of re-employment in this new project. He kept coming to the ACP in that hope, reminding Dr Alamgir of his desperate need for 'some role' in the new project. Initially, Dr Alamgir appeared to appreciate the situation and sympathised with Assef. However, when the new team was put together Assef was told that there was no position in the project that would suit his profile. Assef was furious. Now trained in the GIPA Principle and participatory approaches, he complained to me that the non-PLHIVs in the HIV sector were 'eating money in our name'; 'If *our people* are not involved in these projects then it is unjust and discriminatory'. Even before the current crisis, he said;

> 'My contract [at the ACP] was renewed every six months, but every time, I received my salary only after four months had already passed. It took time to process it from the donor [to the ACP]. This would leave me with only two months before the end of the contract [and the time for a potential renewal]. My tension would start to mount. *We* do not have job security. If *our people* do not get these opportunities, how will *our* capacity be built? [Assef's emphasis]

In what appeared as 'using master's tools to dismantle master's house' (Lorde 1984), he used the language of participation, empowerment and community–*our people*, *our money*– against

the very individuals who had taught him this language. Frustrated by the lack of prospects of continuing at the ACP, he put on his activist hat and spoke out indignantly; 'I was very much afraid to say these things in past but now, being an activist, I think that all they can do is to throw me out [of the ACP] by saying that they don't have money to pay my salary because I speak too much! That's the maximum that can happen!'. He questioned the rules of the game in the HIV sector; 'I was the first ever PLHIV who was employed at the ACP. There were at least 2000 registered HIV positive people before me. Why could they [ACP] not employ one before me?'. Losing his position at the ACP, according to him, would be a great for all HIV positive people. He said;

> I have done so much for my [HIV positive] community. I have learnt so much and I am willing to learn so much more. I want to do so much for them. I want someone to take me, to give me an opportunity, only then I will develop and further progress. When I first came to the ACP, I was completely nil [didn't know anything] but now I am going on international level. When I go in the community and they ask me to conduct awareness sessions, I can give trainings without even looking at the materials. My capacity has been built so much. I now sit in panels to answer questions of people from the general population about HIV and AIDS.

Hinting to explain why Dr Alamgir ignored him, Assef pointed to the internal frictions within the PLHIV community where a number of newly-diagnosed HIV positive individuals had 'fallen prey' to manipulation by people like Dr Alamgir (*hath aa chukay hain*). He warned that the whole HIV sector will have to face problems if experienced individuals like him- whose 'capacities were already built'- started to look for jobs elsewhere. He said; 'I want to bring myself openly in the PLHIV community, slowly slowly, and I am also doing that, slowly slowly. I have given interviews at many places, live interviews, here and there. As you know there is still a lot of fear in our community'. The field of HIV/AIDS activism was no longer as narrow as it had been a few years ago when Assef had come to the fore. Following the large donor investment in this sector, spearheaded by the World Bank's Enhanced Programme, new CBOs of HIV positive people had emerged and there were more AIDS activist competing to be 'seen' and be part of the HIV response. Some of these were better educated than Assef and other had more privileged social and economic backgrounds, giving them a greater spread of networks across NGOs, the government, and the development sector as a whole. Assef, on the other hand, still struggled to 'come out' completely and was heavily reliant on a few PLHIV friendly individuals in donor agencies and the ACP. He had networked himself into global bodies of HIV positive people but these were of little use to

him in this time of crisis when there was little money left in this sector and the activist and employees of HIV/AIDS competed with each other over it, which often resulted in self-destructive tensions.

Closing Doors: An Unsure Activist

Aseff braved expulsion from his military employment due to his HIV status, suffered dehumanising experiences at the hospital, became part of the networks of support with other HIV positive people, and started earning a decent living by working in the HIV sector; the free-of-cost ARVs had helped save him from, what he called 'a mental collapse' when he was thrown out of the military, and a boom in the HIV sector – following the Enhanced Programme in 2003 – had given him a lifeline in the form of a respectable source of livelihood. As the HIV sector was scaled down, he was being pushed again into the hostile milieu of social ostracisation and joblessness. He had taken on an HIV positive identity selectively –disclosing his positive status strategically – but now he questioned his decision to 'come out' as it compromised his survival outside the HIV sector, in a discriminatory legal framework. He reflected;

> I feel that I have relied more on others after I was diagnosed with HIV. I rely a lot now. I think in my mind; 'ok, since I am diagnosed I will rely on the [PLHIV] association, I will rely on the ACP and I will rely on UN Pakistan to give me a job'. Earlier, I used to say to myself 'ok, what is the harm in applying at various places [for jobs]' but now I have stopped doing that because I know they will ask for the medical tests and I will be rejected. So, why waste money on applying for jobs… if there is a vacancy in the government for which I fulfil all requirements, it's often written [in the advert] that a medical examination will take place, and so on. So this is a mental pressure that brings change in one's life.

He had valued his work in the HIV/AIDS sector, took pride in his performance and was developing confidence in his ability as an AIDS activist. But now, with the ACP closing its doors on him due to receding external funding for HIV and lack of commitment of government towards this problem, what options was he left with? Would he set up his own CBO, like some other activists had done? 'No', he explained, 'the donor situation is weak.… [there is] a crisis. I do not want to set up a CBO that gave [to its members] only motivation and nothing else …everyone has a pocket, you know!'. With no job, no income and no

foreseeable prospects of earning, it was becoming difficult for him to continue to support his family or even to maintain a positive outlook on his own life. According to him, whilst the ARVs were available free-of-cost with the Global Fund support, the two main problems of HIV positive people in Pakistan were the lack of access to medicines for opportunistic infections, and the lack of employment opportunities. He believed that the first problem would disappear if the second was addressed effectively; 'give us jobs and you are free to take away the free medicines facility'.

CONCLUSION

Aseff's story is also the story of HIV sector as a whole in Pakistan. He relied on the HIV sector for his living and the HIV sector relied on external funding for its own survival. Both were plagued by extreme social stigma and discriminatory legal frameworks of the state. The enhanced response to HIV was neither sustained nor under the stewardship of the government, contrary to the rhetoric of the World Bank (and as Harman 2010 has observed of sub-Saharan Africa). A small number of influential NGOs and private firms emerged as the key players as the result of the policy of contracting-out. The pursuit of an illusionary 'market –efficiency' through contracting-out HIV/AIDS prevention and control services provided a thick ruse for the state to hide behind – a state that has historically evaded addressing this important issue in its health policies and legal framework. The World Bank-pushed scale-up created a blip of hope and opportunity for HIV positive activists like Assef and his colleagues in the HIV/AIDS sector, but only to leave them in despair afterwards. Agreeing to invest in the HIV sector by the Musharaf's government was a 'token' for the military regime along the same lines as employing Aseff as the 'PLHIV Coordinator' was for the ACP- to be seen as 'enlightened moderate' (Musharraf 2004)and PLHIV-friendly respectively.

Much of the ethnography that I have presented in this paper confirms the need for drawing attention to the agency of 'actors and networks', for which the 'new ethnography of aid' proposed by David Mosse and colleagues provides a useful theoretical framework. However, I demonstrate that 'actors and networks' do not operate in a predictable milieu or an even political environment and that the processes of 'translation' and 'mediation' of development goals do not take place in a power vacuum. In the 'AIDS industry', where 'byzantine international bureaucracies fight turf wars with one another'(Pisani 2008: 9), it might be misleading to characterize development agencies and practitioners as agents of imperialism

or neo-colonialism. Yet, there is ‘a sense of imperialism of thought, particular cultural models and categories being imposed upon and often accepted in the developing world’(Stirrat 2000: 41). In Pakistan the ‘cultural model’ for HIV prevention that was advanced by the World Bank was a neoliberal one, following the Bank’s agenda of achieving liberal outcomes by neoliberal means (Harman 2010). It turned government bureaucracies into hybrid organisations with corporate-style flexible work cultures, and reduced the state to the role of a purchaser of services from the private sector. As Stacy Pigg (2002:110) argues in case of Nepal, because of the ‘dependence of the state on donor funds, the donors can leverage public policy to support their own programmatic priorities’. In securing funds for HIV prevention from multilateral agencies, the receiving ‘countries have to show that there are HIV positive people on the project design team, that the government is in partnership with ‘civil society’, and that they are being inclusive of the ‘vulnerable groups’’(Pisani 2008: 273). Aseff’s elevation as ‘PLHIV Coordinator’ was not accidental or merely an act of pity; and neither was the scaling-up HIV sector under the military regime a benevolent gesture of the state- a state that continues to criminalise its own citizens for their (different) sexual preferences and that leaves the fate of its (post-devolution) AIDS Control Programme to the continuity of external aid rather than the increasing need of its HIV positive people.

My argument, therefore, is that whilst we study, as ethnographers of aid, the complex agency of the actors – their meaning-making, translations and mediations in the ‘social life’ of projects– we must not lose sight of the broader political field of repressive state apparatus and the planetary institutions where the locus of state power appears to be shifting in the global neoliberal order.

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