



## Introduction

“Willing to start ARVs<sup>1</sup>: Do I tick it or *not*?!” the nurse almost shouted, while pointing to the “adherence counseling checklist” laying on the large office desk in front of her.<sup>2</sup> All prospective recipients of antiretroviral treatment (ART) in public health centers in Tanga, Tanzania, during the time of my research (2008–2011) were required to answer the sixteen questions on this list before being provided with the pharmaceuticals that would potentially return them to health and extend their lives for years. Did the client come on the appointed date? Spouse’s serostatus known and treated accordingly? Disclosure to at least one relative/friend? Client understands what ART does: improve immunity/less opportunistic infections/ART not a cure? Client understands treatment as continuous and lifelong treatment? So read the list of questions, at the end of which the health professionals were asked to estimate whether their clients’ “commitment/readiness to adhere to treatment” was (1) Good, (2) Indeterminate, or (3) Poor.

“I ask you *not* to tick it, so I can investigate the other medicine,” replied Haruna,<sup>3</sup> the patient sitting on the other side of the office desk, shyly staring at the ground. The atmosphere in the small room was tense. It was difficult to tell if the vague smile on the nurse’s face was meant to express disdain or compassion. A moment later, she seemed to decide for the latter. “I won’t take you to the doctor, because I feel pity for you.” After a short discussion, she conceded that, after all, the treatment was voluntary, yet she strongly recommended that Haruna come back after some time in order to verify the effect of the herbal medicines that he wanted to try instead of ARVs. “Patient not willing to start ART,” she noted on the checklist and—loudly reading out what she was writing as a warning—added that he had been fully informed about the possible negative consequences of his decision for his health. “We’re finished!” she concluded and called in the next client.



This scene occurred at the HIV Care and Treatment Center (CTC) of the Bombo Regional Hospital in Tanga, a city with approximately 250,000 inhabitants on the shore of the Indian Ocean in northeastern Tanzania. The treatment center operates under the Tanzanian National HIV/AIDS Treatment Program, which began providing cost-free ARVs in November 2004. It is one of the numerous health facilities for the treatment of HIV/AIDS that opened their doors in Tanzania and many other African countries within the last one and a half decades, and which form part of a health intervention of an unprecedented scale: the global rollout of antiretroviral treatment.

Since the early 2000s, global HIV/AIDS treatment has been pushed forward by a heterogeneous assemblage of international policymaking bodies, national development agencies, private philanthropic foundations, transnational nongovernmental organizations, and, mainly, North American global health and research departments. Two well-heeled funding programs were established and have since provided the largest part of the financial support to the global intervention: the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)—a multisectoral public-private partnership—and the United States President’s Emergency Plan for AIDS Relief (PEPFAR)—a program that is administered by the US Department of State and is considered to be the largest disease-specific governmental health intervention of all time. The progress that has been made during roughly a decade and a half is immense. In mid-2017, some 20.9 million people living with HIV across the globe had access to ART (UNAIDS 2017b, 1), a 30-fold increase in comparison to the year 2000 (cf. UNAIDS 2015, 13).

The logic behind this worldwide spread of a biomedical technology is part of what can be called a large-scale process of “epistemological standardization—a standard set of solutions, responding to a standardized set of framings of the problem that link biomedical notions to what have become globalized received wisdoms about HIV and AIDS” (Cassidy and Leach 2009, 15). With respect to treatment (that exists alongside—and in a competitive relationship with—other forms of HIV intervention such as social modes of HIV prevention, impact mitigation, and care and support), standardization targets not only the technical management of HIV through pharmaceuticals and clinical protocols. It also seeks to govern the domain of the social in prescribing—for instance, the nature of



an effective relationship between health professionals and patients. More than that, it interferes in the moral sphere by meticulously stipulating patients' desirable conduct and subjectivities.

The respective directives find their expression in international health policies and treatment guidelines issued by major global health institutions like the World Health Organization (WHO). They are adopted by transnational programs such as PEPFAR and are translated into national guidelines, which provide the protocols for clinical HIV management in countless health facilities on the ground and guide counseling processes that reach deep into patients' private lives. In defining patients' rights and responsibilities, and ultimately determining who will be granted access to life saving technologies, these directives and guidelines become instruments of "social triage" (Kalofonos 2008, 9; see also Nguyen 2010) that are an exemplar of the functioning of standards "as central sites of power—organizing and channeling flows of knowledge, capital, and resources in specific directions, and blocking others" (Petryna and Kleinman 2006, 12).

Through standardized, "universal" treatment regimes, ART patients are subjected to the "therapeutic sovereignty" (Nguyen 2010, 6) of a global health apparatus that assumes the regulation and management of the health of entire populations in territories where eroded state treasuries and deficient infrastructures prevent national governments from meeting this responsibility. These regimes aim to transform the targeted patients' bodies through biomedical technologies, but also to fashion their subjectivities by propagating "more intimate technologies" that "target the way in which [they] care for [their] bodies, constitute families, talk to [their] lovers, raise [their] children, and live out [their] sexuality" (Nguyen 2010, 186). Thus, in HIV treatment centers—the sites of the global HIV treatment's local materialization—it is not only therapeutic technologies that are transferred and offered in the form of blood tests, pharmaceuticals, and laboratory equipment. Simultaneously, the health facilities are also places where a globalized form of AIDS knowledge, and the corresponding rationalities and moral regimes, are transmitted (cf. Hardon and Dilger 2011).

In Tanga, I got to know many people who signed onto ART and readily submitted themselves to the treatment regime in a technical and moral sense. Many of them fared well. They bore witness to



the pharmaceuticals' power to restore health and induce dramatic changes in their shattered biographies. I visited one man at his workshop where he repaired electronic devices for several hours a day; this was just a few months after his treatment uptake, at which point he had barely been able to walk. Another woman who had been too weak to feed herself was, after taking the drugs, able to prepare chai tea and *chapatis* (flatbread made of wheat flour) for her children before walking them to school and selling fruits at the local market for the rest of the day. ARVs enabled many people who had been excluded from social life to resume their roles as family and community members, to reconstitute their disrupted relationships, and to continue their work or studies, while those living with HIV who had not yet experienced the destructive effects of full-blown AIDS had a good chance of avoiding this devastating experience altogether. But there were also cases like Haruna, which complicated the narrative of positive transformation.

Haruna had heard about the transformative power of ARVs at length during the educational sessions provided at the CTC, and to which all patients who were eligible to start treatment were required to attend. Why then, I wondered, would he refuse to receive this promise of life, in the form of tiny, multicolored capsules, despite the nurse's insistent warnings and opt for taking a local healer's herbal medicines instead? In order to better grasp what was at stake for Haruna, his story requires further elaboration.

## **Haruna and Zahra: Navigating Local Moral Economies**

When my research assistant, Edna, and I first met Haruna at his HIV test at one of Tanga's CTCs shortly before Christmas 2008, he was forty years old and earned his living as a freelance construction worker, struggling his way from one short-term contract to the next. Unfortunately, the test turned out positive. His CD4 count of 68 cells/ $\mu$ l indicated that his immune system had already been severely affected by the virus, and he was therefore scheduled for ART initiation.<sup>4</sup> Throughout the procedure of treatment preparation, Haruna was attentive and understood everything that the nurse explained to him about the therapy and how to live with it. But the discussion took an unexpected turn when, during his



“adherence assessment,” she finally asked him, “So, are you ready to take these medicines for your whole life as long as you are in this world?” Instead of responding directly, Haruna started to talk about his wife Zahra, who had tested HIV-positive two years before. With a CD4 count of just above 200 cells/ $\mu$ l, she had not started ART, but had been told to get it checked again after a few months. Haruna had consulted a “traditional healer”<sup>5</sup> well known to his family and had administered the herbal medicines he obtained to Zahra. She kept doing well, had become pregnant, and had given birth to an HIV-negative girl. When, after a while, she had her CD4 count tested again, she happily registered that it had risen to above 600 cells/ $\mu$ l. Therefore, Haruna told the nurse that rather than initiating ART, he intended to start taking the same herbal medicines as Zahra. As indicated above, however, the nurse simply insisted, this time in a louder voice: “Are you ready to take the medicines?!” A short discussion evolved, the nurse grew increasingly annoyed, and—her finger pointing to the question on the checklist—she raised her voice once more: “Willing to start ARVs’: Do I tick it or *not*?!”

Two months later, I rode my bicycle along the dusty roads of a neighborhood in Tanga’s expanded outskirts where Edna and I were to visit Haruna and Zahra in their modest home, a mud house with two bedrooms separated by a tiny kitchen. When we arrived, they introduced us to Zahra’s parents who were visiting, asked us to follow them into their bedroom, and closed the thin wooden door behind them. As the room was too small to accommodate any other furniture, we all took a seat on their bed. After they had shown me a large pile of family pictures and Haruna had told us at length about the additional income he had once made with the rental of a PA system, I hesitantly asked them if we could talk about their health condition. They smiled politely—and remained silent. Obviously, they felt too uncomfortable to talk about the issue while Zahra’s parents were sitting next door, but they had been too respectful to call me and postpone the interview date.

A few days later, we met again in the patio of a school in the city center, where a friend of Haruna’s was a teacher. The distance between us and the few students who were studying on the other side of the patio and the droning noise of a TV somewhere in the background gave Haruna and Zahra enough confidence to talk about their health situation, albeit in very low voices. Haruna told us that



they were still carrying on with their “experiment”: Zahra continued taking the therapeutic mixture from the family’s herbalist, while Haruna resorted to a self-made herbal concoction. Neither considered ARVs an alternative. While Zahra pointed to the positive effects of the herbal medicine she was taking, Haruna explained that his unstable work situation required a high degree of mobility. At times, he had to spend several weeks out of town, and he worried about forgetting to take the pills regularly in such a situation. In contrast to what he was warned about with regard to ARVs, he reported that there were neither any preconditions to nor adverse effects of taking his herbal medicines. Strongly convinced of their potency, he even had plans to combat his family’s constant financial precariousness by producing these on a commercial basis. Even some nurses at one of Tanga’s health centers had secretly expressed their interest in his concoction, he proudly revealed.

Zahra and Haruna had not told anyone about their infection in order to mobilize social support—as suggested by the nurses at the hospital. Instead, they told me stories of heavily stigmatized HIV-positive people in their neighborhood, where HIV was still considered a shameful disease and a death sentence. During a second interview some ten weeks later, Haruna reported his latest laboratory results: his hemoglobin level had risen and he had gained four kg of weight. Zahra remained quiet, but Haruna explained that she was also doing well. They had not yet had time to go back to the CTC to get another CD4 count, Haruna claimed, before reaffirming their decision not to commence ART as long as the herbal medicines were effective.

One afternoon about four months later, Edna received a phone call. Haruna delivered the sad news that Zahra had died two days earlier. One week after giving birth to a baby boy, she had succumbed to what was, according to Haruna’s speculations, a severe malaria attack. A few hours later, still shocked, Edna and I attended the mourning ceremonies at Haruna and Zahra’s crowded house. Amid the loud lamentations of the women present, Haruna sat in the bedroom, his newborn son in his arms. Absentmindedly, he received our contribution to the costs of Zahra’s burial and mumbled something about where his children would be accommodated so that he could continue to work. Then he was summoned by the group of elder men reciting prayers for the deceased in the shade of a tree in the front yard.



The following week, we met Haruna again in the school patio. Staring at the table in front of him, he calmly explained to us—and maybe to himself as well—what had happened. Together with Zahra, he had gone to the CTC to check the advance of their immune systems' recovery. Fortunately, his CD4 count had risen to more than 200 cells/ $\mu$ l, so the nurses had instructed him to come back after three months for the next follow-up. Zahra's CD4 level had also increased, and they happily returned home. Zahra finally gave birth to their son in their neighborhood's health center and soon after returned home. One week later, however, she suddenly caught a high fever and fell into a coma. At the hospital, she received several drips and blood transfusions, but nothing would ameliorate her condition. After three days, she died without ever having regained consciousness. As was often the case when people died in hospital in Tanga, the ultimate cause of Zahra's death remained unknown.

After Zahra's passing, her sister and brother-in-law took four of Zahra and Haruna's seven children, including the newborn, with them to the capital of Dar es Salaam, so that Haruna could continue to work and take care of the eldest children. When I asked Haruna if any measures had been taken to prevent perinatal HIV transmission to his newborn, he was not sure if Zahra had been enrolled on a program for the Prevention of Mother-to-Child Transmission (PMTCT). Apparently, they had never talked about it. I recommended that he inform his brother-in-law and ask him to take the baby to a hospital in Dar es Salaam, but Haruna hesitated. On the one hand, he repeatedly expressed his anxieties about being stigmatized and did not want to risk a rupture with his in-laws. On the other hand, he wanted to ensure the appropriate care for his baby. Only after further explanations about the risks of perinatal HIV transmission did he consider asking his brother-in-law to take the baby to hospital. Due to Haruna's frequent work-related absences, however, I never managed to follow up on him throughout the rest of my fieldwork.

## The Rationale of Refusal

Haruna's insistence on using herbal medications instead of ARVs, his decision to remain silent about his and his wife's HIV status, his ignorance of whether or not she had enrolled in a PMTCT program, and his hesitance about informing his brother-in-law about



the possible HIV infection of his newborn son may be read as “a refusal of assuming an AIDS identity, of becoming that biological being that the virus and the regimen of its treatment determine its host to become” (Kistner 2009, 11). Clearly, this case exemplifies the collision between the “rules” and implicit moral exigencies of a global health intervention, and the concerns of local “beneficiaries” situated in webs of social solidarity that face the danger of disruption through their association with HIV. While many ART patients’ practices of self-fashioning seemed to develop in accordance with the treatment regime’s moral requirements, in Haruna’s and several other patients’ cases, frictions emerged.

Whether these frictions resulted from scientific ignorance and irrationality—as local health professionals often assumed—is, however, a matter of perspective. In Haruna’s eyes, his and Zarah’s conduct was the result of a well-considered decision. Aside from anticipating that he would not be able to harmonize the rigid treatment regime with his working conditions, he judged the drugs’ prospective consequences on the basis of previous negative experiences with biomedical pharmaceuticals. Instead, he opted for herbal medicines from a well-known local healer, which in his experience were highly effective, had no negative side effects, and did not require lifelong intake.

Haruna and Zahra’s refusal to disclose their health status can, in turn, be understood as an equally reasonable decision in consideration of the HIV-related stigmatization that they had repeatedly witnessed in their community where knowledge about ARVs was scarce. Given this environment and their fragile financial situation, it later seemed self-evident to Haruna not to disclose to his brother-in-law and so risk the proper care for his children. Indeed, the case shows how Haruna had to negotiate “conflicting moral economies” (Nguyen et al. 2007, 31). On the one hand, health professionals encouraged patients to develop a positive attitude, to disclose to others, and not to stigmatize themselves (see Chapter 4). On the other hand, his dependency on kinship-based networks of social support required the careful maintenance of secrecy around his health status. Haruna’s dilemma thus tellingly confirms that “the ways people deal with HIV/AIDS are based not *exclusively* on knowledge . . . and technologies of the self that are derived from . . . AIDS campaigns but . . . have become embedded simultaneously in . . . the





social and moral priorities formulated by communities and families in relation to the disease” (Dilger 2012, 76).

## **From the Global Health Intervention to the Individual Lifeworld: Making Sense of What Is at Stake**

In this book, I explore the articulation and effects of the encounter of standardized material and sociomoral technologies that are transported around the world under the umbrella of global HIV/AIDS treatment with local forms of knowledge, infrastructures, and moral economies. I address processes of convergence but also of conflict and friction (cf. Tsing 2005) that evolve through this encounter, seeking to contribute to an understanding of “the disconnects between public health notions of responsible behaviors, including moral ways of thinking and acting, and the situated ethics of the everyday struggles of men and women in Africa” (Langwick, Dilger, and Kane 2012, 2). The unfolding of global ART in Tanga is thereby examined based on the premise that “pharmaceuticals affect the human body as a site of control and creative experience,” but that “drugs and treatment strategies also go beyond the body, affecting and potentially reshaping interpersonal, family, and community domains” (Petryna and Kleinman 2006, 8).

When carrying out the research this book is based on, I was interested in understanding the financial and political parameters of Tanzania’s national HIV treatment program in relation to larger scale developments in the realm of global health politics and activism. What particularly caught my attention, though, was the specific social and (infra)structural concretization of patient enrollment and surveillance in Tanga’s treatment centers. Taking on the perspective of hospital ethnography (Van der Geest and Finkler 2004; Long, Hunter, and Van der Geest 2008), I explored what kinds of relations were established between “target populations” and the “global health apparatus” within these sites of mass HIV treatment. I focused on the power dynamics involved in treatment preparation, the transmission of biomedical knowledge to patients, and the long-term control of the therapy’s effects in Tanga’s health facilities. This included an examination of how far these processes engendered “empowered” and self-responsible



patients, as called for in international and national guidelines (e.g., NACP 2012).

Beyond such institutional settings, however, I wanted to learn about the therapy's inscription in patients' life worlds: the ways in which the ARVs affected their bodily well-being; their sense of a return to "normalcy" after treatment initiation; and their anxieties and aspirations with regard to their long-term use of these pharmaceuticals. Furthermore, I wished to explore how ART was managed in patients' social environs, and what transformations it provoked therein. I placed particular emphasis on the treatment's effects on diverse forms of sociality, ranging from the interactions and communication among friends, couples, and within families to the organization of care and support within more institutionalized contexts like HIV (self-)support groups. How does ART enable processes of reconstructing patients' formerly disrupted social relations, I wondered? Who is informed to what extent about the everyday implications of living with ART in patients' social surroundings, and what kinds of support structures are mobilized or disrupted? What effect do treatment uptake and resulting physical transformations have on families' and friends' readiness to get tested for HIV? What dynamics, necessities, and discourses does ART evoke within (self-) support groups, whose focus prior to the advent of treatment had been the mutual provision of social and moral support?

Considering that Tanga is particularly well-known for its density of "traditional healers" (McMillen 2004; Scheinman 2002), I set my third larger focus on the emplacement of ART within the region's highly pluralistic therapeutic landscape (Feierman 1985; Giles 1995; Langwick 2011; Parkin 2014). I explored the varying ways in which Christian and Muslim religious leaders, as well as traditional healers, integrated ART into their conceptual frameworks of disease causation, theological and moral reasoning, and therapeutic practices. Of particular interest was the question of whether and to what extent patients' engagement in discourses and practices of traditional and religious healing interfered with their adherence to their biomedical therapy.

Through these thematic foci, I sought to gain a deeper understanding of how "global ART" was transferred, appropriated, "lived," and conceptualized by a multitude of actors at the local level, ranging from clinicians to patients, from policymakers to specialists in



spirit possession. A central concern, thereby, centered on achieving a sense of the extent to which the availability of ART has indeed actuated the “normalization” (and medicalization) of HIV/AIDS that was envisaged by activists, medical professionals, and health policy-makers as coming along with the drugs’ increasing availability in all regions of the world (Moyer and Hardon 2014).

Throughout the entire project, I was guided by the “biographical life course perspective” (Van der Geest and Chamberlain 2011, 236). Building on the idea of “the social life of things” (Appadurai 1988), this approach traces the social lives of medicines (Whyte, Van der Geest, and Hardon 2002). It thereby draws attention not only to the different levels of social organization that pharmaceuticals pass through in their global trajectories, but also to the varying “regimes of values” they traverse and the distinctive meanings they are ascribed in particular stages of their “life cycle” from production, marketing, and prescription to distribution, purchasing, consumption, and finally their efficacy” (Appadurai 1988, 4; see also Hardon and Sanabria 2017; Van der Geest and Chamberlain 2011; Van der Geest, Whyte, and Hardon 1996, 153; and Whyte et al. 2002). Applying this to the matter of this book, I trace the life trajectory of ARVs. This begins with what could be viewed as their “prenatal” phase in terms of the political-economic framework that shapes the conditions of their production, and ends with their “life after death” in terms of their efficacy—both physical, in the sense of individual patients’ (possibly) relieved bodily suffering, and sociocultural, in the sense of the effects (or lack thereof) that these recoveries have within patients’ social surroundings and beyond (cf. Van der Geest and Hardon 2006).

The biographical life course perspective serves as a useful analytical tool to account for the multitude of levels of social organization, actors, and complexes of meaning/values that shape and are affected by the global circulation of pharmaceuticals. However, it does not imply any specific way to *theoretically* grasp the multifarious workings of power within and across these levels and entities. To this purpose, I additionally draw on the notion of “governmentality,” as coined by Michel Foucault (1991). It designates a specific political rationality, according to which government not only includes administrative forms of domination and disciplining but also more subtle kinds of guidance through which subjects, perhaps even unwittingly,



are steered toward particular forms of self-control. Government, in this sense, is understood as “the conduct of conduct” (Foucault 1982, 220–21) and as “a continuum, which extends from political government right through to forms of self-regulation” (Lemke 2002, 59). Such self-regulation, in turn, is to be achieved through the fostering and application of particular “technologies of the self, which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being,” (Foucault 1988, 18) so as to achieve, not least, desired states of optimized health and well-being. In the domain of health and welfare, the fostering of such technologies constitutes a mode of governing through which individuals are to be motivated and enabled to modify their own conduct in such a way that the sum of these practices of self-management are convenient for the population as a whole (cf. Bunton and Petersen 2002; Miller and Rose 2008; Rose 2007). The inducement of proper self-regulation is to complement other, perhaps more overt biopolitical activities of registering and regulating the population and its biological processes, be this in the form of “collecting, collating and calculating data on [its] characteristics . . . (births, deaths, rates of disease, levels and types of employment etc.)” (Nettleton 1997, 210), or establishing, designing, and implementing health institutions, policies, and interventions to the end of its positive development.

Against this background, I view biomedicine and public health as institutions that exercise power through the acquisition of a particular kind of knowledge and correlated practices of disciplining and surveillance, normalization and standardization, inclusion and exclusion. But simultaneously, both biomedicine and public health intervene deeply in the vital matter of populations and the individuals that compose them through less imposing, more horizontal forms of power including the subtle and suggestive promotion of particular, presumably appropriate forms of risk-assessment and self-care that are to be internalized by the subjects of their interventions. As will be shown in the course of this book, these characteristics apply particularly well to the apparatus of global HIV treatment.

Notwithstanding the enormous analytical potential of governmentality, the critique has been formulated that in his elaborations on the notion, Foucault preoccupied himself too much with processes occurring *within* sovereign states rather than studying “power



relations between polities” (Kelly 2010, 1; see also Ingram 2009). In the “post-Foucauldian” era, scholars working on governmentality made efforts to rectify this shortcoming. Taking this further development into account is particularly important for the attempt to apply the governmentality perspective to the analysis of health care provision in Africa, which throughout the past two to three decades has increasingly been privatized and transnationalized.

To begin with, it is important to note that a crucial characteristic of Foucault’s notion of modern political power represented by “governmentality” is its

refusal to reduce political power to the activities of the state. Indeed, for Foucault, governing . . . is not merely a matter of *the* government and its institutions but involves a multitude of heterogeneous entities: from politicians, philanthropists, and state bureaucrats to academics, clerics, and medics. What thus counts in thinking about governmental power is not simply the state but also all these other actors, organizations, and agencies concerned with exercising authority over the conduct of human beings. (Inda 2005, 6)

In support of this argument, shifting the focus from the state to the multitude of nonstate actors involved in the governing of health and well-being is essential for the analysis of public health interventions in Tanzania and elsewhere in Africa. The examination of the “proliferating global institutional ecology of pharmaceuticals” (Petryna and Kleinman 2006, 6) in the case of HIV treatment, for instance, reveals a staggering number of heterogeneous actors involved in global ART provision: governmental institutions and nongovernmental (transnational and domestic) organizations, multiple constellations of private-public partnerships, university departments and research institutes, pharmaceutical companies, churches, and even the military (cf. Nguyen 2009a, 196). Mass HIV treatment programs are thus an example par excellence of how to transfer national governments’ sovereignty and responsibilities to “transnationally constituted conglomerates, which have come to perform statelike functions all across Africa” (Dilger 2009, 102).

This has much to do with the stringent structural adjustment programs (SAPs) that the World Bank and International Monetary Fund (IMF) began prescribing for destitute African governments in the wake of the world economic recession of the 1970s as a



precondition for receiving financial loans. Reflecting the fundamental tenets of neoliberalism, these programs were based on the premise that “development” and social welfare were best achieved through the engagement of market-based, private, and nongovernmental actors rather than state interference. They imposed “a steep reduction in governmental expenditure for health care, education, and housing programs, including a significant reduction of salary expenses for public sector employees” (Dilger 2012, 64; see also Ferguson 2006; for analyses of the negative impact of these structural reforms on health care provision in Tanzania, see Lugalla 1995; and Turshen 1999). The consequence of such massively interventional international politics was the deepening of mass poverty, not least due to the rapidly increasing stratification of the African wage labor market and the entrenchment of large subpopulations in conditions of long-term unemployment and informal petty trade (cf. Mbembe 2001, 55ff). This has left numerous contemporary African governments in a state of economic stagnation, if not downturn, and massively diminished their capacities to reliably provide even basic social welfare.

The SAP-supported reorientation toward nongovernmental actors as the major drivers of development led to an increasing fragmentation of the Tanzanian and other African public health sectors, a process that has been referred to as “NGOization” (Hearn 1998) and “projectification” (Whyte 2013). While this yielded some positive effects in terms of improved health care provided by often transnationally financed and powerful nonstate entities, the desired results remained territorially delimited to islands of “medical prosperity” with vast areas of continuing under-provision in between (cf. also Ferguson 2006; Geissler 2015, 14f; Sullivan 2011a). Furthermore, it has been critically observed that the innumerable newly emerging projects in the area of health care “enact unequal relations of power, reinforced in the discourse of ‘donor’ and ‘recipient,’ and . . . are unstable, driven by short-term funding cycles and working through a variety of often-precarious institutional ‘partnerships’” (Prince 2014a, 209).

The proliferation of nonstate actors and the increasing reliance of health care sectors on external donor funds is particularly pervasive in the context of HIV/AIDS. The disease’s framing as an “exceptional humanitarian emergency with security implications” (Ingram 2013,



6) provided humanitarian agencies with a powerful legitimization to move into sub-Saharan Africa in order to ameliorate its inhabitants' suffering and secure their survival. The resulting configurations of the "government" of African (sub)populations' health by transnational entities constitute a striking example of the contemporary shifts in power relations that prompted Gupta and Ferguson to extend Foucault's notion of governmentality

to modes of government that are being set up on a global scale. These include not only new strategies of discipline and regulation, exemplified by the WTO [World Trade Organization] and the structural adjustment programs implemented by the IMF, but also transnational alliances forged by activists and grassroots organizations and the proliferation of voluntary organizations supported by complex networks of international and transnational funding and personnel. The outsourcing of the functions of the state to NGOs and other ostensibly nonstate agencies, we argue, is a key feature, not only of the operation of national states, but of an emerging system of transnational governmentality. (Ferguson and Gupta 2002, 990)

Placing the focus on the transnational governmentality at play in the global response to HIV/AIDS has helped identify dynamics that have been referred to as "therapeutic sovereignty" (Nguyen 2010, 6) and "therapeutic domination" (Rottenburg 2009). Critical observers have argued that these forms of exercising power largely reduce social agents to mere passive human bodies (McFalls 2010, 322f), inasmuch as

people's lives are constructed according to the medical priorities of HIV interventions independent of their actual lived experiences within their context [and] the framing of the disease together with proposed solutions to many problems it articulates is referenced to the agency of external experts. (Seckinelgin 2012, 454)

While this attests to the analytical purchase of viewing the global ART rollout through the lens of transnational governmentality, a further theoretical approach is needed in order to extend the analysis to the realm of affected people's social, cultural, and moral contexts of everyday life. "The high-profile 'global' regimes shaping health-care provision such as transnational HIV treatment programs are important objects of anthropological analysis," Ruth Prince argues similarly. "Yet . . . we must be careful not to privilege the agency of



the global and overlook how local interests, actors, sensibilities, and social forms are often what anchor externally planned interventions in a meaningful way (Prince 2014b, 14f; cf. also Dilger 2012).

This resonates with other critiques of the interpretations of biomedical health interventions in Africa as instruments of biopolitical subjection that have burgeoned within the last two decades or so. “Tak[ing] issue with . . . the idea that medical practices and interventions simply produce disciplined subjects, simply work,” these studies foreground “moments of *resistance and creativity*”, as well as “the inevitable *incompleteness* of any disciplining project especially in Africa . . . and even . . . the outright failure that is built into the biopolitical endeavor” (Geissler, Rottenburg, and Zenker 2012, 11—emphasis in original).

What is needed, then, for a comprehensive understanding of how people respond to strategies of medical power is a “phenomenology of everyday life and subjectivity” (Lupton 1997, 104) that is capable of accounting for “the ways [global] configurations are constantly constructed, un-done, and re-done by the desires and becomings of actual people—caught up in the messiness, the desperation, and aspiration, of life in idiosyncratic milieus” (Biehl 2011, 115).

People’s ways of dealing with ART in their day-to-day lives—including their (non)compliance with medical professionals’ instructions, their ideas and practices concerning sexuality and reproduction, their ability to reconstruct their damaged self-image, and their capacity to resume social roles and economic activities—are profoundly shaped by their sociomoral entanglements in their lifeworlds. In my attempt to adequately account for the fundamental importance of often highly contingent and rapidly transforming social relations, as well as people’s multiple moral longings, I found inspiration in the “local moral world.” Arthur and Joan Kleinman first introduced this concept in a coauthored article in which they propose that the ethnographer take a particular orientation, one that closely attends to “*the overbearing practical relevance* in the processes and forms of experience. That is to say, *something is at stake* for all of us in the daily round of happenings and transactions” (Kleinman and Kleinman 1991, 277—emphases in original). Eliciting what is locally (and morally) most at stake for people afflicted by illness, pain, and other forms of suffering, the Kleinmans argue, should form a central concern for the ethnographer. In fact, a few years later,





Arthur Kleinman delineated the pursuit of an “ethnography of experience” as a core task of (medical) anthropology (Kleinman 1994, 190). Yet it is important to note that he does not propose restricting analytical attention to the level of the particular and idiographic. Notwithstanding the emphasis on the (inter)subjective sphere in which moral stakes are claimed and suffering is experienced in the form of instantaneous incidents or prolonged periods of felt resistance to one’s fundamental moral aspirations, he does not argue for a complete disengagement of individual experiences from the social processes by which they are shaped. After a person’s “microcontext of experience” has been explored, he rather suggests that it “can be further contextualized by a view from afar that relates this highly focused perspective to the larger-scale political, socioeconomic, and cultural forces that impinge on the local world” (Kleinman 1992, 131).

I hold the notion of the local moral world to be particularly fertile for the analysis of the experiences of people living with ARVs in Tanga. The first benefit I see concerns the special emphasis the concept places on the *pragmatic* aspect and contingency inherent to individual ART patients’ moral concerns and on the inseparability of these concerns with the moral longings of other persons within their social surroundings or networks, no matter how restricted these might be. The focus on people’s “everyday pragmatics” and lived experience serves as an effective measure against too hasty abstraction and the attribution of particular individual practices, conceptions, and conduct to the impact of structural forces and social characteristics like gender, class, political position, and ethnicity. It also precludes viewing individual practices as entirely determined by power dynamics such as the transnational governmentality exerted by the global HIV treatment apparatus. Without denying the imprint that these dynamics and collectivized experiences leave on individual subjectivities—that is, individual persons’ “inner life processes and affective states” (Biehl and Kleinman 2007, 3)—I believe that such a moment of analytical deceleration is expedient in order to take adequate account of the complexity and vicissitudes of affected people’s lifeworlds and fundamental moral concerns. Only in this way, I argue, can we gain a profound understanding of people’s conceptualization of and attitudes toward HIV treatment and correlated social technologies like HIV disclosure.



A further merit I see in using local moral worlds as an analytical lens is related to the specific idea of experience evolving in the intersubjective sphere, as was proposed by Kleinman and other phenomenologically oriented anthropologists (e.g., Crapanzano 2010; Csordas 2008; Jackson 1989, 1998). Understanding experience “as an interpersonal, intersubjective, realm of engagements, transactions, communications, and other social activities” (Kleinman 1992, 128) inevitably implies the need for the researcher to render her/himself visible, at least as a temporary constituent of the research participants’ local moral worlds. “The ethnographer,” Kleinman notes, “is ‘called’ into the stories and lives by the moral process of engaged listening and by the commitment to listening. That call to take account of what is at stake for people becomes an instructive aspect of the ethnographer’s sensibility” (1999, 89).

As will be seen in the case studies provided in this book, what Kleinman designates as following a “call” could just as well materialize as a process of “blundering into” particular research participants’ lifeworlds. No matter how this process may be conceived of, however, I fully agree that trying to understand and make these local moral worlds intelligible to others, without reflecting on and revealing how the researcher her/himself has participated in and shaped these worlds, would constitute a flawed process of anthropological knowledge production (cf. Stoczkowski 2008). I therefore attempt to make my relationships, at least with the protagonists among my research participants, and the ways in which I became involved in their navigations of the quandaries of life on ART, equally as transparent as their social relations with other persons who coconstituted their central moral concerns.

The focus on the local moral worlds of ART patients further has consequences, both with regard to the methodology of the present study as well as to the representation of its results. In order to provide profound insight into “what was at stake” for people living with ARVs in Tanga, I present my ethnographic material predominantly in the form of extended case studies. On the one hand, this accommodates the understanding of anthropological research and knowledge production as an intersubjective endeavor, inasmuch as “the extended case method emulates a reflexive model of science that takes as its premise the intersubjectivity of scientist and subject of study” (Burawoy 1998, 4). On the other hand, a central aim of



the extended case method centers on applying “reflexive science to ethnography in order to extract the general from the unique, to move from the ‘micro’ to the ‘macro’” (Burawoy 1998, 5). As outlined above, this is an analytical move that will not be disregarded, but only be accomplished after a thorough immersion into the particular life circumstances of people living with ARVs and their struggles to arrange with the chronicity of their health status with all its economic, social, and moral implications.

Taking inspiration, finally, from the idea of “slow research” (Adams, Burke, and Whitmarsh 2014), in this book, I wish to illustrate the close entanglement of ART as a globally circulating biomedical technology with the lived economic, social, and moral realities of its recipients in a specific African locality. This runs counter to the tendency in the global health arena “to dismiss local specificities because they get in the way of large-scale comparisons and scaled-up implementations” (Adams et al. 2014, 180). The resulting complexity may be daunting when it comes to deciding on the design of future interventions in the field of HIV/AIDS, since it points to the shortcomings of the currently dominating top-down and technocratic “magic bullet” approach that is narrowly focused on “treating our way out of the epidemic” (cf. Merson et al. 2008; see also Pfeiffer 2013) through the scaled up provision of pharmaceuticals (Biehl 2007). But it is my hope that this book sheds some additional light on “the trial and error, the endless tinkering, of real people in specific circumstances trying to figure out what works for them” (Biehl and Petryna 2013, 9) and potentially contributes to a closer alignment of future HIV interventions with the needs of the people they target.

## Outline of the Book

The book consists of this introduction, eight chapters, and a conclusion. Chapter 1 provides a historical and demographic overview of Tanga, followed by an outline of the local therapeutic economy and the landscape of social support for people living with HIV/AIDS. It then offers a detailed description of the research sample and the methods I utilized, including some reflections on research ethics as well as my own positionality and emotional engagement in the field. Chapter 2 outlines the historical and political-economic background



of the global ART rollout before it turns to the history of HIV/AIDS and the efforts to respond to the disease in Tanzania, including the country's National Care and Treatment Program.

Chapter 3 focuses on the translation of (inter)national HIV treatment policies and guidelines into daily clinical practice in Tanga. Exploring the concrete articulation of treatment expansion from the Bombo Regional Hospital to several smaller health centers across the city, it accentuates the challenges and constraints that health workers perceived in their attempts to provide high quality care to rapidly increasing numbers of patients. In a further step, it offers a description of a workshop for health workers and voluntary community care providers that aimed to establish an effective continuum of treatment surveillance from health facilities to patients' domestic and private lives. Attending to the uncertain sustainability of Tanzania's treatment program in consideration of donor phase-outs and funding flatlining in the wake of the global financial crisis of 2008, finally, it binds the local materialization of ART provision back to the global political economy.

Chapter 4 elaborates on the micro-politics of ART enrollment and monitoring in Tanga's HIV clinics. Giving attention to the power relations shaping the organization, performance, and supervision of the processes involved in producing treatment literacy and surveilling patients' treatment adherence, it analyzes whether these engendered the actualization of the well-informed, empowered, and self-responsible ART patient that has been called for and indeed observed to be constructed in other African settings at the dawn of the era of HIV mass treatment (Nguyen 2010; Robins 2006).

In Chapter 5, the focus of attention shifts from the routines and power dynamics within biomedical institutions to the inscription of ARVs in patients' local moral worlds beyond the treatment centers. The chapter takes a close look at the physical, social, and moral aspects of the process of reconstitution after ART uptake, primarily from the perspective of individual patients, and explores their strategies for, and difficulties with, restoring a sense of normalcy to their lives. Thereby, particular attention is paid to processes of bodily transformation, to the reconstitution of patients' positive sense of self, to the moral implications of their (re)engagement in sexual and reproductive activities, and finally to their anxieties as well as aspirations concerning their future as long-term ARV users.



The question of whether ART implicates a normalization of people's lives is further pursued in Chapter 6, with a focus on the context of the kin-based networks in which patients live their everyday lives with ARVs, rather than patients' inner affective states and individual attitudes toward their medicines. The predominant issues of interest here are the forms, scope, and effects of patients' communication about their health status and therapy within their social environment; the quotidian management of ART, as well as the (limitations of the) provision of care and support within mostly familial solidarity networks; and the dynamics of HIV-related stigmatization and discrimination that shaped the social interactions within these networks.

In Chapter 7, I turn to HIV (self-)support groups, which constitute a further important social domain for people living with ARVs. Drawing on the observations made during numerous meetings of such groups in the city, the chapter examines the extent to which these biosocial collectives serve as platforms of modeling patient subjectivities, much in the same fashion as the CTCs. It further highlights the particular forms of care and support that group members actually receive (and mutually provide) in practice, the difficulties the groups face in coping with state bureaucracies and navigating Tanga's confined economy of social support for people living with HIV/AIDS, as well as the limitations of biosociality as a factor of the groups' social cohesion.

Chapter 8, finally, takes the Tanzanian mass-healing phenomenon that became internationally known as the Wonder of Loliondo as a prism for exploring the interrelations of HIV/AIDS and ART with religious and traditional healing practices. The Wonder of Loliondo serves as a particularly illustrative example of the contested nature of therapeutic and interpretive authority in relation to HIV/AIDS in Tanzania's highly heterogeneous landscape of healing traditions. The first part of the chapter differentiates the political, social, economic, and moral dimensions and implications of this large-scale phenomenon. Drawing on the comments of religious leaders and traditional healers in Tanga on the Wonder of Loliondo, as well as the narratives of two patients who were simultaneously undergoing ART in Tanga and setting their hopes on the herbal medicine they had received in Loliondo, I will then return to the local context and elaborate on these actors' varying forms of conceptual boundary-making and



pragmatic transgression of the epistemological divide between science and religious and “traditional” healing.

## Notes

1. Antiretroviral drugs for the treatment of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).
2. Parts of this introduction have been published in Dominik Mattes, “‘We Are Just Supposed to Be Quiet’: The Production of Adherence to Antiretroviral Treatment in Urban Tanzania,” *Medical Anthropology* 30, no. 2: 158–82.
3. All names of research participants appearing in this book are pseudonyms. In some cases, additionally their gender or other personal details were changed in order to protect their identities.
4. The decrease of CD4 cells—the main targets of HIV—indicates the disease’s progress. Based on WHO recommendations (WHO 2006, 14), the national guidelines in force during my first field stay in Tanga in 2008/2009 prescribed ART initiation at a CD4 level below 200 cells/ $\mu$ l, irrespective of the patient’s clinically observable symptoms (NACP 2008, 134). Throughout the following years, this limiting value was first raised to 350 cells/ $\mu$ l (WHO 2010) and then to 500 cells/ $\mu$ l (WHO 2013). In 2015, the WHO finally recommended: “ART should be initiated among all adults with HIV regardless of WHO clinical stage and at any CD4 cell count” (WHO 2015, 24). The implementation of these changing recommendations each time implied a massive increase in the number of patients eligible for treatment, which in turn significantly enhanced the challenges facing the national health care infrastructure. To date, the Tanzanian Ministry of Health has adopted the respective latest recommendations only after a delay of two years. The “treatment for all” policy was thus adopted in 2017 (NACP 2017).
5. The terms “traditional healers” and “traditional medicine” bracket together a wide variety of medical practices and imply equally heterogeneous—often politically instrumentalized—assumptions of what “the traditional” is meant to designate (see Feierman 1985, 100). This diversity also applies for Tanga, where *waganga wa kienyeji* (local healers) are engaged in spirit possession and exorcism, witchcraft (*uchawi*), herbalism, Quranic healing, bone-setting, and ancestor veneration (Mackenrodt 2011). Clear-cut boundaries between the “main types of traditional healers” (Mshiu and Chabra cited in Gessler et al. 1995, 146) were difficult to identify, since the majority of the healers flexibly combined several diagnostic and therapeutic practices.