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# Governing Health Risk by Buying Behaviour

Sophie Harman

**Abstract** This paper considers the role of conditional cash transfers as a mechanism of governing health risk by buying behaviour change in sexual practice. Conditional cash transfers have come to be identified as a potential solution to the problem of HIV prevention, and as such look likely to be applied throughout countries with high prevalence rates in sub-Saharan Africa. The paper considers the implications of two pilot studies in Tanzania and Malawi for governing the risk of HIV infection. It outlines the problem of behaviour change and individual rationality, the potential of conditional cash transfers as a relatively inexpensive programme with high outcomes, and some of limitations and implications of these initiatives for individual bodies, rationality and global health governance. The paper makes the argument that conditional cash transfers should be met with caution and that governing health risk by buying behaviour represents the intersection of biopolitical control with neoliberal forms of economic incentive through financial gain. The balancing of long term health needs with short term financial gain induces will to change behaviour: the problem being the sustainability of such change in the absence of financial gain and the long term consequences of constructing behaviour.

**Key words:** Conditional Cash Transfers, Risk, neoliberalism, HIV/AIDS

The 2010 International AIDS Conference in Vienna was surrounded by buzz over the role of conditional cash transfers as a mechanism of preventing HIV infection. Two trials in Malawi and Tanzania had shown that cash payments to schoolgirls and youths on condition of school enrolment or non-HIV infection had been an effective tool in efforts to prevent HIV. The relationship between health risk and individual behaviour has been at the crux of policy interventions within global health governance: how to make individuals responsible for their own actions and how to make people engage in non-risky behaviour. Cash solutions as a means of incentivising rational behaviour change or replacing alternative choices have become increasingly recognised as an effective means of fulfilling these objectives. This paper explores the role of conditional cash transfers as a means of governing health risk by buying behaviour change. It does so by first outlining the problem of behaviour change in governing global health, and second, the origins and purpose of conditional cash transfers as a solution to these problems. Third, the paper discusses the potential of such policies, and their record of success in alternative development strategies and what they mean for global health governance, before outlining the practical ramifications and shortcomings of such policies, and the logic that underpins them. In so doing the paper argues that despite the

short term appeal of such programmes, the widespread use of cash transfers, particularly those conditional on sexual health, should be met with caution and that the use of conditional cash transfers as a means of governing risk through buying behaviour presents an intersection of biopolitical control with neoliberal forms of economic incentive through financial gain. Where socio-economic factors become too difficult to address and individual choice and behaviour too problematic to change, economic incentive provides the only viable option for policymakers seeking to elicit short-term, measurable health outcomes. Risk is used to justify mechanisms of biopolitical surveillance, education and knowledge and neoliberal economic incentive. It is this intersection of biopolitics and neoliberalism that has come to underpin new ‘innovations’ that define global health governance.

*The Problem of Behaviour Change and the Role of the Individual*

Global health governance is concerned with the surveillance of emerging health threats, constructing political will to respond to health concerns, and the pursuit of change within individual behaviour as a means of eliciting better health outcomes for all. It is this third concern—behaviour change—that this paper engages with. Socialised and non-socialised health systems all have in common the need for individuals to take responsibility for their individual behaviour and personal health balanced with holistic and integrative systems of health and social care provided to some degree by the state and non-state actors. Individual behaviour is central to the pursuit of a long and healthy life, at the forefront of which is mitigating and preventing health risk. Individuals are exposed to a large swathe of information about health risks, perceptions of risks, and the need to take responsibility for their own health from national governments and intergovernmental bodies such as the World Health Organisation (WHO). With all risks, the onus is on the government or the international body to identify and raise awareness about the risk, provide medical treatments and prevention strategies, whilst the individual remains the main cite of responsibility for the management and acknowledgement of their own health risk. Regardless of any state or non-state intervention, it is the individual that is the primary site of risk perception, and crucially, risk management.

The logic underpinning such emphasis on the individual is the liberal understanding of the individual as a rational actor with a specific set of freedoms and responsibility over their

body, which with the right kind of information will maximise their own self-interest, and safeguard against risk (see Williams 2008). The balance between this logic and the level of state intervention required to maximise individual behaviour change and choice underpins debate over reform of domestic national health structures from the National Health Service in the UK to global health campaigns launched by institutions such as the WHO and the World Bank. Incentivising behaviour change has become a central feature of rational choice models that according to Smith (2009), have adopted a new right approach combining classical economics and rational choice theory in such a way as to suggest that behaviour change is intrinsically linked to change in incentive. Incentives, regulation and choice have become the cornerstone of domestic healthcare systems (Smith 2009), and are now increasingly being applied to the global health problems such as HIV/AIDS. This has led to the state engaging in 'moral power' (Smith 2009: 217), that applied to the global context leads to a framing of risky, non-risky and moral policy making that focuses on the individual as the site of tension and change. The problem being that the widespread use of such incentives 'assume rationality in a narrow sense of utility maximization' (Smith 2009: 169).

The degree to which individuals rationally maximise their own health and avoid risky behaviour is limited by two main factors. First, individual behaviour change, choice and perception of risk are determined by socioeconomic factors, such as income, education, and opportunities or lack thereof. Low socio-economic status and educational attainment can restrict self esteem and self-worth, thus putting a low premium on an individual's concern about risk and life. Individuals living in low socio-economic conditions have limited access to resources that enable them to engage in less risky behaviour – whether educational and information services or basic health care provision. Limited self worth and a lack of services may lead individuals to perceive health risk as an everyday part of life, a form of pleasure, or a small risk in regard to more pressing concerns of lifestyle choices. This leads to the second explanation as to why individuals engage in risky behaviour, perception of risk. Individual habits and the perception of risk are bounded to different types of rational behaviour and pleasure. Rationality is about maximising an individual's own well-being; this could be their pursuit of specific freedoms, well-being, money, family and individual health (Hiness 1988; Ward 2002). However, what is important and a source of pleasure differs between individuals and how they perceive and rationalise specific risks in regards to their own sense

of worth and individual happiness. For example, a form of risky behaviour such as over-eating and obesity can be determined by socio-economic factors and issues of personal self esteem, but can also be associated with pleasure and enjoyment in eating and drinking. In this case an individual may rationalise that their day to day eating habits gave them pleasure against the risk of long term illness. The long term is often a central component of such rationality, the idea that health risk refers to an 'other' or a concern to be addressed in old age. Thus, health risk depends on individual perceptions of health and risk. What may seem irrational to some is rationalised differently by others. Individuals apply different rationalities to different health concerns, or displace health risks as an 'other' not relevant to them or their individual behaviour. Long-term health benefits alone are often not enough incentive to induce behaviour change in individuals.

As a disease that is both a driver and driven by socio-economic inequality and poverty (Barnett and Whiteside 2002; Poku 2001; Whiteside 2002), the problems associated with governing individual behaviour change and perceptions of risk are particularly acute in the case of HIV/AIDS. HIV is a high risk infectious disease in countries with prevalence rates of over 3%. Yet, many people living in these countries engage in high risk sexual relationships. This can be explained by the fact they lack education or awareness of the transmission of HIV, that they are in a socio-economic position that restricts their ability to negotiate safe sex, or they rationalise unprotected sex in a way that offsets the risk with other gains, whether instant pleasure or gratification or child birth and familial stability. The problem here is thus of education, socio-economic status and individual pleasure and need. Socio-economic, cultural factors provide an extreme restriction on individual choice and behaviour change. For example, women may find negotiating safe sex both within and outside of marriage difficult due to the financial aspect to sexual relationships, whether it is from commercial sex work, to intergenerational relationships that offer financial security, or access to property rights through marriage. Cultural and socio-economic factors can limit the ability of individuals to access information and have autonomy over how they use such information. It therefore may appear a rational or logical choice for women to refuse or refrain from sexual intercourse with a partner who is either HIV positive, or perceived to be HIV positive, yet this depends on an individual's autonomy to make such a *choice* and the

offsetting of such choice against much more immediate risks, such as loss of financial support and social stigma.

Context is central to the ability of individuals to gain access to education and awareness campaigns, and their capacity to engage in such prevention strategies. Where education exists, it can be problematic. Confusion over biomedical research and the denial by state leaders and individuals that HIV is not the cause of AIDS has led to questions over what is the right kind of knowledge and who or what can or should be believed, and the role of the state in governing individual's lives and their bodies (Youde 2007). This denial has arguably set back prevention efforts considerably. For example, once coming to power, Nelson Mandela remained silent over the emerging HIV/AIDS crisis in South Africa, only in his later Presidency becoming vocal about the problem. His successor Thabo Mbeki denied the relationship between HIV and AIDS, and the current President of South Africa, Jacob Zuma publicly stated he was not worried about contracting HIV after having sexual intercourse with an HIV positive woman because he had had a shower afterwards (Jacob Zuma in BBC News 2006). This right kind of knowledge is not just evident within specific states and state leaders, the global HIV/AIDS response has promoted a limited prevention message that prioritises abstinence and being faithful to partners above all else. Controversial projects such as the US government's President's Emergency Plan for AIDS Relief (PEPFAR) initiative and funding from religious denominations such as the Catholic church has seen an abundance of abstinence-based policies and little awareness or promotion of condom use as a key tool in prevention strategies (Harman 2010). Needle exchanges are not widespread globally and only minimally used within prisons as either pilot projects, prison-specific or a national policy in under ten countries (Lines et al 2006; Harm Reduction Coalition 2007). Whilst extreme, these policies represent a general unwillingness to recognise or discuss sexual intercourse, reproduction and pleasure within the global HIV/AIDS response. The onus is on educating individuals in a specific way that restricts their sex life, and thus reduces the risk, with little understanding of the meaning of sex or individual behaviour and the context in which behaviour is decided upon, and/or engaged with. Key to which is the perception of risk by both the policymaker and the individual. Individual choice and behaviour change thus becomes further restricted by the policy responses and global aid interventions tasked to combat the disease.

Responding to HIV/AIDS requires a complex combination of appealing to individual rationality and perceptions of risk to facilitate behaviour change and tackling the socio-economic drivers of the disease. The core problem in preventing HIV transmission is its main mode of transmission is sexual intercourse. Reproduction, the continuation of the human race, relationships, families and forms of individual happiness and pleasure are dependent on sex. Hence it cannot be abolished. What it can be is regulated or practiced in a safe manner, yet this is increasingly problematic in a world where discussions of sex and pleasure are often seen as private issues, far from the domain of public policy-making, particularly that of the state and intergovernmental institutions. The result of which is a combination of interventions that deal first with socio-economic factors through what has become known as ‘multi-sectoral’ interventions, and second behaviour change initiatives that seek to alter individual choice and perception of risk.

Multi-sectoral interventions refer to the need to involve every aspect of state and society in combating HIV/AIDS (Harman 2009). The onus here is on inclusion of the non-health sector as a means of recognising the relationship between HIV/AIDS and poverty and the exceptionalism of the disease, and the need to break stigma through making the issue everyone’s concern. The result of such a multi-sectoral approach emphasised by international institutions such as the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (hereafter the Global Fund) and the World Bank, and multiple governments across sub-Saharan Africa, has been a scaling up on HIV/AIDS interventions and mass participation to create a form of ‘AIDS biz’ (Pisani 2008) and wider awareness of the problem. This approach has been successful in raising awareness and facilitating an increase in participation but in turn has led the HIV/AIDS response to lose its focus, specifically in terms of individuals, their perception of risk and individual behaviour change (Harman 2010). Participation is limited with inclusion in the practice of policy-making and agenda-setting being limited to government ministries and international donors (Harman 2010). Hence innovative policy ideas and project trials tend to come from donors not the community.

Despite a shift towards addressing more socio-economic concerns and social stigma over the last ten years, changing sexual behaviour has been at the cornerstone of HIV/AIDS interventions since its identification as gay-related immunodeficiency syndrome (GRID). Behaviour change is done through a number of strategies: peer to peer learning, behaviour change communication, and public information campaigns emphasising the need to abstain, be faithful, use a condom (Harman 2010). However, these efforts have failed to make a breakthrough in regards to the differing perceptions of immediate and long-term risk, the rationality behind such perceptions, or the pursuit of pleasure. Whilst minimal success in preventing HIV transmission can be afforded to a host of problematic state-based and global policy-making, as well as socio-economic determinants, at the core of this problem is the individual and how to appeal to an individual's rationality and perception of risk. Despite some success of education initiatives and peer to peer learning, there is a need to 'innovate' new ways of appealing to individual rationality and choice in behaviour change and the perception of risk. At the centre of which has been the need to provide new forms of incentive or purpose beyond health concerns to enable wider behaviour change in the short term to elicit long term global health goals.

Recognition of the need for new incentives or 'innovations' to enhance progress in combating HIV/AIDS has become a dominant feature of global health governance over the last three years. The purpose of innovations and incentives has been to provide policy-makers with new tools and mechanisms for combating infectious diseases. At the centre of these new innovations is the use of conditional cash transfers as a means of inducing behaviour change, particularly in regard to the transmission and spread of HIV. These conditional transfers offset the context to risk-taking and use financial incentive as a means of situating unsafe sex as not only a long term health risk, but a short term economic risk. Their application, however, raises several questions about the politics of governing individual behaviour and shaping perception of risk in global health governance to suggest that underpinning such approaches remains the liberal emphasis upon individual rationality that where lacking through education or socio-economic opportunity can be induced through economic means. Perceptions of risk are framed by the international donors that devise policy and trial projects, not by people living with HIV/AIDS or people living in communities affected by the disease. Hence there is both a problem in the design, logic and



application of cash transfers as a means of governing sexual behaviour. In developing this argument it is first important to identify what conditional cash transfers are and how they have been applied to HIV/AIDS governance in terms of buying behaviour.

### *Conditional Cash Transfers and Buying Behaviour*

Conditional cash transfers originated in Latin America in the mid 1990s as a mechanism of reducing intergenerational transmission of poverty through investment in human capital and social protection. The logic behind such transfers was that services and supply-side public sector provision were available to the poor, the poor were just lacking in incentives or ability to use such services. Hence, cash transfers would be provided to poor households as an efficient means of assisting or facilitating demand for basic public services that would equip individuals with the basic capabilities of education, nutrition and primary healthcare. These basic capabilities would give poor households more equal opportunities in life (Caldes and Maluccion 2009; deJanvry and Sadoulet 2006; Gertler 2004; Gilter and Bahham 2008; Skoufias and DiMaro 2008; Todd et al 2010). Conditional cash transfers are predominantly given to women who are perceived to be more reliable in spending money on the human development of their children than men (Gilter and Barham 2008: 271). Commonly, these transfers are conditional on child school enrolment, attendance and continuation from primary to secondary; adequate nutritional support to children and regular visits to healthcare centres to measure such nutritional efficacy. They have come to constitute a prominent feature of poverty reduction strategies throughout the Latin America, involving hundreds of thousands of households, and billions of dollars of investment. Two of the largest and flagship conditional cash transfer projects *Oportunidades* in Mexico and *Bolsa Familia* in Brazil had budgets of \$2.5 billion and \$700 million respectively by 2004 and a huge outreach to the number of families involved (Bradshaw 2008; deJanvry and Sadoulet 2006; Gertler 2004; Skoufias and DiMaro 2008; Todd et al 2010). The funding for such programmes draws from a mix of government budgets, and significant loans from the World Bank.

Health has always been a central component of conditional cash transfers. However, cash transfers have only focused on health as a wider component of nutrition and social support to ensure long-term and sustained education for children from poor households (Barber and

Gertler 2009; Barham and Maluccio 2009). Good health beyond nutritional support or prevention strategies have not been a feature of the first generation of conditional cash transfers. The increase in the number of cash transfers, and their perceived success or innovation as a poverty reduction strategy in Latin America has led to a broadening of the possibilities for this tool, particularly in healthcare. It is within this wider context of the need for innovation and readily adaptable solutions to confront some of the problems of the poorest families and households in the world that conditional cash transfers as a means of HIV prevention were trialled.

The first trial relating to HIV transmission and conditional cash transfers represented the standard format of transfer seen in Latin America. In January 2008 the World Bank launched a conditional cash transfer programme in Malawi to ensure uptake and continuation of girls aged 13-22 in education. Those that regularly attended school would receive \$10-15 a month. The programme was predominantly funded and managed by the Bank with additional funding and support from the Bill and Melinda Gates Foundation and the Spanish Impact Evaluation Fund (World Bank 2010a; Baird et al 2009). The outcome for education was positive, with 95% of the study staying in education, compared to 89% of the control group. However, the interesting finding that related this study more directly to HIV/AIDS was the finding that the HIV infection rate was at 1.2% compared to the 3% of the control group: a total lower prevalence of 60% (World Bank 2010a). World Bank Senior Economists attributed the causal explanation for this as being a decline in transactional sex, as 90% of the control group had received an average of \$6.50 in gifts of money from partners (World Bank 2010a). It is this decline in prevalence associated with conditional cash transfers that have heightened the broader social and health impact of these initiatives, and provided further justification for their role as a key development tool.

A Tanzanian trial cash transfer project differed from Malawi in that its specific focus and objective was the promotion of behaviour change through safe sex. In 2008, the *Encouraging Safe Sexual Practices among Youth using Rewards* project was established to see if cash transfers could act as an effective means of reducing risky sexual behaviour (World Bank 2008). The World Bank provided the majority of the \$1.8million for the project that involved 2394 young adults (World Bank 2010a). The trials were funded by the World Bank and the Hewlet

Foundation, and implemented by the Ifakara Health Institute, the World Bank Development Economics Research Groups, and the University of California at Berkeley. The study was conducted in two districts of Southern Tanzania - Kilombero and Ulunga – with participants aged 18-30 living in HIV ‘hotspots’ identified from the Demographic Surveillance System database and the 2006 STI prevalence study. 3000 participants from 10 villages would be regularly monitored for STI transmission over a one year period. These screenings would not test for HIV, but for STIs associated with risky sexual activity and HIV susceptibility: Chlamydia, gonorrhoea, syphilis, trichomonas, mycoplasma genitalia and HSV-2 (herpes simplex virus 2), all of which besides HSV-2 can be cured. Crucially, for ethical reasons, the conditional cash transfers would not be tied to HIV status, despite the purpose of the study being to reduce HIV infection. Participants would participate in counselling and life skills sessions in support of their participation (World Bank 2008). The Tanzanian trial saw a 25% reduction in the number of participants who had previously engaged in unsafe sex.

The outcomes of these two trials in Tanzania and Malawi were announced at the 2010 International AIDS Conference in Vienna to good reaction. Both types of conditional cash transfer were seen to have a positive impact on the sexual health of the girls and young adults involved in the trials, with an overall change in sexual behaviour. The World Bank found that conditional cash transfers were effective means of delaying sexual activity in young girls. In addition, the Malawian project delayed marriage and pregnancy (Baird et al 2009). The findings of these two trials received significant media attention in July 2010 in Africa, Europe, and North America, most of which was positive, and featured quotes from the World Bank’s Global HIV/AIDS Program Director David Wilson and the World Bank Senior Economist Damien De Walque who conducted the study and described the use of conditional cash transfers in a widely publicised press release as ‘creative new approaches to help people change their behaviour’ (World Bank 2010b). In addition, an independent study published as a working paper within the Bank’s Development Research Group described the use of cash transfers for HIV prevention as ‘win-win programs’ (Baird et al 2009).

#### *Creative and Innovative Potential of Conditional Cash Transfers*

Conditional cash transfers applied to more broad health and social interventions pose a number of potential benefits for behaviour change and a decline in risky sexual practices that

reduce HIV infection. First, they have the potential to break the cycle between HIV infection and poverty by directly addressing basic capabilities such as access to education. Education is the primary arena beyond the family where young people learn about HIV and AIDS, and methods of preventing HIV infection. Moreover, greater education can lead to feelings of self worth, independence and employability among youths. These are integral factors in breaking the poverty cycle, especially for women. A lack of education can result in females having less access to information on sexual health, absence of skills to equip them in the workforce, and may lead to them relying on males for economic support. This in turn can increase the rate of transactional sex, intergenerational relationships and less female control over her body, all of which exacerbate HIV infection rates, particularly among young women.

The case of young women points to a second benefit to conditional cash transfers, they have positive outcomes for women who are disproportionately infected and affected by HIV/AIDS (Harman 2011). For some cash transfers are effective means of promoting self esteem and empowerment (Vincent and Cull 2009). HIV/AIDS has been increasingly identified as a feminised epidemic as the impact and disproportional infection rates of the disease have become recognised over the last ten years. Conditional cash transfers support young women and girls in school, and gives them slight financial independence from men. Moreover, in giving the cash directly to female members of the household, women have more control over family budgets, and empowerment in managing such small grants from the government and institutions such as the World Bank. It can be argued, that this shifts the pattern of community driven development in which funding is often concentrated with the male village elder, or male-headed households to bring women to the centre of budgetary control and support, particularly towards young girls. Conditional cash transfers not only break the cycle of poverty and the feminised nature of the epidemic through education, but support a wider role of women as economically in control and independent of that of men.

The third benefit of such transfers is that contrary to previous attempts to address the multi-sectoral aspect of HIV/AIDS, they allow for measurable outcomes and success rates, and have a more targeted purpose other than the loose category of ‘community empowerment’ that previous World Bank strategies have emphasised. Previous interventions by the World

Bank have involved the rapid deployment of funds as a means of enhancing community participation within the global HIV/AIDS response. Conditional cash transfers develop the logic of such an approach – that communities are the best setting in which to educate and respond to the HIV challenge – but are more targeted and less loose-knit. They are more cost-effective, in that the cash transfer is relatively low and easy to administer once established with outcomes allocated to a specific funding stream (deJanvry and Sadoulet 2006: 28).

The final potential of conditional cash transfers as a means of reducing HIV infection rates through behaviour change is that the two trials of HIV-specific transfers in Malawi and Tanzania suggest that they work. Conditional cash transfers govern risk by not only reducing the socio-economic determinants of risk and individual behaviour through education and the provision of social safety nets, but change the perception of risk to that of immediate financial loss rather than long term health gain. Individual risk assessment thus becomes based on short term financial benefit as well as long term health and development outcomes. Both of which are arguably a win-win situation. However, the long-term effects and implications of such transfers are not so clear-cut.

#### *Problems and Perceptions of Risk*

The success of conditional cash transfers in achieving reduced HIV infection rests on the future ability to translate cash transfers into long-standing behaviour change that uses better health outcomes rather than financial gain as the incentive. There are several obstacles to achieving such change that are an intrinsic part of the conditional cash transfer as a mechanism of risk management. These problems are intrinsic to both the framing of risk in cash transfer design and the practical application of such programmes. The most common obstacles are those seen from previous cash transfer projects in Latin America: the utility of giving money for what people may do independently of the cash transfer (deJanvry and Sadoulet 2006: 6), the potential distortion they may have towards local labour supply (Skoufias and DiMaro 2008: 954), and the rate of such transfers as too low or too high to elicit action/distort local economies. In regards to HIV/AIDS, the question more often than not becomes more normative as to whether conditional cash transfers ought to be used for something individuals *should* be doing. An individual's long term and productive health *should*

be enough incentive to not engage in risky behaviour, however as the previous section suggests the risk is offset by a number of other risk factors and the context in which the individual engages in such behaviour. This normative argument sees a return to the type of debates outlined at the beginning of this paper between the need to provide better health outcomes for all through individual responsibility or through state intervention and provision. On the one hand, conditional cash transfers in the main continue to place the onus of better health outcomes on individual responsibility, with a lack of recognition of the socio-economic context in which decision-making takes place. On the other, interventions such as cash transfers maximise individual's basic capabilities by providing them access to education and better health and thus greater equality of opportunity. However, such access is selective and raises several ethical questions about who is left out, why and what about their claims to state and World Bank support.

The question of who is left out limits sustained behaviour change. Rewarding some with cash incentives can be seen as a disincentive for those who do not receive such cash. This is a problem endemic within the global response to HIV/AIDS, where local communities have increasingly been found to not engage in activities that help themselves and their community unless they receive financial support to do so. One senior official from the Tanzania Commission for AIDS (TACAIDS) explained the current situation with the HIV/AIDS response in conversation in 2009 with the following analogy: when people used to get a snake in their house they would come together to work out how to get rid of the snake; now they shut the door and wait for some money to pay for them to get rid of the snake. This leaves policy-makers reliant on cash transfers in a bind. Not only do they have to prioritise who to give money to, the longer a project is sustained, the longer individuals rely on the money. The perception of risk thus comes about loss of income or welfare benefits, as well as the loss of life. The risk is thus both short and long term. Once the incentive is there, it is hard to remove it. Whilst behaviour may be learnt, the risk associated with unprotected sex will only be in regard to the long term, with short term problems of nutrition, education and financial loss remaining. Economic incentive through financial gain alone as a means of inducing rational self-promoting behaviour is not enough to sustain long term change. As once the incentive is not there, a trickle down effect or learnt through practice behaviour does not necessarily take place. Individuals are to a certain extent malleable to state and

global policy-making, but sex and sexual behaviour is an arena of social life in which they are often exempt. Cash incentives go part of the way to offset risk through financial reward, but ultimately such risk and reward is balanced against pleasure and reproduction. Cash transfers can regulate sex and sexual behaviour but they cannot abolish sex or promote abstinence altogether.

A pertinent obstacle to the long term success of conditional cash transfers is that of sex. Safe sex through abstinence, one partner or condom use restricts reproduction and can impact on family planning. Conditional cash transfers incentivise unprotected sex only between non-HIV positive couples or present the risk of HIV infection through unprotected sex as not a risk worth taking. For some this may be a useful side effect on family planning in countries with large populations, or for reducing mother to child transmission of HIV. For others this has significant implications for individual choice, the family and forms of social engineering that restricts childbirth within specific socio-economic demographics.

Despite being presented as having a form of emancipatory potential for women, the emphasis placed on women as carers and more likely to invest money in their children perpetuates gendered norms of women-as-carers or women-as-mothers, and the attitudes of men towards their families and poor financial budgeting. In this sense, conditional cash transfers perpetuate the notion that women are the solution to the male problem of intergenerational and family poverty (Bradshaw 2008). As Bradshaw and Quiros Viquez (2008) argue, these transfers can be seen as an extension of what Chant (2006) calls the 'feminisation of poverty alleviation' wherein women bear the burden of responsibility and are the site of international development initiatives. Initiatives such as conditional cash transfers are posed in such a way as to present an emancipatory function for women who are able to manage and control resources, and fulfil roles outside of the family. However, such logic presupposes women are not already performing such function and leaves open the question as to what happens once the money has gone (Bradshaw and Quiros Viquez 2008). Moreover, promoting behaviour change through cash incentive in women specifically positions women as economic objects malleable to financial pressure. Thus re-enforcing gendered dependencies on resources external to women's labour. This is particularly relevant to HIV/AIDS which is increasingly feminised both in terms of the disproportionate number

of women infected and affected by the disease, as women bear the brunt of care for family and neighbours within local communities as well (Harman 2011). The introduction of conditional cash transfers as a key tool in the response to HIV/AIDS will most likely embed this burden of care and responsibility of responding to the disease at a local level, and further stereotypes of men as not responding or somehow not committed to the response to the epidemic.

A fundamental problem with conditional cash transfers is the sovereignty and self-regulation of an individual's body. The governance of HIV/AIDS has much to do with the regulation of the body and the construction of appropriate or particular behaviour, and the promotion of a right kind of knowledge. Conditional cash transfers play a significant and intrusive role within this. Having been designed in Washington DC cash transfers prevent solutions to a specific perception of risk put forward by policymakers such as the World Bank and its partner organisations. It is both the right kind of risk perception and how this perception translates into cash transfers practice that can be seen to represent a direct form of Foucault's understanding of biopower, in which sex, sexuality and pleasure is regulated and organised in a manner that is seen as more productive for society, and crucially economic development (Foucault 1976: 140 – 141). Conditional cash transfers organise a specific form of sexuality that promotes abstinence or safe sex as a means of regulating the bodies of the poor. The distinction toward regulation of the poor in developing countries suggests the biopolitical dimension of segregation and hierarchy are clear mechanisms of governing the body (Foucault 1976: 141). Key components of conditional cash transfers are surveillance, data, monitoring, and segregation – essential sources of biopolitics, and for some crucial mechanisms of global health governance as bodily control (Elbe 2005). According to Elbe, it is the language of risk that enables biopolitical power to justify, maintain and extend the power of institutions and sovereign states within global health governance through the framing of 'risk groups' and 'risky behaviour' (Elbe 2008: 178). Framing specific individuals as 'high risk', 'risk groups' that engage in 'risky behaviour' has the effect of segregation, stigma, racial metaphor, and in the extreme, eugenicist visions of society (Elbe 2008). Conditional cash transfers extend this framing of risk groups by accentuating difference in society and rewarding what comes to be constituted as non-risky behaviour with cash benefits.



Biopolitical mechanisms of control through surveillance, data collection, and behaviour change education and knowledge are not enough to regulate and change sexual behaviour. The efficacy and tools of biopolitical control are limited in their ability to regulate and reduce sexual activity and behaviour as they do not have the means or ability to offset pleasure, desire or reproduction. Risk, fear and stigma are all significant factors in eliciting change, but they are not cognizant of perceptions of fear and risk. Individual perceptions of risk and fear are dependent on socio-economic concerns and rest on long and short term needs and desires. To fully regulate the body and behaviour, risk must appeal to the short and long term and be context specific. High HIV/AIDS prevalence clusters in areas of extreme socio-economic poverty and inequality, hence any methods of behaviour change need to address the immediate needs, concerns and risks of people living in poverty: they need to provide financial incentive for behaviour change and better health outcomes, and crucially: risk that such financial reward can be withdrawn. In fulfilling such a function, conditional cash transfers represent the intersection of biopolitical control of the body within wider processes of neoliberal political economy. The central justification of which is risk and perceptions of risk.

*Conditional Cash Transfers as intersection of biopolitics and neoliberalism*

Conditional cash transfers reflect a clear method of constructing political will and risk where risk and will is not forthcoming. This is a central component of the system of governance that constitutes the global response to HIV/AIDS, the use of economic incentive as a means of eliciting wider processes of change (Harman 2010). This is evident in the approach institutions such as the Global Fund and the World Bank take to promoting reform and adoption of multi-sectoral HIV/AIDS policies within national and local government structures (Harman 2010). Conditional cash transfers extend this mechanism, but engage in the broad category of political will through the wider construction of risk and perceptions of risk. Economic incentive has become an integral part of neoliberalism in practice. As an ideology, economic system or political project, neoliberalism refers to the reduction of state intervention and the primacy of the market in providing effective policy outcomes. At the core of such an ideology is an opening up of states to the free market competition and financialisation of the global political economy (see Harvey 2005; Harrison 2010). In terms

of global health care, such neoliberal policy has led to cuts of state-based health funding, and increase in public-private partnerships and the role of the private sector more generally in providing health interventions, and a need for market-based solutions to deliver better health outcomes, particularly in developing countries (Larkin 2008; Lee 2003). For neoliberalism to work in practice it requires incentives based on financial gain, whether it be the gain of public funding for a state or civil society organisation to implement a specific project, or for an individual to reform their own sexual behaviour. Economic incentives through financial gain provide the political will needed to elicit wider liberal reforms within a state or individual. In the case of conditional cash transfers and HIV/AIDS such liberal political will refers to the construction of rational actors that balance their long term health with their short term needs.

A central project of global HIV/AIDS governance and global governance more broadly has been liberal reform that promotes democracy, representation, transparency (Harman 2010; Williams 2008) and the *right* sort of relationships between individuals and their bodies. Conditional cash transfers reflect the liberal underpinnings of such an approach in their emphasis on individual responsibility and the need for levelling-up of welfare and state-based incentives as a means of providing better health outcomes for all. Individuals are seen as malleable within behaviour change programs, that with the right kind of education and knowledge they will rationally choose to enhance their own self-interest. Increasingly such malleability has depended on context of individual choice and how they limit such choice. The purpose of conditional cash transfers is to address the context, i.e. socio-economic concerns, within the wider approach of multi-sectoralism, by using cash support. However, the conditional element of cash support suggests something far more reformist to the wider agenda of those that fund and promote such reforms. They introduce financial transaction and a shift in perception of risk, to make the risk more about financial loss than poor health outcomes. In so doing they create a dependency and segregation between the have and have nots. The financial incentive of such transfers suggests that when logic, education and specific knowledge bases fail to appeal to liberal, rational individuals, economic incentive through cash transfers will instigate such reforms. For such neoliberal policies to work requires a specific form of disciplinary neoliberalism, that relies less on legal-constitutional

structures normally associated with such a term (see Gill 2005), but more on systems of biopolitical control.

A mix of neoliberal economic incentive through financial gain and key components of biopolitical control – surveillance, monitoring and the promotion of the right kind of knowledge – produces a new form of disciplinarity that uses risk as justification and a tool of political control. Risk is individualised and located in short term economic loss, and places less emphasis upon long-term sustained risk factors such as loss of life or ill health. Hence these mechanisms of control only provide short-term solutions and fail to address the rationality underpinning certain sexual behaviour, be that desire, pleasure, reproduction or the socio-economic contexts that offset the threat of illness or loss of life. Biopolitics presents a convincing argument for understanding processes of governing global health; political control over the body is a systematic function of global health governance, however, the body remains susceptible to individual desires and needs that education and knowledge control mechanisms fail to address alone. Economic incentive goes some way towards doing this, specifically in contexts of social, economic and political inequality. However the longevity of such programs may come into question.

#### *Implications for Global Health Governance*

Despite these cautionary implications, conditional cash transfers will become the new model in which global health governance operates. Cash transfers perform key roles essential to the main paradigm of global health: they are performance-oriented, show measurable results, engage in social protection, and can be replicated in multiple different contexts. Donors, states and institutions can devise projects cheaply and quickly and show measurable outcomes as a means of showing immediate results. Cash transfers are presented as having great success and potential by lead institutions within global health such as the World Bank, development policy discussions, and academic publications (see Barrientos et al 2010). Cash transfers will not only be limited to HIV/AIDS, but will be applied to multiple health contexts, as health planning adopts wider trends trialled within global AIDS policy, and the immediate, cost-effective ‘benefits’ become clear.

These 'benefits,' however, must be measured against the following practical implications for the future of global health policy more broadly. First, global health interventions will continue to reflect domestic healthcare reform. Specifically in the emphasis on incentivised behaviour for both individuals and health professionals and the use of regulation as a form of ensuring standardisation and the right kind of behaviour change in western health systems. Second, global health will see a continuation of the marketisation of individual behaviour as the choices they make are not conditioned by their liberal need to rationally maximise their own health but economic gain and reward relative to that of the health market. Third, individuals not states or social groups will become the central contention and site of delivery within global health governance. Failure to provide better health for all will become conditioned by morally just or wrong behaviour of individuals identified by states and international institutions, leading to wider contradictions within, and thus ultimately an undermining, of the right to health. Fourth, the use of incentives will skew the balance between the state, the market and the individual within global health governance, leading to a growth of the market, the responsibility of the individual in the provision of better health outcomes, and the re-assertion of a co-ordination-based management role for the state and international institutions. This will result in a diffusion of responsibility among multiple actors in which the individual will be blamed for any failure in policy, as opposed to those who design and implement cash incentive programmes.

The role of conditional cash transfers in governing risk through buying behaviour rests on the individual's role in allowing for their behaviour to be brought, and the context which affects such a choice. The emphasis on economic incentive for reform in global HIV/AIDS governance, and the consistent call for new innovations within global health governance would suggest that this element of individual reform through disciplined economic incentive and biopolitical control will remain, and in many ways frames how global health governance operates and is understood. Global health governance is about governing the body and the extension of biopolitical control as a means of changing individual behaviour and relationships within the wider state and neoliberal global political economy. When biopolitical control mechanisms and incentives fail, economic conditionalities and neoliberal forms of private understandings of the self, other and profit come into play. What is

constituted as risk and perceptions of risk are as much about financial gain and incentive as they are about health outcomes and the threat of infectious disease.

## **Conclusion**

Conditional cash transfers are a new mechanism of promoting behaviour change and increasing HIV prevention strategies within global health governance. Their backing and support from the World Bank and interest from wider actors in global health suggest they are going to become a prominent feature and tool in the global politics of health and disease. Conditional cash transfers govern health risk by buying behaviour and altering perceptions of risk by introducing economic incentive. Perceptions of risk are specifically framed by policymakers in global centres of decision-making. Risk to good health, longevity in life and familial support is context specific, and whilst vitally important to people living in developing countries, is often offset by more immediate concerns of economic support and well-being. Providing welfare grants and framing 'bad' behaviour as an economic risk seeks to address the problem of socio-economic determinism in which these decisions are made through providing short term solutions for both immediate and long term gain. Conditional cash transfers have the potential to change behaviour and provide a breakthrough in prevention strategies. However, their usage in combating HIV/AIDS and adoption as a key tool within global health governance should be met with caution.

Cash transfers rest on a narrow conception of rationality that suggests economic gain is the most effective means of incentivising individuals to maximise their own health utility whilst ignoring fundamental problems such as pleasure, insecurity, reproduction, desire, property rights or violence. The emphasis of conditional cash transfers is on abstinence and protected sex at the cost of wider questions of reproduction and pleasure. The success of conditional cash transfers in HIV prevention is dependent on coverage, longevity and individual responses to such conditionalities and rationality. They provide an additional burden for women who are the main site and providers of these incentive schemes and re-enforce those gender stereotypes of women-as-carers that perpetuate inequality. Education projects such as that of the Malawi scheme have the potential to address some of these concerns, but cash transfers conditional on sexual health do not.

Cash transfers conditional on the sexual health and behaviour of individuals raises specific ethical questions as to what constitutes morally right behaviour and wrong behaviour by rewarding the good and penalising the bad with a loss of financial support: ‘good’ behaviour is rewarded through cash transfer and ‘bad’ behaviour is stigmatised. What constitutes such moral behaviour is dependent on the economic modelling of institutions such as the World Bank and the states in which these policies operate. Cash transfers introduce the notion of morally good or bad, right and wrong sexual behaviour and as such undermine any rights-based approaches to people living with HIV, efforts to reverse the stigma surrounding the disease, and accentuate problems of self esteem for those who do not receive the money or have been withdrawn from the programme.

As a component of global health governance, cash transfers represent the extension of the marketisation of global health to the individual. Market reform of the health sector has occurred within the state and economy in health systems throughout the world, from western states, to developing countries, to those states rebuilding health systems after conflict. Cash incentives for behaviour change have extended the market to the governance of individual bodies. As such, they exemplify the merging of biopolitical control and neoliberal reform that has come to underpin global health governance. Risk and the perception of risk are used as a key justification for the application and extension of such mechanisms. Economic incentive through financial gain, monitoring and surveillance, the reproduction of specific forms of risk-adverse knowledge and behaviour and the stigmatisation of ‘risk groups’ are central components of the management of health risks by institutions such as the World Bank and the Global Fund in responding to the HIV/AIDS pandemic. These mechanisms fail to address the long-term socio-economic and short-term individual rationalities that drive unsafe sex such as reproduction and pleasure, but provide a short-term solution that has more to do with bodily control than risk aversion. Hence, HIV/AIDS has come to be governed as a risk by buying behaviour.

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