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Stigma and strategy in Pakistan's HIV prevention sector

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NGOs often portray commercial sex workers, injecting drug users, transgender people (*hijrae*), and homosexual men as quasi-legal persons who are locked in a policing-criminality relationship with the state, and who therefore need them to mediate this relationship. By advancing such portrayals, NGOs in Pakistan's HIV prevention sector capitalize upon the presumed cultural difference of the so-called risk groups of HIV. They appropriate stigma against these groups as a strategy to access funds and to fortify their own position as brokers in the unstable donor-dominated funding landscape of HIV prevention. In doing so, the NGO leaders and members end up stabilizing stigma and reinforcing its attendant inequalities in the socially conservative environment of Pakistan. The discriminatory legal framework that criminalizes sex outside marriage and non-therapeutic use of drugs goes unchallenged by NGOs, despite their apparent support for universal human rights, partly because the status quo stabilizes these organizations' position as brokers between state and donor agencies and the so-called risk groups of HIV.

Commercial sex workers, transgender people (*hijrae*), homosexual men, and injecting drug users are considered to be epidemiologically high-risk groups for HIV transmission in Pakistan. These groups not only face considerable levels of social stigma, but are also criminalized under Pakistan's legal system, thus making it even harder for them to access HIV/AIDS-related services, such as the free antiretroviral treatment which has been available in government hospitals since 2005. Under the Pakistan Penal Code – a continuation of the British colonial Indian Penal Code of 1862 – sex outside marriage and the non-therapeutic use of drugs are punishable offences. According to Section 377 of the Penal Code, 'carnal intercourse against the order of nature' is punishable with life imprisonment. Further severity in these colonial-era laws was added during the military regime of General Zia-ul-Haq in the 1980s, as part of the regime's social conservatism and attempts to Islamize the state and society: the *Hudood* Ordinances made *zina* (sexual intercourse outside marriage) punishable with death (Jahangir & Jilani 1990). Pakistan returned to democracy in the 1990s, with successive unstable civilian governments, but was again under a decade-long

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military dictatorship, under General Pervez Musharraf, between 1999 and 2008. This latest military rule had an agenda of 'enlightened moderation' to counter religious conservatism in Pakistan in the post-9/11 world. Since 2008, Pakistan has had several democratically elected governments, but sharia-inspired laws, such as the *Hudood* Ordinances and the blasphemy laws of the previous conservative military regimes, remained firmly enshrined in the country's legal system, in spite of attempts to repeal them by the Musharraf regime and subsequent democratic governments.

In this context of religious conservatism and the criminalization of those who are deemed most at risk of contracting HIV, NGOs have become very important actors as 'go-betweens' in the state's provision of HIV/AIDS counselling and treatment services. However, as I will elaborate in this article, the NGOs' role is not just to provide a bridge between HIV-related services and their quasi-legal users, but also to *stabilize* this quasi-legality and use it for their own purposes. I use the term 'quasi-legal' instead of 'illegal' to emphasize that insofar as the law is concerned, the person who commits an illegal act, such as sex outside marriage or non-therapeutic use of drugs, is not illegal per se. This is in contrast to the Criminal Tribes Act of 1871, which criminalized entire communities on the assumption that anyone born into those tribes was a 'born criminal' because of the 'criminal tendencies' of their tribe (Quraishi 2005: 51). The list of criminal tribes included 'eunuchs', in the colonial terminology: today's transgender people or *hijrae*. In the colonial system, therefore, their very existence was criminalized. By contrast, the current distinction of quasi-legality from an outright 'illegal' status for HIV risk groups allows the government to tacitly accept donor money or set aside public funds for HIV prevention among them, without breaching the legal code. It also allows NGOs to work with their client populations without breaking the laws on aiding and abetting criminals.

HIV's epidemiological risk categories, such as 'female sex workers' (FSWs), 'male and transgender sex workers' (MSWs, TSWs), 'injecting drug users' (IDUs), and 'men who have sex with men' (MSM), were originally premised on the sexual and drug use behaviour of individuals. These epidemiological categories have now become the identity categories with which NGOs label their client groups, and with which individuals may increasingly identify themselves. The term MSM first emerged in the United States in the 1980s as a scientific and bureaucratic coinage – like, but in contradistinction with, the earlier 'homosexual' – to signify the sexual behaviour of men who engaged in anal intercourse with other men but did not identify as gay (Boellstorff 2011). Ironically, given its coinage in the attempt to bypass the politics of self-identification with sexual preference, as this label travelled the globe as part of HIV prevention templates, it became an identity category (see Boyce 2007; Khanna 2009; Mahajan 2008).

In this article, I examine the use of stigma by the leaders of NGOs working with stigmatized groups to further their own position as brokers of HIV prevention projects. The NGO leaders' uncritical endorsement of the selectively criminalizing socio-legal and cultural milieu of Pakistan reproduces stigma and its attendant inequalities for those who are most at risk of contracting HIV, while at the same time it raises their NGOs' profiles as gatekeepers for HIV-related interventions. For these NGO leaders, social stigma thus becomes a strategic resource for accessing donor funds in an unstable donor funding landscape. I argue that this is a form of 'accumulation by dispossession' under the neoliberal governmentality of global health and development. David Harvey developed the term 'accumulation by dispossession' as an adaptation

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of Marxian 'primitive accumulation', which, according to him, 'entails appropriation and co-option of [the] pre-existing cultural and social achievements' of a community (2003: 146). In the ethnography presented here, instead of the pre-existing cultural and social achievements of HIV's risk groups, it is the social stigma against them – their 'undesirable difference' or 'spoiled identity' (Goffman 1963) – that is appropriated by NGO leaders for their own accumulation. In doing so, the NGO leaders do not take away or *dispossess* them of their stigma but, rather, stigma against them becomes more entrenched, as a thing of economic value and an asset in the scramble for donor funds.

This article draws from an ethnographic study of the politics of Pakistan's HIV/AIDS response which I conducted between 2010 and 2011. During fieldwork, I was primarily based at the National AIDS Control Programmes (NACP) in Islamabad. This gave me opportunities to observe the NGO actors who were interacting with the government through the participatory modes of governance that hold sway in the HIV/AIDS response under the 'Greater Involvement of People Living with AIDS' (GIPA) principle (see Boesten 2007; Piot & Aggleton 1998). The NACP was not very different from other government departments in Pakistan, yet this masculinized office space was also a place where *hijrae* sat in meetings with government officials, international experts, and civil society leaders to discuss the future of HIV prevention in the country, and where the NGO representatives of women, religious minorities, MSM/men who have sex with men, commercial sex workers, and HIV-positive people were seen in discussion with high-ranking bureaucrats, public health experts, religious leaders, journalists, and the leaders of UN agencies and bilateral aid organizations. The participatory mode of HIV governance brought them all together to devise HIV policy and make pronouncements about what an effective and appropriate response to HIV in Pakistan should be.

In contrast with this mingling in the policy corridors, those belonging to the epidemiologically established risk groups did not show up at the government's HIV treatment centres unless their access was mediated by an NGO. One treatment centre manager described to me that the 'transgender and groups like that don't come unless they are connected to a proper NGO'. Another lamented that transgender people and homosexual men faced double discrimination for their HIV-positive status and their gender identity or sexual orientation: 'When a transgender walks into a hospital, nobody knows that he is HIV positive, but because of our particular mind-set we already discriminate against them'. Their access to HIV treatment centres was mediated by the NGOs, who designated them as their 'target populations'. Meanwhile, treatment centre managers regretted that the turn-out of IDUs was generally low. Yet one reason for this low turnout was that the treatment centres relied on NGOs to bring only 'clean addicts': that is, those who were receiving detoxification for at least two months without a relapse. 'We have very limited resources', explained the senior doctor in charge of an HIV treatment centre in a large public sector hospital. Reiterating the neoliberal logic of value for money, she added, 'We want to take only those patients who would adhere to their HIV treatment'. She claimed that she could tell a 'clean drug user' from an unclean one by just looking at them. If in any doubt, she would send them to the psychiatry department of the hospital, where the suspect would be interviewed to establish whether they could be trusted about their stated 'clean' status.

Goffman understood stigma in terms of undervalued self and the attempt to hide it because of its status as an aberration of the normal, a process he described as 'stigma management'. Stigma puts the person bearing it at a disadvantage; therefore, they attempt to hide it or try to 'pass as normal' (Goffman 1963: 87). This classic

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understanding of stigma as a significantly discrediting attribute of the individual was critiqued powerfully by scholarship on HIV/AIDS-related stigma and discrimination. Parker and Aggleton argued for an understanding of stigma and stigmatization as 'intimately linked to reproduction of social difference' because 'stigma feeds upon, strengthens and reproduces social inequalities of class, race, gender and sexuality' (2003: 13). More recently, Tyler has written poignantly about stigma as 'the machinery of inequality', a 'violent practice of exploitation and social control' (2020: 252) that functions as a 'dehumanizing praxis of subjugation' (2020: 270). She draws attention to the structural conditions of stigma production, from histories of slavery, colonialism, and capitalism to the practices of social abjection under the neoliberal welfare state. Stigma operates as an 'inscriptive form of power' (2020: 49), she observes, along interwoven axes of race, class, gender, and sexuality. In Pakistan's HIV sector, this inscription of stigma against commercial sex workers, transgender people, IDUs, and homosexual men manifests in their criminalization, their exclusion from HIV prevention services, and their dehumanizing treatment by staff at HIV treatment centres.

Beyond this critical attention to the structural conditions of the production of stigma, and its intersectional inscriptions as a form of power, Staples argues that those in South India who identified as 'stigmatized' by 'leprosy stigma' 'take on and interact with their classification in ways that are sometimes difficult to predict' (2011: 122). Using Hacking's (1998) notion of 'ecological niche', Staples analyses the biographies of individuals with 'leprosy stigma', teasing out their multiple social identities of class, caste, and gender, demonstrating the convergence and impact of diverse factors on individuals' experience and management of leprosy. While Tyler is convinced that 'stigma has been resisted by those it is pressed upon' (2020: 29), Staples (2011) helps us to see that the stigmatized can take on and interact with their stigma in unpredictable ways.

Building on this literature concerning stigma, I argue not only that in Pakistan's HIV prevention sector stigma operates as a mechanism for social control and exploitation in the hands of the powerful, but also that the stigmatized groups and individuals may use it strategically for their own gains. Goffman anticipated the use of stigma by stigmatized individuals for 'secondary gains' such as 'an excuse for ill-success that has come his way for other reasons' (1963: 21). However, my ethnography shows that rather than an excuse for individual failings or misfortune, stigma may be used by NGO leaders and members as a strategy to gain access to donor funding. I argue that this strategic use of stigma is undergirded by a neoliberal ethos of responsibilization (Beckmann 2013; Miller & Rose 2008) and entrepreneurship (Kelly 2006; Qureshi 2014), and the data determinism of international health and development under the 'sovereignty of metrics' (Adams 2016) and 'audit cultures' (Strathern 2000) of modern institutions. Enterprising individuals from within the target groups of HIV interventions are enabled by the 'participatory' development approach, such as the GIPA principle, to capitalize on their work as the translators and brokers (Lewis & Mosse 2006) of global health interventions. In analysing their brokerage, I draw attention to the presentation of stigmatized self – as MSM, IDUs, or commercial sex workers – as a valued asset in HIV prevention markets; a form of social capital that helps build financial capital through the ingenuity and entrepreneurship of NGO leaders.

My focus in the following sections will be on three case studies of HIV-affected communities in Pakistan, whose NGO leaders I observed in action at the National and

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Provincial AIDS Control Programmes and later interviewed in detail. I will build an argument about the extraction of value from stigma, and strategies for gaining access to resources by NGO leaders and members. The first two NGOs were established and spearheaded by politically connected and socially privileged individuals, whereas the third NGO represents a community initiative in the historically deprived and socially marginalized red-light area of Lahore. In referring to the target groups these NGOs served, I will use labels such as IDU, MSM, commercial sex workers, and transgender people, which, as I observed above, have become pervasive identity categories in the HIV prevention sector in Pakistan. I will use pseudonyms for individuals to disguise their identities. Although the NGOs discussed in this article may not be completely unidentifiable to those familiar with the HIV prevention sector in Pakistan, my use of pseudonyms stops them from being identified through simple internet searching. I draw mainly on interviews with the bosses of these three NGOs. However, my analysis is also informed by interviews and interactions with other members of these NGOs and colleagues in the HIV sector more broadly.

Being MSM

Jay set up the first NGO for MSM in Pakistan in 2011 with the financial support of a Global Fund for AIDS, Tuberculosis, and Malaria regional grant for HIV prevention in South Asia. Jay was not publicly 'out' as 'gay' at that time but he said that 'coming out' was not a big problem due to his privileged social class and supportive family. He saw his NGO as synonymous with the global LGBT rights movement, but he presented it to the public as a 'male health NGO' because, as he told me, it was 'not yet the right time' for an open LGBT rights movement in Pakistan. There were a few underground LGBT networks in the country, and some local gay websites with members in their thousands, but they were not 'really gay'. For them, argued Jay, 'being gay means, having sex, promiscuity, multiple partners, one night stands!'

By allowing this NGO for MSM to operate under the name of 'male health', the government of Pakistan was able to circumvent the illegality of male-to-male-sex in the country, while at the same time responding to the international concern about a seemingly growing epidemic which had this quasi-legal population at its centre. Jay set up the NGO's office in a rented bungalow in Lahore which was hidden from the watchful eyes of the general public and away from interfering government bureaucracy. The NGO's office had no signboard or other markers to distinguish it from the surrounding bungalows of the nouveau riche in an up-and-coming residential neighbourhood. When I went to interview Jay on an August afternoon in 2011, I was greeted by Shabnam, the office girl, who offered me a glass of ice-cold water with a big smile and ushered me into his office.

Jay described his NGO as an organization 'for MSM, of MSM, and by MSM'. All of the dozen or so employees, except for one technical adviser, were 'MSM or transgender'. They were selected very carefully on the basis of their commitment and desire to work on MSM-related issues. Their education and other skills were of secondary importance, Jay told me. For example, neither of the two recently selected 'technical officers' had particular professional skills, education, or experience to work in the health and development sector. One was a telecoms engineer, and the other had worked in the marketing department of a mobile phone company. 'Being MSM' was the main criteria for their selection. 'We have something in common', Jay explained, and added, 'We are

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all MSM, and we all have the desire to work for MSM … Only an MSM can understand other MSM'.

When interviewing candidates for employment in his NGO, Jay told me he always made sure that one of his *hijra* friends would be by his side as part of the interview panel. If a candidate reacted awkwardly to being interviewed by a *hijra*, Jay could then tell he was 'not really an MSM'. This practice of queering the job interview so as to assess the real motives of a candidate for joining the MSM community underscored Jay's statement that only an MSM could understand another MSM, thus typifying MSM as a distinct subjecthood and establishing a cultural difference of MSM from non-MSM. It also gives credence to the view of some figures in the HIV prevention sector, who I heard complaining that those who present themselves as MSM may lie about their 'real' (heteronormative) sexuality in order to gain access to material benefits that come from membership in this community, such as employment in Jay's NGO.

The NGO's task under the Global Fund project was to bring together those men and transgender people who have sex with men into a community under the banner of MSM. 'Have you met Shabnam?' Jay asked me in English, gesturing towards her as she brought coffee for us in his office. 'She is a *hijra*', he continued, without waiting for me to answer.

> She works for us here. She is trying to learn English these days. She is our office girl. She is a sex worker as well. She does sex work at night on M.M. Alam Road [an expensive shopping area and pick-up spot], which is [work] as far as I am concerned and, I think, most of my staff: sex work is work. They are not stealing, they are not begging.

Shabnam's embarrassment on being described in so many words – in English – was obvious. Jay was perhaps subjecting me to the same kind of embodied personal politics test as he did to new candidates for employment – or perhaps just showcasing the authenticity of his NGO, which welcomed the downtrodden *hijrae* into its folds because they were also MSM, even if they might not go with that label.

I wondered how many times Shabnam had been presented like this by her new boss in this job and whether she also saw herself as her boss did. Meanwhile, Jay continued talking about her over her head, explaining how he had offered her some extra money for cleaning the upper portion of the office-bungalow, where he lived with his boyfriend, but she did not accept it until her guru came to negotiate the terms of extra work on her behalf. Referring to this structure of guru-disciple relationships (see Nanda 1999), he said with some satisfaction, 'I think it is good for these people because they do not have anyone else'. Shabnam stepped back and stood silent. Jay continued, while looking at her and me, 'They do not have parents, so they need …' he paused, 'kind-of an authority figure. They live in an environment where there is a lot of sex, a lot of drugs, a lot of alcohol abuse, and if they don't have an authority figure they can actually get out of control'.

The contrast between Jay's and Shabnam's situations was revealing of the range of backgrounds that his NGO would bring together under the banner of MSM. His description of the typical environment in which *hijrae* like Shabnam find themselves – replete with sex, drugs, and alcohol abuse – and his emphasis on the need for an authority figure, because they 'can actually get out of control', reinforce a stereotypical image of uncontrolled *hijra* sexuality. In contrast to these caricatures, literature from across South Asia details that *hijra* is primarily a gender identity – also often termed as a 'third gender', or transcending gender – rather than a sexual behaviour category

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or sexual identity per se (see Reddy 2005). Despite widespread stereotypes about their hyper-sexuality and sex work being their main source of livelihood, not all *hijrae* are sexually active with men or other *hijrae*. Anatomically, some of them might have ambiguous genitals, and others might have had their genitalia removed through surgery, but a large number comprise those who have unambiguously male genitals. Some of these latter category may be in monogamous heteronormative sexual relations with their wives and have children in their families of origin while they live with other *hijrae* in cities (Collumbien *et al.* 2009).

Jay explained the typical path to becoming a *hijra* in Pakistan as the following:

> The lower-class families do not accept effeminate male children because they are a disgrace to the family honour. Therefore, they are either thrown out of home or they run away on their own. Now, who will take care of these effeminate males except the *hijra* gurus? The gurus take these boys and raise them as a parent, both as a mother and a father.

Jay valued the *hijra* networks for parenting these young people when they were rejected by their families of origin. At the same time, he also regretted that many of these underprivileged effeminate male children were 'forced' into becoming *hijrae* when 'they really are not', and that they were open to exploitation by gurus who forced them to sell sex or beg on the streets. He assumed a stable MSM subjecthood for these effeminate children who had been forced to take on a *hijra* identity. Therefore, enlisting them as MSM in his NGO was like restoring them to their authentic subjecthood.

Shabnam maintained a friendly posture with a polite smile on her face, holding the empty tray close to her chest before Jay finally told her she could leave. It appears that the young effeminate boys who were first subjectified as *hijrae* were now summoned to become 'MSM' – the subjects of HIV prevention. Despite his ambivalence towards the *hijra* networks for their exploitation of young effeminate men, Jay was keen to work with them so as to increase the membership of his NGO. 'It makes my life easier', he said. 'You just have to contact a few gurus in a given area!' He did not shy away from co-opting and replicating the patriarchal structures of seniority and control of the *hijra* networks in pursuit of achieving membership numbers to demonstrate project success, therefore, in order to achieve numerical targets set by the Global Fund as a 'condition precedent' for the release of funds. Stereotypes about *hijra* sexuality were thus reinforced by their blanket inclusion into the category of MSM because it served the NGO's target for forging this new community and strengthened its position as the broker for HIV prevention in this group.

Addicted to making money

Like Jay, Jamal, the CEO of Pakistan's largest NGO for IDUs, also came from a privileged background. His father had strong cross-party political connections in the ruling elite in Pakistan. He had also served as a federal minister in previous governments. Jamal had been an IDU in his youth but later he quit drugs and established what he called 'Pakistan's first rights-based drug treatment facility'. In the early 2000s, his NGO did the kind of work that Jay was now engaged in: that is, translation and operationalization of the terms of the international donors of HIV for the Pakistani context. The NGO carried out surveys on HIV prevalence to establish IDUs as the main 'vector' of the spread of infection. Jamal claimed that there was a 'science to HIV prevention' among drug users and that only his NGO had perfected that science in Pakistan because it was an NGO of ex-drug users. Based on this strength as insiders, and Jamal's mastery

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over brokering international donor-funded interventions for HIV prevention, the NGO won major projects funded by the European Commission and the World Bank in the early 2000s. By the time of my fieldwork in 2011, this NGO had become the single most powerful actor in HIV prevention in Pakistan; it was seen as more powerful than the government's HIV/AIDS bureaucracy (see Qureshi 2015).

In his interview with me, Jamal glossed IDUs as uneducated, unemployed, and poor. Most of them had 'been on the street for ten to fifteen years', he said. 'A typical IDU', he continued, on the authority of having been one of them, 'hates authority, has very low self-esteem, poor health, and no skills … Where is he going to find a job?' This stereotyped image was used as the justification for a unique detoxification/rehabilitation programme that Jamal's NGO had pioneered. 'We do a fifteen to twenty days' detox and then employ them immediately on our farms', he explained. The NGO's farms, in four major cities of the province of Punjab, were attached to the residential detoxification centres – or perhaps the other way round, as Jamal described these centres as 'our farms' rather than 'our detoxification centres'. On these farms/detoxification centres, the residents were trained in intensive agriculture by giving them a patch of land to work on. Some of them were allowed to build a temporary hut in a corner of an allotted patch of land and bring their wives and children to live and work with them. 'The idea', explained Jamal, 'is that they were addicted to drugs, so now we get them addicted to working and making money'. They produced vegetables for the farm, and their wages were determined by the size of the patch they were given to work on.

Like Jay, who did not trust the desire of a supposed MSM before he put it to the test in job interviews, Jamal also did not trust drug users with the money they earned from their farm labour. Typifying a drug user on his farm, he explained, 'You were somebody who never had any resources. Suddenly you get a salary of 10,000 rupees. The first thing you do is that you buy a mobile phone, you waste all the money'. Therefore, the NGO handled their earnings by sending the wages straight into their accounts with a sister micro-finance NGO. This micro-finance NGO, which was ostensibly outsourced to teach farm residents how to manage their finances, told them that the best use of their money was to reinvest it by leasing more land at the farm, for which it made payments directly to Jamal's NGO. Thus, the money earned by the recovering drug users circulated between these two sister NGOs. The IDU-turned-farm labourer was regarded as unworthy of trust because he had been a drug user. The stigma of untrustworthiness was reinforced and used by these NGOs in ways that fortified them.

The HIV-positive drug users registered with this NGO were sent to live and work at a farm that was famous for its vineyards. They were regularly taken to a government HIV treatment centre to receive free medicine. The NGO's role in this partnership with the HIV treatment centre was to ensure that patients were 'clean' and that they adhered to the prescribed treatment, as mentioned before. Jamal agreed with the doctors at the HIV treatment centres who declined to provide HIV treatment to 'unclean' and potentially non-adherent drug users. He did accept the WHO's recommendation of universal access to HIV treatment regardless of one's drug use status (WHO 2006: 61) as a matter of human rights. However, in practice, he argued, potentially non-adherent, 'unclean', drug users should be institutionalized first, to stabilize their condition before starting their HIV treatment, and the best way to institutionalize them was to confine them in the residential detoxification facilities of his NGO, so as to 'get them addicted to making money'. Opiate substitution therapy, or OST, which is a widely accepted method of stabilizing drug users' condition while undergoing detoxification, is illegal

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in Pakistan. Jamal's NGO is not known for advocating for its legalization, despite his political connections and influence within the ruling elite. In fact, Jamal presented the illegality of OST as a justification for his NGO's approach to detoxification through farm labour. It is difficult not to conclude that it was not in the NGO's interests to work for legalization of OST or indeed to campaign for decriminalization of non-therapeutic use of drugs.

IDUs continue to be seen as the main driver of the HIV epidemic in Pakistan and the legal ban on OST remains unchallenged. Meanwhile, Jamal's NGO has grown exponentially in last twenty years, especially during the HIV scale-up decade between 2000 and 2010 (Qureshi 2015). In addition to their agribusiness, the NGO now had a Labrador dog-breeding facility at one of its farms, which was also the farm where HIV-positive drug users were kept for rehabilitation through farm labour. The NGO also had a showroom at its Islamabad office that sold expensive leather handbags, which were hand-made by drug users and their wives. With the detoxification centres/farms firmly established, the NGO's operations were now gravitating towards 'capacity building' rather than service delivery. That is to say, the NGO would now manage big grants by subcontracting service delivery to smaller NGOs. Jamal was working on getting the Global Fund 'addicted' to his NGO as the indispensable actor for IDU-related interventions in Pakistan. He said:

> Right now I am trying to get the Global Fund addicted to us … let the first two years pass, then we will sit down and say, 'OK, let's shape up … It is also up to us if you want to engage' … If they think they are going to be the only ones to decide whether to engage or not, then they are mistaken. We can also say, 'Sorry, find a new partner!'

Addiction was not just a metaphor that Jamal used for describing binding partnerships, it was his approach to business relations with his donors and clients alike, removing it from its negative association with the world of drugs putting it to use for increasing his NGO's assets. He lived in a large farmhouse and drove an exorbitantly expensive new BMW 700 car. Many colleagues in the HIV sector were critical of the lavish lifestyle of this NGO boss.

Both Jay and Jamal came from privileged backgrounds. They spoke fluent English and were articulate personalities. Both had found a niche in the development sector, carefully cultivating their respective 'risk groups' and advancing a discourse of rights-based approaches in high HIV policy forums. They made creative use of stigmatizing stereotypes and illegality of their 'risk groups' in advancing their NGOs. In the final ethnographic case, I turn to Jamila and her husband Shah, two less privileged NGO managers, to explore their strategic and contingent encounters with international health and development and their uses of stigma associated with the 'risk group' they served.

'Yes, I'm a sex worker!'

Jamila and Shah lived in the red-light area of Lahore, where they ran an NGO for the education, health, and welfare of commercial sex workers and their children. The NGO's office was set up in a small one-room annexe of Jamila's ancestral home in a narrow alley of *hira mandi* ('diamond market' – another name for the iconic red-light area of Lahore). From outside, this room appeared to be a sort of outgrowth of a three-storey building. Inside, the NGO's office, with its curtain shrouding a narrow opening in the wall, which sheltered off the private residence from visitors to the public space of the

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office, and the narrow staircase leading discreetly onto the street below, retained the architectural mould of the 'office' in the vernacular sense: the front room of a house in a red-light area where guests or clients would be entertained by dancing girls (Saeed 2002).

'My name is Jamila and my strength is that I was born and brought up here [in the red-light area]. This is my plus point'. Jamila began her interview with me with these sentences, her gaze fixed on the voice recorder. She narrated how, many years ago, when she had been looking after her sick mother in hospital, a team of doctors had offered her to work for them to assist with the collection of blood samples from commercial sex workers for an HIV-related project. 'Everyone at the hospital knew that I was from the *ganda bazaar* [bad/dirty market]', she recalled, referring to her origins in the red-light area. For these doctors, she became the 'contact person' for all the HIV surveillance activities in the neighbourhood. Later on, she set up her own NGO for HIV awareness-raising in the community. The NGO handed out food packages to around 200 sex workers every year, in Ramadan, in return for them promising, in community meetings, to stop commercial sex work during the holy month. Moreover, the 'community outreach workers' of the NGO were required to give up sex work as their primary occupation. Jamila argued that, apart from distinguishing outreach workers from '*aam* [common] sex workers' in the area, there were practical reasons for this requirement: an outreach worker could not be allowed to interrupt her NGO work for a sex client: 'Sometimes we have donors, sometimes we have visitors, sometimes the targets are hard to achieve, and sometimes a meeting is in progress', she explained. NGO work, like sex work, also appeared to be unpredictable in this donor-dominated unstable landscape of funding for HIV prevention.

NGOs like Jamila's claimed a large membership base to gain access to donors' funding, and sometimes they were required to show their numbers in order to maintain that access. This appeared to give rise to a contestation over the authenticity of NGO members as 'real' sex workers. Jamila's husband, Shah, had recently been hired to work with a team of researchers evaluating a donor-sponsored project of a rival NGO. This rival NGO, according to Shah, claimed to have registered 2,000 sex workers as its members, yet it had failed to bring sufficient numbers for focus group discussions run by the NGO: 'The same girls kept coming in different get-ups – *burqa*, *niqab*, *hijab*, *abaya*'. 'These dummy sex workers', according to him, 'were actually common women (*aam aurateen*) from the general community' who passed as sex workers in order to claim the participation fee. He alleged that this rival NGO routinely presented 'non-sex workers' as 'sex workers', in seminars, workshops, and meetings, to prove that the NGO had great outreach and membership. Moreover, according to him, sometimes these women did not even know that they were being presented as sex workers or that some of the other participants of these events were real sex workers.

To prove her own NGO's authenticity in contrast to the one mentioned above, Jamila shared that on one occasion when the rival NGO could send only a handful of sex workers to a donor-organized event, the donors contacted her in panic and she managed to send more than 100 at very short notice. They were all 'genuine sex workers', she emphasized: 'I told the organizers, "Choose whichever you like, send her to the stage and you shall see, she will say, 'Yes, I am a sex worker!'"' Like the drug users who were required to be 'clean', trustworthy, and connected to Jamal's NGO in order to receive HIV treatment, as described earlier, or the young men who had to prove the authenticity of their desire for MSM in front of Jay, it appears the members of Jamila's NGO had to

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be willing to affirm 'Yes, I am a sex worker!' in order to qualify for participation in donor-sponsored programmes.

Ironically, Jamila also said that she was against making a *tamasha* (show or display) of sex workers in order to please donors: 'They are not monkeys to be made to put on a show in front of donors … A real donor will give us money on the basis of our work anyway, without such measures'. She shared very proudly that for the first time in Pakistan's history, she took an 'ex-sex worker' to a conference in Nepal, where this woman 'presented' herself before the audience: 'It is because of our NGO that these girls are now empowered to share their problems'. Jamila said she never took her NGO's donors to visit sex workers' homes in the red-light area – except for 'our proper donor, who has been funding us for last eight years'. Like Jamal, who supported the WHO's recommendation of HIV treatment regardless of the drug use status of an individual but in practice aligned himself with doctors who declined treatment to 'unclean' drug users, Jamila also appeared to uphold international development's values of human rights and personal dignity of her NGO's beneficiaries, but in practice she had to display numbers and extract testimonials in order to establish her NGO as an authentic and reliable 'contact point' for the donors and to effectively compete with her rival NGOs.

Jamila had no qualms about presenting her NGO member at a conference in Nepal to showcase sex workers' empowerment through her NGO before an international audience, yet she and her husband were very critical of a recent workshop in Pakistan sponsored by the UN Population Fund (UNFPA) where participants reportedly raised a slogan 'sex workers *zindabad*' (long live sex workers). As Shah uttered these words, telling me about the event, Jamila touched her ears and muttered '*Allah muuaf karee*' (God forgive us) to show her disapproval of the idea.

The story of Jamila and Shah's activism is remarkable in its moral ambiguity towards sex work. They run an NGO for sex workers; Jamila presents her belonging to this community as her 'plus point'; they show great concern for the authenticity of sex workers in HIV prevention projects; yet their outreach workers and the beneficiaries of their food ration scheme must give up sex work, especially in Ramadan. They are against the *tamasha* of sex workers, yet the proper donors are escorted to sex workers' homes to see them for themselves. The NGO is against *tamasha*, yet it puts its members on stage in front of conference audiences to give testimonials as authentic sex workers. These ambiguities and apparently contradictory choices reflect the extreme stigma against sex work in Pakistani society, yet the necessity of using this stigmatized marginal position to gain access to resources for HIV prevention is evident in the strategies of NGOs like Jamila's.

Authenticity, as expressed through belonging to the red-light area with an ancestral home and residence in an *office* in the vernacular sense, and the ability to work in sex workers' networks to recruit numbers for projects and initiatives became a valuable resource for Jamila and Shah to access donor funding. Achieving and displaying targets in this landscape has a premium over provision of care and confidentiality, despite the widespread stigma attached to sex work.

The 'non-sex worker' participants of workshops for sex workers, as described by Shah above, may or may not exist, but if they do – as he insisted – then they appear to be momentarily taking on the much-stigmatized identity of sex worker in order to obtain minor gains such as participation fees, travel costs, and the like. As opposed to a stigmatized person trying to 'pass as normal' – as in Goffman's theory of stigma management – here we have a 'normal' person trying to pass as stigmatized. They

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put stigma to creative uses, and in doing so these women are perhaps not acting very differently from NGO bosses and community leaders, albeit at a much smaller scale – for the workshop participation fee. Thus, it is not just the NGO leaders but also their members who simultaneously appropriate and capitalize upon, as well as stabilize and reinforce, stigmatization of their groups. Moreover, such strategies for gaining access to funds may be outwardly disapproved of, as with Shah's disapproval of the use of inauthentic sex workers in workshops, yet in practice they seem to be broadly accepted in the HIV sector, across NGO leaders, members, and donors. Thus, when Shah wanted to raise the issue of 'fake' sex workers in a workshop with a representative of an international donor, who also happened to be present there, he was told not to mention it again.

Conclusion

In the three case studies presented here, I have attempted to show how some people within stigmatized groups turn this structural relation into a thing of economic value for themselves. My findings echo Tyler's claims concerning how 'stigma is designed, crafted and activated to govern populations on multiple scales in diverse sites' (2020: 269). However, the ethnography presented here collapses the boundary between agents and subjects of the regimes of governance built around stigma. It is not only the doctors at HIV treatment centres, as outsiders to the so-called risk groups, who draw on social stigma against drug users to justify their exclusion from HIV treatment. But, as I have shown, NGO leaders drawn from within stigmatized groups such as MSM, IDUs, and commercial sex workers also strategically use stigma to extend their control and leadership of their respective risk groups. Rather than countering or challenging stigma, or campaigning for legal reform, they use the power of stigma to advance their own positions in the HIV prevention sector. Complicating Tyler's arguments, then, stigma is not necessarily always 'resisted by those it is pressed upon' (2020: 29). I have advanced an understanding of stigma not just as a structure of violence, with a clear distinction between its victims and perpetrators, but also as a strategic asset, which in practice blurs the boundary between victims and perpetrators of stigma. Staples (2011) opens up the range of possibilities by drawing out the unpredictability of ways in which stigmatized people interact with their stigma. My ethnography shows that stigma is used as an asset by NGO leaders, when they perform and lay claim to a stigmatized identity and project it outwards, in a gambit of authenticity as representatives of HIV-affected communities, and as part of trying to evolve an economic niche for their NGO in the HIV prevention market. In doing so, I argue, they simultaneously take on and appropriate these identities *as well as* reinforce the stigmatization of the affected communities, such as through stereotypes of addiction, uncontrolled sexuality, untrustworthiness, and faking of identity.

The epidemiological understanding of sex workers, transgender people, homosexual men, and people who use drugs as 'risk groups' for spreading HIV has added to the pre-existing stigma against them. In addition, however, the sort of NGO work which uses stigma as a thing of economic value, which I have drawn out here, has also provided further impetus to stigma as 'the machinery of inequality' (Tyler 2020) in an already conservative social, cultural, and legal environment. NGO leaders have used the context of illegality and pre-existing stigma against these groups to advance their own projects of accumulation by dispossessing them of HIV prevention resources such as free treatment at HIV treatment centres, or indeed the hard-earned money from

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their farm labour. The NGOs' role as brokers in this 'field of power' (Elyachar 2005: 29) – a field that was characterized by unstable donor-dominated funding for HIV prevention – often required them to speak to, and even play up, stigmatizing stereotypes about their client groups, thus further entrenching stigma and inequality against them. Ironically, this has happened under the banner of participatory development and rights-based approaches in global health, such as the GIPA principle, which have ended up strengthening the grip of these gatekeepers and brokers over HIV-related interventions. Moreover, ordinary members of client groups were compelled to play up their stigma or pass as stigmatized at NGO events for small financial gains, thus capitalizing upon as well as stabilizing and reinforcing stigmatization of their groups.

In addition to the social and legal conservatism and unstable funding of HIV prevention, the 'context of *culture* and *power*' (Parker & Aggleton 2003: 17, emphasis added) for the stigmatization of the 'risk groups' in Pakistan is dominated by a neoliberal ethos of development, such as quantifiable targets and 'value for money'. The drug users at HIV treatment centres were met with humiliation and denied treatment, not only because of the existing social stigma against them but also because of the treatment centres' managers' concerns with achieving targets as a 'condition precedent' for continued funding from the Global Fund. Thus, a mode of global health governance that privileges metrics over people's lived experience (Adams 2016) combines with existing narratives of delinquency and untrustworthiness of drug users to produce their exclusion from HIV treatment. 'Unclean' drug users were denied HIV treatment because they could not be trusted to stabilize as a number in the 'achieved targets' registers of the 'audit cultures' (Strathern 2000) of global health, and their exclusion was blamed on their own 'irresponsible behaviour', such as not taking up residence at one of Jamal's NGO's farms. Other neoliberal tropes such as 'value for money', 'efficiency', and 'limited resources' were also mobilized by doctors to explain this exclusion. Apparently, limited resources could not be 'wasted' on potentially non-adherent drug users who did not have an NGO oversight.

This confluence of existing stigma and neoliberal governmentality – responsibilization, metrics, and value for money – to exclude certain sections of population from services is not limited to drug users. Indeed as Tyler has argued, stigma is deeply embedded in the social relations of capitalism, and abjection has a foundational role in today's neoliberal governmentality: '[S]tigmatization operates as a form of government which legitimizes the reproduction and entrenchment of inequalities and injustice' (2013: 8). The strategic use of stigma under the neoliberal governmentality of HIV prevention in Pakistan, as I have described here through NGO leaders' projects of accumulation, is not only enabled by the quasi-legal status of HIV's 'risk groups' but also enhances their illegality by extending stigmatizing stereotypes against them (e.g. all *hijrae* are MSM, most MSM are inauthentic, and sex workers and drug users are untrustworthy), thus enabling and strengthening discrimination against them in law and society. This has implications not only for the human rights of the so-called risk groups but also for the global campaign to end the AIDS epidemic.

To end the AIDS epidemic by 2030, the Global Commission on HIV and the Law has called upon countries to 'outlaw discrimination, repeal punitive laws and enact protective laws to promote public health and human rights for effective HIV responses' (UNDP 2018: 6). In contrast with India, where, despite inheriting the same penal code as Pakistan, NGOs have successfully challenged Section 377, in Pakistan these movements for radical reform, or indeed even for the legalization of OST,

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have not gained traction. Here, HIV prevention NGOs pay lip service to the UN's recommendations, but in practice their leaders continue to strengthen their own status as brokers between international donors and the subjects of HIV prevention. These NGOs are not known for enabling the kind of social collectivities that would push fiercely against these legal barriers, counter social conservatism, and redraw the field of power in ways that challenge stigma against those who are most affected by HIV and advance their universal human rights.

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Stigmatisation et stratégie dans la prévention du VIH au Pakistan

Résumé

Les ONG présentent souvent les travailleuses et travailleurs du sexe, les consommateurs de drogues par injection, les personnes transgenre (*hijrae*) et les hommes homosexuels comme des personnes quasi-légales, enfermées dans une relation « répression/délinquance » avec l'État et qui ont donc besoin de ces organisations pour servir de médiatrices. En promouvant de telles représentations, les ONG œuvrant à la prévention du VIH au Pakistan exploitent l'idée reçue que les groupes dits à risque d'infection sont culturellement différents. Elles s'approprient la stigmatisation de ces groupes comme une stratégie pour accéder à des financements et pour fortifier leur propre position comme médiatrices, dans un contexte de financement de la prévention du VIH instable et dominé par les bailleurs de fonds. Ce faisant, les dirigeants et les membres de ces organisations finissent par ancrer la stigmatisation et par renforcer les inégalités qui lui sont associées dans l'opinion socialement conservatrice du Pakistan. Malgré leur soutien apparent aux droits humains universels, ils ne remettent pas en cause le cadre légal discriminant, qui criminalise les relations sexuelles en dehors du mariage et l'usage non thérapeutique des drogues, en partie parce que le statu quo conforte leur position de médiateurs entre l'État et les organismes bailleurs de fonds, d'une part, et les groupes dits à risque d'infection par le VIH, d'autre part.

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