

UNDERSTANDING THE ROLES OF PARTNERS IN PARTNERSHIPS

FUNDED BY THE GLOBAL FUND

A Dissertation

by

RAVI MALLIPEDDI

Submitted to the Office of Graduate Studies of
Texas A&M University
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

December 2007

Major Subject: Communication

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Approved by:

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ABSTRACT

Understanding the Roles of Partners in Partnerships

Funded by the Global Fund. (December 2007)

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Chair of Advisory Committee: Dr. James Aune

The field of international development has always been intertwined with the economic thought dominant in the West. Even before its conception with the Marshall Plan to rebuild Europe, it carried a strong Keynesian preference for the state. The neoliberal assault on the welfare state in the 80s, followed by the partnership era that brought both the public and the private sector together to work for a common cause have been the focus of attention by development scholars and others alike. The present study focuses on a multilateral development aid agency, the Global Fund, which funds public-private partnerships in the field of health care in developing countries. Drawing on the debates surrounding the welfare state and the civil society, as well as the debates surrounding the public-privates partnerships, the present study poses three questions in relation to the Global Fund: (1) how are the diseases framed in the partnership framework, (2) what are the roles of the private sector in partnership, and (3) what are the roles of the public sector in partnerships. Based on the textual analysis of fifteen proposals approved by the Global Fund in the sixth round of funding, this dissertation

tries to situate the working of the Global Fund, and the proposals it funds, within the larger debates surrounding development and partnerships.

The findings of the present study are: (1) the diseases are framed largely in socio-economic terms, (2) the private (for-profit) sector is marginalized in the discussion and implementation of proposals, (3) the civil society participation is seen as essential to the success of the proposals, and (3) the state is seen as important in the discussion of the diseases, although there is a great deal of ambiguity surrounding the roles of the public sector in partnerships. It is hypothesized in the concluding chapter that the reason Global Fund is able to attract a great deal of funds and support from actors across the political spectrum could be because the organization funds programs that foreground civil society, liked by people of different political inclinations, and backgrounds the discussion of the state, the epicenter of controversies surrounding development. By being “strategically ambiguous” about the role of the state in the development of the people, the proposals are made apolitical and appealing to people both on the left and the right.

DEDICATION

To Mom, for letting me go

&

To Bob, for taking me in.

I happen to believe that questions are hardly ever wrong; it is the answers that might be so. I also believe, though, that refraining from questioning is the worst answer of all.

Zygmunt Bauman
In Search of Politics

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“Every time you compose a book your composition of yourself is at stake,” wrote E.L. Doctorow. That and much more is at stake with a dissertation, and if not for the following people I would have *never* gotten this done:

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hand all through the circumcision. For patting my back and kicking my butt, and for being there all along despite his SOTS (Sick-Of-This-Shit) syndrome! What would I have done without you?? And thanks to Charlie who understood the futility of this enterprise and helped me hasten the process. For the incision, the ‘Aha!’ moment. Barbara, I cherish the love and care and the empathy during my ups and downs in PhD program. Cynthia was kind enough to be on my committee, and taught the best introductory course; thanks for being so prompt, professional and supportive.

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This dissertation was just a small step on a steep learning curve with various milestones: two surgeries, two broken arms, a heartbreak, a baseball-bat assault, long silent nights, loneliness of laundromats and airports, sad smell of gas stations and fast-food joints, Kerouacian dreams of roads not taken and roads forsaken, ghost towns inhabited by the FoxNews creatures, and on and on... Each was a huge challenge. All these wrapped into a dreary desolate depressing dark-aged place was the biggest motivation to get done, to get out. In the end I also feel like acknowledging the sad fact that, in Hemingway's words, when the age demanded my generation to sing, dance and

rebel we resigned to cynicism, apathy and denial, and instead of trying to change the world by engagement, “we took the world as given” (like Updike lamented). But when emotional, cultural and geographical dislocation leaves one lifeless in an anomic society full of elaborate courtesies and dizzying sensory simulations (like someone described Japan) – where so much of life is *lost in translation* at street corners, inside lifeless McMansions, in academic hallways, and even in salacious spaces – all I can say at the end of this dissertation, with a huge sigh of relief, is: “Free at last, free at last. O god almighty, free at last”!

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CHAPTER I

INTRODUCTION TO THE STUDY

William Easterly (2006), who was the World Bank's economist for 16 years, begins his book *The White Man's Burden* with an interesting example:

In a single day, on July 16 2005, the American and British economies delivered nine million copies of the sixth volume of the Harry Potter children's book series to eager fans. Book retailers continually restocked the shelves as customers snatched up the book. Amazon and Barnes & Noble shipped preordered copies directly to consumers homes. There was no Marshall Plan, no international financing facility for books about underage wizards. It is heartbreaking that global society has evolved a highly efficient way to get entertainment to rich adults and children, while it can't get twelve cent medicine to dying poor children. (p. 4)

Easterly's angst stems from the fact that "the West spent \$2.3 trillion on foreign aid over the last five decades and still had not managed to get twelve cent medicines to children to prevent half of all malaria deaths" (p. 4). And malaria kills nearly a million people each year. He adds, "the West spent \$2.3 trillion and still had not managed to get three dollars to each new mother to prevent five million child deaths" (p. 4). The gut-wrenching statistics go on. In light of these facts, it is hard to contest Easterly's conclusion that the West aid has "done so much ill and so little good."

Yet, the word 'development' conjures up evocative images that mobilize public sympathy, support, and spending: a starving kid in Somalia, an emaciated AIDS patient in India, refugees scrambling for food in Ethiopia, images of famine, genocide, death. While some claim that this has led to "compassion fatigue" and to "the pornography of

This dissertation follows the style of *Journal of Communication*.

war, genocide, destitution and disease” (Moeller, 1999, p. 2), international development aid has turned into a multi-billion dollar industry, with over \$100 billion spent in 2005 alone (OECD, 2006). When so much is being spent and “so little good” is said to have been done, it becomes important to understand the trajectory of international development that prompts one to reach this conclusion. In this chapter, I will give a historical overview of international development, the various forms and actors associated with it, the trends and tribulations due to global political changes, and how the state, the market and the civil society have been imbricated in the discussion and deployment of international development aid. The chapter concludes with the discussion of the public-private partnerships that have become central to the development aid strategies in the twenty first century and the critique of the partnerships as Trojan horses for neoliberal ideas on public welfare.

Forms of Aid

Keeping with the fad in recent social research to claim that the concept being studied is hard to define, one can confidently make a similar claim about the concept ‘development’; it changes its color and connotation based on the official document it sits on. In his book, *The History of Development*, which explains how the word transformed from its western origins to “Global Faith”, Gilbert Rist (2003) contends that by using the word ‘development’ for “the sum of virtuous human aspirations” (p. 10), the term loses its heuristic value:

In the name of this fetishistic term... schools and clinics are built, exports encouraged, wells dug, roads laid, children vaccinated, funds collected, plans established, national budgets revised, reports drafted, experts hired, strategies concocted, the international community mobilized, dams constructed, forests

exploited, high-yield plants invented, trade liberalized, technology imported, factories opened, wage-jobs multiplied, spy satellites launched. When all is said and done, every modern human activity can be undertaken in the name of 'development'. (p. 10)

Despite this, development aid is provided in definite forms. There are reified categories in the development aid literature used extensively to talk about different types of interventions. While it is impossible to neatly compartmentalize aid into clearly defined boundaries, these categories are reified for heuristic purposes, for differentiating one form of aid from another. To that extent, instead of treating each form separately, one should acknowledge how each form overlaps and interacts with other forms to combine what has come to be known as Official Development Aid (ODA). Some of the main forms ODA takes are:

Humanitarian assistance and emergency relief: Aid given in response to direct human suffering caused by natural catastrophes, extreme poverty, wars and other conflicts is called as emergency relief. Humanitarian assistance, in addition to emergency relief, comprises of protection, rehabilitation and repatriation of refugees, support for those who are politically persecuted, human rights activities, among others.

State and voluntary aid: Aid is financed by funds collected from the public or interest groups or by a share of state foreign aid funds, and the aid is provided by NGOs and other volunteer organizations. State aid has been channeled through the private sector as well. Private enterprises support for development is very limited, and has been mainly in the form of technology transfers in connection with direct investments as a form of aid.

Financial, technical and commodity assistance: Financial aid consists of subsidized credits and loans; technical assistance is the transfer of knowledge in the form of advice, training, and concrete problem-solving; and commodity assistance included food and capital goods.

Project, program and policy-oriented aid: Projects are interventions generally limited in time and space and have clearly defined goals; if the individual projects are so large that they have many subordinate goals and strategies that they are called a program. As the programs also grew to extend aid to whole sectors in society, like agriculture, health, and education, mainly through structural adjustment programs (SAPs), the aid is called as policy-oriented aid.

Bilateral Aid: the aid that is given directly by a country to another country.

Multilateral Aid: the aid is secured from multiple sources and distributed through an international agency to one or more countries (Degnbol-Martinussen & Engberg-Pedersen, 2003).

None of the categories is exclusive, and aid usually encompassing at least a few of the categories mentioned: for instance, bilateral aid given for programs that are humanitarian in nature also might involve policy changes in the recipient country. Also, the nature of aid can change in time: projects usually evolve to programs, and the dialogue can move away from technical and organizational aspects to one that is political and aims at changing the structures of society and management of development processes. The difference between development assistance and emergency relief has become vaguer as well. For instance, from the 1990s, development oriented relief has

been used to change the structures and institutions of a country so that they can survive even the worst catastrophes, and used both to distribute emergency relief and to improve subsequent development (European Commission, 1996). So, the form the aid takes reflects a particular ideological approach to problem-solving, and usually changes its form and function over time; what started off as project aid can change to assistance, then to cooperation, and to partnership (Cox et al., 1997). This pliable nature of development assistance has smoothed the way for many international organizations to intervene in almost all economic, social, cultural aspects of life in many developing countries.

Genesis of International Development

Although I have claimed that the concept of development is hard to define, even from Aristotelian times the idea was in vogue, and was taken up by many modern thinkers following Aristotle (who used it in naturalistic terms and applied it to the “development” of society). The current notion of development – the idea that people need outside intervention to better themselves – can clearly be traced back to the ideologies that encouraged colonial conquests, taking special force following the voyages of Christopher Columbus, who in the name of Christ and evangelism opened the doors for economic profit and political prestige for the West. Colonial power spread its tentacles across the globe, and philanthropic and humanitarian ideals were marshaled to support these ruthless invasions and exploitations. The zeitgeist of the time was succinctly summed up by Victor Hugo, who at a banquet commemorating the abolition of slavery, put it like this:

In the nineteenth century, the White made a man of the Black; in the twentieth century, Europe will make a world of Africa. To fashion a new Africa, to make the old Africa amenable to civilization – that is the problem. And Europe will solve it... Go forward, the nations! Grasp this land! Take it! From whom? From no one. Take this land from God! God gives the earth to men. God offers Africa to Europe. Take it! Take it, not for the cannon but for the plough! Not for the saber but for commerce! Not for battle but for industry!... Pour out everything you have in this Africa, and at the same stroke solve your own social questions! Change your proletarians into property-owners! Go on, do it! Make roads, make ports, make towns! Grow, cultivate, colonize, multiply! And on this land, ever clearer of priests and princes, may the divine spirit assert itself through peace and the human spirit through liberty! (as quoted in Rist, 2003, p. 51).

This ideology refuses to go away from the Western political imagination, and has been preserved in more than a fossil form to the present times (like the Bush government's rhetoric on the invasion of Iraq!). But at an institutional level, the Covenant of the League of Nations at the end of the First World War was the first permanent international political institution that deployed the concept of development in addressing the needs of nations. For instance, China requested assistance in its modernization effort by seeking both knowledge and capital; the first request concerned health and hygiene, and gradually the collaboration extended to education, transport and the organization of rural cooperatives (Degnbol-Martinussen & Engberg-Pedersen, 2003).

But the Second World War was the pivot on which the global politics turned, making it a defining moment in the history of international development. In an effort to reconstruct Europe after the devastating war, George C. Marshall, the then USA's foreign minister, proposed a development plan in 1947 to aid countries to rebuild their economies. This has come to be known as the Marshall Plan, initiated in 1948, and was

deployed alongside the workings of the Organization for European Economic Cooperation (OEEC) (the precursor of the OECD) to rebuild Europe. The following year, Marshall expanded his aid to include countries that were “threatened” by communism, from within and without. His proposal was included in the so-called Act for International Development (AID), which benefited countries like South Korea and Taiwan with considerable transfers of resources from the USA starting in 1954. Although the support for Western Europe's reconstruction was phased out in the mid-1950s, development assistance was increased simultaneously to countries in the Middle East and Asia followed by aiding other countries in Latin America and Africa. For the most part, the distribution of foreign aid in practice by the USA was dictated to a great extent by national security considerations.

Unlike the USA, countries like the Great Britain and especially France from the start based their assistance more on moral considerations, but could not wean away from their ties with their own former colonies. “Unofficially, however, this priority was also based on promoting their economic and commercial interests, including continued access to natural resources, raw materials, and markets in the former colonies” (Degnbol-Martinussen & Engberg-Pedersen, 2003, p. 9). But in the case of the Nordic countries, it was the moral and humanitarian goals that dominated their foreign aid programs. This was the product of historical thinking that the rich have to help the poor for the welfare of the society, which shaped the development of the Nordic welfare states and led to improved conditions for poor and resource-weak groups in their own populations. Similar ideology propelled these countries in their development efforts.

At the institutional level, an alphabet soup of organizations came into existence to address the interconnected nature of global conditions that affected local economies (UN, ILO, IMF, IRBD, ADB, DANIDA, UNDP, to name a few). The most prominent among these that dealt with global peace and security was the United Nations, founded in 1945 to replace the League of Nations to facilitate cooperation in international law, economic growth, international security, social development and human rights issues. As UN was established as an organization striving for peace and stability during the post-war period, many countries saw it as playing a key role in development as well. Many countries, especially the Nordic countries, have continued to give high priority to the development work and humanitarian aid carried out by UN organizations. However, in recent years, the role of UN has become marginal in development while the role of the Brettonwood institutions has increased simultaneously.

Although not directly related to development initially, three key international institutions emerged during this period, and continued to increase their influence on the developing economies all around the world. They are: the International Monetary Fund (IMF), the World Bank, and the General Agreement on Tariffs and Trade (GATT) (which morphed into World Trade organization in 1994). The IMF and the World Bank are also known as the Brettonwoods Institutions, because plans for their establishment were drawn up at a conference in Bretton Woods, New Hampshire, in July 1944.

As will be discussed later, the overarching objective associated with the IMF, the World Bank, and the GATT was to shape and maintain a system of what has come to be termed as “embedded liberalism.” This framework encouraged free trade at the

international level and later came to promote free market values as means of attaining economic growth and maintain peace between labor and capital. The reconstructed global economy, it was hoped, would bring economic growth in the developing countries while protecting the interests of the western capitalist powers. Broad, stable prosperity brought about by the workings of these multilateral institutions was seen as the most reliable defense against the spreading of communism in the Third World.

State-Oriented Development

As the aim of the Marshall Plan and other international development agencies was to improve the living conditions of the people in the developing world, these agencies actively sought economists who posited theories of economic growth. Among the economists in institutions such as the United Nations and the World Bank were early pioneers of development thinking: the Finnish economist Ragnar Nurkse, the Austrian economist Paul Rosenstein-Rodan, the German-born economist Albert Hirschman, the West Indian and later Nobel Laureate economist, Sir Arthur Lewis, and the American economic historian Walt Whitman Rostow. All these economists were influenced by the works of English economist John Maynard Keynes, whose macroeconomic theory held sway in 1930s and 1940s. The economists mentioned above “agreed with the Keynesian assumption that poor economic performance reflected a lack of aggregate demand, rather than from a shortage of, or limits to, resources, though Keynes had come to this conclusion based on his knowledge of the advanced capitalist nations, not from studying the dualistic, less-developed economies to which this insight would be applied” (Cypher & Deitz, 1997, p. 129).

Keynesian theory posited that an unregulated capitalist economy was susceptible to severe depression, and government spending on welfare projects will work as a safety net to save economy from collapsing due to unpredictable market forces. Keynes subverted the dominant neoclassical belief that full employment can be secured in a self-regulating market by claiming that full employment is only possible under conditions secured outside the market through the state's intervention. As the results of markets were mixed, and as markets worked well in some spheres of public life and failed in others, "under certain conditions, an assertive, and even a leading, role for government was to be encouraged and was perhaps necessary" (Cypher & Deitz, 2004, p. 129). He suggested various measures by the welfare state – policy, public works, taxation, monetary policy, change of interest rates – that could deal with market failures. The work of Keynes has been summed up as "a twofold strategy build on active government intervention through (1) the macro-management of the economy to ensure economic growth under conditions of full employment, and (2) a range of social policies dealing with the redistribution of the fruits of economic growth, the management of its human effects, and the compensation of those who suffered from them" (Pierson, 2007, p. 30). In the long term, it was assumed that a competitive market, in conjunction with a responsive and efficient government, would achieve best results, and the role of the government in development would be reduced to its stabilizing function as it already happened in the West. Thus, while the market was ultimately seen as the source of welfare, the dominant development economic thinking of this period emphasized the role of government in the welfare of its citizens.

The Keynesian system of economic growth was more closely aligned with the ideals of social democrats of the time, who also favored the welfare state. Many social democrats upheld the core concepts of Marxism, like its critique of capitalism, but wanted to reform a few arguments in order to give a human face to capitalism. While the radical Marxists wanted to replace capitalism with socialism, giving control to the state, social democrats opined that instead of replacing capitalism it should be reformed democratically from within through state regulation. They favored expansion of the roles of the welfare state through state sponsored programs, and creation of organizations and unions that can stem the excesses of capitalism and unpredictable market systems. They believed that it is through evolutionary processes, and not through revolutionary acts, that socialism should be achieved. Through taxation and policies, the state had the potential to redistribute resources and wealth among its citizens. By social programs that benefited the working class, like universal access to health, education and employment, or through nationalized banks and heavy industries, an egalitarian system could be brought into being. In the postwar years, the social democrats position became even softer in relation to capitalism, and the focus moved away from socialism to primarily reform and regulate capitalism. This complacency came under strong criticism from traditional Marxist who saw no redeeming value in capitalism and cautioned that social democrats are on a slippery slope to ultimately becoming capitalists themselves.

In this climate, the development programs were planned and funded by international donors, and so these programs were soaked in the dominant ideology of the west and exported to developing countries. “The dominant paradigm encouraged macro-

economic planning and promoted a high degree of state intervention in the economy” (Melkote, 2001, p. 75). This preference for the state translated itself into a notable preference for industrialization as the driving force of economic growth, with the belief that the industrial sectors would uplift other sectors of a society, much like the age old aphorism “rising tide lifts all boats.” Therefore, in the 1960s – the decade of "trickle-down" economics – the development aid went mainly to the state mechanisms to fund the development of physical infrastructure like roads, dams, telecommunications, etc. Donors typically concentrated their projects within developing countries line ministers, boards and state enterprises. The traditional rural labor was taught to adapt to the needs of modern industries by training and education. This led to migration of labor from rural areas to urban, industrial areas, leading to urbanization and its concomitant problems. This in turn increased the role of the welfare state in its provision of services and safety nets to the working classes.

Disillusionment with the State

During the 1960s, dissatisfaction with the dominant development aid strategies and their effect became palpable. Not only where there no signs of automatic trickling down of benefits of modern technology, but also large segments of the population missed out on the economic growth that followed in the wake of decolonization; the foreign aid benefited only the state-bearing elite. The state sponsored mega industrial projects like dams and power plants turned into fiascoes because they were not adapted to local cultures, markets and the surrounding infrastructure, or to the existing management and maintenance capacity. The main criticism of the aid strategy was that

the poor got very little out of resource transfers and the gap widened between the West and the rest (Baum and Tolbert, 1985).

The 1970s saw a change in aid strategies used. Among donors, the World Bank became influential with a new focus on poor people as a productive force that should be used to bring economic growth during the post-war period. Similarly, the ILO led the way in arguing for fulfillment of basic needs (like food, water, housing, health, education) as a prerequisite for economic and social development (ILO 1977). The dominant aid strategy took the form of integrated rural development projects, and was aimed at large parts of the local economy, especially small farmers; it also involved much of the central and local administrations and focused on reaching out to large parts of poor people. Around this time organizations within civil society began to play a role in foreign aid, mainly because international and local NGOs began to function as channels for aid, and also because the Scandinavian countries and others hoped that the public involvement through NGOs could carry out various functions of development and help in fulfilling basic needs and act as advocates for the poor.

The aid strategy of the 1970s ran into many problems like the decade it followed. Most of the resources were siphoned off by the elite or local authorities, or were wasted due to lack of coordination among ministries, boards and levels, leaving most of the needy people wanting of public services. Also, the dominant paradigm was the top-down planning without any input from the recipients of these interventions, which led to inefficient allocation of resources and designing of projects because they failed to function in local setting. Most of the strategies of the sixties and the seventies were

influenced by the experiences gleaned from the western nations tinkering with the welfare state economics (based on Keynesian economics). On hindsight, it seems rather naïve on these economists part to think that the growth trajectory of many western nations could be replicated in the developing economies by going through clearly defined stages (for instance, like Rostow's five-stage model implied). With the rise of the new social movements in the West combined with the postcolonial critique of neo-colonization and western-centric development discourses, many in the developing countries began to view the western aid with suspicion, especially when the rhetoric of modernization did not translate into any concrete benefits to the poor people.

Neoliberalism and the Welfare State

Alongside the growing discontent in the developing countries with the dominant aid strategies implemented mainly through the state, the seventies also marked a change in the global politics: the oil crisis of 1973, the decline in growth rates in the OECD countries, the election of anti-statist governments in Great Britain, US and Germany (Reagan, Thatcher and Kohl respectively) changed the face of international economy. But it was the debt crisis in the early 1980s that led to restructuring of the world economic order. The oil price increases spurred by OPEC in and after 1973 created inflation worldwide. Shift in US monetary policy increased the interest rates, and as US dollar dominated loan interests, the cost of the loans went up for the countries that relied on Western institutions. The enormous revenues generated by OPEC countries were deposited with commercial banks that in turn invested the money in developing countries in need of foreign exchange to promote industrialization (as described above).

Also, the increased pressure from the poor and middle classes for greater redistribution of the benefits of 'development' posed challenges to national governments in the Third World that tried to control it by increased borrowings from abroad.

Even from the late 1960s onwards there was a growing discontentment among the left and the right about the reconcilability of advanced capitalism and the welfare state. The New Right, a term that stands for the unhappy yet lasting marriage of the neoliberals and the neoconservatives, viewed the welfare state with disdain because it subverted the moral, economic and political freedom that only freewheeling capitalism could provide. It was the neoliberals who gave the movement a theoretical and intellectual impetus by reviving the Adam Smith's views on liberal capitalism.

Neoliberalism has its roots in the Austrian school and the 'Chicago School', a school of thought led by Milton Friedman as a response against the work of John Keynes.

Spokespersons of this school shared a profoundly cynical view of the state and presented 'market' and 'state' as forces naturally hostile to one another. Friedman claimed that "the scope of the government should be limited. Its major function must be to protect our freedom both from the enemies outside our gates and from our fellow citizens: to preserve law and order, to enforce private contracts, to foster competitive markets"

(Friedman, 1962, p. 2). Friedrich Hayek (1982), a leading proponent of neoliberalism, provided a more rigorous critique of the welfare state in his *Law, Legislation and Liberty*. He theorized that regulating the market will always have suboptimal outcomes and always reduce the overall welfare to the citizens. He insisted, "Only limited government can be decent government because there does not exist (and cannot exist)

general moral values for the assignment of particular benefits” (Hayek, 1982, p. 102). Therefore, he concluded that the welfare state stands for “undermining the justice of the market, confiscating the wealth of the more successful, prolonging the dependency of the needy... and overriding individual freedom” (Pierson, 2007, p. 45). Thus, “government serves as the scapegoating device for all ills in the body politic. And in the romantic drama spun by libertarians, the market assumes the role of a hero in vanquishing government” (Aune, 2001, p. 9).

Aune, in his book *Selling the free market*, goes on to write that the theoretical explanations are not essential for the free-market rhetoric to triumph in public policy. He focuses on popular right-wing writings of philosophers such as Richard Posner, Ayn Rand, Robert Nozick, and Charles Murray as well as politicians such as Ronald Reagan, Pat Buchanan, and Newt Gingrich to show how the neoliberal thought, based on rational choice theory – the view of human beings as rational actors always in pursuit of individual happiness and utility maximization – has pervaded contemporary economic policy discussions in the public realm, which does not do justice to the welfare needs of a community or a country. “The principles of rational choice... have become all purpose templates, or rhetorical topoi, for making complex cases of political and economic behavior understandable and explainable” (Aune, 2001, p. 46). Having established a “rhetoric of economic correctness” through a twisted rhetorical logic, the free-marketeters conclude “government intervention in the marketplace is always bad” (p. 169).

Pierson, in his book *Beyond the Welfare State?*, sums up the New Right hostility towards the welfare state:

In brief, both elements of the New Right are hostile to welfare state interventions because (1) its administrative and bureaucratic methods of allocation are inferior to those of the market; (2) it is morally objectionable (for both the sponsors and the recipients of state welfare); (3) it denies the consumers of welfare services any real choice; and (4) despite the enormous resources devoted to it, it has failed either to eliminate poverty or to eradicate unjust inequalities of opportunity” (Pierson, 2007, p. 42).

Thus, the New Right concludes “the welfare state is uneconomic... unproductive... inefficient... ineffective... despotic... a denial of freedom” (p. 48-49).

Neoliberalism in International Development

In the international arena, the early 80s saw the rise in the rhetoric of the New Right in the form of neoliberalism. In August, 1982 Mexico defaulted on its debt payment, which signaled a similar reaction from heavily indebted Third World countries with a potential to snowball into a collapse of the global financial system, which came to be known as the debt crisis. The WB and IMF pushed by their most powerful shareholders – the US, Great Britain and Germany – intervened more dramatically to address the crisis, and it required a radical restructuring of Third World economies. Their prescription for poor countries became known as ‘structural adjustments’ when implemented as programs by the World Bank and IMF, or is also known as the ‘Washington consensus’ or ‘neoliberalism’.

As discussed earlier, by early 80s, with the coming of conservative prime leaders to power in the UK, the USA and Germany, the support for the welfare state was dwindling. Thus, in the wake of debt crisis, the IMF and the WB (dominated by

economists devoted to neoliberal ideology) were seen as institutions that can liberate markets overburdened by state interference. Solution to the debt crisis involved imposing structural adjustment programs (SAPs) which were aimed at the promotion of production and resource mobilization through the promotion of commodity exports, public sector reform, market liberalization and institutional reform. The policies comprise privatization, liberalization, and deregulation. Privatization involves the sale of state-owned enterprises and shifting of social services to private sector; liberalization requires reducing barriers to free flow of trade and investment and reducing subsidies for certain essential goods; and deregulation means reducing the level of state control over the flow of capital, goods, services, and domestic labor markets. These institutions urged poorer countries to adopt free market principles, opening their economies to unconstrained foreign investment and foreign competition. This had a profound impact on the international development aid as well:

Adoption and implementation of an IMF-approved SAP became a prerequisite for obtaining financial support. The World Bank (WB), regional development banks and most major Northern bilateral donors followed suit, so that it became impossible for an indebted country to borrow from them without a SAP. This economic conditionality was complemented in 1990 by political conditionality, the prerequisite imposed by the British and other donor governments for so-called 'good governance' as well as approved economic policies (Simon, 2002, p. 88).

Also, the Cold War rhetoric played into the allocation of aid during the period. Governments in Western-oriented developing countries received most of the aid from the OECD countries and the multilateral organizations, with only limited concern about the extent of poverty in these countries or how democratic their governments were. The

West defined the conditions for receiving aid, which comprised the introduction of liberal economic systems that were open to the world economy with regard to both exports and imports and the flow of capital.

It would be harsh to conclude that all the loans and aid were conditional. The UN system, the Nordic countries, Holland and Canada were partial exceptions; the aid was given with more regard for poverty, but still within the framework of structural adjustment programs and thus the logic of free-market capitalism. The World Bank and other institutions set a ceiling for structural adjustment programs share of total loans; at least two-thirds of the Bank's activities were projects that mainly targeted physical and social infrastructure, and majority of the funds still went to the state authorities. Also, more donors tried to involve civil society in health and education programs through channeling aid through international and local NGOs (Degnbol-Martinussen & Engberg-Pedersen, 2003).

Failures of Neoliberalism

By the late eighties, the effects on neoliberal policies on the well being of people all across the globe started to become noticeable. Critiques were launched on neoliberalism from various fronts because of its adverse effects on the health, democracy, employment, environment, social mobility and cultural institutions. At a theoretical level, neoliberalism lent itself to critique because “no human being can for long live solely as Homo economicus, so all free-marketeers end up with elements of irrationality in their systems” (Aune, 2001, p. 168). This irrationality at an individual, theoretical and global level were exposed by prominent personalities like Joseph Stiglitz,

Amartya Sen, David Harvey, Noam Chomsky, George Soros, and Paul Krugman, to name a few, who lent their voices and intellectual support to global anti-neoliberal movements. The international institutions like the World Bank, the IMF and WTO came under severe scrutiny by scholars who found uncompromising evidence to show the failures of markets in engendering well-being and security to the people. .

The studies on impacts of SAPs, the euphemism for neoliberal policies in the eighties, were frequently harsh. For instance, Mohan et al (1999) in their exhaustive study of literature on the impacts of SAPs across the world conclude that “the application of neo-classical orthodoxy created a whole set of new problems or exacerbated existing ones” (p. xiv). While they do agree that there have been a few beneficiaries of this system -- large traders, import-export merchants, rural agricultural producers, including peasants – they claim that the evidence points to the fact that most segments of the population that came in touch with SAPs saw their living standards fall.

In the realm of health the ill effects of neoliberalism were adverse as well, and the marketization of health care proved to be disastrous to the majority of people all across the globe. Instead of using economic measures such as GNP or GDP to measure development, Kim et al (2000), in their book *Dying for Growth*, use health as the primary indicator of successful development, and find noticeable negative impact on global health due to neoliberal economic policies. They provide incisive evidence on how the World Bank, the IMF, transnational corporations and market-favoring government like the US government diminish the health prospects of the poor all across the world. At a theoretical level, Rice (2002) says that “in recent years have seen a surge

of interest in reforming the organization and delivery of health systems by replacing government regulation with a reliance on market forces” (p. 1) He states that “one of the main reasons for the belief that market-based systems are superior stems from a misunderstanding of economic theory as it applies to health” (p. 4). Through his work he goes on to show that “such conclusions are based on a large set of assumptions that are not met and cannot be met in the health services sector” (p. 4). Therefore, from the beginning of late eighties, the neoliberal thinking came under increasing scrutiny, and the Brenttonwood institutions became lightning rods of criticism for promoting neoliberalism, pushing its proponents to come up with other strategies that are more humanistic and acceptable for populations. Thus, the debates surrounding the primacy of the state and the market went on into the nineties and after, without reaching any clear consensus both within and without the international development field.

Civil Society as a Way Out

Alongside these debates about the importance of the market and the state, starting in the 60s and into the neoliberal era, “a third complex of institutions, a definable ‘third sector’ occupying a distinctive social space outside of both the market and the state” (Salamon and Anheir, 1997, p. 1) started to emerge in the international development scene. “Key concepts which serve to give expression to the distinctive values which set the third sector off from the market and government sectors are philanthropy, altruism, charity, reciprocity, mutuality and the ethic of giving and caring” (Evans and Shields, 2000, p. 3). This third sector is popularly known as the civil society. Although the concept has been around from the time of Greeks, the recent meanings of it go back to

Thomas Hobbes and John Locke, and have been theorized in the works of Friedrich Hegel, Alexis de Tocqueville, and Karl Marx, to name a few key thinkers. But the recent popularity of the term makes it hard to define despite its popular usage in disciplines across the social science spectrum. Civil society has come to stand for various meanings: non-governmental organizations, political parties, faith groups, transnational associations, social movements, and so on. The terms are used interchangeably here because:

[Civil Society's] burgeoning popularity accelerates the accumulation of inherited ambiguities, new confusions and outright contradictions. For this reason alone the expanding talk of civil society is not immune to muddle and delirium. There are even signs that the meanings of the term 'civil society' are multiplying to the point where, like a catchy advertising slogan, it risks imploding through overuse (Keane, 1998, p. 8).

Therefore, civil society as a concept and its history is not expounded here (see Van Rooy (1999) for an excellent overview), instead the focus is on its relation to development and its appeal to actors across the political spectrum.

Everybody Loves Civil Society

The civil society organizations are sought after by the political right. The reason for this being, they claim (contrary to the evidence), "the rise of the modern welfare state has destroyed or seriously jeopardized the whole array of mediating institutions, including voluntary organizations, that were formerly available to buffer the individual from the impact of impersonal, macro-institutions such as the state" (Gidron, Kramer and Salamon, 1992, p. 6). What neoliberals aim at is to shrink the role of the state and encourage markets. "As private voluntary agencies, NGOs could occupy this new niche quite comfortably, particularly, for instance, in participation in the social safety-net

projects and social investment fund that were supposed to alleviate the immediate effects of structural adjustment” (Eade, 2004, p. 10). This stops the development initiatives being handed back to the state that neoliberals dislike. Also, the belief was that working outside the state, the NGOs will provide services more efficiently, but more importantly, for lower cost.

As the interventions into the political systems of the developing countries and reshaping them in the like of western capitalist democracies ran into rough waters, institutions like the World Bank, the IMF and USAID started funding civil society as part of encouraging ‘good governance’ in the nineties. Critics claim that this “exclusive aspect of the emphasis on ‘civil society’ lies in its rejection of parties and governments, its embrace of the civil society/state opposition... In fact, the very concept of ‘civil society’ masks the class nature of its components—multinational corporations, banks and mafia, set next to social movements, trade unions, civic bodies—while collectively demonizing the state.” (Sader, 2007). Thus, supporting civil society, which by its definitional nature is non-governmental, helps in distancing the social movements working for alternative hegemony “from the themes of power, the state, public sphere, political leadership and even, in a sense, from ideological struggle” (Sader, 2007). Also, civil society articulates the values of individualism like self-reliance and ownership of their own welfare, invoking similarities with market ideals.

While this is the case with the neoliberals, the people on the far left support civil society as well, ironically as a counter force to neoliberal policies as well as due to the cynicism towards the capitalism-favoring state. Due to blurring of class differentials in

the postwar societies, hegemonizing of radical spaces by surveillance and autocratic states, Marxists turned their lens to the alienation and cultural dominance of the late capitalism, viewed the welfare state as squelching the spirit of proletariats and delaying the revolution indefinitely. Accentuated by the debates of Nicos Poulantzas (1973, 1978) and Ralph Miliband (1969), added to Gramscian criticism of capitalism, these neo-Marxists claimed that the interests of the welfare state are more in line with the maintenance and reproduction of capitalist social relations than that of the working class; the state focuses on turning humans into factory labor through discipline and surveillance; and denies the working class the ability to control its own welfare. The welfare benefits that people enjoyed were seen largely as the unintended consequences of the workings of advanced capitalism. Not all neo-Marxists viewed the state in such cynical terms (for example, Ian Gough (1979) and Claus Offe (1984) provided different perspectives on the welfare state within Marxist tradition) but there was an intellectual and social push towards finding alternatives to provide public welfare.

The reasons for supporting civil society by the left were many. They believed that the civil society is better at articulating an alternative voice to public problems than the state or the market. The role played by peoples' organizations in both Latin America and the Soviet bloc in the eighties, bringing significant political change, led the left scholars to believe in the power of civil society in holding governments accountable and pushing for democratization agenda. Suddenly civil society was seen as teeming with radical possibilities, and theorists and activists advocated the idea that communities can take charge of their own destinies (Friedmann 1992; Chambers 1997). A few scholars

opined that a strong and healthy civil society can only be formed when it is not associated with the market and the state (Esteva and Prasak 1997; Escobar 1997). A few others, following the footsteps of Robert Putnam (1996) who proposed social capital created by strong civil society as a tool for social change, have proposed working with the state as an alternative to building political spheres to bring the two closer to work towards a healthy democracy. The recent wave of anti-globalization and anti-neoliberalism movements, claiming that “another world is possible”, have relied heavily on the civil society groups to muster support to stall some of the most powerful economic and political groups from dictating the terms of welfare and security.

Therefore, “such proponents of community enablement, who seek alliance among different sectors, thus cross the path of those who promote market forces but find community participation to be a necessary component of privatization strategies” (Miraftab, 2004, p. 90). Thus, the concept of civil society and the working of NGOs has become extremely appealing to the right and the left, not to speak of the people in between.

Civil Society and International Development

The fall of the Berlin Wall and the collapse of the Soviet Union brought the Cold War to an end, leaving an impression across the globe that the liberal market capitalism (American style) has triumphed over socialism (not just the Soviet style but as a political alternative). It was considered so momentous in western history that Francis Fukuyama celebrated it as “the end of history”. Much to his chagrin, history persisted in the face of the New World Order (eloquently coined by then president of the US). The end of Cold

War coupled with the rise of neoliberal wave changed the political landscape around the globe in the nineties.

The nascent markets on the other side of the iron curtain beckoned eager investors, and the trend was aped by the international development aid. The OECD countries shifted the focus of their aid to a significant extent towards Eastern Europe and the so-called transition countries, which consisted of the former socialist countries with central planned economies. With the end of the alleged threat posed by communism to liberal democracies of the West, there was a marked fall in the total aid and, not surprisingly, a marked increase in demands for political reforms in these countries (Kener, 1994; Sandler, 1997; Killick, 1998). The aid came with explicit demands for democratization (multiparty elections), respect for human rights and ‘good governance’. The last aspect meant “inclusion of civil society in political decision making processes; open and transparent political-administrative systems that were accountable to the citizens; control of corruption and misuse of power; and a certain degree of decentralization of power to the local authorities” (Degnbol-Martinussen & Engberg-Pedersen, 2003, p. 10). Along with this, aid was aimed directly at redistribution of power and resources to target groups to reduce their marginalization and powerlessness (Stokke 1995; Hopkins 2000).

Since the mid-1980s, NGOs have come to play an increasingly prominent role in international development cooperation. One of the reasons for this has been the rise of the neoliberal thought in the eighties, as discussed earlier, which reflected in the distrust of the states in the Third World. More resources were channeled to support the workings

of the market economy with a concomitant increase in channeling public funds to NGOs in both the North and South. David Rieff (1999) in his polemical essay 'The false dawn of civil society' contends that:

Apart from a few principled nationalists, libertarians and Marxists, most well-intentioned people now view the rise of civil society as the most promising political development of the post-cold war era... In the framework of development aid in particular, the shift from channeling assistance to governments, as had been the case well into the eighties, to offering it to local nongovernmental organizations has been justified not simply as the inevitable prudential response to states misusing aid but as a way of building civil society (Reiff, 1999).

As discussed earlier, the World Bank, which was the key institution in international development and which also promoted neoliberal ideology in the developing world through structural adjustment policies, started to support NGOs through aid. Therefore, it is not surprising to see that "NGO involvement in the implementation of WB-financed projects grew rapidly during the 1980s and 1990s, as some staff came to see NGOs as potential project implementers in a period when many governments' service delivery capacity was shrinking. Fewer than 10 per cent of projects between 1973 and 1988 were reported to involve an NGO, but the World Bank reports that one-third of projects approved in the 1990s involved an NGO in some role" (Nelson, 2002, p. 499). Also, the World Bank document 'Working with NGOs' pointed out in 1995 itself that "since the mid-1970s, the NGO sector in both developed and developing countries has experienced exponential growth.... It is now estimated that over 15 percent of total overseas development aid is channeled through NGOs."

NGOs were also preferred by other bilateral and multilateral institutions in implementing projects because of the comparative advantages NGOs have over the state.

These advantages were:

NGOs provide expertise in “development software” (participatory approaches, community organizing, stakeholder ownership strategies); NGOs are more innovative, adaptable, cost effective and aware of the local situation; and their grassroots representation brings legitimacy and community mobilization to the programme. NGOs strengthen the state through their participation in improving the efficiency in government services, acting as strategic partners for reform-oriented ministries, filling in gaps in service provision, and helping the government forge ties with the grassroots (Desai, 2002, p. 495).

Limitations of Civil Society

With a focus on providing social services to the poorest and marginalized groups like health and welfare, which were traditionally provided by the state, the role of NGOs has generated an intense debate in development literature, as well as NGO circles, to understand if the gap-filing strategy is the responsibility of the civil society organizations. The contention is that NGOs are rarely able to carry out the welfare activities of the state in the long term, and because they can reach limited groups of targeted people leaving out many people who also have been left in the lurch by the state.

There is mounting evidence to back this claim: Several studies made during the last decade show evidence that NGOs are relatively good at achieving short-term goals. In a comprehensive study sponsored by Development Aid Committee’s (DAC) in 1997 it was found that the immediate goals for the NGOs under study had been successful in 90 per cent of the cases (Riddell, et al., 1997); the positive long-term effects for the poor

and the NGOs impact in a broader context were hard to document. The sustainability of such projects was found to be unreliable in the long run as well (Fowler and Biekart, 1996). A similar study done on the work of Danish NGOs in 1999 revealed that projects related to the social areas had positive immediate effect on the living standards of the poor but the results were mixed in relation to income-generating projects. Also, similar to the previous study, the long-term impacts were difficult to document (Oakley, 1999). The study concluded that the strengths of NGOs' lay in relieving the terrible effects of poverty rather than in removing the fundamental causes of poverty.

Moreover, in the light of NGOs reliance on external funds to carry on their projects, questions are raised in relation to whether NGOs have lost some of their political independence and altruistic character, and instead have come to tow the lines of aid organizations' objectives and strategies. Although the reason the civil society has become prominent receiver of funds is because of the underlying notion that strengthening it leads to an equal distribution of power among the state, market and the civil society, many have contest this claim as well. Like Howell and Pearce (2000) state:

Yet organizations within civil society do not enjoy the same degree of power. Business associations, for example, are more likely to be better resources and wield greater political leverage than trade unions or community groups. The power of the market thus permeates and shapes the composition of civil society... Thus the interactions of state, market, and civil society are overlaid by contradictory purposes and value, the resolution of which may not necessarily favor the sustenance of civil society nor guarantee stability. The alliances and coalitions are not always self-evident nor conducive to redistribution of power and wealth (p. 77-78).

That said, the NGOs in the South have to rely heavily on the Northern NGOs for funding and survival. When these NGOs try to obtain funds directly, they often meet

with opposition from Northern NGOs. A survey by the British government in 1995 showed that 80 per cent of NGOs surveyed opposed aid being channeled directly to Southern NGOs (Wheat 2000). A few of the reasons given were: Southern NGOs are more vulnerable to donor influence; they tend to operate in fields with availability of money rather than what the poor need; they fill the gap left open by the withdrawing welfare state, and they are susceptible to manipulation both by donor agencies and political groups.

Since the end of the Cold War, more and more bilateral donors have placed increasing emphasis on recipient countries' democratization and respect for human rights, both as aid conditionalities and as development goals. Multilateral organizations such as the World Bank and the UNDP cannot explicitly demand political forms of government, but they have advocated such reforms by placing emphasis on civil society and good governance. These translate into increased meddling with the recipient countries' political affairs in the name of good governance, recommending political-administrative reforms that help dividing the development labor between the state and the private sector. These explicit and implicit demands by donor agencies that advocate the involvement of civil society in decision-making processes can be beneficial but in the case of extremely aid-dependent countries this could be problematic because the priorities of the poor in these countries can differ from that of the international agencies: if the countries heed to people's request they might lose of the aid, but if they do not heed to the poor, the projects might not be effective, thus creating a paradox for these countries (Moore, 1998). Even agreeing to the conditionalities leads to what Howell and

Pearce (2000) called “the larger question of the morality of interventionism.” They question:

Is donor support to civil society another manifestation of neocolonialism in the post-Cold War era, aimed at controlling the nature of political regimes and extending global markets? Do donors have the right, let alone the capacity, to shape other civil societies? By projecting their own visions and understandings of civil society, do they not undermine the ability of local organizations to set their own priorities and agendas, to vocalize their own imaginations of social and political change? (p. 72)

It is undeniable that the various changes in the late twentieth century, huddled under the term ‘globalization’, created new conditions for growth and societal development in developing countries, mainly in Asia and Latin America. The benefits have been uneven at global level as well as within the nations. This led to intense debate within the development circles on the trajectory of development aid.

On one extreme is the view that development should be handed over to market mechanisms. Most development assistance is given as official aid from states in the North to states in the South, or from multilateral organizations to states in the South. Many consider this support of the states in the South to be a fundamental problem. Not only these states have not shown the expected results but inhibited economic development that could be brought about by market forces. They opine that the developing countries should open their economies and carry out policies that make them attractive for foreign enterprises and investors. Therefore, the role of aid is to contribute to free trade and so, development cooperation should be privatized.

According to the views at the other extreme, there needs to be an increase in the development aid to the countries in the South. The economic globalization in the form of

neoliberal ideas has worsened the living standards of people in poor countries, and negatively affected the external conditions of development (Degnbol-Martinussen and Lauridsen, 2001). These poor countries, with unstable political systems, weak markets, inadequate infrastructure, rampant corruption, etc, fail to attract foreign capitalists and investors. Instead of struggling to integrate these countries in the world economy, the focus should be on creating conducive environment for development and raise the overall standard of living so that in the long run, these countries could participate in the global trade and reap benefits from market-led development. Thus, the aid to the marginalized countries should be increased and not decreased (Riddell, 1996).

Debates like these produced several new aid strategies. Since fewer aid funds were available even while the target areas for aid were becoming increasingly more inclusive, it was necessary to use more inexpensive forms of intervention and to concentrate aid more. This was reflected in the new form of development strategies – Partnerships.

Public-Private Partnerships

The idea of partnerships for development cooperation has been around for a long time. Even in 1969, the Pearson Commission on International Development proposed partnerships between donors and recipient countries as a way of effectively dealing with development (Pearson, 1969). But even then, the notion of partnerships was non-specific, and the Commission suggested having specific objectives for all actor involved. From then, the definition of partnership has been very vague. For the purpose of this chapter, I adopt WHO's definition of partnership as a means to 'bring together a set of

actors for the common goal of improving the health of populations based on mutually agreed roles and principles” (WHO, 1999). According to WHO, the following principles need to be included in partnerships: beneficence, autonomy, non-maleficence, and equity.

The public-private partnerships did not take root until late 1970s, and the partnerships that UN promoted were not received with enthusiasm because of lack of trust between sectors. Partnerships in international development were limited to mainly between the governments of developing countries and donor agencies (World Bank, 1998). The NGOs working on development did not collaborate with other sectors because the NGOs sector was mainly trying to reform the other sectors through public mobilization. But by early 1980s the neoliberal ideology started to change the attitudes towards the state and the market, as discussed in the previous chapter, and this was picked up by international agencies that started to promote public sector reforms (Babai, 1998). Partnerships were introduced as a solution to the failures of the welfare state:

Since the end of the cold war, two concurrent global trends—government enablement of markets and government enablement of communities—have enlisted policy makers concerned with local economic development. A third trend advocates the marriage of those two, on the grounds that partnership of communities and the private sector, mediated by the public sector, achieves a synergy able to overcome certain shortcomings of each of the other trends—a win-win situation. The public-private partnership has been celebrated by international development agencies as a key strategy for delivering services to cities of the third world (Miraftab, 2004, p. 89)

The World Bank adopted the first policy for partnership with NGOs through ‘Operational Policy Note’ in 1981, and around the same time the UN agencies like the UNICET and WHO started to work in collaboration with local and international NGOs

and transnational corporations to implement projects (Sikkink, 1986). Although these initial partnerships ran into rough waters, by late 1980s, the partnership between various sectors became mainstay of international development as well as part of welfare projects in the western countries. By early 90s, there was a strong shift towards including various sector for public projects, and, like Bill Clinton declared, “the era of Big Governments was over”. As described in the previous chapter, by late 1980s the structural adjustment policies promoted by the World Bank and IMF, which were aimed at promoting free-markets in developing countries for economic growth, showed disastrous results on the societies in which they were implemented. This led to an ideological shift in the neoliberal thinking, and most advocates of free market moderated their stance from freeing the market to modifying the state’s role in development. Partnerships were proposed as a way of achieving this end.

Also recognized by the international community around this time was the idea that development cannot be brought about by any single actor, and welfare of people should be addressed by all the stakeholders that are affected by the problems. This was reflected in the field of health where “there has also been an increasing recognition that the determinants of good health are very broad and the health agenda is so large that no single sector or organization can tackle it alone” (Buse & Walt, 2000, p. 549). Therefore, the consensus was that “emerging health problems required a range of responses beyond the capacity of either the public or private sectors working independently, and therefore bridges had to be built between them” (p. 549).

The World Bank was on the forefront of promoting partnerships, and the inclusion of civil society and private sector was strongly encouraged in most of the proposals funded by the Bank. Similar views were espoused by the UN Secretary-General, that there has been a paradigm shift:

We are moving from a world in which the state had sole responsibility for public good and business maximized profits independently of the interests of society at large, to a world where success depends on the close synergy of interests among business, civil society and the state (as quoted in Buse & Walt, 2000, p. 550).

Other bilateral organizations and multilateral organizations followed suit and the partnerships became the new paradigm of international development, including global health. The essence of partnership can be captured in the following lines by Abugre:

The purpose of the ‘partnership’ framework is to address what recent diagnoses of the aid industry conclude are the critical gaps which accounted in the past for the ineffectiveness of aid. These are identified as: (1) the lack of local ‘ownership’ of policies and programmes, perceived as the key to good management; (2) inappropriate donor behaviour, including [insufficient] aid coordination and the ineffectiveness of conditionality as a surveillance and quality control mechanism and; (3) the underlying environment, including the nature of policies, institutions and the political system. Consequently, partnership seeks to address inclusiveness, complementarity, dialogue and shared responsibility as the basis of managing the multiple relationships among stakeholders in the aid industry. (as quoted in Fowler, 2002, p. 499)

Public-private partnerships have become central to the international development landscape as well as the global health field in the past decade. PPPs have steadily increased since 1982 and reached a high-point in 2000. Buse & Harmer (2004) claim that in 2000, these partnerships in health peaked with 17 new partnerships and then “the flurry of partnership launches has subsided, providing breathing space to reflect upon the political implications of this important mechanism” (p. 49). The literature related to

PPPs is vast, with scholars taking different stances on the issue. Below I will provide a brief overview of the literature, with the pro-PPPs and anti-PPPs stances, as well as the idea that there is a great deal of ambiguity surrounding PPPs that require further elaboration.

Literature Review of Public-Private Partnerships

Huxman (1996) talks about the “collaborative advantage” in relation to partnerships, in which he claims that the individual advantages of each sector will not ever measure up to address the problems that plague modern societies. Only by joining hands and working on the comparative advantages – which he calls as collaborative advantage – can the problems be eradicated. He even goes on to say that this is “the only way to tackle major societal problems” (p. 2). Following the same line of thought, Lasker et al (2000), in discussion about partnerships about healthcare, state that a great deal of synergy can be developed by bringing various sectors together, and building on the strengths of each sector can we come up with unique solutions to unique problems that affect our societies. He calls this “partnership synergy”.

A few scholars talk about the advantages of partnerships in concrete terms, like investment, profit, service efficiency, and risk taking. They claim that the public sector could reap benefits by partnering with the private sector because, given the track record of the private sector, there will be improvements of program performance, reduction of cost, better service delivery and a major risks sharing as well as sharing of responsibilities (Pongsiri, 2002). On the other hand, the private sector can benefit from these partnerships as well: the public sector collaboration could lead to better investment

potential, lead to a more profitable outcome, and by working on more projects that the public sector is capable of, the private sector can expand its business interests and reach (Scharle, 2002). The conclusions these scholars reach by focusing on the advantages is that it is a win-win situation, leading to better outcomes for all. This is not to claim that they accept partnerships as one-stop solution for every problem but the idea is that if one can work through the issues that crop up during partnerships, everyone will benefit in the long run. Thus, the essence of partnership lies in the creation of added value through cooperation among various sectors (Henderson and McGloin, 2004; Jamali, 2004). These scholars draw the attention to the costs incurred by the state in providing services that have been burdensome on tax payers, and given the economies of scale of public projects as well as huge infrastructure involved, only through synergies and joint decision-making on these projects can there be more efficiency in delivery of services and improvement in the overall standard of the society (Henderson and McGloin, 2004). A similar argument is put forth by scholars like Widdus (2001), and Nijkamp et al (2002) who view partnership as not a move to privatization of the state in piecemeal fashion (as will be discussed later) but more as a pursuit of common goals of public and private sector accomplished through sharing resources, capitalizing on the strengths and advantages and reaching a win-win situation.

At a more macro level, Mandell (1999) views collaborations as a tool for creating good governance. By including the views and concerns of society through collaboration, better decisions can be reached compared to the decisions made by government alone. Thus, Mandell views partnerships as a tool to subvert the domination of one sector over

public life. A similar view is espoused by Googins and Rochlin (2000) who claim that the society is ridden with conflict, competition and imbalances in power which can be overcome by partnerships. In their view partnerships can be innovative in a way that will help various constituencies of a society come together and work with the differences and address issues of power. Intersecting with Robert Putnam's work on 'social capital' in creating healthy democracies, Roberts et al (2002), from a different view point, propose that the partnerships have the potential to create social capital, not just locally but globally, leading to new institutional frameworks that accommodates diverse viewpoints, mainly for subordinate groups. In Ben Fine's (1999) words, "Developmental state is dead -- long live social capital!"

These are a few strands of argument favoring the public-private partnerships which give an overview of one side of the debate surrounding the issue. On the other hand, the partnerships have been criticized for smuggling neoliberal ideas through the assault on the state commitments to the public. I will provide a brief overview of the other side of the argument, more detailed than the one just described because the focus of this study is on the neoliberal ideology and its working in various forms.

Scholars who critique partnerships do it based on the notion that the partnerships are promoted by people who want the market to take over the role of the state in providing welfare. One of the reasons why the partnerships came into vogue is due to the arguments for privatization of public works, an assault on the welfare state (Savas, 2000; Bingman & Pitsvada, 1997). This dovetails with the arguments put forth by neoliberals who see the welfare state as bloated and burdened by inefficiency and inadequacy to

deal with problems posed by capitalism. This logic, as we have seen, permeated the development rhetoric, leading to many developing countries adopting the free-market logic in implementing welfare projects (Osbourne, 2000). Because public-private partnerships do not attract a similar kind of criticism like the neoliberal policies do, many scholars who studied partnerships (like Rosenau, 1999 and Payne, 1999, for example) failed to look at who really benefits for partnerships in the long run, and what issues should be problematized in relation to the debate surrounding the market, the state and the civil society (Miraftab, 2004). Here, I draw on the scholarship of Linder (1999), Evans & Shields (2004) and Miraftab (2004), and focus primarily on the ramifications of neoliberal ideology, as discussed by these scholars, on the relation between the public and the private sectors in partnership.

Linder (1999), talking specifically about the public and for-profit private sector partnerships, contends that “rather than struggling to redefine the boundary between public and private, with the former typically ceding territory to the latter, partnering works to blur them” (p. 36). He states that both the neoliberals and the neoconservatives find partnerships appealing because of their interest in privatizing the state. He identifies and links six uses of the term to their respective meanings in neoconservative and neoliberal ideologies: (1) PPP as management reform: Partnerships are promoted as “innovative tools that will change the way government functions, largely by tapping into the discipline of the market... Government managers are expected to become more like their business counterparts, than vice versa.” (p. 40) (2) PPP as problem conversion: By which Linder means “The task for government managers shifts from getting their own

practices in line with entrepreneurial mores to reframing the problems they face in a way that will attract profit-seeking collaborators” (p. 41) (3) PPP as moral regeneration. Partnerships lead to blurring of commercial and noncommercial differentiations that government programs rely upon, (4) PPP as risk shifting: Partnership assigns the supporting role to commercial interests, thus “the purposes remain public, even though the resources are eventually mixed” (p. 45) (5) PPP as restructuring public service: Partnerships can serve as “a means for effectively deregulating employment relation through the substitution of unorganized workers” and lastly (6) PPP as power sharing: Partnerships “spread control horizontally, especially in regulatory matters where control has been concentrated in the government” (p. 47).

In an effort to “reveal serious discrepancies between the theory propounding partnerships as a third world panacea and their consequences in actuality” (p. 89) Miraftab (2004) extends Linder’s (1999) critique of partnerships to both for-profit private sector and non-profit sector in her study of PPPs in South Africa. She lists the following conceptual issues as significant in understanding the politics of PPPs and expose the neoliberal ideology that permeates it: (1) Definitional imprecision: She claims that “terminological sloppiness in debates about PPPs fosters convenient ambiguities in defining the roles and expectations of each partner” (p. 92). For instance, it would be hard to know what role the state serves in development and also, non-profit sector could be conflated with for-profit private sector and this ambiguity could hide the power relations between various actors involved in projects. (2) Associated Action: “Who initiated the process and sought partnership with the other sectors is significant...

For example, is the community filling a gap for the public or private sector by performing tasks that organizations in those sectors prefer not to perform—perhaps by providing cheap labor?” (p. 92). If this is so, then the community is used and not really supported, like Evans and Shields (2005) state. (3) State intervention: The neoliberal logic operates through partnerships by claiming that “the state, instead of rowing, should steer and let the private sector and other non-state actors ‘row the boat’ to provide public services and basic infrastructure” (p. 93). The state might focus on policy making or administration and leave the responsibility of welfare to other sectors that might not be able to live up to the expectations, leading to shrinking of welfare commitments by the state.

Lastly, Evans and Shields (2005) provide an overarching critique of the partnerships and expose the long term effects of neoliberal ideology on the relation between the state, market and civil society. They use the term ‘the third sector’ for the spaces and people outside the market and the state, and warn that through public-private partnership there is a tendency to use this third sector rather than support it. The long term effects of this change are in line with the neoliberal idea of promoting market as a solution to public welfare. “As the state removes itself from providing a social safety net, others assist in legitimizing this process and providing residual services” and by doing so, they add, “The third sector occupies a strategic place in reshaping the state-market relations by contributing to the legitimation of the market society” (p. 4). While the public-private partnerships emphasize the importance of the third sector on the well being of the citizens, by dragging the third sector in to fulfilling the needs of the state,

“the third sector is repositioned as transitional, standing between a social-provision welfare state past and a marketized minimalist state future” (p. 7). The main role of the state, then, “becomes that of service manager and policy director” (p. 10).

As mentioned earlier, the state emphasizes on policy while part of the work is relegated to other sectors. Evans and Shields (2005) say that the third sector is not treated as important in making the state policies as it is treated when it comes to sharing the state’s workload. This is done to depoliticize resource allocation in the society by the state and eventually hand it over to the workings of the market, which neoliberals think is more efficient than the state: “Since policy is a form of politics, which is largely about resource allocation, especially in the case of social policy, it is necessary to marginalize politics. Distancing those who set the policy framework from those who consume the ‘product’ is strategically important” (p. 4) for neoliberals. Along with this depoliticization the non-profits lose autonomy because of their contractual relationship with the state, which will divert their attention for advocacy and social change. While historically the third sector opened contentious place in relation to the state and made it accountable for the welfare of its citizens, due to this commercial relationship with the state, “the third sector is being positioned to contribute to the silencing of voices by serving as a mediating agent of conflict and producer of social goods. In essence, it becomes a buffer zone for the state” (p. 7). Ultimately, partnerships lead to the “diminishing of the advocacy role of the third sector [which] deters access to the policymaking process, especially for the most marginal and underrepresented in society” (p. 7).

Ambiguity about Partnerships

Perhaps the reason why public-private partnerships are so heavily debated is because of the ambiguity that surrounds the concept. Finney and Grossman (1999) cautioned that partnerships are “undervalued, loosely defined” and suggested a serious examination of the concept. Googins and Rochlin (2000) state: “what passes for partnership defies clarity of conception – representing a vast terrain of idiosyncratic arrangements with minimal agreements on definition and composition” (p. 129). Two years later, Teisman and Klijn (2002) wrote that “it’s become popular to advocate partnership arrangements but the reality of partnerships is ambiguous” (p. 201). So what is a partnership? How does one define it? Here is a short list of definitions found on the internet, and from other sources:

An “alliance between the government and the private sector, in a formal or informal, written or oral form in order to realize projects for the benefit of the citizenry as the whole” (Roos, 1999)

New problem-solving institutions that can work creatively and flexibly outside the existing bureaucratic framework (Reich, 2002)

“Collective strategies” with “advancing a shared vision” as a motivating factor, and an expected outcome of “joint agreements” (Gray, 1996)

Arrangements between government and private sector entities for the purpose of providing public infrastructure, community facilities and related services. Such partnerships are characterized by the sharing of investment, risk, responsibility and reward between the partners. (Ministry of Municipal Affairs, British Columbia, 1999)

The term “public-private partnership” is particularly malleable as a form of privatization. It is defined broadly as an arrangement in which a government and a private entity, for-profit or nonprofit, jointly perform or undertake a traditionally public activity. It is defined narrowly as a complex relationship -- often involving at least one government unit and a consortium of private firms --

created to build large, capital-intensive, long-lived public infrastructure, such as a highway, airport, public building, or water system, or to undertake a major civic redevelopment project. (Savas, 2000)

The above definitions reveal the fact that the concept of partnership is malleable, leading to various interpretations and implementations. (For a discussion on conceptualization of partnerships from various perspectives, see Kickbusch and Buse, 2000, Kickbusch, 2003, and Buse and Harmer, 2004). Perhaps this lends the concept for people at both ends of the spectrum to see it either as a solution to the problems faced by the state and the society, or as a tool to subvert the role of the state and colonize the society with neoliberal ideals. However one looks at it, without proper consideration of various aspects of the partnership it is foolish to wholly accept or reject partnerships (Bateley, 1996). The purpose of this literature review is to provide insights into the debate surrounding public-private partnerships and why it is important to study it in an era where more and more public works are done under its shadows. To sum up this section, public-private partnership has become a popular slogan in twenty first century discourse about development and the state, which requires a closer examination by scholars interested in development.

Conclusion

I started this chapter with an example in Easterly's (2006) book *The white man's burden* in which he laments the fact that "the West's efforts to aid the rest have done so much ill and so little good." Easterly proposes a few solutions to the problem. He takes a rather cynical view of the bureaucratic states in the developing countries as well as the market reforms peddled by aid organizations like the World Bank. In his view, the civil

society actors should become entrepreneurs who works within the logic of the market and become, what he calls as, 'searchers' of solutions. He calls for the grass root actors to come up with their own demands that could be met by aid agencies, bypassing the traditional state structures. Easterly is but one of the many scholars who come up with different combinations of the state, the market and the civil society to address the issue of development in developing countries.

Like this chapter has shown, the debate surrounding development always took place around the key concepts of the state, the market and the civil society. The debates were largely the product of global changes that influenced the dominant discourse surrounding the welfare of the public, and based on the political thought of that period highlighted one concept over the other, or combination thereof, as having the potential to solve the problems faced by world population. From the above exposition, we can reach the following conclusions:

1. The state has been central to the discussion about welfare and development.

People across the economic and political spectrum defined their stance in relation to the state, thus making it the most controversial concept in the history of development. One can position the radical left to the orthodox right based on their views on the role of the state in human society.

2. There is irrefutable evidence that the markets alone cannot solve human problems, and at best the effects of market mechanisms on public welfare have been mixed. The policies espoused by free-marketeters, mainly through neoliberal ideas, have had disastrous consequences on the well being of majority of people

all around the globe. This is clearly evidenced, both in theoretical as well as applied realms, in the field of health as well.

3. Civil society has become seductive to both the left and the right in recent decades, albeit for various reasons. Unlike the state, civil society as an alternative does not generate the kind of controversy that has embroiled the development and welfare literature. The concept has become more and more diffused in recent years, making it easier for people of various political inclinations to use it for various purposes.
4. Public-private partnerships have become integral to development projects in recent years. While the belief is that the welfare of the public can only result through the reliance on comparative advantages of various sectors, there is a growing criticism in the scholarly community that these partnerships are used by neoliberals to slowly whittle away the welfare state, opening up more spaces for the market to colonize them by using civil society as a decoy.

In conclusion, the political economy of public-private partnerships in the field of international development provides an opportunity for social scientist to understand the contours of debates surrounding human welfare, and prepare them with scholarly tools to deal with the rapid changes that are shaping the twenty first century.

CHAPTER II

RATIONALE AND METHODOLOGY

What do the following people have in common: George Bush, the rock star Bono, Bill Gates, Nelson Mandela, Kofi Annan, Hollywood actors Rupert Everett and Tom Hanks, the social entrepreneur Bobby Shriver, media mogul Ted Turner, among a million others? Or to put in differently, what do the following organizations have in common: the UN, the right-inclined World Bank, the left-inclined Oxfam, the market-favoring USAID, the state-favoring Nordic organization DANIDA, the noble-prize winning Doctors without Borders, the communist government of China, corporate firms like Apple, American Express, Armani, the market loving World Economic Forum, the civil society driven World Social Summit, Viacom, Vanity Fair, MTV, the government of Iceland, and even the French Postal Service? They all actively support ‘the Global Fund to Fight HIV, TB and Malaria’!!

The Global Fund to Fight AIDS, Tuberculosis and Malaria (‘the Global Fund’ from hereafter) is an independently run public-private partnership was officially started in 2002. It is a multilateral organization that raises money from governments, businesses and individuals around the world, and supports partnerships by providing funds to fight AIDS, TB and Malaria. An international board of nineteen voting members and four non-voting members govern the Global Fund; the board consists of government representatives from donor and recipient countries, representatives from affected communities, private sector, foundations and NGOs. The non-voting members are the representatives of UNAIDS and the WHO, the World Bank (who serve as the Global

Fund's trustee). There are various committees that advise the board on specific areas of difficulty: like Ethics, Policy and Strategy, management of the Portfolio, and Finance and Auditing. To support and promote partnerships, a large group of stakeholders come together to the Partnership Forum, held twice a year, to review progress and provide suggestions to the board. A special group called the Technical Review Panel (made up of health development experts) thoroughly examines the technical merits of every proposal made by recipient countries. They can then recommend the board that a grant can be approved without any conditions, or approve with conditions. The rejected proposals can be rewritten and resubmitted, on TRP suggestion, or they can reject it completely. All these activities must conform to a comprehensive set of by-laws which guide the Global Fund in its mission and rules. The Global Fund is a Swiss non-profit foundation, and so it must conform to appropriate Swiss laws.

The Global Fund has become a principal force in the fight against HIV/AIDS and the leading force against malaria and tuberculosis. “The Global Fund supports 30% of HIV/AIDS programs, about 65% of TB treatment and 45% of malaria treatment programs worldwide” (Kaiser, 2007). Global Fund Executive Director Michel Kazatchkine states that “So far we estimate that the programs funded by the Global Fund have saved the lives 1.8 million people -- that is the lives of 3,000 people a day who would otherwise be dead from AIDS, TB and malaria” (Reuters, 2007). He also informed that about 30% of funding for the organization comes from the U.S., and 55% comes from European Union countries (Reuters, 2007). The Global Fund in August,

2007 announced that it aims to triple its annual spending to between \$6 billion and \$8 billion by 2010 to meet the needs of developing countries.

The Genesis of the Global Fund

As discussed in the previous chapter, the disillusionment about effectiveness of aid spread in the post-cold-war climate, leading to rethinking about the dominant development strategies employed. Against this backdrop and political climate, the Global Fund was established in 2002. Unlike any previous or subsequent initiative, an overwhelming and instantaneous international consensus led to the formation of the Global Fund; it was the result of multiple forces pushing from various sides. Keith Bezanson (2005) lists a few of these forces as follows:

- In two successive G8 meetings, the governments of the leading industrial countries agreed that, although existing bilateral and multilateral development institutions play important roles, these alone could not channel the large volume of new resources necessary to combat the global health pandemics of HIV/AIDS, tuberculosis and malaria.
- Agreement was reached between United Nations agencies and donor governments to form a single global fund to fight HIV/AIDS and other deadly diseases.
- African heads of state at the Summit on HIV/AIDS in Abuja assigned highest priority to the creation of a global trust fund to treat and prevent infectious diseases and pledged to raise domestic health spending to 15 percent of their national budgets.
- Civil society organizations lent overwhelming support. Activist NGOs joined forces with development NGOs. The 2001 Social Summit in Puerto Alegre called for “Global support for global action through a global fund to defeat AIDS, malaria and tuberculosis.” At the same time Médecins Sans Frontières was awarded the Nobel Peace Prize and called for the creation of a new global trust fund to confront the AIDS epidemic.
- Technologies for successful treatment of HIV/AIDS: In the 1990s, it became clear in developed countries that alleviation of suffering was possible through the

new ARVs. This raised profound questions of global access and global equity which organizations such as the Treatment Action Campaign were quick to take up. They were effective and successful in challenging the international community, gaining extensive media focus and challenging the pricing policies of the large pharmaceutical firms (p.7)

Due to this unprecedented consensus and great momentum the idea of a global fund created, the standard conventions were abandoned in establishing the Global Fund. At the UNGASS meeting in 2001, participating states adopted a Declaration of Commitment that endorsed the call for a global fund. Less than six months later, the Board of the Global Fund met for the first time in Geneva! The Global Fund started its operations with financial pledges of US\$ 1.5 billion, mainly from bilateral donor agencies, and immediately approved projects worth over US\$ 600 million through a first proposal round. From then on, the financial support grew explosively. By the end of 2002, the Global Fund had approved 56 proposals in 37 countries worth US\$ 567 million. “By 31 December 2006, the Global Fund had signed grant agreements worth US\$ 5.3 billion for 410 grants in 132 countries. In just over three years, the Global Fund has disbursed US\$ 3.24 billion to grant recipients” (The Global Fund, 2007c). By September, 2007, the Global Fund’s commitment has reached \$8.4 billion, and the funds pledged to the Global Fund crossed \$10 billion mark. Such is the track record of the organization.

As a result of such support, during its short lifetime the Global Fund has become a household name. If one were to use Google as the yardstick to measure the presence of an organization in mediascape, a Google search for the words “The Global Fund to fight HIV, TB and Malaria” results in nearly 500,000 web pages. Several hundred new

references are made to the Global Fund every day in newspapers around the world and in several languages. The Global Fund, together with other partners like the UNAIDS, has managed to spread global awareness of the three diseases over the past five years, and along with it spread the fame of the organization as well. New financing mechanisms for international development have come into existence: like companies that take the ProductRED mark on their products donate a portion of profit from the sale to the Global Fund, or a new tax on airline fuel proposed by the Chancellor of Germany, or selling of stamps by the French Postal Services (with the Global Fund logo on them). In almost all international forums for health and development there is almost invariably a mention of the Global Fund and the desirability to support its working and its purposes.

Why Study the Global Fund?

The document *The Global Fund to Fight AIDS, TB and Malaria: What we are, what we do* (for the sake of readability, the quotes that have only page numbers in this chapter are from this document) is key to understanding the organization because the Global Fund uses it as a manifesto of its philosophy and working. This philosophy is reflected in other publications by the organization. It is important to study the Global Fund because of the following aspects mentioned in the document:

The Global Fund is a multilateral development organization: The Global Fund is clearly a development organization, for two reasons. One, it gets most of its funding from OECD countries in the form of Official Development Aid, the funding claimed by these countries as given for development purposes. Liked stated in the previous chapter, this kind of arrangement – where multiple countries give funds to one institution to fund

multiple projects – makes the Global Fund a multilateral organization working for development of the third world countries. Also, the Global Fund does not fund countries that are categorized not classified by the World Bank as low-income or middle-income. On the other hand, the Global Fund clearly states that its organizational goal is to smoothen the way to development in the developing countries. The rationale for funding the three diseases itself is couched in development terms: “As problems with no respect for borders, AIDS, tuberculosis (TB) and malaria continue to spread despite efforts to scale up the fight against these diseases over the past few years, thereby threatening economic progress and potentially undermining the welfare of populations” (p.3). It funds the proposals not just to address the problems posed by the three diseases but as a means to a larger end, which is development: “As a universal public good, the Global Fund represents an investment in a future where diseases that impede development are overcome through collective effort” (p. 15).

The other ways through which the Global Fund addresses development issues is by supporting the Millennium Development Goals (MDGs), which are clearly formulated to support development in countries all around the globe: “The Global Fund was created to fill unmet needs and achieve substantial, measurable impact on the burden of disease in the countries it funds, thereby contributing to the achievement of the Millennium Development Goals (MDGs)” (p. 7). By subscribing to these international development ideals as espoused by various international organizations, the Global Fund promotes itself as a development organization. Not only it subscribes to the goals and ideals but also it relies on development experts to support the organizational work in

other ways: “As a financing mechanism, the Global Fund does not itself provide technical assistance and capacity-building support to current or potential grant recipients. Instead, the Global Fund relies on development partners to provide such support to grantees” (p. 5). From these statements one can conclude that the Global Fund is a multilateral aid organization that is working in the area of development.

The Global Fund focuses on Public-Private Partnerships: The uniqueness of the Global Fund, as the organization claims, is its promotion of public-private partnerships. It only funds proposals that have this component, where the public and private sectors come together and join hands in fighting the diseases, which directly and indirectly contributes towards development:

One of the most important innovations in the design of the Global Fund is the bringing together of the public and private sectors at all levels of the Global Fund’s and its recipients’ decision-making processes. From the Global Fund Board to the CCMs, from governance to program implementation, governments work closely with representatives of civil society, including faith-based organizations (FBOs), the private sector and communities living with the diseases. In doing this, the Global Fund fosters a model where government and other parts of society together take responsibility for the planning, coordination and implementation of health programs (p. 4).

This is the essence of public-private partnerships. The reason partnerships are sought after by development agencies as well as other actors was provided in the previous chapter. It is done mainly to draw on the comparative advantages of both the public and the private sector, each complementing the efforts of the other: “By encouraging both government and civil society organizations to utilize each of their comparative advantages, the Global Fund is in practice advocating a model which harnesses the skill and value of each sector, ensuring the effective design and implementation of quality

programs which will have a greater impact on mitigating the global effects of AIDS, tuberculosis and malaria” (p. 5).

This partnership is reflected in the composition of the Country Coordinating Mechanism (CCM), which is a body of actors who oversee the complete aspects of the proposal, from writing to implementation and evaluation: “The CCM model used by the Global Fund encourages new and innovative alliances among partners in recipient countries, drawing on the active participation of civil society as well as government, multilateral and bilateral partners and NGOs” (p. 8). The proposals written by the CCMs encapsulate the views, roles and responsibilities of each sector, thus reflecting the partnership. This, according to the Global Fund, is unique about the organization itself and the projects it funds: “These proposals and strategies are developed as the result of a close partnership between governments, civil society, the private sector and affected communities. Through its multi-sectoral engagement, the Global Fund represents an innovative approach to international health financing.” Added to this, the importance of partnerships is underscored by the organization by conducting Partnership Forums: “Every two years, the Global Fund convenes a broad group of stakeholders in a Partnership Forum” (p. 6). Therefore, the Global Fund is an organization that actively promotes public-private partnerships as solution to development problems.

The Global Fund claims that it is not influenced by any ideology: The organization claims that it does not promote a particular ideology, neither does it dictate terms to the countries it funds on how to spend the money. By basing the criteria solely on the technical aspects of the proposal and leaving the complete control of writing the

proposal and implementation of the projects to the countries, the Global Fund claims to act solely as a funding mechanism: “To ensure that the Global Fund finances effective programs, the Board relies on an independent panel of health and development experts. The TRP reviews eligible grant proposals for technical merit and recommends high-quality proposals for funding by the Board” (p. 12). The organization is performance driven, meaning that it funds proposals only for two years after which the proposals have to show the promised results for the Global Fund to continue funding: “The Global Fund was created around the concept of ‘performance-based funding’. Essentially this means that only those grant recipients who can demonstrate measurable and effective results from the monies received will be able to receive additional funding”(p. 6). It funds not based on the means mainly but on the ends that the proposals reach in two years.

To further show that the organization does not influence the work it funds, the Global Fund finds a need to claim that it does not have any organizational member working outside its headquarters or in the country where the proposals are implemented: “The Global Fund’s purpose is to attract, manage and disburse resources to fight AIDS, TB and malaria. It does not implement programs directly, relying instead on the knowledge of local experts.” And goes on to add: “The Global Fund does not have a country-level presence outside its offices in Geneva” (p. 10). The confidence of the organization is reflected in its emphasis on transparency. Unlike other development organizations like the World Bank and the IMF that use public money (through government funds) to run their business, and fund public projects as well, but are highly secretive about their workings and extremely exclusionary in their practices, the Global

Fund claims that it has nothing to hide: “The Global Fund’s commitment to transparency is illustrated by the broad range of information available on the website. All approved proposals, signed grant agreements and grant performance reports are available for review in unedited form, as are documents discussed at Board meetings” (p. 8).

Decisions on what programs and projects to implement in a country and what to do with the money that the CCM receives from the Global Fund are country-controlled and country-driven. It is left to the recipient country’s CCM to organize and structure the work with complete autonomy. Added to this, the Global Fund accepts outside criticism, and it actively seeks external critique and makes this available to all as a matter of policy and practice on their website as well.

The Global Fund is support by actors across the ideological spectrum: As discussed earlier, perhaps no other organization in the history of development has attracted so much support and appreciation like the Global Fund, and that too in a historically short period of time. This is a rather unique phenomenon. From the right leaning president of the United States to the left leaning governments like China, from organization like Oxfam to corporate firms like American Express and Armani, from the international organizations like the UN to local NGOs, from rock bands like U2 to world richest man Bill Gates, everyone wants to support the Global Fund. With its organizational rhetoric, the Global Fund seems to have dissolved the contradictions and have managed to garner support as well as funds from actors of really different stripes and shapes, and entrust these diverse actors with the duty to address the problems posed

by three worst diseases in human history. How does the Global Fund manage to obtain this unanimous support?

While it is easy to explain this support for the Global Fund as the product of mortality caused by these diseases, the reality is not that simple. The United Nations reports that an estimated 4 billion cases of diarrhoeal disease occur every year, causing 3 million to 4 million deaths, mostly among children (Umesh et al, 2003). No organization has been established to address that problem, nor has there been an international consensus of the need to have one. Although there have been innumerable studies that documents the death-causing effects of debt in Highly Indebted Poor Countries (HIPC), the initiatives for debt relief and the institutional arrangements under HIPC, for example, were driven largely by civil society and were initially staunchly resisted by many donor agencies, governments and the financial sector (Oxfam International Report, 2001). Millions of deaths occur each year because of hunger-related causes (Black et al, 2003) - 16,000 children die every day – yet there has not been a concentrated movement or a global initiative to deal with the problem. Also, "it took five years to build the fragile and limited consensus that led to the establishment of the Global Environmental Facility (GEF) in 1991 although media and activists have been screaming about the impacts of global warming for decades" (Bezanson, 2005, p. 6). When the mortality and misery caused by all the above causes is clearly comparable, if not worse, than the three diseases why has not there been a global effort or international consensus on dealing with these problems as compared to the support received by the Global Fund? The present study does not focus on this particular aspect, nor is this a comparative study.

But the question of why the Global Fund has become such a popular organization lurks underneath the questions posed by this study.

The Global Fund has become a symbol of a successful organization: According to Kazatchkine, the Global Fund director, the organizations is clearly exceeding its targets (Medical News Today, 2007). Added to this, the statistics show that the popularity of the Global Fund is only increasing, and more governments (including Iceland and Greece) are supporting the organization. The Global Fund claims that there is a reason for all the support; it has a unique set of achievements to boast about by the middle of 2007:

HIV/AIDS: more than 1 million people are receiving ARV treatment

Tuberculosis: more than 2.8 million people have been treated under Directly Observed Treatment, Short-course (DOTS)

Malaria: approximately 30 million ITNs have been distributed

Additional results in treatment, prevention and care include:

- 9.4 million people reached with HIV counseling and testing
- 23 million malaria treatments delivered
- 1.2 million orphans provided with basic care and support
- 23 million people reached with community outreach services
- 3.6 million people trained to deliver services (p.14).

Added to this, for the first time in history, the WHO has admitted that the TB cases all over the globe have peaked. While the malaria is on the rise, statistics show that more and more people are able to gain access to treatment and nets. Rajat Gupta, chair of the Global Fund's board, said, "Through effective in-country management of our grants and strong partnerships, Global Fund-supported programs can help contribute to attaining the U.N. Millennium Development Goal to halt and reverse the spread of HIV/AIDS, TB and malaria and reach the G8 goal of getting HIV/AIDS medication to everyone who needs it by 2010" (Global Fund, 2007). Given this, as well as the fact that

the Global Fund has become a formidable force in global health financing, the Global Fund can inspire other organizations to emulate its working style as well as enable the formation of organizations that work for other development and non-development causes.

Objectives of the Present Study

To sum up the reasons: the Global Fund in a multilateral development organizations, which means that the larger discourses surrounding international development (as described in the previous chapter) have bearing up the working of the organization. If the organization promotes public-private partnerships as unique solutions to global health problems, given the critique of partnerships as neoliberal Trojan horses, it behooves scholars to study the partnerships funded by the Global Fund to see if they are susceptible to such charges. This is especially important in the light of the claims made by the organization itself that it does not promote a particular ideology and funds proposals based solely on their “technical merit”. What will happen if the funding is suddenly reduced? What will be the consequences if the developing societies are faced with new problems, health wise and otherwise? If the Global Fund runs out of its support, can the mechanisms it set in motion sustain without much support? Or, like the critics of neoliberalism claim, will the markets take over the spaces left open by the state?

All these questions take on a sense of urgency and added importance because of the success stories surrounding the Global Fund. If one can safely conclude that the organization working is beneficial in the long run, then other organizations can be

formed on similar grounds. If one cannot reach a conclusion, then one should view the Global Fund and its idea of development cooperation with caution and suspicion, providing reasons for the same.

The present study is based on textual analysis of the proposals funded by the Global Fund. Instead of trying to find the answers in the proposals, one could try to understanding the organizational rhetoric by analyzing the publications and policies of the Global Fund, or interview the organizational members about their views on partnerships and development and what they think of the state, the market and the civil society. Or study the formation and working of CCMs and the way the projects are implemented on the ground, for instance. All these can be fruitful in their endeavor. But the present study focuses solely on the proposals that were found to be of “high quality” by the Global Fund, the proposals that the organization thinks would bring the necessary change as hoped by the donors and the public alike. Other choices were eliminated mainly due to financial limitations, but the assumption is that the questions can be answered by studying the proposals as well.

The Global Fund explicitly claims that it is just a funding mechanism and leaves the ownership of the projects to the countries in which they are implemented. The funds are distributed based on the “technical merit” and “high quality” and continues to fund only those proposals that show “performance.” What is the Global Fund’s idea of “technical merit”? What kind of proposals are approved as “good quality” and funded? While this can differ from proposal to proposal, the organization evidently funds reveals its criteria by deciding to fund proposals that meet the organizational criteria. If one

assumes this to be the case, then it is worthy to find if there are any similarities among the proposals that get funded, or discrepancies for that matter. If one finds a pattern in the proposals, then it suggests that a particular form of partnerships is being promoted by the Global Fund. If one does not find a pattern in these proposals then one can convincingly say that the ‘technical merit’ as described by the organization is too varied to generalize. What about the proposals that are rejected by the Global Fund, or were asked to be modified to fund? This is an interesting question, but the present study does not focus on rejection. It focuses on promotion of a particular (or multiple, as case might be) kind of cooperation between actors approved by the Global Fund. Like detailed in the previous chapter, people (and organizations) belong to various political camps (like neoliberals or social democrats, for instance) based on what actor they favor in their solutions for welfare or development (market for neoliberals and a reformed state for social democrats respectively). But in the case of the Global Fund, people from various political stripes support the organizations, raising a few questions. The primary aim is to understand the role played by the state, the market and the civil society in the proposals approved by the Global Fund. To pose the question in a slightly different way: What role *should* the state, the market and the civil society play in a proposal for it get funding from the Global Fund?

The above question presupposes that there are different roles available for various actors to play in relation to the problems posed by the three diseases: HIV, TB and Malaria. This brings us to another important question: why were the proposals written in the first place? If the proposals have to get the approval from the Global Fund,

they need to provide explanation on why these particular diseases are public health problems, and why these problems cannot be handled by the extant resources in the country, requiring outside funds. To extract this information, among other things, the Global Fund, in its application for the funds, asks the proposal writers to explicitly state the following aspects of the problem: CCM composition, memberships information, epidemiological background, description of national health system, challenges to the national health system, what needs to be done to overcome these challenges, financial needs, objectives/goals of the proposals, activities undertaken, stigma and discrimination, focus on gender, sustainability, monitoring and evaluation, and so on. Only by framing the diseases as problems that cannot be addressed by the existing health system in a country can the proposals writers make a case for the need for public-private partnerships that the Global Fund is willing to fund. Also should be explained in the process of writing the proposal what activities are undertaken and by whom so that they draw on the comparative strengths of each sector. Therefore, only by understanding how the diseases are framed as problems needing funds can we further understand what solutions are proposed for what aspects of the problems. This in turn will help us understand what roles do the state, the market and the civil society play in the sharing the workload required to address the problems posed by these diseases.

Research Questions

- (1) How are the diseases constructed as public health problems in the proposals approved by the Global Fund?

(2) What is the role of the public sector (or the state) in the public-private partnerships described in the approved proposals?

(3) What is the role of the private sector (for-profit and non-profit sectors) in the public-private partnerships described in the approved proposals?

Data Sample

In the application, the Global Fund states that there has not been any change in sixth round compared to the fifth round proposal except for the sixth round does not have health system strengthening as a separate component. As mentioned before, the fifteen proposals that have been selected for this study resulted in a total of 1440 single-spaced pages. This included a few pages in each proposal for graphs and in the case of malaria, country maps. Also, there were a number of tables for financial description and for signatures. The proposal application itself is a rather detailed questionnaire that the CCM from each country needs to fill to apply for funding.

The proposal for the sixth round has the following components to it:

Component 1: This component has the following sub components:

General information on the proposal

Proposal funding summary

Previous Global Fund grants

Component 2: This component is about the technical eligibility with the following sub-components:

Country level income

Counterpart financing

Focus on poor and vulnerable people

High disease burden

Functioning of coordinating mechanism

Board and inclusive membership

Selection of NGO representation

Conflict of interest

Process of forming CCM

Component 3: This component is about the type of applicant (whether it is country CCM

or non-CCM). Sub components are:

Mode of operation

Organizations part of CCM

Proposals endorsement

Component 4: This is the component that deals with the description of the disease and the

rationale for submitting the proposal. Primary sub components are:

Executive summary

Synergies with other diseases, if any

Epidemiology and diseases specific background

Disease control initiatives and broader development frameworks

Description of national health system

Financial and programmatic gap analysis

Current and planned sources of funding

Additionality

Goals, objectives and service delivery areas

Links with overall national context

Activities proposed in the proposal

Links to other Global Fund grants and other donor programs

Activities to strengthen the health system

Target groups, and Social stratification

Gender issues, Stigma and discrimination, and Equity

Sustainability

Principal Recipient information, capacity, legibility

Sub-recipient information, capacity

Monitoring and evaluation

Procurement and supply management of health products.

Multi-drug resistant TB

Technical and management assistance and capacity building

Component 5: Budget summary, in which the budget is laid out in detail.

From this it is evident that the Global Fund proposal really elicits great deal of information from the recipients to understand the problems posed by the diseases as well as the activities proposed as interventions to address the problems.

Based on the component 5, the budget summary, the funding based on the three sectors shows that 9 proposals requested more than two-thirds of the funding for the government, one proposal (Bangladesh) requested almost equal amount of funding for both the government and the state, three proposals (South Africa, Ukraine and Peru)

requested more funding for the non-governmental sector, and only two proposals (Benin and Guinea) request nearly fifty percent of the funding for the private sector and thirty percent for the government. Except for the proposal from Benin, in all the other proposals the private sector received negligible amounts. Overall, nearly 60% of all the funding in all the proposals goes to the government, 30% to the non-governmental sector and 10% to the private sector (mainly because of the two countries, Benin and Guinea).

Rationale of Textual analysis

Although textual analysis has been popular in social science for a long time now, the popular usage of 'text' has been relegated to representational mediums, like movies, newspapers, conversations, interviews, symbols, artwork, and even places and physical actions have been treated as texts by social scientists to understand reality (Fairclough, 1995; Taylor et al., 1996; Wood & Kroger, 2000). There are various genres of text (Bhaktin, 1986), each produced within its own set of conventions. These texts help in organizing the temporal, spatial and even social dimensions of reality (Yates & Orlikowski, 2002). Texts are used for persuasion, interpretation and marginalization purposes as well (Fairclough, 1992). "Texts that conform to an appropriate genre, however, will provide an easily recognizable template through the information they contain and the way in which it is structured". Therefore, texts have been studied not just as communicative tools but as a means to legitimize and maintain a particular point of view, opening up spaces to contest power, mainly through discursive forms.

Documents as units of analysis have been largely neglected by research scholars in social sciences. Instead, like Derrida generalized about the western civilization, the

spoken word was given primacy over the written word. This happens despite the fact that modern organizations, to a large extent, depend on documents and records for their operations and organizing, be it in the form of policies, mission statements, or bureaucratic reports. McCulloch (2004) opines that “documents can provide potent evidence of continuity and change in ideals and in practices. They are a significant medium through which to understand the ways in which our society has developed” (p.11). Documents contain ideological undertones and normative assumptions that need to be explored to understand the power differentials that operate in today’s societies. As discussed earlier in the chapter, this study is based on textual analysis of proposals approved by the Global Fund to understand how the roles of the state, the market and the civil society are constructed in these proposals.

Methodology for Textual Analysis

Unlike using a large sample and following a rigid framework of research, my research deals with a single organization and a limited data set, which in the research literature is termed as a case study. This kind of research is done mainly for the purpose of exploration and interpretation instead of testing a hypothesis or approaching data with a specific outcome in mind. The case study is “a means of investigating complex social units consisting of multiple variables of potential importance” (Merriam, 1998, p. 41). The aim is to gain a thorough understanding of a phenomenon under study and come up with a hypothesis that could be explored extensively in future research. Thus, this approach has been used both to generate and test hypotheses (Flyvbjerg, 2006). Because the study

is done with limited data, the conclusions are mainly limited to the data under study with a potential for generating larger generalization through future research (Merriam, 1998).

The aim of the current project is very modest: to understand the roles of the public and private sector as stated in the proposals, and based on the findings compare it to the literature on the public sector, private sector and partnerships to see if there is a dominant theme that runs through all the proposals which will help us reach conclusions. To that effect, it is hard to even operationalize 'partnership' because, as will be discussed in the analysis chapter, there is no standard definition these proposals follow to talk about partnerships. Given these limitations, I decided to use a quasi-grounded theory to answer my questions. By this I mean that the grounded theory was used not in a belief that a core category for each sector would emerge at the end of the analysis around which everything other theme would fit neatly, but rather in hope that coding the data would provide insights into the nature of partnerships and connecting the codes and themes would help in hypothesizing about the nature of partnerships as constructed in these documents. Given most case studies end up with a hypothesis after analysis to understand the phenomenon studied, I propose a hypothesis at the end of this dissertation.

The fifteen proposals were subjected to coding. This is done in two steps; the first step, the text was read to look for "units of meaning" (Rosengren, 1981, p. 34), also called as unitizing, in which the large chunks of text is broken into discreet and manageable units for further analysis. This meant reading the entire text in the proposals, line by line, and finding lines that talk about a particular theme under study. As Marshall

(1981) states, “the units are really fairly obvious--you get chunks of meaning out of the data itself” (p. 36). Each unit dealt with a particular meaning, but given the nature of the research questions, a few units had more than one meaning or theme embedded in them. It was noted accordingly for further use. The second step is categorizing or coding, which is to sort the data into meaningful categories. This is done after unitizing the data, which helps in generating meaningful categories out of the units (Coffey & Atkinson, 1996). In grounded theory, there are three types of coding a researcher needs to do before he or she can draw major conclusions or form a theory. They are open coding, axial coding, and selective coding. The researcher produces initial set of codes through open coding, which is done mainly for exploratory purpose, and many of these codes are discarded upon finding that they do not appear frequently. For my analysis, if a code was found in more than three documents, it was kept for axial coding. During open coding, keeping my research questions in mind I selected only those lines that dealt with some aspect of the diseases under study, the state, the market of the civil society. Determining what lines should be kept for the next round and what lines should be discarded was a difficult job. The units are selected based on their value in answering the research questions, which is the heuristic value of the units, and were also selected based on the capacity of the unit to stand by itself (Lincoln & Guba, 1985). Lines that did not address the questions under study were discarded, for instance, lines that talked about the work of WHO or USAID in a country were discarded.

Not all proposals are written in the same way, some have better descriptions than others. For instance, Aidspan, an independent watchdog of the Global Fund, in analyzing

the strengths and weaknesses of the proposals submitted to the Global Fund state that the proposal from Eritrea, which contained “excellent situational analysis” (Aidspace, 2006: 10) whereas a few other proposals under study were not mentioned. The selected lines varied in length; a few consisted of a single sentence while other lines captured the essence of the topic under study in an entire paragraph or more, which could not have been truncated without losing the meaning. By the time all proposals were coded, I was very familiar with the dominant themes running through my data. This helped me to start theorizing about initial themes that emerged in the data. I separated these lines into three different categories: the diseases, the public sector, and the private sector.

Once the data was openly coded, I began axial coding in which all the codes and categories were compared looking for connections between categories in order to generate themes. I used my research questions to guide me in further categorizing my data. My research questions fall into three categories – the diseases, the public sector and the private sector. Lines that address a research question were put together, and if they fell in two separate categories, I put them in both. At this stage I could clearly see a few sub-categories, or sub-themes, emerge within the three broad categories. I selected lines based on the following criteria: for the lines related to the state, I defined the state as “any entity that is related to the government and is run by the government”. For the for-profit private sector, any lines that were related to profit-making entities referred to in the proposals were chosen. In most of the proposals this sector was called private sector. As non-profit organizations (and in a broader sense, civil society) are usually defined by “what they are not, rather than by what they are” (Eade, 2004: 12, emphasis in original) I

selected lines related to this sector by separating lines about actors that are not related to the state nor the for-profit sector.

In selective coding, a core category is looked for in the categories that emerge during axial coding. No core category emerged in relation to the research questions: But the dominant themes did emerge in relation to each questions asked. The diseases were framed predominantly in socio-economic terms, the for-profit sector was treated marginal to the discussion, the civil society (through NGOs and community participation) emerged as an essential aspect for the success of all the proposals. No dominant themes emerged for the public sector in the data; the state, and the public sector, is talked in very ambiguous and factual terms in all the proposals. To that extent, I hypothesize that one of the reasons for the popularity of the Global Fund among actors from various constituencies could be due to funding preferences of the organizations. The proposals that get funded have following themes in them: (1) the civil society is deployed as integral to proposals success (which is attractive to actors at both ends of the political spectrum) and (2) the state is treated with “strategic ambiguity” (Eisenberg, 1984), lending itself to ambiguous interpretations by anyone interested in making claims about the state in the proposals (which does not lend to ideological analysis of these proposals in relation to the state). Because most debates in international development and health have been around the role of the state, while promoting civil society at the same hand, the Global Fund steers itself away from controversy by funding proposals that do not take a strong stance on the workings of the state but do about the civil society.

CHAPTER III

FRAMING OF DISEASES

This chapter addresses the first objective of this research: How do the proposals construct the diseases as problems needing interventions? To that effect, the focus is on finding the dominant themes that are found in relation to the diseases. The themes, found in all the proposals, are (1) diseases are public health problems, (2) they are related to poverty, (3) all diseases are talked in economic terms, (4) diseases are spatially oriented, (5) diseases are gendered, (6) diseases are related to ignorance in public, (7) inadequate bio-medical resources cause the problems, and (8) larger socio-economic forces have bearing upon the prevalence of diseases. The chapter concludes on how the above construction of diseases as problems opens up spaces for various actors to come together and address these issues. At the same time it opens up room for the discussion on how the work should be divided among various actors and who would be good in addressing what aspect of the diseases.

Diseases as Public Health Problems

All the proposals claim that “to reduce malaria morbidity and mortality until the disease is no longer a public health problem in the country” is the primary goal. In all the proposals, the prevalence of HIV, TB and/or Malaria is treated as a public health problem. This claim is substantiated with statistics that show how the diseases cause high mortality rates among populations, and how a very high number of people contract and carry the disease-causing virus leading to a potential burden on the society and the health system. The rationale for interventions through the proposals stems from this claim

about the disease and why it is important to fund the proposal: to save thousands, if not millions, of lives that are affected. In the case of Ukraine, for instance, mortality caused by the disease is foregrounded in the description of the epidemiology through the following statements:

Ukraine has the most severe HIV and AIDS epidemic in Eastern Europe & Central Asia, with an estimated 377,600 people living with HIV as of the end of 2005. These estimates include 344,000 people living with HIV aged 15-49, or an estimated adult prevalence of 1.46% (Ukraine, 2006, p. 44).

If mortality is treated as a serious problem to public health, the increase in infections poses a similar problem; the statistics used show that new infections lead to mortality:

Every day more than 20,000 people get infected with the tuberculosis bacillus, more than 5,000 people develop TB disease, and more than 1,000 people die of TB. In 2005, about 1.3 million TB cases were reported by the Revised National Tuberculosis Control Programme (India, 2006, p. 52).

Having made this case, the proposals make a case for funding by concluding that the interventions planned by these proposals save precious lives. To continue with the example of India,

The rate at which the RNTCP expands over the next few years and is able to maintain the existing quality TB services provided over the next few years, will markedly change the number of new TB cases (India, 2006, p. 54).

Also, the potential for the diseases to spread is treated with great caution in the proposals. The potential of people getting infected, the potential loss it might cause to a country, is seen as a reason why the disease is a public health problem. For instance, in Eritrea, due to previous interventions, “at present malaria accounts for 4% of total OPD morbidity and 13% of all admissions (as compared with 32% and 28% respectively in

1999). Case fatality rate in children under-five admitted to hospital has dropped to 1.4% (compared with 7.4% in 1999)” (Eritrea, 2006, p. 46). Yet, the proposal makes a case for the need for interventions by claiming that:

The national context is unique and exciting; the country has achieved enormous success in malaria control in recent years and now has the opportunity to consolidate on this success and further reduce levels of malaria to the point that this disease is no longer a public health concern. This requires a shift in focus and a move into a new phase of malaria control in the country; focusing on surveillance and targeted use of the full complement of effective interventions available (Eritrea, 2006, p. 54).

Majority of the proposals state that they do not have sufficient data about the prevalence and incidence of disease; when it comes to dealing with the diseases, the proposals want to err on the cautious side. There are plenty of statements that substantiate the view that most of the statistics is an approximation of the prevalent problem:

Even in the most conservative estimates, based on the number of smear-positive TB patients registered over the past several years, TB contacts in need of active tracing, referral for testing and follow-up may exceed 7,500 people per year. Most of them remain untraced and untested” (Lesotho, 2006, p. 36).

There is no specific data on prevalence of the disease, yet most proposals claim that the real number is higher than stated officially, which lends a sense of seriousness to the description of the disease: “Between 1986 and 2005, the number of officially registered cases of HIV-infected people is 598, 167 of which progressed to AIDS. According to expert estimates, the number of HIV-infected people is five times larger than official figures show” (Ukraine, 2006, p. 62).

The lack of data is also due to the fact that the patients avoid reporting or using the health facilities, as in the case of Georgia, “The opinion of the local malaria experts

that the real number of malaria cases might be much higher due to some lapses in the registration, the habit of some patients to avoid medical assistance and conduct self treatment should be also considered” (Georgia, 2006, p. 63). There seems to be inadequate data about the specific age groups affected by the disease as well: “In Bangladesh males are the predominant sufferers (54.9%) and majority (>54%) of the patients are in the age group of 15+ years. Information on burden of malaria in <5 children and pregnant women is inadequate” (Bangladesh, 2006, p. 40). All these quotes point to that fact that although there is no quantitative data available to understand the severity of the problem, the proposals rely on the received wisdom that, for whatever reasons, the official statistics (through the government, presumably) are always lower than the real number and so, we should presume the worse and act on it.

According to the proposals, there is a lack of coordination among various actors in the field to get a good estimate of the number of people affected by the diseases: “There is gross under reporting of the malaria cases and deaths in Bangladesh. It is assumed that the number of cases and deaths from malaria would have been three times higher if information from the community, NGOs, private hospitals and service providers could be included in the routine surveillance reports” (Bangladesh, 2006, p. 75). This also implies that if proper reporting mechanisms are in place, the data would be noticeably higher than what it really is. Evidence to this claim can be found in the statements like:

The descending trend of case notification, which had been observed during the last few years, was due to insufficient searches, combined with a lack of case referrals by some of the health services providers. Nevertheless, the IGSS began to notify all cases detected by the institution since 2004. This explains the

increase of 20% in TB incidence when this new information was incorporated to the National Vigilance System. (India, 2006, p. 67)

Therefore, overall the proposals' claim that the diseases are public health problems because of the quantitative indicators on mortality and morbidity among populations. Even when the data is insufficient, one could presume that the number is always higher because statistics, or lack thereof, are always underestimated and underreported.

Diseases are Poverty-Related

The issue of poverty is intricately related to the diseases and stands out prominently in all the proposals. Almost all the people who are targeted by these proposals come from low socio-economic backgrounds, people who are marginalized in a national health care system. Unemployed labor, sex workers, nomads, drug addicts, street children, and tribal people, the thread that binds these people together for intervention is poverty. The following extract from the proposal from Bulgaria for TB shows how poverty and diseases are intricately connected:

The majority of Roma communities in Bulgaria live in poverty – 84% of the Bulgarian Roma people are below the poverty line (World Bank 2000). Among the people of Roma origin poverty is 11 times higher than that among the people of the Bulgarian ethnic community. Unemployment level among Roma people is between 70% and 90%. The majority of the Roma population lives in very poor neighborhoods with undeveloped infrastructure. The housing conditions are extremely poor, sometimes 10 people share a room... The information available indicates that Roma communities are the most vulnerable regarding health and social problems in Bulgaria. The average life expectancy of Roma people is 10 years less than the average for the country... Among Roma people Tuberculosis often occurs parallel to other chronic diseases which further complicates the development of their condition. According to a recent rapid assessment carried out in seventeen big cities in Bulgaria, Roma TB patients represent 50% of all TB cases. (Bulgaria, 2006, p. 56)

This extract shows that poverty is related to lack of resources, lack of employment, lack of infrastructure, proper housing, and have reduced life expectancy which in turn makes the people from the Roma community particularly vulnerable to TB. Diseases are caused due to complex interactions between biological and socio-economic factors make people susceptible to diseases. These diseases do not affect people uniformly, nor do they affect all the people in an area equally. Poverty is region specific, or put differently, socio-economic factors decide where one lives, which in turn affects their vulnerability to the disease. In the case of India, the proposal for Malaria focused on three districts where poverty is rampant and so is the disease:

This proposal would ensure continued implementation of the RNTCP activities in the states of Chhattisgarh, Jharkhand and Uttaranchal, which will benefit over 63 million population of these 3 states. As per the list released by the Planning Commission in India, nearly 42% of the population in these 3 states reside in the 100 most poor and backward districts of the country. Nearly one-fifth of the population in these three states resides in tribal areas. (India, 2006, p. 44)

Poverty is also closely linked to inequality in the society; unequal distribution of the diseases is a reflection of unequal distribution of resources in a society. This is the reason one never hears about the rich getting affected by the disease as severely as the poor, which shows that the diseases have basis in the material reality. For instance, Guatemala, in its proposal for TB, claims the same:

The CCM and the Ministry of Health recognize that the main source for the diseases that this proposal deals with is injustice, inequality and poverty. The Government of Guatemala is fighting inequality in many fronts, and this proposal allows for governmental organizations and the civil society to extend their support to populations who are not being provided with adequate services. This proposal seeks to offer the best health care to the poorest patient in the community. People contract TB due to social inequalities. It has been known for centuries that TB is a disease with a social-economic origin (Guatemala, 2006, p. 38).

One important aspect of the people who contract the disease is the nature of their employment. Migrant laborers, sex workers, nomads, unemployed youth, for example, form specific target groups for interventions. It is their need for livelihood, their search for employment, their underemployment, that exposes them to these diseases. For instance, in the case of Eritrea,

Malaria in Eritrea is closely associated with poverty. In the northern zobas of Northern Red Sea and Southern Red Sea, marginalized nomadic ethnic minority groups often carry the greatest burden of both poverty and disease. In addition, non-immune individuals traveling to highly endemic lowland areas towards the border with Ethiopia and Sudan for seasonal work are at a very high risk of malaria. (Eritrea, 2006, p. 38).

Poverty leads to unsafe conditions because it is the lack of material resources that deters from acquiring goods like mosquitoes nets, proper sanitation, or good housing, all of which contribute for the spreading of a disease like malaria, for instance: “The geographical and eco-environmental condition in 13 high endemic districts is favourable for vector breeding. In three hill tract districts, at least half of the population is indigenous and the housing conditions are not good enough to protect them from mosquito bites” (Guinea, 2006, p. 42). Poverty also means lack of resources that could help one get proper health care and use appropriate health services. Lack of resources translates into the inability for someone to take preventive measures through good sanitation habits, good hygiene, good food and proper care of oneself. In case of India, the proposal makes this point explicit:

About 50% of the families are marginalized poor and their basic needs are compromised in terms of inadequate food consumption, poor sanitary conditions, poor access to education and health care. Moreover there is a seasonal

aggregation of labor forces in these high endemic districts from non-endemic areas who represent another vulnerable group for malaria. (India, 2006, p. 57)

For someone to deal with sickness they have to have resources to access established health care, which translates into user fees and fee for medication. Poverty delays visits a doctor, and adversely affects treatment. As the diagnosis and treatment of the disease is part of the public health care system (and private to some extent, as will be discussed later), lack of money which in turn leads to lack of health insurance, could mean the poor people in need of health care are not able to access the health facilities, be it in public or private realm.

Of note is the fact that the number of cases with smear-positive severe disseminated pulmonary forms is going up which speaks for late discovery of patients due to delays in seeking medical care, insufficient coverage of TB contacts and inadequate response to this problem within the primary health network. This is a particularly severe problem for people with no health insurance who are left outside the coverage of the primary health network, and also for people from risk populations, like prisoners, Roma, IDUs, street children (Bulgaria, 2006, p. 52).

Therefore, the most defining characteristic of these diseases is poverty.

Disease in Economical Terms

Morbidity and mortality caused by malaria are significant obstacles to achieving delivery of this poverty reduction strategy. Malaria constitutes a financial burden on government, households and the private sector through the direct costs of treatment and through lost economic productivity. WHO's Commission of Macroeconomics and Health recently reported that malaria, tuberculosis, and HIV/AIDS alone can reduce the annual GDP growth rate by 1.3%.⁹ Malaria is known to exacerbate poverty due to loss in productivity which could amount to 7-10 days loss of working days for a malaria patient, in addition to further losses by those attending the sick for each bout. According to a study by the Harvard University Center for International Development and the London School of Hygiene and Tropical Medicine, between 1965 and 1990 malaria cut one percentage point per year from the annual growth rates of 27 African economies, including Eritrea. Efforts to control malaria would therefore definitely contribute to poverty alleviation (Eritrea, 2006, p. 46).

The paragraph above neatly sums up the construction of the diseases in economic terms. The usage of the term “economic” here stands for the effect these diseases have on the economic output of a community or a country. Diseases have bearing upon the economic condition of the individual, community, society and the country at large. Addressing the problems posed by the diseases is seen as a way of addressing the economic and developmental issues that plague the developing countries. Drawing on the international indicators of a healthy economy, and the notion that good economy and growth is indicative of healthy citizenry, the proposals make a case for economic growth by using these interventions as means to achieve economic equality, which in turn seems to spur the national growth in economic terms. All this is based on the idea that poverty is the affect of the diseases, (never a cause) and using poverty as a linchpin, these proposals deploy activities that purportedly have beneficial economic effect on the people and communities addressed.

The diseases also described in economic terms based on the financial burden they have on a country, adding economic aspect to the public health problem. For instance, in the case of India, we find: “The direct and indirect cost of TB to India amounts to an estimated \$3 billion annually” (India, 2006, p. 46) and South African proposal mentions:

Most countries in the world including South Africa are facing an increase in the burden of disease and the challenge of adjusting their health systems to cope. Health care expenditure in South Africa was approximately R107 billion in 2003/04. This is equivalent to 8.7% of GDP in that year which is relatively high by international standards; it exceeds that in the majority of countries of a similar level of economic development and similar to that in many high-income countries (e.g. UK) (South Africa, 2006, p. 41).

Therefore, most proposals claim that the funds are directed mainly towards poverty alleviation and development of the society: “This GFATM proposal for reducing burden of malaria has direct linkages with the above mentioned targets of the government programme in the larger context and is expected to contribute significantly to the overall economic and social development process” (Bangladesh, 2006, p. 66). And in the case of Bulgaria, “[Government of Bulgaria] endorses priority on control of Malaria, TB and other major communicable diseases as a means of poverty reduction in the broader framework of national development” (Bulgaria, 2006, p. 43). Even the other benefits engendered by the implementation of the projects are couched in economic terms: “Benefits will be reduction and prevention of further economic loss, of increased expenditures of the communities and households on health, school absenteeism, losses of tourist industry. And as a whole it will lead to an increase of the living standard of the population” (Georgia, 2006, p. 51).

Continuing the construction of the disease in economic terms, the proposals claim that through the implementation of the projects and programs talked in the proposal, these disease would be managed effectively and patients who are in their productive age group would return to work, thus contributing to the economic development of the community and the country. The families of these people would be dually benefited, it is stated: On one hand “they would not have to spend scarce family resources on the treatment of the person – a major factor leading to debt especially in the lowest income families” and on the other hand “when these persons are successfully cured, they would in turn help replenish the family finances” (Benin, 2006, p. 65). The

same is found in the proposal from India as well, which states in no uncertain terms the effect TB has on the productive population of the society, because it affects the population that is the workforce of a country: “TB remains a serious public health problem in India, primarily affecting people in their most productive years of life and more common among the poorest and marginalized sections of the community. Almost 70% of TB patients are aged between the ages of 15 and 44 years of age” (India, 2006, p. 40). Therefore, if the productive population of a country goes back to work, then the poverty levels will go down, which is seen as one of the major goals of all the proposals.

The proposal from India goes on to state that:

Studies suggest that on an average 3 to 4 months of work time is lost as result of TB, resulting in an average lost potential earning of 20-30% of the annual household income. This leads to increased debt burden, particularly for the poor and marginalized sections of the population... Control of TB is significantly contributing to reduction of poverty at both the individual and national level. Improved productivity of workers by reducing absenteeism, preventing incapacity from ill health, and by averting TB deaths among these workers, add to the productivity capacities of the economy (India, 2006, p. 43).

Like discussed in the earlier section, poverty and the disease are closely linked in all the proposals. One of the ways in which the proposals make a case for funding is to claim that these interventions would alleviate poverty. If poor people do not have access to health care, providing them with adequate health services is seen as a solution to the problem. By doing so, the proposals deftly deflect the attention from addressing poverty directly:

The government, with the support of its key development partners, is in the process of finalizing Eritrea’s Poverty Reduction Strategy Paper. The paper ranks inadequate health services as well as low accessibility to health services as the third most important cause of poverty. It is well established that addressing the

disease burden of a country will reduce the vulnerability of the population to poverty (Eritrea, 2006, p. 49).

Here we can clearly see that the lack of health services is seen as the cause of poverty and not the other way around. By accessing health care, it is implied, the poverty level of the people will be changed. Thus, it is assumed that healthy people by default have enough employment and opportunity to make their lives better in the society, and it is the disease that is causing them not to avail such opportunities. The social conditions are never made central to the discussion about poverty; the lack of employment, the prevalence of social safety nets, the political system, all are treated as working well for citizens if they are just healthy.

The diseases are also treated as “burden” on the people and the nation. The seriousness of the disease is conveyed in the economic terms as well, and the interventions are aimed at reducing this “burden” to ease way to the well being of people. This aspect gets accentuated in the poorer sections of the society, mainly. In the case of Lesotho,

Improved programme performance will reduce the burden of TB upon health services as TB patients are cured and TB/HIV patients begin to live longer and more productively after TB treatment. The involvement of the community will further reduce the load...The combined effect of efficient disease control will be to mitigate the economic impact of TB and HIV and consequently reduce the financial burden upon the GOL. (Lesotho, 2006, p. 63).

The health services will reduce the financial burden on already poor people, making it easy for them to access health care and be healthy. For instance, in the case of Benin TB project, it is claimed that poverty is the key factor and the way intervention would help is to reduce the burden on the poor people who have to spend money on

transportation: “Poverty is a key factor in the epidemiology and management of both TB and HIV. Extending microscopy services to rural areas and facilitating treatment at community level will reduce the financial burden upon communities in commuting to facilities for investigations and treatment.” Inadequate health services and lack of access to health services are treated as the cause of poverty. This leads the proposals to make as strong case for interventions:

Tuberculosis is a socially significant disease leading to reduced bodily fitness, higher disability and death rates and having negative impact on the financial and social stability of the affected individual, his/her family and society in general. The enormous damage caused by the disease in the personal and social perspective, as well as the considerable cost of treatment for severe and multidrug-resistant forms, call for a society-wide mobilisation of all available resources in the fight against TB (Bulgaria, 2006, p. 55).

The primary intention of all the proposals seems to be to reduce poverty through interventions. By doing so, the proposals seem to imply that the diseases cause poverty and not the other way around. By constructing diseases in this way the focus shifts from the poverty that causes disease to the disease itself. The issues of poverty and social injustice are separated from the activities taken up by the proposal, and as long as poverty is seen as the affect of the disease, activities related to addressing poverty are removed from the proposal. Through this construction of diseases, the political aspect to the cause of diseases is totally sidelined and subverted. The room for reformation of social systems, the accountability of the state towards poverty levels in the country, the structural constraints that exist between poverty and prosperity are not addressed. Although all the proposals make explicit the connection between poverty and disease, no socio-economic indicators can be found in the evaluation of the diseases; no indication

of how the poverty levels have changed due to the interventions, no mention of the socio-economic status of the population in the evaluation of the programs. Thus, the proposals depoliticize the context of diseases and treat them as causes and not effects.

Diseases Are Spatial in Nature

Diseases are spatially oriented, and are more prevalent in one area than the other. That is, people of a specific region are more vulnerable to disease than people in other areas. Most people who get affected by them are either in remote area or are marginalized from the society that they hardly have any access to health care facilities, like the rural-urban divide. In all the proposals we find that, in a country, a few states or regions have higher number of targeted populations, or at least prone to have higher number than other regions. Incidence is based more on where the people live, like tribal areas and nomadic people, for instance. All the proposals state that the rural people are more adversely affected than the urban people, and people in remote areas are more affected than people who are easily reachable by conventional health services.

All the three diseases seem to affect populations in a particular geographical area within a country: “Unlike other European countries, the tuberculosis incidence in the capital city is close to the average incidence for the country, but in almost half of the regions of the Republic of Bulgaria the tuberculosis incidence is higher than the average rate” (Bulgaria, 2006, p. 52). This is attributed to concentration of Roma population in particular areas. In the case of malaria (as will be discussed later in this section), the population is susceptible because of their living in epidemic prone areas or movement from one region to the other:

In addition there are almost 500,000 ethnic minority people in northern and eastern coastal zobas who lead a nomadic or semi-nomadic lifestyle and who are thus difficult to target with conventional health delivery mechanisms. The non-immune populations of the central highlands are also vulnerable to malaria when they move from highlands to the lowland areas during malaria transmission season (Eritrea, 2006, p. 44).

This holds good for people who move for reasons other than livelihood, like tourists and visitors who become vector carriers for these diseases:

We must take into the consideration the fact, that Black Sea resorts are visited by many guests from different parts of the world... Having in mind that this is a former malaria endemic territory and the existing intensive migration of the population of the whole country in summer time to the resorts situated there a risk of expansion of malaria in this part should be considered (Georgia, 2006, p. 41).

The issue of regionality of these diseases becomes accentuated in the case of rural-urban divide. Given the historical focus of public health care on the urban areas where most of the industrial laborers lived (as described about the welfare state which is believed by neo-Marxists as tool to supply labor for advanced capitalism), the rural areas are neglected in providing health care to populations: “Malaria is predominantly a rural disease affecting primarily the most impoverished groups of rural population (92% of the cases in 2000-2004). Groups at a higher risk are also the ones living in the areas bordering Azerbaijan and workers at Baku-Jeihan” (Georgia, 2006, p. 42). The people in the remote areas and near borders do not reap the benefits of a public health system either, as evidenced in the proposal from Bangladesh:

[O]ut of the total 64 districts, 13 are in the high endemic area for malaria transmission... The targeted 13 high endemic districts belong to the bordering hilly and forest areas. The communication is difficult in most of the areas of these districts. Health facilities and service providers are inadequate. Presently about 40% of the people have access to diagnosis and treatment of malaria from the health facilities (Bangladesh, 2006, p. 46).

This issue is highlighted in all the proposals of all the three diseases. Irrespective of what the health problem is, the area of residence, and the nature of movement primarily based on livelihood needs, seems to be rather decisive in who is going to suffer from these diseases. In case of TB in India, where the proposal is for three states with high incidence rate, “nearly 42% of the population in these 3 states reside in the 100 most poor and backward districts of the country. Nearly one-fifth of the population in these three states reside in tribal areas... [the population] which is largely socio-economically backward and living in hard to reach tribal and hilly areas” (India, 2006, p. 38). In South Africa, for instance, one can find a similar situation in the case of HIV that seems to be region-specific as well: “Place of residence is a significant factor in the distribution of HIV infection. Informal rural and informal settlements have the highest prevalence of HIV. Mostly the poor and unemployed inhabit these areas. In general it appears that in South Africa HIV prevalence is higher in rural areas than in urban areas” (South Africa, 2006, p. 42).

Regionality, mainly through the place of residence as well as the location, is seen as a problem because of the remoteness of the target population from mainstream health services and facilities. Most of these areas, including rural areas, are treated as hard to reach. Like discussed in the next chapter, private sector is not seen to address the needs, and the government facilities find it harder to reach the population. As majority of the populations living in these areas are poor, there is a particular need to address the health needs of the populations through the proposal. Therefore, constructing the disease in spatial terms helps make a strong case for getting funds for interventions that are not

addressed, or have been addressed, in the national public health system or the private health care. In case of India, for instance,

The populations in these three states, which is largely socio-economically backward and living in hard to reach tribal and hilly areas, would through this project have obtained the dual benefits, firstly of getting easily accessible high quality TB care free at point of use and secondly drastically reduce out of pocket expenditure and reduce treatment delays. (India, 2006, p. 76).

Even when the health system of a country is seen as effective in reaching populations that are in need, a case is made for expanding the facilities so that all the populations are brought into its fold, as in Eritrea:

It has been the Government of Eritrea's policy to extend health care to the rural areas to increase geographical coverage as much as possible. Since independence there have been more focus on developing health station and centres. This has remarkably improved coverage though there is still room to cover and some facilities are still more than 100km apart. Many of these facilities also lack some amenities such as electricity, water supply, fencing, incinerators, placental pit, and need general renovations. (Eritrea, 2006, p. 41).

Unlike TB and HIV, malaria is mainly caused by climatic conditions. The geography and climatic conditions are determinants in the breeding of mosquitoes that cause malaria. Therefore, in the proposals related to Malaria the climate and geography is emphasized in the populations getting affected by the disease: "Large differences in altitude across the country contribute to the complex transmission picture. Transmission is usually described as highly seasonal and unstable, although this generalization masks a high variability" (Mozambique, 2006, p. 44). A few regions, mainly the ones bordering other countries, are said to be more susceptible than others.

In 2005 malaria transmission was mainly recorded in two southwestern regions – Kakheti and Kvemo Kartli... Although there was a decrease in the number of reported malaria cases during the past years, considering the epidemic situation in the neighbouring countries, the intensive migration of the population, the local

environmental and climatic conditions and other factors, it is obvious that there is a risk of epidemics, unless surveillance and control activities are further improved (Georgia, 2006, p. 43).

Even though Malaria is related to climatic conditions, one should never forget that it is the poor who are affected by the disease: “Malaria in Eritrea takes a disproportionate toll on the poor, affecting mainly farming communities in hard to reach areas” (Eritrea, 2006, p. 74).

Therefore, for the quotes above it is safe to conclude that the diseases are constructed in spatial terms and dichotomized in a way that legitimizes leaving a few people out of the safety nets of a society. By claiming that people are hard to reach, stay away from the conventional health care systems, the proposals create spaces for interventions in these areas, and in the lives of people living in these areas. No explanation is given to why this has been the case all along given the fact that most of the people who suffer from these diseases seem to be living in these areas historically. Thus, the proposals take ahistorical approach towards diseases.

Diseases Are Related to Ignorance

The diseases are treated as a public health problem because of lack of knowledge among the public about the disease, on how the disease is spread, what precautions need to be taken, following the treatment, prevalence of stigma, and so on. One of the reasons why there is lack of knowledge is because of the socio-economic situation of the population; the poor and the marginalized do not have access to education or information. Hence, most of the interventions about the treatment, as well as precautions, are aimed at these people.

One aspect of the disease that all proposals address is the issue of stigma. Stigma is seen as a product of ignorance, not knowing that these diseases could be treated and that they are caused by viruses and not due to immorality. Also, stigma is associated to a disease that is contagious and decisively fatal, like in the case of HIV. One could hazard such a guess because in the case of malaria, where the mosquitoes transmit the disease, there is no stigma attached: “Because malaria is endemic, not transmitted directly between people and non-contagious, there should be no instances of exclusion and/or discrimination” (Guinea, 2006, p. 65). Of all the proposals related to Malaria, only the one from Bangladesh hints at some stigma related to it:

Unlike HIV and TB, there is no significant stigma or discrimination associated to malaria patients in Bangladesh. Some misbelieves in the indigenous community remains regarding causation of disease. However the proposed IEC activities will help in increasing community awareness for seeking early treatment and prevention of malaria in the remote and underprivileged communities. (Bangladesh, 2006, p. 75)

Here one could note that the prevalence of stigma is seen as due to lack of knowledge about the disease and lack of awareness about treatment and prevention. Thus, stigma is product of ignorance.

When stigma exists, as in the case of TB and HIV, it seems to deter the usage of health facilities; it discourages people to deal with the disease and approach any health care facility for treatment. The best way to overcome this problem is to spread awareness about the disease through information, education and communication (IEC) campaigns and through community mobilization. For instance, in the case of Blugaria that focuses on Roma community,

The stigmatization of people suffering from TB is one of the biggest obstacles to communicating within the community and to looking for healthcare services on the part of the Roma population. Therefore, the elimination of discrimination against people living with tuberculosis is one of the priorities in the mass campaign and public work under the Program. (Bulgaria, 2006, p. 65)

The stigma related to these diseases is more nuanced because people who are affected by these diseases also suffer from other forms of discrimination: due to their socio-economic situation they are marginalized from the health services, which could also reduce their negotiating power in their interactions with the health care system. So, stigma and discrimination work intricately within a social system that ultimately affects the health of the population:

The risk groups of intravenous drug addicts, alcohol dependent people, children living rough on the streets, and the refugees are subject to additional discrimination: firstly, they are discriminated as a marginal group per se, and secondly – their suffering from tuberculosis is superimposed over the first type of marginality based discrimination. What should not be underestimated is also the internal marginalization and discrimination with respect to the victims of tuberculosis, which exists within the risk groups themselves. All this brings about the emergence of serious barriers of a multi-faceted nature, which impede the timely discovery and effective treatment of TB patients in these groups. (Bulgaria, 2006, p. 68)

The notion that stigma is prevalent due to lack of information and education is made more explicit in the reasons given for interventions. Stigma seems to be attached to diseases due to the fear that diseases are incurable. Once the disease is looked at from a bio-medical perspective, the scope for stigma seems to drastically reduce, according to many proposals. Most proposals that talk about stigma also talk about mass media and IEC materials as a way to cope with the problem: “Cured patients acting as DOT providers to future patients and advocates for the programme, will act as potent symbols to the community of the fact that TB is a curable disease and should be seen as just

another infection that needs antibiotic treatment for cure” (Guatemala, 2006, p. 61).

Added to that, the nexus between HIV and TB makes the stigma more complex, because historically HIV has been highly stigmatized because of the sexual aspect of the disease.

Combined trainings on TB and HIV/AIDS will contribute to reducing stigma among health care workers, while IEC messages will include specific messages on reducing the ancient stigma attached to TB, which has now been linked to HIV/AIDS. The sight of previously gravely ill TB patients making marked improvement to TB treatment linked with HIV treatment and care will hopefully make the HIV positive status more acceptable in the general population (India, 2006b, p. 65).

There seems to be stigma within the groups affected by the disease. Even in such cases, spreading of awareness and information is treated as the solution.

The field work with these high-risk groups will contribute to the opportunity to raise these patients’ awareness of the TB issues and will help to overcome the internal stigma and discrimination within the risk groups themselves. On the other hand, the effective treatment of tuberculosis patients from these high-risk and marginal groups will contribute not only to the decreasing stigmatization and discrimination with respect to them, but also with respect to all TB patients in general. In order to achieve this, we shall rely to a large extent on the national campaigns and other mass media events, which will be targeted at society at large (India, 2006, p. 65).

In a few cases the problem seems to be the lack of knowledge about the disease and about the cure for the disease. Not knowing how to use the health facilities, not knowing what preventive measures exist, not knowing how to treat the patients, etc are all treated as the problem that could be overcome by the dissemination of information.

“The great majority, of cases occur in returning travelers and migrants. The population is diverse. These persons often lack the knowledge to treat malaria promptly and correctly and often use self-treatment methods” (Mozambique, 2006, p. 67). The ignorance of the

health care providers is seen as the cause of the problems related to the prevalence of disease among communities:

Unfortunately, sometimes there is a negligent attitude to patients from the Roma community by medical personnel, as well as insufficient consideration of these people's low level of literacy and need for special consulting and additional motivation on the issues of tuberculosis treatment and prevention in the Roma families. This issue will be an important part of the training curriculum of the medical personnel and the Program assistants from the Roma community itself. (Bulgaria, 2006, p. 97)

The behavior of the people affected by the disease is seen as a problem as well, and in many cases, behavior change campaigns (BCC) are introduced as a way to address this problem:

Further, communities have not been sufficiently empowered through advocacy, communication and social mobilisation to improve their health seeking behaviour and their understanding about TB and its management and their participation in TB control activities. This proposal seeks to contribute to rectifying these challenges (Lesotho, 2006, p. 85).

The goals of the proposals are framed in the terms of knowledge and behavioral change as well: "Achieve changes in attitude, conduct and behavior in the general population, as well as within the health system staff, for the benefit of all action undertaken against TB and the affected patients" (Benin, 2006, p. 64). Therefore, one of the major interventions is to do an extensive campaigning to spread knowledge about the disease as well as encourage people to adopt healthy behavior so that the diseases could be handled:

This output will be achieved through concerted behaviour change communication efforts involving both the mass media and community outreach through a package of IEC methodologies. As a result, by 2009, 80% of women of child-bearing age should know the preventive benefits of ITNs, 90% of women of child bearing age in high incidence sub-zobas should know the preventive benefits of IPT. In addition, by year five, 90% of mothers and guardians should

recognise the need for early malaria treatment for within 24 hours of onset particularly for underfives (Eritrea, 2006, p. 45).

Therefore, by constructing the disease as problems because the public does not have enough information or knowledge about this, which causes stigma and discrimination, the proposals open up spaces for mass media campaigns and community outreach which are addressed in the proposals, and which help make case for funding.

Diseases Are Gendered

Women and children are treated as important target populations, and all the proposals give special attention to women, especially pregnant women and children, and their health and well being. Statistics are marshaled to show how women are special victims of these diseases.

Women bear the blunt of the challenge of HIV and AIDS. Women account for 55% of people living with HIV and AIDS in South Africa. This difference is more pronounced in the age groups 20-24 years and 25- 29 where the HIV prevalence rates are 23.9% for women to 6.0% for men and 33.3% for women to 12.1% for men, respectively... The HRSC data also show that South African children have a high HIV prevalence. In the 2-4 age group, 4.9% of boys and 5.3% of girls are HIV positive, translating into an estimated 129 621 children (South Africa, 2006, p. 45).

In the case of malaria, which is caused due to mosquitoes' bites, "there was little difference in the prevalence of malaria infection by age and sex groups" (Eritrea, 2006: 65). Yet, the affect of malaria on pregnant women is acknowledged: "This plague also afflicts pregnant women through its repercussions with regard to birth weight, premature childbirth, abortions and anaemia, particularly in 1st and 2nd pregnancies" (Eritrea, 2006, p. 65). While all the population is targeted by proposals related to malaria, the need for special attention to the women and children is highlighted: "While for most

service delivery areas activities will be targeted equally irrespective of gender, the targeting of LLINs will prioritize pregnant women (and their young children) in highly endemic communities” (Georgia, 2006, p. 59). There is a strong emphasis on the gender aspect of the disease not because they are affected more but because they are at higher risk due to lack of access to health facilities, in the case of children it is due to their inability to take care of themselves:

The programme expects to be able to cater for the whole population at risk. The services will be adequately made available to the whole community at risk without any prejudices related to either sex, gender, color or race. However, understanding that pregnant women and children are the ones at higher risk, they will be given priority whenever services become limited for whatever reason (Bangladesh, 2006, p. 61).

In the case of TB most proposals claim that men are more affected than women:

A constant feature in the case notifications under the RNTCP is that more male patients are detected than female patients, with the ratio of being 1.8: 1. A number of epidemiological studies have demonstrated that in all age groups, pulmonary TB is predominantly a male disease. In fact, it is male cases that may have lesser access compared to females. It is also seen that male patients are more likely to default from treatment and have slightly worse treatment outcomes than female patients. However there is greater stigma attached to the disease amongst female patients than males. (India, 2006, p. 71).

Given this, the focus still stays on the female populations. This is due to the fact that the Global Fund encourages all the countries to focus on women in their proposals, because historically women lacked proper access to health care: “Male TB patients outnumber females by 1.4:1, though females are disproportionately affected by HIV/AIDS. This discrepancy highlights that there are possible gender inequities in access to TB diagnosis and treatment” (Lesotho, 2006, p. 59). And even though more men are affected by TB, it is the women who are stigmatized and bear the greatest brunt of the disease:

While two thirds of the cases are male, TB takes a disproportionately larger toll among young females, with more than 50% of female cases occurring before 34 years of age. This all comes with in addition a devastating social cost – more than 300,000 children are forced to leave school because their parents have TB, and more than 100,000 women with TB are rejected by their families. (India, 2006, p. 64).

Overall, the proposals state that women have harder time accessing health care compared to men, and children are more vulnerable than adults. A special focus on addressing the needs of these people and helping them to better health is central to all the proposals funded by the Global Fund:

The access to healthcare services of women refugees and refugees at large is difficult on the whole due to cultural, religious, and language differences. The women refugees often do not seek medical aid and contacts with medical establishments because they have language difficulties, do not know the healthcare system, or have cultural inhibitions. (Bulgaria, 2006, p. 75).

Therefore, one can conclude for the above that the diseases are constructed as gendered in these proposals, and the plight of women and children is highlighted. It is stigma and lack of empowerment among women that is seen as a problem needing intervention, and because a high percentage of women are getting sick due to the diseases, the proposals make a case for funding, and a role for intervention at the same time.

Diseases Are Bio-medical in Nature

By terming it biomedical, I mean that diseases are treated as problems because of their relation to medicines, medical infrastructure, doctors, and lack of medical training.

Medicine/Drugs: The diseases are a problem because the viruses that cause these diseases develop resistance to drugs that are used to treat them. All the three diseases face the problem of multi-drug resistance, although it is found to be exceptionally acute,

in recent years, in the case of TB. Due to MDR, the mortality rate has gone up and it has become rather hard to deal with the issue. Also, MDR is expensive to treat because of the nature of the drugs involved.

Another challenge to TB control in India is multi-drug resistant TB (MDR-TB). The data available to date shows that levels of MDR-TB remain relatively low, at around 3%, amongst new patients and 12% in retreatment cases. However these relatively low percentage figures translate into a large absolute number of MDR-TB cases, who can transmit their drug resistant disease to others and require effective treatment. (India, 2006, p. 46)

Most of the cases, the rise in MDR is attributed to the ignorance of the practitioners who do not carefully administer the drugs and monitor the patients, and in other cases it is seen as ignorance on the part of the patient who do not stick with the drug regime to be completely cured.

Worrying levels of resistance to anti-TB drugs have been detected in the country. The resistance study undertaken during 2002-2003 for essential anti-TB drugs (H, R, E and S) indicated a primary resistance of 35% and a primary MDR of 3%, probably due to the absence of treatment supervision in other institutions of the health sector that are not incorporated into the DOTS strategy (Benin, 2006, p. 45).

Even when the drugs are available in the international market, the problem is that these drugs do not reach the people in need of them. This lack of access to drugs, mainly due to the socio-economic condition of the victims, makes it a public health issue:

The exact prevalence of MDR-TB is not known. Furthermore, most second-line drugs for their treatment are not available and most patients with MDR-TB do not receive adequate treatment. As a consequence, the death rate is high among them and there is a real risk of creating further resistance and increasing the duration of spreading the infection to the population (Guatemala, 2006, p. 36).

In this way the medicinal aspect of the disease gains importance in description of the disease as a health problem that needs funding for drugs.

Co-infections: Due to the rise in HIV cases all over the globe, TB has become a major cause of death in the HIV population. This sets the two diseases apart, although most of the focus is on containing TB so that the weak immune system of HIV patients is not compromised. It is one of the reasons the proposals can include both HIV and TB components for funding. The need for addressing the TB epidemic is made through the invocation of data that shows that a great number of HIV patients die of TB. Controlling TB is seen as a way to controlling HIV epidemic as well: “The TB problem is further compounded by an estimated 5.2 million people in India infected with the human immunodeficiency virus (HIV), TB being the commonest opportunistic infection among HIV infected individuals” (India, 2006: 44). This in turn has an adverse effect on the health systems because they have to cope with both the diseases simultaneously. “The burden imposed by the intersecting epidemics of TB and HIV upon the health delivery systems has led to overwhelming of health facilities to the detriment of patients, communities and health care workers” (India, 2006, p. 44). Therefore, it is the biological nature of the disease that aggravates the problem faced by the public, foregrounding the bio-medical aspect of the diseases.

Infrastructure: All the proposals request funding to improve their health infrastructure. By this they mean the laboratories, equipment, transportation facilities, and shortage of staff, all of which form the health system of a country. The main reason why so many patients are unable to access services and improve their health is attributed to the lack of proper infrastructure. The main reason for the condition is blamed on the

lack of funds necessary to maintain these facilities. The following excerpt from the proposals by Georgia to fund its malaria initiatives clearly conveys the point:

Several factors placed Georgia at risk for the re-emergence of malaria: severe financial constraints contributed to reduction of the vector control activities and for no full-fledged epidemiological control, increasing mosquitoes population and breeding places, increasing of the population movements, especially to and from Azerbaijan where malaria epidemic broke out, destruction of the public health services, a shortage of insecticides, drugs, equipment and consumables necessary for malaria surveillance and control in the country and as a result, epidemics of relatively large scale for WHO/EURO countries occurred in Georgia. (Georgia, 2006, p. 48)

As one can notice, along with the other factors talked before – the climate, migration, poverty, etc – the lack of health infrastructure is emphasized in the above excerpt. All the proposals, therefore, say that one of the major goals in the proposal is to improve the infrastructure that can help in dealing with the diseases better:

Establish or upgrade infrastructure of laboratory services: The MOHSW will establish and upgrade microscopy centres to increase access to laboratory services. This will entail refurbishing and re-equipping some facilities, and upgrading the laboratories at Maseru, Leribe and Mohale's Hoek to enable them to perform as regional laboratories capable of mycobacterial culture. The regional laboratories will be stocked with sufficient supplies and reagents to meet their expected microscopy and culture case loads (Eritrea, 2006, p. 71).

The other primary concern in all the proposals is lack of health staff. Due to brain-drain, due to good pay in private sector and due to fear of disease, there is an inadequate number of people working in the health system that is essential in tackling the problems posed by these diseases. One way to achieve this goal is to use funds in hiring new staff, both in the public sector as well as the NGO sector to deal with these diseases. This is done by increasing the pay scale of the workers so that they are attracted to come into this sector, and to train and educate them to save them from burn-

out. Like discussed in the next chapter, other way of dealing with the problem is to include community into the interventions and encourage them to take ownership of the projects.

It should be pointed out that there are major constraints which need to be overcome, particularly in the field of human resources, which are insufficient in both number and quality, which lack motivation and equipment, and which suffer frequent shortfalls with regard to drugs, insecticide treated nets and laboratory materials and reagents (Peru, 2006, p. 59).

The expansion of health staff is treated as a part of health infrastructure, and by focusing on the infrastructure, one focuses on the health system.

Training: Like discussed earlier, the lack of data about the diseases is a problem, which is the result of a weak surveillance system. “Weak surveillance system is responsible for a delay in detection of focal outbreaks and timely action for containment.... Capacity to predict and contain outbreaks is inadequate in the district and upazila levels” (Bangladesh, 2006, p. 76). Also, added to the lack of infrastructure there is a lack of attention from the health care providers given to these diseases: “We assume that there is hidden morbidity as well, because a large percentage of the patients are diagnosed at a late stage of the disease due to the insufficient diagnostic capacity and attention of the primary care physicians to tuberculosis” (Benin, 2006, p. 63). Given this condition, it becomes essential to train people in detecting and reporting the cases to the doctors. Added to that, there is a strong emphasis on training doctors and health staff about issues related to the diseases.

About 5,600 general practitioners are registered in Bulgaria, unevenly scattered in different regions. Most of them are not specialised doctors (some are specialised in general medicine, internal medicine, paediatrics, surgery etc.), but have received no adequate postgraduate training on TB. This is an important

cause for the delayed referral of TB patients and people at high risk of contracting TB, to the specialised health network, delayed diagnosis and treatment. Developing and distributing a TB Manual, and the provision of training to at least half of GPs, particularly in regions with high incidence, is an important task that requires funding (Bulgaria, 2006, p. 50).

Like this section shows, the disease is constructed in bio-medical terms by focusing on the medicines, infrastructure, co-infections, and training to show that the diseases are spiraling out of control because these factors contribute to the spread of diseases. The proposals seek funds to address these bio-medical aspects, and as will be shown later, most of the funds go to this aspect of the disease.

Diseases Are Related to Transnational Issues

Changes in political systems and society at large have influence on the spreading of the diseases; they affect the everyday life of the people within, and without, a nation's border, and reflect on the health of the populations. A few proposals acknowledge these broader social changes in the country, its history, and how they affect the current condition of the disease. For instance, the proposal from Georgia about Malaria states that:

After the eradication [of Malaria] there was no indigenous transmission but at the middle of the 1990s the risk of its renovation increased because of the gradual rise of imported malaria cases following the occurrence of the large-scale malaria epidemics in the bordering countries and the social economical and political changes in the region including Georgia... Since 1991, after the collapse of the Soviet Union, the country has faced worsening of socio-economic conditions and serious financial problems and the malaria situation became critical in terms of maintaining malaria - free status. (Georgia, 2006, p. 54)

How these broader changes in the society contributed to the increase in disease and how these changes play out in the everyday access to health care and life on the patients in described later on in the proposal:

The severe financial constraints prevented anti malaria activities at a sufficient scale and contributed to reduction of the surveillance, of vector control activities and to no full-fledged epidemiological control, destruction of the public health services, a shortage of insecticides, drugs, equipment and consumables necessary for malaria surveillance and control in the country. The public health services were under staffed and under equipped. Because of the poor payment there was a shortage and permanent turnover of the specialized medical personnel. The shortage of qualified staff and laboratory equipment and consumables brought about the complication of the situation and prevented containing the outbreaks (Georgia, 2006, p. 55).

Here we can find evidence that all the aspects of the diseases described above – disease framed in economic, regional, bio-medical, gender, and spatial terms – are product of the larger changes that take place at a societal level that later percolate down to other levels, affecting the incidence and prevalence of the diseases. Like described above, one can find a causal relation at this level, although this aspect of the public health system is never talked about in most of the proposals.

Except for a few proposals, all the proposals sideline the importance of history in existence of the diseases. While TB and Malaria have been killing a great number of people historically, the proposals bracket only the recent past and talk about the disease in ahistorical and to a great extent in apolitical terms. For instance, importance of historical factors is stressed in the proposal from South Africa in its struggle with HIV epidemic:

South African statistics continue to reflect the legacies of the apartheid era with people living with HIV and AIDS being found in every race group in South Africa, although the observed prevalence differs. HIV prevalence in Africans is substantially greater than in any other racial group as estimated HIV by HSRC, 2005 survey: African – 13.3%; Coloured – 1.9.1%; White – 0.6%; Indian -1.6%). (South Africa, 206, p. 40).

Other way in which the macro conditions affect the spread of diseases is talked in relation to the borders. In many proposals, borders become very contentious zones around which the diseases are spread. In case of Eritrea, “Political instability also continues to be a serious risk. A renewal of hostilities with Ethiopia would result in massive population movements which, as in the past, would likely fuel any malaria outbreaks and could lead to a fulminate epidemic” (Eritrea, 2006, p. 38). And at another point in the proposal we find that:

Eritrea regained its independence in 1991 (ratified by a referendum in 1993) following a 30-year war with Ethiopia. This extended war, combined with the recent border conflict, which caused the temporary displacement of tens of thousands of people, continues to imperil the development of the economy, health and other social sectors, and the overall quality of life. (Eritrea, 2006, p. 65)

The border problem is also related to refugees, who in recent years have gained international attention due to the problems they face, mainly health and survival issues.

Refugees seeking protection in the country originate predominately from countries like Afghanistan, Iran, Iraq, Somalia, Armenia, etc. In some of these country the infectious disease rate, including tuberculosis is substantially higher than that in Bulgaria. The difficult integration process of these refugees in our country attributed mainly to the language barrier, low professional qualification, poor access to the local labor market as well as to some other aspects, results in prolonged periods of poor living conditions for the majority of them even after obtaining refugee status in Bulgaria which further contributes to development and spreading of tuberculosis among the refugee’s community. Moreover, after Bulgaria joins the European Union in 2007 as a full-member state, the number of asylum seekers and receivers is expected to increase, in view of the Dublin 2 Regulation which will further deepen the problem. (Bulgaria, 2006, p. 71).

This shows that the spread of disease is not related to just the aspects within the borders of a country or within the capacity of an existing health system. The political and social

changes at an international level contribute to the increase in the disease burden. Yet, issues like these never make it to many proposals.

Thus, the larger social forces that displace people can aggravate the health systems of many countries, leading to a greater need to address these problems. While these issues have a strong bearing on the prevalence of the disease, they are left to development projects to handle while the health projects, like the ones discussed in these proposals, just focus on the aspects that are quantifiable in nature and micro in their setting. This particular aspect of diseases as problems cannot be addressed with interventions within a country's border. A transnational approach that is very political in nature is required to address these issues. Although these are the most determining aspects of the cause of poverty and illness in these countries, these issues are never addressed in the proposals.

Conclusion

The focus of this chapter was to see how the diseases were constructed as public health problems by the proposal writers so that the Global Fund would find a need to fund the programs proposed in the proposal. To that effect, the various aspects of the diseases were explained in the proposals to give an idea to the reader of the proposal how the diseases are posing a threat to public health, and how the funds given would help in alleviating the situation. The aim of the chapter was to answer the first objective of the research, which is: What spaces for intervention are created in the proposals through the description of the diseases that can later be handed over to various sectors in

the public-private partnerships that are integral to all the proposals in addressing the issues? To that extent, this chapter helps us in reaching the following conclusions:

1. By describing diseases as public health problems based on the mortality and morbidity rates, the proposals reduce the problem to numbers and make the problem quantifiable, which makes it easier to operationalize the interventions. Like discussed in the chapter on the rationale for the study, the Global Fund talks about its results in very numeric terms: “1.8 million lives saved” While this can be seen as pragmatic, by reducing the disease to numbers can miss out of other aspects that need to be taken into consideration.
2. Diseases are related to poverty. The rich are never talked about as facing the problems due to the diseases, which goes to show that poverty causes the people to suffer from these diseases, mainly. But the proposals repeatedly claim that diseases are the cause of poverty and not the other way around. By doing so; the diseases deflect attention from poverty that causes the disease to disease itself, and then create a role for various actors to addressing the problems posed by these diseases to address the poverty issues. This takes away the political aspects that cause the diseases and make the proposals very “technical”. Therefore, none of the actors – the state, the market, the civil society – have to deal with poverty as cause of the disease.
3. By talking about the diseases in economic terms the proposals given an impression that the ultimate outcome of the interventions is economic growth, the aim of development strategies for the past five decades. Thus, description in

these terms brings it close to the debates in development, opening up spaces for discussion of who should be responsible for what aspects of economic growth.

4. Diseases are spatial in nature. Describing diseases as problems because of the location of the people affected by it in remote or rural areas on one hand, and situating them in the socio-economic continuum on the other opens up roles that have not been met by conventional health care systems. Who is responsible for reaching this people will be addressed based on framing diseases in spatial terms.
5. The same could be said about framing the disease as related to ignorance. As people lack knowledge and empowerment, and stating that the diseases are a problem because of this aspect, we are left with the debate on what are the best ways to address this issue? Who should be put in charge of bring change in this particular area?
6. Diseases are constructed as gendered. Women are given special treatment because of the historical marginalization they faced on many fronts. This raises the question of how to address this issue. What actors can help in improving the living standards of the women? The state, the market, the society? Or combination of these?
7. Because the infrastructure is so bad, the doctors and staff are undertrained, the viruses are resistant to drugs, and there are not enough drugs to pass around, the diseases have become a problem. This bio-medical aspect focuses on the health infrastructure and highlights the 'technical' aspect of the disease as well. How will these inadequacies be addressed, and by whom?

8. Transnational politics and cross-border issues have significant influence on the economy and politics of a nation-state, which in turn will be reflected on the health system and on the health of citizens. While this is the overarching framework in which all the other aspects of the diseases are played out, the proposals never include this in any of their activities or interventions. These macro-forces are acknowledged as having effect on health infrastructure, and quickly the discussion turns to infrastructure and what can be done about it. By doing so, the forces that shape public health are not given space to be discussed or addressed in these proposals. The state, the market and the civil society have to take action on this aspect of disease.

In conclusion, this chapter has shown how constructing diseases as public health problems have opened up spaces for various actors to step in and take control. By communicatively highlighting a few aspects and deflecting attention for a few other issues, the proposals made case for interventions at many levels, none of which are political or structural, and a few are made 'technical'. Given the fact that the proposals quoted above were funded, we can safely assume that the Global Fund finds this particular construction of diseases as acceptable and approvable. In the next two chapters, I will focus on how various sectors – public and private – fill these spaces and address the problems posed by diseases in this chapter.

CHAPTER IV

THE ROLES OF THE PRIVATE SECTOR

In this chapter, the focus is on the second objective of the research: What roles does the private sector play in the public-private partnerships described in the proposals? To that effect, the dominant themes that are found in relation to the private sector in these proposals are described in this chapter. The private sector is not clearly defined in the proposals. I start with this issue, and talk about for-profit sector and what role it plays in the proposals. Then I discuss how civil society is it deployed in these proposals, and the dominant themes surrounding it. The themes found in the proposals are: (1) civil society's participation is very integral for health interventions, (2) community empowerment happens mainly through civil society, (3) civil society organizations are good at delivering services, (4) civil society organizations are effective in reaching the hard-to-reach populations and regions, (5) civil society is good at giving voice to the needs of targeted populations, (6) civil society helps in people taking ownership of the projects, and (7) civil society shares the burden of the government and society through its involvement. Civil society participation -- be it through community volunteers, women involvement, or through the involvement of community-based organizations like NGOs -- is seen essential for the success of the proposals. The chapter concludes on how these roles of the civil society relates to the overall discussion on public-private partnerships, and the implications it can have on the state, which will be discussed in detail in the next chapter.

What Is 'Private'?

Like discussed in the second chapter, the Global Fund boasts that the unique feature of the organization is that it primarily funds proposals that use public-private partnerships. Proposals that draw together the comparative advantages of both public and the private sector get funded by the Global Fund. A cursory glance at the proposals reveals that by 'public' the proposals mean government-run services. Under the term "private", various organizations are lumped together: bilateral and multilateral organizations, private sectors, NGOs, faith-based organizations, community workers and volunteers. The concept of civil society is rather diffused in these proposals as well: the term is used for NGOs, community based organizations, civil society organizations, women groups, involvement of public, etc. As the focus of this chapter is on the 'private' aspect of the public-private partnership, the discussion is on for-profit sector, as well as civil society, by which I mean all the actors that are not government related or for-profit sector related. While there is not a great deal of similarity between the private sector and the civil society in the proposals, there is a visible similarity between the way community and civil society organizations are talked about in the proposals; therefore, community and civil society are used interchangeably as well.

The Global Fund makes it mandatory to include representatives from the 'private' sector in Country Coordinating Mechanism (CCM) which submits the proposals. It is here the for-profit organizations and civil society groups participate and contribute to the writing of the proposal and implementation of the programs. All the proposals have roughly 30-40% representation from 'private' sector in the CCM.

Therefore, by civil society, we are implying mainly non-governmental organizations (NGOs) (including faith-based organizations) as well as representatives from people who are affected by these diseases, which again implies a representative from a group like PLWHA (People Living With HIV and AIDS). The community gets interfaced with the government through the involvement of NGOs predominantly:

Affected priority populations will participate in the planning and execution of the proposal through their representatives in the Country Coordination Mechanism. The social mobilization component at the community level will be incorporated through strategic alliances with community organizations and NGOs that work in the rural development of the country (Burkina, 2006, p. 16).

The activities described in the proposals use multi-sectoral approach due to which the proposals have lines that talk about the activities in an all-encompassing fashion, like the following line:

The programme intends to build and utilize capacity across all sectors of the economy. It will work through the national health system, private sector providers, community-based organizations, NGOs and multilateral agencies, and it will foster improved coordination across these sectors. It is anticipated that this project approach will deliver short-term gains to project beneficiaries while promising longer-term sustainable enhancement of the entire malaria control effort in Eritrea (Eritrea, 2006, p. 14).

Here we find that the project is being implemented by all the available actors in Eritrea. Lines like this do not say much about the roles each actors or sectors play in implementation of the activities. And lines like these abound in the proposals. That said, the proposals do mention the characteristics of each actor and their comparative advantages these proposals rely on to make a case for including 'private' sector in the implementation of programs proposed. Of all the sectors, it is the non-governmental sector that is talked about very clearly, foregrounding the advantages of including this

sector in partnership. Even in countries that do not have strong civil society organizations, like Eritrea quoted above, there seems to be an urgent need to focus on the community organizations.

Eritrea is a small country with few NGOs and there are limited number of civil society groups involved in the field of malaria control. The option of national advertising and public tender was considered but deemed inappropriate. Indications for interest to participate were received from ESMG, NUEW, NUEYS, faith based associations and association of disabled & orphans. These groups were invited and participated in proposal development and their inputs were incorporated (Eritrea, 2006, p. 71).

From this, we can conclude that the importance of the NGOs in the writing and implementation of the proposals lends the concept of civil society, used in the broader sense of the term, to description and discussion.

For-Profit Private Sector

The discussion about the for-profit private sector is very marginal in all the proposals. Like discussed earlier, the proposals do not lend themselves to define what constitutes the private sector. Every proposal defines the private sector in a different way. For instance, a few lump for-profit sector together with the NGO sector, like in the case of Burkina Faso,

In addition to the public sector, there is a growing private sector with 448 private health structures and 44 faith-based structures. This sector includes profit-making private clinics, care institutions depending on associations, and non profit-making Non-Governmental Organizations (NGOs). The private sector participates in the medical management of people infected by HIV (Burkina Faso, 2006, p. 41).

The private sector is conflated with non-profit sector quite explicitly in a few proposals, like the one from Peru: “Some capacity limitations to be considered depend on the intervention setting, if this corresponds to the public sector or to the non profit

private sector” (Peru, 2006, p. 38). But in many cases there is a real difference between the non-profit sector and the for-profit sector: “This proposal aims to strengthen health systems through skills development to improve delivery quality, and a strengthening of linkages and partnerships within government and between government, civil society and the private sector” (South Africa, 2006, p. 16). Therefore, for the purpose of this section, the private sector is treated as the for-profit sector in health.

Private sector operates predominantly in the urban areas. This is in line with the dominant view of the private sector as driven by only profit motive, which means that people who have economic resources to participate in a transaction are sought after by this sector, and caters to their needs. Urban areas have been more attractive for private sector because of the concentration of working classes with disposable incomes. This idea is reflected in the proposals as well:

Both public and private health facilities are highly concentrated in urban areas and are less well distributed in rural areas. Many rural communities do not have easy access to health services and usually have to travel long distances to have their health needs attended to. This has also been a factor in rural and informal settlement communities not being able to effectively access HIV and AIDS services (South Africa, 2006, p. 49).

There is a distinct preference by the private practitioners to work in the urban settings, like in the case of Lesotho: “There are approximately 120 registered private practitioners, some of whom are not practising in the country, and most of whom operate in urban areas” (Lesotho, 2006, p. 40). While the private sector thrives in urban areas, the provision of health services in rural areas is predominantly taken care by other sectors, primarily the public sector: “The principal health care provider in Mozambique

is the public sector with the private sector confined to the larger cities and towns” (Mozambique, 2006, p. 44).

Added to this, a few proposals make a point to mention that the private sector is mainly curative in nature, providing specialized care instead of preventive care. This is again in line with the tradition of the private sector, which focuses on curative aspect because curative aspect of diseases is predominantly biomedical in nature, and can be quantified and profited easily as compared to preventive care. This puts the onus of preventive care on the shoulders of the public sector: “Alongside the public health sector, India also has a very vibrant private sector, which is however focused primarily on providing curative care” (India, 2006, p. 55). The proposal goes on to add "However, in urban areas, it is the private sector which is the dominant provider, as also for specialist care” (India, 2006, p. 55).

The private sector is expensive compared to the public sector, which translates into marginalization of the poor from private health care. Like mentioned earlier, majority of the people targeted by these proposals are poor and marginalized, and these people have to rely on other sources to take care of their health needs: “As already indicated, India has a large private sector mainly urban based. Poor have a limited access to these services largely on account of affordability and the absence of a social insurance system” (India, 2006: 56). In the case of South Africa, for instance,

The average spending on each individual covered is about eight times higher in the private sector than in the public sector. When it makes health policy, government seeks to safeguard the viability of all parts of the health system while striving for a more equitable and fair sharing of resources between the private and public health services (South Africa, 2006, p. 50).

Here we find that the government has to intervene to make health services equitable and make them accessible to public, because left to itself the private sector will not provide any services for people who cannot afford them. Having made this case, a few proposals encourage the inclusion of private health care providers and services in their proposals so that the people in need of health care can access them:

It has been documented that a large number of patients seeking health-care from private providers belong to poorer socio-economic groups. By involving a significant number of private providers in RNTCPDOTS, especially those with a higher TB-patient load, the proposal seeks to also decrease diagnostic delays and cost of treatment, thereby reducing the spread, morbidity and mortality of the disease and the burden on individuals, families and the country at large (India, 2006, p. 62).

The proposals involve private sector mainly for service provision while the preventive and informative aspects are left to the public sector and the civil society organizations: “Furthermore, there is a concerted effort in both TB and HIV components to involve the private sector in the delivery of TB and HIV services. Both TB and HIV/AIDS programmes will work with the private sector to involve private practitioners and widen the health provider base for both diseases” (India, 2006b, p. 56). Therefore, a few proposals make a case for inclusion of private sector in various activities, saying that because the private sector has a strong presence in the health sector, their inclusion will only lead to better outcomes:

There is a felt need to make concerted and coordinated efforts to involve the private sector in the delivery of DOTS and mainstreaming their contribution towards the larger public good... Such a strategy has the potential to reduce diagnostic delays, increase case detection rates, improve treatment outcomes and reduce the cost of TB management to the patient (Lesotho, 2006, p. 64).

The private sector becomes marginal in the implementation of the proposals, which clearly reflects the total percentage of funds that goes to the private sector – 2% of the total funds distributed by the Global Fund! While the rhetoric of the Global Fund and the proposals in that of public-private partnership, the private part of the term is mainly composed of civil society and very little of for-profit private sector. This reluctance to engage with the private sector and yet use the term ‘private’ to indicate a sector that is outside the realm of government becomes immediately noticeable in the proposals funded by the Global Fund. Why is there such reluctance in including the private sector in the activities of the proposal? What roles do the proposals see the private sector playing in the health of the populations? Why is the term ‘private’ used in public-private partnerships when the term has been conventionally used to describe for-profit sector? These are a few questions that one has to think about in relation to the inclusion of private sector in the proposals.

Civil Society

Civil society is integral to all the proposals; it is the heart that pumps the much needed life blood into community’s health. While the Global Fund states community participation is required in the composition of Country Coordinating Mechanism (CCM), the proposals use the terms ‘civil society’ and ‘NGOs’ in relation to a great deal of activities mentioned in the proposals. This relationship between activities and actors helps one to understand certain claims made about the nature and effectiveness of civil society in general.

The Global Fund demands that the selection of civil society organizations is done in an open and transparent fashion so that their inclusion is not controlled by any single organization, group, or even the government. The opportunity of being part of CCM should be open to all communities and NGOs, and should be widely-publicized. Civil society organizations that can play a meaningful role in addressing the problems posed by the diseases are selected. Secrecy that could lead to suspicion, distrust, and lack of faith in the working of CCM are strictly avoided, according to the Global Fund. Therefore, the Global Fund claims that the inclusion of civil society in the process is not agenda-driven. By this inclusion, we have to conclude that the interventions are not simply run by any one sector (read: the government) but in partnership with other sectors working in the field of health; thus, the core of each proposal is the partnership between public and private sector.

The claims made about civil society in these proposals are not mutually exclusive; there is a good overlap of various roles that civil society is asked to play in the proposals. In a single breath the proposals talk about multiple aspects of civil society to highlight the importance of including community and community organizations in the proposals. Yet, for the purpose of this chapter, only the lines that highlight one aspect over the other are chosen to be included in the sections that highlight the particular aspect.

Community Participation

Most of the interventions are targeted at the communities; for these projects to be successful, community participation is seen as critical. Community members are

involved, or encouraged to involve, in most of the activities so that the benefits of the interventions reach all the people. Many claims are made about targeting the communities and by doing so the community is constructed in a way that makes it essential to the deployment of various interventions. What is community participation? What are the benefits of participation? The major themes on participation cut across all the sections about civil society.

Community participation lends voice to the disease-affected people who have been marginalized in the health discourse. By being part of the proposal writing and implementation, communities affected by these diseases get a chance to address their needs and shape the solutions that are sensitive to their background and adaptive to their conditions. “Moreover, the meaningful participation and representation of civil society and affected communities in the national response to HIV/AIDS will strengthen the collective voice and role of the sector in influencing national policy development, strategy and implementation” (Ukraine, 2006, p. 66). Unlike the top-down strategy where the community is the recipient of the interventions, this is seen as a bottom-up approach, making the process inclusive and participatory. “The involvement communities and their partnership with the formal and informal health sectors to empower them in their own health development are crucial. Community mobilization is an integral part of the proposed project malaria control activities” (Bangladesh, 2006, p. 65).

Community participation is seen as integral because it influences behavior of individuals as well as the community. Almost all behavior change campaigns in the

proposals are implemented either by the community or mass media. By doing so, it is presumed, the communities' behavior can be changed, which will have a decisive effect on spreading of the disease, and through participation, education, and mobilization better outcomes can be expected from the proposals: "BCC activities will be undertaken at community level and through mass media. NGOs will mostly implement BCC and advocacy activities" (South Africa, 2006, p. 71). Or to put differently, "Source reduction and improvement of environment with community participation will be promoted through IEC campaign, which is part of Integrated Vector Management (IVM)" (Georgia, 2006, p. 69). Community's change of behavior will have beneficial affects even in the long run, making the community health sustainable, and the projects will be sustained without outside help at the end of the proposal time period:

The BCC activities initiated under this project will be continued beyond the project period focusing on low performing areas with the support of government, NGOs and private sectors. Human capacity developed at the community level during the project period will remain in community and sustain beyond the project period (Ukraine, 2006, p. 84).

As the disease is caused partly due to the behavioral aspects, addressing this aspect of the disease through community mobilization would help in reducing the spread of disease and by raising awareness about the disease on one hand and making them responsible for their health on the other. Like discussed in the earlier chapter, this is a response to the construction of the diseases as a problem due to lack of information and emphasis on the bio-medical nature of the disease: "A strengthened HED and scaled-up community involvement in TB control will result in improved health promotion messages on TB and TB/HIV at community level and spur better health seeking

behaviour and utilization of TB control services” (India, 2006a, p. 67). The onus of mobilizing communities for their own good, to make use of the health infrastructure, is put on the civil society organizations. By doing so, the proposals, in a way, stress the comparative advantage of the civil society organizations compared to public health facilities: “First, there will be improved access to and utilization of existing public health infrastructure through enhanced community mobilization. NGOs and PLHA networks will take the lead in mobilizing communities for treatment, care and support” (Peru, 2006, p. 59). This holds good for the faith-based organizations as well, which have an extensive reach in the communities they work for and become effective tools in mobilizing the communities to be part of the health initiatives promoted by these proposals: “In the other states of Bihar, Chattisgarh, Orissa, West Bengal and Gujarat, faith based organizations have extensive reach and capacity for community mobilization. Their network of 150 small faith based health posts will be utilized by linking them to the community care centers for referral and follow up” (India, 2006, p. 77).

The main tenet of participation is that people are involved at various levels of activities. The duty of improving the health of a community is not considered to be a special province of medical authorities or the government alone; it requires everyone’s involvement. All the proposals encourage communities to engage at various levels of the work. This could lead to reduction in the disease burden:

Community participation in the implementation process will be the key approach to achieve the objectives. Beneficiaries of the proposal are also involved in many areas related to health activities in the target districts. Community leaders from indigenous groups in the hill districts will be involved for planning, implementation and evaluation of malaria control efforts in the community.

Reduction in the disease burden will exert positive impact on the health and well-being of the community at large (Guinea, 2006, p. 55).

The positive impact of community mobilization can be seen in quantitative terms as well, in terms of treated cases, incidence rates and use of health facilities:

Improving access to quality TB diagnosis and patient-centred care through community mobilisation will contribute to the attainment by 2012 of 70% case detection and 85% treatment success of new smear positive cases by 85%, and to the examination by smear microscopy of 60% of TB suspects and screening for TB of 60% of contacts of smear positive index cases (Georgia, 2006, p. 74).

This section shows how the community participation and mobilization is seen as essential to the success of the proposals. This is promoted because the community organizations like NGOs can voice the needs of the people, can help change the behavior of the communities to adopt healthy lifestyles, will help in accessing the health services, all of which in turn will lead to reaching the goals mentioned in the proposal. Therefore, the proposals make a strong case for community participation in partnerships, and once this is done, like will be shown in following sections, the proposal goes into details on the advantages of community participation as well as the organizations that are working for communities, like NGOs and faith-based organizations.

Civil Society Understands the Problems Better

One of the major advantages the civil society organizations have, as mentioned above, in relation to other sectors is the perspective they bring to the table; they have access to community views that are not available to the outsiders. By doing so, the proposals takes into consideration the attitudes, beliefs and culture of the community that is being targeted and make the programs more reflective of the needs of the people who are being targeted by interventions:

This proposal stresses on mitigating the impact of HIV on the families especially women and children... Inputs of female PLHA will be incorporated while designing training programmes in order to deepen the team members' understanding of gender issues and encouraging change in their attitudes and practices (South Africa, 2006, p. 72).

In the proposals, outreach takes many forms: advertising the proposal's activities in the mass media, using newsletters, conducting workshops and meetings. But the most effective techniques are the ones that involve direct, personal contact that is offered in an accepting spirit. The communities that are involved in the process are mainly from the affected groups, and the organizations that are involved are the ones that have experience in dealing with the particular disease under consideration. The special interests of these sectors and their experiences with dealing with their own community are given a chance to be foregrounded in these proposals. For instance, the community members' involvement could lead to better understanding of the condition and reduce stigma and discrimination among the community members as well as in the health setting of the society:

PLHA will play a crucial role in community mobilization, treatment adherence and home based care as peer educators and outreach workers. They will be preferred as health workers in the community care centers after imparting adequate training. This will give a unique opportunity to involve PLHA and to reduce stigma and discrimination in the medical setting as well as in the community (India, 2006, p. 78).

The Global Fund views the inclusion of people from the targeted community as a prerequisite for submitting the proposal. As most of the people targeted are poor and vulnerable whose voice has been historically marginalized in dominant discourses about health and development, the proposals make a strong case for their inclusion: "Eight border districts belong to outbreak prone areas. Evidences from the community, their

direct and indirect experiences for prevention and control of malaria have been considered during the planning of intervention” (Bangladesh, 2006, p. 55). People who understand the community better can encourage their community members to use the services provided and because they know how the community operates, they can persuade people to use the existing health services:

The Roma population in Bulgaria represents some 10% of the population but they are overrepresented among the TB cases. Many of them live in closed communities with limited access to health care... There is a need for hiring workers from their own communities, familiar with the cultural background of the group. They would act as mediators and facilitators to health care and be trained for screening suspect cases and following patients under ambulatory treatment. This is considered as a prerequisite to improve the situation and increase the cure rate (Bulgaria, 2006, p. 62).

Another reason for taking the community members on board is to convey the health messages to these populations effectively. Like stated before, because the targeted population tend to be poor and illiterate the formal communication channels do not work effectively in reaching these populations. Therefore, non-traditional means of communication, mainly interpersonal communication along with mass media, is seen as effective in these situations. The language and the culture of the targeted people are taken into account: “People living in remote areas are disadvantaged because of poverty, illiteracy that impedes early care seeking in these populations... Community health volunteers will be recruited from their own community to communicate effectively, BCC activities will be addressed in the indigenous languages” (Lesotho, 2006, p. 75). As it is hard to reach all the community members, a few proposals make a special case for targeting the key members of the community through education and training so that they

can influence the opinions and beliefs of their community members, much like a two-step process of communication:

ACSM activities will target community leaders, including chiefs and local authorities to increase the awareness of the importance and benefits of access to TB and TB/HIV services by all members of the community, with particular reference to females, children and other vulnerable populations (Guinea, 2006, p. 58).

This previous section focused on what community participation can do to the objectives mentioned in proposals. This section explains one of the strengths of the community: the familiarity with culture, their own experiences, and their ability to reach out to others in the community, be it leaders or people affected by the diseases.

Reach the Hard-to-Reach

Civil society organizations are claimed to be effective in reaching people at two levels – one is geographical and the other is social. People are stated as un-reachable if they live in an area that is not accessible by conventional means and areas where there are no proper health care services, or they are un-reachable if they are poor and marginalized within a society irrespective of their geographical locations. Rural and remote areas are examples of the first kind and the PLWHA and drug users are examples of the second kind. In addressing the needs of these particular populations or people in these particular regions, civil society organizations are deployed as solutions in all the proposals.

By talking about the civil society organizations as the solution to reach these unreachable populations, the proposals directly and indirectly claim that the state and the market mechanisms are not effective in reaching not just the remote areas of a country

but the rural areas as well (this idea will be discussed in detail in relation to the state in the next chapter). It is in reaching these hard-to-reach areas the comparative advantage of the civil society organizations is highlighted. By handing over the responsibility of reaching these segments of populations, the government and the private sector are freed from the obligation of expanding their services to these areas.

NGO support is essential in scaling up malaria control interventions particularly in areas where the coverage of government health services are limited due to various constraints. Also, NGOs have comparative advantage in mobilizing communities to become active partners (Ukraine, 2006, p. 44).

Also, like discussed earlier, it is received wisdom that markets operate well only in areas where the provider of goods and services can make profit. Because the people living rural and remote areas are generally poor, the market provision of health care does not exist. It is understood without stating that the private sector does not find an incentive in providing care for people without money. Therefore, one can find a strong indication in the proposals that the provision of health care services in these areas should be handed over to the NGO sector as they are most effective: In the proposal from Guatemala, we find a similar trend:

World Vision Guatemala, (WVG) is a non profit, private foundation, with more than 50 years of experience working in social development programs in Guatemala. During this period, WVG has implemented projects directed to the poor and rural populations of the country, with an emphasis on health, education and social transformation (Guatemala, 2006, p. 86).

Even other international NGOs working in the area of health seem to support civil society organizations because they have a history of providing health services in the rural areas, as in the case of Lesotho's TB proposal. A case for handing over the provision of health care in rural areas is given over to the Lesotho Flying Doctors

Service, which is supported by Development Cooperation Ireland and the Mission Aviation Fellowship because it “provides emergency medical service and supports rural health care programmes” (Lesotho, 2006, p. 78).

If geographical nature of the problem is one aspect in which these civil society organizations are effective compared to the government or the market, the other aspect is the poverty and marginalization of the targeted people. The needs of these people can best be met by NGOs that can work with them to make their lives better. There is a strong shift in the proposals towards handing over the job of reaching these sections of population to the community organizations and the civil society:

The opportunities provided by the existing TB network will be integrated with the primary healthcare system (GPs), NGO capacity for work among vulnerable populations (Roma, prisoners, drug users, alcoholics) in implementing activities under the programme. Setting up local networks among health services and NGO structures will contribute towards the establishment of an effective horizontal network for field work. The coordinated activities of these partners are expected to ensure a more adequate treatment in the continuation phase, particularly among vulnerable groups (Bulgaria, 2006, p. 65).

There is a distinct division of labor among the partners in the proposals where the public health facilities are used to treat the patients but the way patients are encouraged to use these facilities is through the deployment of the NGOs to reach the populations.

The results, the proposals claim, would be better health outcomes:

The activities included in this Proposal, with the integrated efforts of the primary and specialised health networks, and the involvement of NGOs working with vulnerable populations, will contribute to the more complete identification of these groups' health needs. The Proposal may serve to establish a model of co-operation between the health system and community-based/non-governmental organizations to penetrate and provide health services in hard-to-reach communities. This model can be applied (or adapted) to other socially significant diseases (Georgia, 2006, p. 77).

Not only are the NGOs good at reaching these hard-to-reach populations, they are effective in mobilizing people to use health services available to public in these areas:

A major task for NGOs, in collaboration with TB diagnostic laboratories, will be to find the cases with current positive test results and provide counselling to them among risk populations. For this purpose, field workers will motivate TB patients to seek treatment by referring them, and often accompanying them to the specialised TB treatment facility (India, 2006, p. 65).

The people who reside in the hard-to-reach areas are usually poor and vulnerable people. So, these two aspects are not mutually exclusive and the proposals that talk about reaching the poor people also talk about reaching them in the hard-to-reach areas. The reason for using the civil society organizations is because of their ability to address these problems better.

Considering the geographical barriers in such areas, sputum collection and transportation systems would be established, and convenient DOT through community volunteers would be ensured. Mobility in such areas is costly due to larger distances and non-availability of local transport (Benin, 2006, p. 76).

Therefore, the importance of NGOs is highlighted by the advantage they have over other sectors in reaching people that are in remote and rural areas, and people who are marginalized because of their health status or their behavior. The proposals want to draw on this strength of NGOs to successfully reach the goals of reducing the mortality and morbidity caused by these diseases.

Service Provision

One of the ways in which the communities and community organizations can involve at important levels in program implementation is by taking the responsibility of providing services. In short, under the umbrella of 'community participation', provision of services and responsibility of the usage of services are decentralized in a participating

community to the level of community and organizations that work with them. The result is a proposal that has many of its new activities handed over to the NGOs that are capable of reaching communities and make use of available community resources.

A good deal of these services which were traditionally administered by government bodies are now slowly handed over to the NGO sector. From distribution of nets to administering of drugs to recruiting patients to health services, there is a decisive move towards expanding the role of NGOs as health service providers in the target communities. The proposal of Bangladesh clearly sums up all the advantages that an NGO has in working on the interventions related to the diseases:

Bangladesh has an extensive and very dynamic NGO sector. The NGOs are providing low cost or free of charge preventive and curative services in rural and urban areas. NGOs are working in the field of development and health sector including malaria. NGOs contribute largely to major improvement of health indicators. In 13 malaria endemic districts NGOs are providing malaria diagnosis and treatment services at the community level including social mobilization, prevention, treatment of bed nets and referral. In some cases NGOs are also involved in operations research (Bangladesh, 2006, p. 50).

These diseases are seen as problems, among other reasons mention in the chapter on framing of diseases, because most people do not follow the treatment, or do not visit the health services as required. If the patient can seek treatment and is actively engaged in the recovery process then the diseases cease to be public health problems. To make patients do this, and to make them follow treatment regime and use services, the NGO sector is given the responsibility. In this way, NGO sector is slowly replacing the role of the government in and the public health sector is discouraged from expanding its services:

The prompt referral for treatment, as well as the administration and completion of treatment for newly discovered cases are the major preconditions for TB control among risk populations. These goals will be achieved by actively involving non-governmental organizations working with risk populations, which in close cooperation and under the control of health facilities will carry out field tracing of cases with clinical TB symptoms, and provide counselling, referral for testing and treatment, including accompany patients to treatment facilities, and support the successful completion of prescribed treatment (Bulgaria, 2006, p. 65).

The range of activities handed over to the NGO sector is pretty wide. Almost all the activities performed by the government sector are now seen as capable of being provided by the NGO sector:

BRAC, MSF Holland and some national NGOs in the endemic districts are providing a range of services relating to health, education and development. These NGOs are providing community based EDPT, social mobilization activities, and assisting the GoB in treating bed nets with insecticide.... The ICDDR, B, Malaria Research Group (MRG) and Wellcome Trust (Mahidol University, Thailand) are involved in operations research. M&PDC has established partnership with the following BRAC led consortium of 15 NGOs for strengthening and enhancing malaria control programme (Bangladesh, 2006, p. 68).

While the proposals do not mention the services that are provided by the government sector or the business sector, or the advantages of one over the other, we see a clear articulation of the capacities of the NGO sector as well as the rationale for handing over the services to the same. This holds true even for the faith based organizations, which provide similar health services to people in need along with the community members that are involved in the processes:

Churches affiliated with the Christian Health Association of Lesotho (CHAL) own the facilities and run nine of the country's previous 18 HSAs, most of which are in the rural areas. At community level, community health workers, traditional birth attendants, distribution agents and water minders perform or provide some health-related activities (Lesotho, 2006, p. 82).

Major portion of funds go to ‘strengthening of health system’ of a country, which is primarily the public health system. But there is no comparison between the work that public sector can do and the NGO sector, instead there is promotion of NGO sector alone as service providers and implementers of programs that a public sector can do as well. Most proposals make a case for handing over the new services mentioned in the activities primarily to NGO sector:

A total of 80 new microscopic centers with trained manpower will be set up by the BRAC led NGO consortium in the remote areas to provide increased diagnostic facilities. Uninterrupted supplies of laboratory reagents and logistics will be ensured in the new and existing laboratories... 80 new microscopic centers will be established for expanding diagnostic services to reach the un-reached, poor and vulnerable groups in remote areas. These additional centers will be established in remote upazilas and will be functional through NGOs (Bangladesh, 2006, p. 72).

The same principles apply to community members as well, and their participation in the provision of services is actively sought. Some proposals assign specific tasks to community volunteers that are in line with the strategic objectives of the proposal, and highlight the importance of the contributions by the community members. The proposals make certain that their work is clearly-defined and well-integrated into the overall goals of the proposal, and ensure better reach and better usage of facilities and resources:

The strength of the NMCP and consequently this application is that all the major planned activities are strongly institutionalized by being implemented through the existing health system, involving communities. Reimpregnation and distribution of bed nets is carried out by community members, community leaders, local associations and faith based organizations (Guinea, 2006, p. 66).

In case of women, it is particularly noticeable. Because women face marginalization, involving them at various levels helps them in voicing their concerns during the delivery of services as well as encourage other women to use services. Many

services related to gender issues in particular are handed over to women groups and female volunteers:

Participation of women's groups will be encouraged in community mobilization for demand generation and service utilisation; in service delivery as counselors or laboratory technicians; as outreach workers for ensuring treatment adherence and compliance; and in home care teams. Women's self-help groups will be involved in income generation activities and exploring livelihood options and self-financing schemes for PLHA (South Africa, 2006, p. 73).

Therefore, community volunteers and community-based organizations become central to providing services to people. This is done without invoking the public sector or other sector, neither do we find any rationalization for disinvesting most of the new services to the NGO sector. It is assumed that the NGO sector will outperform other sectors, and the time has come to hand over a few reigns of the public health services to these groups so that they can work side-by-side with the state.

Empowerment

The involvement of community and civil society organizations is seen as important for empowerment of the vulnerable and target population. By empowering people, it is claimed that they will have better negotiating power, they will be more willing to access health care, and are better equipped to deal with the problems posed by these diseases. The community involvement in the designing, implementation and execution of the proposal is seen as central to empowerment of individuals and community: "Greater involvement of communities in TB control will empower them to assume greater responsibility for their health, potentially enhance the quality of care and relieve the workload of medical services." A similar feeling is echoed in the proposal from Georgia, for instance: "The involvement communities and their partnership with

the formal and informal health sectors to empower them in their own health development are crucial. Community mobilization is an integral part of the proposed project malaria control activities” (Georgia, 2006, p. 46).

Empowerment is associated with information, advocacy and mobilization. By doing so, the socio-economic aspects of power, the livelihood issues and the mobility of people in social hierarchy are marginalized in the discussion about empowerment. In case of Lesotho, for instance, a case is made for the empowerment of community for its own good: “Community empowerment is likely to increase demand for quality health services and stimulate better health behaviour and participation in disease control efforts” (India, 2006, p. 48). But the way the proposal thinks about empowerment and deploys it precludes larger discussions about the power:

Further, communities have not been sufficiently empowered through advocacy, communication and social mobilisation to improve their health seeking behaviour and their understanding about TB and its management and their participation in TB control activities. This proposal seeks to contribute to rectifying these challenges (India, 2006, p. 49).

This is not to claim that the proposals should include broader issues of power in their discussion about health, but by bracketing the issue to a specific physical condition and addressing just that condition devoid of larger context of disease (like discussed in earlier chapter) we are left with limited solutions to address the problem. For instance,

It has been reported that 40% of incoming cases to the TB program, are women. This proposal will also provide women with the opportunity to become integrated in other strategies like community DOTS, CCC and social mobilization. They will also receive IEC on TB, and will be trained on aspects such as identification, searches, diagnosis and treatment, and will participate in planning and decision taking. Inequalities will be minimized when access is granted to human groups currently in conditions of social injustice (Benin, 2006, p. 68).

Here we find participation and information sharing are seen as effective ways to address the issues of social injustice without proper correspondence to the material reality in which these people live. By being involved in the activities in the proposals, it is claimed, the inequalities in a society are minimized, implying that the injustice is caused due to lack of access. Or to put differently, it is not injustice that causes lack of access but the lack of access causes injustice. Through this the proposals refrain from politicizing the issue of empowerment as related to health.

The need for community participation and involvement of NGOs is greatly accentuated in the case of gender issues; women who seem particularly vulnerable to the disease, leading to feminization of suffering, are best served by NGOs and community participation. In the case of South Africa, for instance,

The HIV and AIDS challenge is clearly feminised, pointing to gender vulnerability that demands urgent attention as part of the broader women empowerment and protection. In view of the high prevalence and incidence of HIV amongst women, it is critical that their strong involvement in and benefiting from the HIV and AIDS response becomes a priority (South Africa, 2006, p. 64).

Most of these empowering activities, particularly in relation to women and the poor, are done by NGOs working in the field. Thus, NGOs are seen as the best way to empower people in the long run and reduce the burden of the diseases.

The aim is to reach and empower communities, parents and out of school youth. Various methods are used such as 'mobile promotion units'. These activities will be implemented by a number of NGOs including the Society for Family Health, Humana People to People, Planned Parenthood Association of South Africa, Moretele Sunrise Hospice and Catholic Health Care (South Africa, 2006, p. 71).

Unlike the public sector which does not need to show a track record of success, the NGOs that work with issues of empowerment are chosen on their track record of

working on similar issues. Because the market or the government are not seen as helping these people, or increasing the capacity of these populations to use health services, the proposals make a strong case for NGOs involvement to have successful outcomes. In Bangladesh, for Malaria, a reputed women's organization is enrolled to provide services:

Mohila Sangshtha is an association of the women for the women. This is one the most prestigious and popular organization for women. It plays an important role in women empowerment and policy making. It has long history to lead the women organizations for ensuring justice and human rights of women. Since women are more vulnerable to HIV/AIDS, hence, was considered most suitable for the membership of the CCM (Bangladesh, 2006, p. 72).

Not only are the women organizations involved but unorganized women are also involved at all levels of the proposals, from inception to implementation. By doing so, the underlying belief is that the participation of women would lead to better outcome of the diseases and help in building the capacity of targeted individuals. Thus, women volunteers work with NGOs and this leads to making better decisions about public health:

Many NGOs are working closely with women groups in the planning process of various activities and service deliveries at community level. The community volunteers and workers of the NGOs are mostly women and selected by their own community. They are in close contact with the women groups and these activities also empower them and promote decision making capacity (Bangladesh, 2006, p. 73).

This section shows that the issues of empowerment and injustice are reduced to the level of information and access, and then are addressed by invoking the NGO sector as the solution, combined with the volunteers coming from the communities targeted. In the case of gender issues, there is a strong preference for women groups and NGOs that work on these issues. While this leads to a strong civil society that can voice the

concerns of the people better, it also takes away the involvement of the state and other sectors in relation to these issues, leaving the NGO sector working alone in most of the cases.

Ownership and Monitoring

Assigning communities to work on new projects gives the proposal a sense of meaningful involvement of the affected populations and groups that work with them. It sounds like their contribution advances the overall effort of the proposal. Having done that, the proposals also tend to hold them accountable for the results. The tendency seems to be that as time goes along, the community has to take responsibility for their own health and become sustainable in the long run by expanding their roles, and take full benefit of their own resources with minimum assistance from outside.

Ownership of the projects is seen as important for the success of the proposal. To do this, various activities are implemented, like meetings and workshops, as a way of strengthening the ties between the health facilities and the communities at large. These activities are aimed at relegating the responsibility to the community:

Strategies and materials to be developed by the project will be developed in close association with the various target groups described above. In addition, the project will hold regular meetings at peripheral level in order to foster closer ties between the health services and target communities and in order to increase the feeling of ownership within beneficiary groups (Ukraine, 2006, p. 68).

As described in the previous section, the empowerment of the community is seen as a way of doing this, so community involvement is essential. Thus, the need for empowerment is tied to the need for communities to take responsibility of their own health. The longer term effect of this is reduced burden on the government and the

society, and reduced burden on the available resources to address these diseases. This can have a positive effect on the entire health system because the more community takes on the work of the existing health system, the better will be the outcomes. So claim a few proposals:

This component seeks to empower communities and people with TB, through advocacy, communication and social mobilization (ACSM), to become more involved in TB and TB/HIV care and support activities and to assume greater responsibility for their health. Greater involvement of communities in TB control will empower them to assume greater responsibility for their health, potentially enhance the quality of care and relieve the workload of medical services (India, 2006, p. 66).

Along with the creation of a sense of ownership, the community members are also encouraged to monitor the execution of the projects. Instead of having an external entity evaluating the work of these community members and organizations, the communities themselves will monitor these projects and be part of the evaluation. By doing so, it is hoped that the community members know if the set goals are in the process of being achieved or not.

Community volunteers will play a key role in Objectives 2 and 4 of the project. Bednet treatment teams, IRS teams and those involved in small scale environmental manipulation activities will be recruited from the target communities. Community volunteers will be involved in monitoring the coverage of certain project components (Mozambique, 2006, p. 40).

This sense of responsibility translates into making the community accountable for the proper execution of the programs and monitor the projects:

Key community members will play a leading role to involve risks groups into TB prevention and control activities. For this purpose, they will be trained by NGOs, and afterwards (at least once every 3 months) will take part in continuing training, supervision and monitoring work meetings (Guatemala, 2006, p. 66).

To do this, the NGOs and the community members are trained in various methods to make their surveillance and monitoring efficient. Knowledge about the disease as well as the information provided by community members to others are important in all the proposals. To that effect, intensive training is conducted for all the groups involved, and NGOs are encouraged to do a whole gamut of these activities. For instance, in the proposal from Eritrea we find that the community members are trained on various fronts, including the ways to keep an eye on the execution of these proposals:

A 3-day training workshop will be held for 45 people – field workers from NGOs working with vulnerable populations. The course will include presentations on: 1) basic knowledge on TB transmission and ways to prevent infection; 2) tracing, counselling and referral for testing of all representatives of vulnerable groups with clinical symptoms suggesting a TB infection; 3) referral for treatment and direct observation in the continuation phase of treatment for all TB patients; and 4), tracing, motivating and follow-up of the chemoprophylaxis of all TB contacts. NGO field workers will be further trained to supervise key community members for work among the respective vulnerable groups (Bulgaria, 2006, p. 56).

Therefore, the NGO sector as well as the communities is encouraged to take ownership of the programs they are part of, and in the long run it is hoped that these changes will help people realize that they can take charge of their own health. Alongside the implementation of activities that contribute towards this goal, the civil society is encourage to monitor its work, all of which will be taught through training and workshops outlined in the proposals and implemented with community participation.

Burden Sharing

Diseases prove to be burdensome to a society on various fronts: financial, resources, labor, social and emotional, to name a few. In an environment where developing countries cannot afford to take care of its own citizens and proposals are

written to reduce the burden these diseases put on the society, with meager government budgets and scanty resources, the involvement of community and civil society organizations is seen as a means of reducing this burden. Community participation and mobilization are stressed because they reduce the burden on society at various levels – the individual, family as well as national.

One of the aims of these proposals, then, is to manage the resources economically. Given the popular notion that NGOs have much lower cost than the services provided by government or market entities, these organizations are handed over a good deal of work to reduce the cost both on the funds given by the Global Fund and the health care services. Thus, NGOs are viable options that have an economic impact on public health expenditure by reducing the overhead costs of many projects:

Improved programme performance will reduce the burden of TB upon health services as TB patients are cured and TB/HIV patients begin to live longer and more productively after TB treatment. The involvement of the community will further reduce the load, staff morale is expected to improve as TB no longer becomes synonymous with a diagnosis of an early death. The combined effect of efficient disease control will be to mitigate the economic impact of TB and HIV and consequently reduce the financial burden upon the GOL. (Lesotho, 2006, p. 60)

The proposal states the same at a different point to emphasize the community involvement: “The proposal therefore seeks to add to the ongoing efforts by scaling up the involvement of communities in TB control and strengthening TB/HIV collaboration, in recognition of the severe burden placed upon Lesotho by the intersecting epidemics.” (Lesotho, 2006, p. 68).

This relates to the framing of diseases in economic terms. By claiming that the disease have adverse effects on the finances of families and on the economy of a

country, the involvement by civil society will address this particular issue, open up resources to encourage economic growth in a society.

Burden is not just financial in nature; even the lack of human resources creates its own burden on the health care system. Even here, the NGO sector seems to provide a way of reducing the burden. When it is not treated as a solution to the problem, it is seen as a way of complementing the available funds for human resources in health sector, which are severely understaffed. In places where there is lack of services, NGOs taking up the provision will reduce the burden on public health systems:

In the area of human resources, it is hoped that this proposal will help to mobilize community and volunteer efforts to provide and support the provision of HIV and AIDS services. The involvement of communities, people living with HIV and AIDS, lay providers (such as counsellors) and other volunteers is important in complementing efforts of health professionals in meeting the high demand for quality services (South Africa, 2006, p. 65).

One can find a chain of events that could lead ultimately to the better outcome of the proposal. One of the aims of the proposal is to reduce the burden on the health system, and this can be achieved in circuitous way by involving the communities, which will have a ripple effect leading ultimately to the reduction of disease burden on the society and the health system. The argument is that only through community involvement can we reduce the impact of the disease on the society, and only through community participation we can the maximum impact with minimum resources that are requested by the proposal:

Improving the delivery of appropriate health promotional messages about TB and TB/HIV to the community will improve health seeking behaviour and enhance adherence to treatment of both diseases. Extending the treatment and care of TB to the community through the proposed health system strengthening interventions in this proposal will increase the community's participation in health delivery,

empower their responsibility for their health, and improve the outcome of treatment. Higher cure rates will result in the eventual reduction of the spread of disease. Reducing the burden at health facilities and continuing professional development will engender better staff morale and reduce attrition (India, 2006, p. 76).

The usage of community resources and local resources is emphasized as well because that would reduce the overall cost of the intervention as well as lead the community to rely on their own resources so that the project would be sustained in the long run. The focus is on using the resources of the community instead of relying on the government funds and help. Self-reliance is promoted by all the proposals, and this is done through community involvement.

Community leaders, particularly religious leaders, village heads and people of note mobilize their communities, including local resources, for implementing and operating basic community services and also health structures in their areas. Within each community there are a health centres management committee, women groups and community societies which provide support towards mobilizing local resources and using health services (Burkina Faso, 2006, p. 58).

Once the diseases are framed in economic terms, it creates a space for argument to reduce the resources used. This is done by involving communities and NGOs, all of which can share the cost of health and use their own resources as well to address the problems. By doing so, the proposals claim, empowerment is brought about, services are used better, and the projects will sustain after external funding runs out. Therefore, civil society can reduce the burden on the state and help the state in addressing the issues that has been the priority of the state until now.

Conclusion

Based on the above extracts from the proposals, we can conclude the for-profit sector (also treated as private sector in this chapter) has been marginal to the discourse of

public-private partnerships. For-profit sector is seen as having urban-bias, curative, expensive and limited in its reach. Most importantly, community participation – through community involvement directly or through NGOs indirectly – is seen as integral for the success of all the proposals. Only through civil society involvement the stated goals in the proposals could be achieved, the proposals claim, highlighting the importance of this sector in public-private partnerships.

In the previous chapter we have seen how the spatial nature of the diseases creates spaces for various sectors to be involved. In this chapter we see that this role is primarily filled by the civil society. Civil society organizations like NGOs are said to reach hard to reach people and places, which emphasizes the comparative advantage NGOs have over other sectors. Most of the work related to these regions and the marginalized people is left to NGOs. The diseases are constructed as problems, among other reasons, due to lack of proper infrastructure or human resources. Also, we find the civil society taking over a good chunk of that role by providing services. Most of the new programs are implemented by NGOs without a very strong rationale.

Diseases are also caused partly by ignorance, like we have seen in the previous chapter, and caused among poor and marginalized people. This opens up spaces to empower people. Empowerment is narrowly defined to include only information, knowledge and access to health care facilities, and inverted to show that the lack of these causes injustice rather than the other way round. By doing so, the proposals become apolitical and stay away from anything that is radical or controversial. Instead, there is a push towards self-reliance, ownership, and making civil society responsible for public

health. Added to this, diseases are talked in economic terms and treated as burdens on the society that have to deal with them. To address this problem, civil society is said to share the burden of the government and the society by working in the areas that the government has been working historically.

In conclusion, we see that there is a strong support for the inclusion of the civil society in the programs supported by the Global Fund. This has been articulated in various ways by the proposals and by attaching different roles left in the description of the diseases in the previous chapter. Therefore, this chapter highlights the aspects of civil society that are found appealing to people for various political backgrounds. There is a unanimous acceptance of civil society as providing solutions to problems posed by these diseases.

CHAPTER V

THE ROLES OF THE PUBLIC SECTOR

In this chapter the focus is on third objective of the study: what role does the state play in the public-private partnerships described in the proposals? To that effect, the dominant themes that are found in relation to the public sector in these proposals are described in this chapter. The public sector is not clearly described in these proposals. Even when described, there is a great deal of ambiguity surrounding the way the state is talked about in relation to the health of the population as well as the role it plays in the partnership: (1) the state is talked in a vague sense in relation to the health of the citizens, (2) the state works with other sectors without drawing attention to itself; (3) the state is a neutral entity; (4) the state has disadvantages that are met by civil society; (5) the state has authority; (6) the role of state is made marginal in the discussion of poverty and disease, and (7) the state is a leader and a manager. The chapter concludes on how these roles of the state relate to the overall discussion on public-private partnerships.

Difficulties in Analyzing the Role of the State

Given the fact that the Global Fund is a development agency and uses Official Development Aid (ODA) money to fund its projects, it has to deal with the state and the civil society while giving out the money. Like discussed in the previous chapter, the Global Fund approves proposals that strongly encourage the participation of the civil society at many levels. This is in line with the ideals of scholars at the both ends of the political spectrum. But when it comes to the state, the proposals do not take such noticeable stance about the state as they did with the civil society. There is a great deal

of ambiguity and assumption about the state that is not conducive to reaching any conclusions. This is mainly because the statements about the state in the proposals are factual and, to a lesser extent, descriptive.

Drawing conclusion from descriptive statements is a tricky thing. For instance, the following lines related to the state appear in relation to ‘training’ the public health staff: “This line of action involves the new printing of a total of 45,000 guides or protocols for the Syndrome Management of the V Round and a total of 90 training workshops for health professionals of the Ministry of Health.” (Peru, 2006, p. 65)... “Conduct training for 700 public sector health providers, 2000 CHA/Malaria Agents and 100 private sector rural drug vendors (RDVs)” (Eritrea, 2006, p. 50)... “In-service training in disease management, epidemic control, disease surveillance, vector control and community mobilization will be conducted for all categories of specialized programme and public health staff” (Georgia, 2006, p. 54). Although all these statements talk about training the public health staff, no real conclusion can be drawn from such factual statements. The same could be said about the following statement: “Khomeani: This is a government-led mass/multi -media communication campaign to prevent the spread of HIV infection and improve care, support and treatment for people infected or affected by HIV and AIDS” (South Africa, 2006, p. 62). Is the state effective in using mass media to educate its citizens? We do not know.

Even statements that claim to be saying something on the surface do not lend themselves to analysis. Like the following line from the proposal from Guatemala: “The MinHealth directs the public sector both in its coverage and extension, and is the most

important direct supplier of health services for the population. It is estimated that 70% of the population is covered by the MinHealth” (Guatemala, 2006, p. 46). (And lines like these abound about the state in all the proposals). Should one assume that 70% coverage is a positive indicator of the public health system? Does the statistics reveal if the poor and marginalized, for whom the proposal is aimed, fall in the 70% covered category or 30% uncovered category? Does the term ‘most important’ in the above statement imply that the government is doing its job well? Or should one worry about not covering the other 30% of the population? Given this difficulty based on the descriptive statements, only statements that connote something about the state are included in making an argument here.

Ambiguity About the State

What role does the state play in these proposals? Is state the government of a country? Is state the public health sector of the country that caters to the health needs of the population? Or is state the nation-state that is described by its borders and history? In the proposals, there is no consistent way the state is talked about. For the most part, we know about the state through the statements related to the ministries of the government, like the Ministry of Health, the Ministry of Education, and the activities done by these. Also, the public health system is discussed with the idea that it represents the government or the state.

In a few instances the country name stood for the state: “Following these important results achieved as part of the 3x5 initiative, Burkina Faso committed itself to the process of universal access to prevention, treatment, care and support within the

framework of the struggle against HIV/AIDS and STIs, because of HIV high prevalence and its negative impact on development strategies” (Burkina Faso, 2006, p. 38). Here, what does the country name stand for? Can the non-governmental sector or the private sector commit itself to the international standards of health care? Treating country in a monolithic fashion, as a nation-state, imposes a form of cohesiveness on all the sectors when such cohesiveness does not exist within the borders. While it might be incorrect to assume that the name of the country stands for the government or the state, there seems to be no other way of understanding the usage in these instances. For instance, “Four years ago, Peru also began the strategy of Panels to Fight against Poverty, which include components for cooperating in efforts to fight against HIV/AIDS” (Peru, 2006, p. 42). For the purpose of this chapter, these lines are taken as representing the state, although no major conclusions are drawn based on such ambiguous usage.

The word ‘national’ is used in a few instances to imply the activities done by the government. It is not uncommon to run across terms like the ‘national authorities’, ‘national strategies’, or ‘national plans’ to discuss the work done by the government in addressing these diseases. The usage reflects the nature of these terms, and implicates the state in the discussion. For instance, the term ‘national authorities’ in the following context clearly stands for the government: “As malaria epidemics, the most serious public health emergencies exist in Georgia during the past years it is essential the national authorities to be prepared to react decisively and promptly to prevent and control them” (Georgia, 2006, p. 62). The same logic can be used to think of ‘national plans’ that are related to these diseases: “All health system-strengthening activities are

within national plans, as they aimed at consolidation of the results achieved by the NMCP and their expansion, and they are linked with public expenditure frameworks” (Georgia, 2006, p. 66). Or the ‘national strategies’ for that matter: “The national strategy for controlling tuberculosis that has been implemented is the global DOTS strategy. Benin is proud to have been one of the pioneers in this strategy, having used it since 1983” (Benin, 2006, p. 49). Therefore, the term ‘national’ in its usage in these proposals can be read as standing for the state, although the ambiguity surrounding the concept is taken into consideration while drawing conclusions.

The clearest way of understanding the role of the state, or the government, in these proposals is by the usage of the term ‘public health system’, which stands for the health care system run by the government and funded by the tax money. The usage is the least ambiguous of all because it is contrasted with other health systems that are not owned by the state, like the private health care or the non-governmental sector. Public health system is not a private health system run on market principles:

The public health sector is the lifeline on which 80% of South Africans depend. About 40 million people are cared for through some 4100 clinics and 400 hospitals, receiving services ranging from community-based and primary health care to highly specialized treatment. The private health care sector serves a far fewer people (South Africa, 2006, p. 51).

In a similar vein, the public health system is not the system run by the non-governmental organizations or the community. For instance,

Important to [the proposal] is increased inter-sectoral collaboration with sectors outside of the public health services. With increased accessibility to RNTCP services, some of the gender based issues will be addressed e.g. difficulty of working males to attend public health services for DOT due to inconvenient opening hours addressed by DOT provision via NGO or private sector health facilities, or by community volunteers. (India, 2006, p. 46).

In this quote we find that the people who cannot go to the public health facilities due to inconvenient hours can go to the non-governmental facilities or community volunteers, which are not the same as the public health care.

In very rare instance, we do find the usage of the word ‘state’ itself to describe the state. “In addition to the political commitment to the struggle against the pandemic at the highest level of the State, Burkina Faso is currently benefiting from a certain number initiatives about access to ARV with financial support from the following sources” (Burkina Faso, 2006, p. 39). Here the word ‘state’ implies the government and means that the highest level in the government is committed to providing the drugs for treatment.

Given this problem, I found it hard to understand how the state is talked about in the proposals. There seems to be some fuzziness surrounding the terms used to describe the state in the development literature, reflected in the proposals as well. Therefore, I read all the proposals carefully to identify lines that talked about the government or the state, or the activities done by the same, to see how the terms used for the ‘state’ have been deployed in the discussion, with particular emphasis on the role the state is asked to play in the health of the citizens of a country.

All Sectors Work Together

If a country wants to apply for funds to the Global Fund, the organization requires the country to have a Country Coordinating Mechanism (CCM), which should include representatives from various sectors of the country that are interested in working on the same issue. While there is no specifications on how this CCM is to be constituted,

the Global Fund strongly recommends that the civil society be represented on it, as well as the people affected by the diseases: Therefore,

CCM Burkina includes representatives from different institutions involved with the struggle against HIV/AIDS, tuberculosis and malaria. It also includes religious and traditional authorities, representatives from civil society, government institutions, NGOs and community associations, as well as people affected by the three diseases. (Burkina Faso, 2006, p. 16)

Here, we find the general approach to constitution of the CCM without real emphasis on any one sector. Most countries have to form CCM to apply for proposals but a country can use any other body within the country that reflects the composition of CCM as expected by the Global Fund. For instance, in case of South Africa, there already is a mechanism that has representatives from all the sectors that is turned into CCM for the Global Fund purposes:

The South African National AIDS Council (SANAC) functions as the Country Coordinating Mechanism (CCM) for the purpose of guiding and overseeing Global Fund supported programmes in the country. It has a broad representation from government sectors, private sector, nongovernmental organizations, faith based organizations, people living with HIV and AIDS, research and academic institutions and other civil society organization. (South Africa, 2006, p. 16)

Although the Global Fund does not state how many representatives from each sector should be involved, especially from the government sector, all the CCMs in all the proposals have the majority of representatives from the government. While the Global Fund requires that in the proposal it should be mentioned the process through which the non-governmental organizations and affected populations are represented, it never requires any mentioning of how the government bodies are included in the CCM, and on what basis. By doing so, the government becomes the major part of the CCM by default, without attraction attention to itself, or requiring any rationale for being so. Moreover, in

most cases, it is the government that places the call in the mass media for NGOs to be included in the CCM, and oversees the process through which these organizations are included, which according to the Global Fund, should be transparent and democratic:

In August 2002, the Ministry of Health invited a large group of organizations representing government, the community and people with HIV and affected by tuberculosis to institute the CCM in Peru. A highly committed response was elicited, which sought not only to propose initiatives and strategies, but also to cooperate in the social monitoring process in relation to the development of Global Fund projects (Peru, 2006, p. 18).

The main purpose of the CCM is to have a public-private partnership in which all the sectors come together to formulate a proposal that reflects the needs of all the stakeholders and uses the strengths of all the constituencies. All proposals have public-private partnerships as the central concept around which all the interventions are planned and implemented, and this concept becomes the solution to the problems posed by all the three diseases. This multi-sectoral approach is discussed in broad brush strokes, and like discussed in the previous chapter, except for the community and civil society, the other sectors are not discussed in any detail, or their involvement is given a rationale. All the proposals, however, mention in general terms how all the sectors are included and are working towards the same cause:

This Plan is the fruit of a broad-based process of common planning with the involvement of diverse agents and sectors of Peruvian society. It exemplifies the understanding that a problem like STI and HIV/AIDS is much more than a health problem and it therefore can and should be approached in a multisectoral way by joint forces throughout the country (Peru, 2006, p. 40).

One main reason provided by most proposals in having public-private partnerships instead of other forms of organizing is that the sustainability of the project is assured when the funding from the Global Fund runs out. As the Global Fund requires

one to state how the projects will be sustained after the funding is over, the various sectors are invoked to explain how it will be possible. Each sector, building on its strength, would continue to carry on the activities required to address the problems posed by the diseases, as described in the following quote:

Public-private partnerships are a cornerstone of the proposal in improving access to care and support services and ensuring a continuum of care. These partnerships will facilitate continued support after the grant period. Delivery of a comprehensive package of services for children infected and affected with HIV will be supported by other ministries involved with children and education and private-public partnerships led by FBOs. To meet drug costs, funding will be mobilized from the state and private-public partnerships and existing mechanisms for drug procurement. New PLHA networks, supported for start-up, will sustain themselves through linkages to income generation programmes. (India, 2006, p. 56).

From the above statements it is evident that there is no real emphasis on what the state's role is in the welfare of its citizens. Added to that, it is the government that has the highest representation in the CCM, without any reference to why this is the case. Also, the state leads the CCM by placing calls for the inclusion of civil society organizations. Despite all this, we are not told about the efficiency or relevance of the state in the implementation of the proposals.

Government Is Neutral

The most noticeable aspect of all the proposals is the way the state is treated as the responsible entity for the health of its population. The importance of the state is emphasized repeatedly without providing a reason or a rationale for it. The proposals claim that the diseases are serious public health problems but never make the state accountable for the conditions. The existence of the state and the public health system

when discussed in relation to the current situation of the diseases are linked to the lack of funds, which in turn reflects in the poor infrastructure and weak human resources, among other obstacles. The state comes out as a benign, neutral entity doing its best for the health of its citizens: “The Government of India (GOI) gives the highest priority to TB control and is committed to supporting the TB control activities in the states for as long as it takes to achieve a situation where TB ceases to be a major public health problem in the country” (India, 2006, p. 40).

There seems to be a great trust in the government in the proposals: “Burkina Faso CCM is chaired by the Minister of health because of the historical commitment of the Ministry of health to the struggle against HIV/AIDS” (Burkina Faso, 2006, p. 14). Also, the government is seen as good at dealing with the challenges posed by the implementation of the proposal: “While India does not have a sector-wide approach or other fund-pooling mechanism in place in the health sector at the central level, the Government will ensure donor funds for HIV/AIDS are pooled and utilized according to national priority” (India, 2006, p. 76). But the proposal from India is one of the few proposals that also state, in passing, the government has neglected its duties: “However, on the overall, such institutional and infrastructure strengthening is required at all medical colleges due to the historical neglect in the investment of resources in tertiary care by the government, even while patient load has been on a steady increase” (India, 2006: 58). It is rare to find statements like these that talk about the negligence of the government that might have caused the problems associated with these diseases. Neither does one find statements that explicitly praise the role of the state in the health of its

people. Therefore, the conclusion is that the public health system is an important system to provide care for the people, and so should be strengthened.

The claim is that the government is the most important provider of public health services in these countries, like mentioned earlier. It is from this role that the government becomes central to the implementation of the proposal, mainly because of its vast public health infrastructure, human resources, administrative ability and other functions that cannot be performed by the market. The aim of all the proposals is to fill in the gaps left open by the government, the aspects of public health that the state cannot fund: “The purposes and objectives of the proposal have a direct relation with the gaps analysed and the strategies designed by the Ministry of Health in the fight against HIV, which are also included in the Strategic Multisector Plan” (Peru, 2006, p. 44). Or in the case of Lesotho: “Much of this need is only partly covered by current government funding, in the form of the regular budgetary support for TB control that covers staffing at central level and at the TB clinics through the integration of TB control within the primary health care system” (Lesotho, 2006, p. 56). Therefore, the need for funding is to complement the work done by the government. Thus, the proposals are a response to the government plans for public health, and to that extent the government plans become central to all the proposals.

The government is talked about in relation to infrastructure of the public health system, the training of health workers and practitioners, procurement of drugs, and the treatment. The proposals claim that the human resources in the public health system are

very inadequate and funds are needed to increase this aspect. The main reason is seen as the move to the profitable private sector by the health staff:

There is currently an imbalance in the distribution of health professionals between the public and the private health care sectors, with the majority of doctors, pharmacists, and dentists in particular placed in the private sector. The introduction of a scarce and rural allowance, the improvement of conditions of work in the public sector... contribute to retention of personnel. (South Africa, 2006, p. 45).

Therefore, there needs to be a focus on human resources:

The quality and quantity of human resources has been identified as a major barrier to the implementation of the government's Comprehensive Plan. Government is currently developing a comprehensive health sector human resource plan, which will inter alia, address the shortage of health care workers in terms of volume and skills (South Africa, 2006, p. 46).

The government needs to hire more people to meet the demands posed by these diseases: "Moreover, the government's level of recruiting for health-care workers, totally inadequate compared to actual needs over the past few years, has created enormous problems in terms of the availability of the human resources needed for the NTP to properly conduct its activities" (Benin, 2006, p. 44).

The other aspect is the infrastructure. The government provides the necessary infrastructure for the working of the public health system:

The RNTCP is integrated with and implemented through the general health services utilizing the available infrastructure. The infrastructure in the general health system are established and staffed by the local state governments and these facilities implement the programme. The infrastructure and regular staff are paid for by the state governments and all investment costs for the basic services under the programme have already been provided for by the state government. (India, 2006, p. 51).

As the government has to provide the infrastructure, the funds aren't sufficient for other purposes that are really needed:

For the past three years the national budget has allocated on average US\$200,000 per year in the context of the Public Investment Program (PIP). This sum is intended exclusively for the development of infrastructure such as building construction and the acquisition of office automation equipment, usually for the central level. It is in no way possible to use these funds for the operation of Program, including the purchase of medications. (Benin, 2006, p. 54).

This inadequacies are to be met by the funds from the donors:

The Bulgarian TB Control Programme received very little support from donors and therefore was financed mainly from the national budget (Ministry of Health and Regional Health Authorities). The national budget is currently financing only the most urgent needs related to treatment: hospitalization of patients and the minimum set of investigations, the cost for first line anti TB drugs, BCG vaccination, salaries of staff as well as sporadic supervision visits in the field as part of the monitoring and evaluation of the program. (Bulgaria, 2006, p. 42).

From the above statements, we can conclude that the state is treated as a neutral entity working for the betterment of its population, an entity, unlike the civil society in the previous chapter, does not require any rationale for getting funds or any need for being accountable for its actions. The only problem the government seems to have is lack of funds to have proper infrastructure and health facilities. The political commitment of the government, or the failure to have such commitment, is not foregrounded. But the question remains: if the government is efficient and committed, why is it that these diseases are such serious problems in these countries? This question is not addressed. The government is just taken as given and becomes part of the proposal in a way that makes it hard to understand its proper role, and by doing so, leaves little room for critically looking at the role of the state as welfare provider, of which health is a part.

Disadvantages of the State

The Global Fund requires that the activities funded by the proposal do not duplicate the activities done by the state or other donor organizations. To that effect, the CCM needs to mention in the proposals the activities done by the state and how the interventions proposed are different from the activities of the state. The funds should be used for those interventions that strengthen the health system of a country, those interventions not supported by the state. For instance, the Global Fund strongly encourages civil society and community to be part of the proposal writing and implementing. While the need for strengthening the health system is the major justification to support the government, the civil society is included based on reasons discussed in the previous chapter. The need for inclusion of civil society is explicitly stated whereas the need for strengthening the public health system, or funding the state institutions, goes without any justification or rationale. Moreover, while discussing the virtues of the civil society, the proposals talk about the state in an indirect fashion. By focusing explicitly on the civil society, the proposals implicitly deflect the attention away from the state and its workings. For instance, it is common to find quotes like these:

Enrich the public health system by forging partnerships with NGO's and communities in imparting health education, raising demand for services and helping communities to cope with and adopt supportive attitudes towards infected and affected families resulting in reducing stigma and enabling earlier identification of HIV infected persons. (India, 2006, p. 63).

Here, the focus moves to the NGOs and communities, and these in turn talk about what a public health system can accomplish by being included in the activities. We know that

the state can accomplish a great deal by including civil society in its activities, but we do not know what the state can accomplish by itself. We do not know to what extent the state needs external help for it to be effective.

The connection between the civil society and the state needs attention. The civil society is included because the state is not capable of providing a few services. The reasons for inclusion of NGOs are described in the previous chapter. The proposals talk about the comparative advantages of the state and the civil society, and talk about the advantages of the civil society to talk about the areas where the government might not do a good job of providing health care. Why the state fails to provide health care in these specific areas is not provided. As an example:

Community organizations (NGOs and persons with HIV) have developed knowledge about innovative promotion and prevention intervention strategies in different target populations. They also have developed knowledge and expertise about the care and treatment of people with HIV, and NGOs have been providing care and treatment for years. They also develop support strategies and provide support to the affected in terminal stages and support to affected and orphaned children, in order to address needs not covered by the government. (Peru, 2006, p. 67).

Why the needs cannot be covered by the government is not mentioned. Why the government fails to develop the same kind of knowledge and innovation, or if the government can strive towards doing the same is not discussed. Moreover, if these expertise and knowledge could be co-opted into the public health system is not treated as an option either. What is presumed here is that the strengths of the community remains with the community and so, the responsibility of providing health care should be handed over to the community or NGOs. The disadvantages in the public health system are treated as unchangeable and permanent, so transforming the public health system to

accommodate these aspects is not treated as an option. The state is not flexible enough to do this, we should presume from these statements.

This devolution of responsibility of the government becomes very glaring in the proposals. On one hand, NGOs can supplement the work of the government:

Prevention of new HIV infections remains a challenge and the Government is committed to the acceleration of prevention efforts to stem the tide of this HIV and AIDS challenge... this proposal supports several initiatives by civil society organizations to supplement on going efforts by the government. (South Africa, 2006, p. 56).

But most proposals indirectly point to the failures of the government in providing care to the people in need as a reason to hand over the workings to the community; in other words, the community takes care of itself because the government is not good at taking care of the community. Even here, the government is not blamed for the failure; it is just treated as a disadvantage of the government by its very nature:

Benin's populations are exposed to and/or affected by the three major diseases. To provide better care, these populations that are outside the government's activities have formed associations/groups represented in the CCM by national NGOs and international NGOs, the religious communities, practitioners of traditional medicine and private sector professional associations. (Benin, 2006, p. 14).

Thus the government failure is normalized and accepted without drawing major attention to the reasons behind the failures of the government or if the failure should be accepted instead of rectifying in an effort to reach these populations.

As the government sector is treated as largely inflexible, the NGOs sector, and to a lesser extent the private sector, is sought for help. These sectors are more responsive to public health needs compared to the public sector: To use a quote used earlier in the chapter:

Important to [the proposal] is increased inter-sectoral collaboration with sectors outside of the public health services... difficulty of working males to attend public health services for DOT due to inconvenient opening hours [will be] addressed by DOT provision via NGO or private sector health facilities, or by community volunteers (India, 2006, p. 67).

The public health system can be inflexible because of its operation hours. As this system cannot be changed, flexible hours can be provided by other sectors, like the private or the non-governmental. Why the government cannot have flexible hours is not stated.

If the problem with accessibility is related to a region, the other sectors are handed over the job of providing services:

Urban areas and urban slums in particular are another challenging area [to public health system]... To improve access of communities living in such slums and in the urban areas in general, there would be increased efforts made to involve private sector and support staff would be provided (India, 2006, p. 50).

It is accepted that the public health system cannot cover the urban areas and slums, so other sectors are sought in providing care. The issue of geographical reach comes up in other forms as well:

The government health facilities are located centrally and can only serve a small catchment area due to difficult communication. Increasing access to treatment will be possible if the malaria diagnosis and treatment services can be provided at the community levels. In addition to government health workers, a total of 1676 health workers will be recruited by the NGOs for this purpose. (Mozambique, 2006, p. 62).

Here, instead of expanding the government health care, the expansion is handed over to the non-governmental sector. We are not told why the government cannot expand its reach. The same logic is used for the vulnerable and high risk groups as well:

Building the capacity of nongovernmental organizations is an important approach to strengthening and expanding essential HIV and AIDS interventions. NGOs complement government efforts in reaching most at risk and vulnerable populations. Enhancing the comparative advantages of both government and

NGO/private sector programmes is important in consolidating the national response to HIV and AIDS and thus increasing the likelihood of achieving the goals of this component. (South Africa, 2006, p. 51)

Here the strengths of the NGOs in reaching the high risk and vulnerable populations are emphasized. But the strengths of the government are not discussed, and the government is absolved in reaching these populations. Yet, the proposal claims that the government has advantages over the non-governmental sector, although the proposal does not find a need to let us know what they are.

The proposal from South Africa clearly sums up the difference in treatment of the state and the civil society. For instance, the proposal from South Africa clearly mentions that there are comparative advantages between the government and the non-governmental organizations: “By enhancing the comparative advantages of both government and NGO/private sector programmes this proposal is making a significant contribution to strengthening the broader health system in South Africa.” But fails to explain the advantages of the government. In passing, while talking about the history of the apartheid, the proposal mentions the duties (and not advantages) of the government:

South Africa is a relatively new democracy that is emerging from a history of social disruption, racial and gender discrimination, associated with inequitable distribution of resources affecting the majority of its peoples as result of Apartheid... Several programmes that ensure access to education, health services, and reduction of poverty, provision of shelter, clean water and sanitation are the thrust of government’s interventions. (South Africa, 2006, p. 46)

None of these activities are mentioned later in the proposal because the proposal focuses on the provision of treatment and prevention (which does not emphasize the above mentioned socio-economic aspects). However, the proposal does take a very clear

stance on the advantages of the civil society: “Stronger involvement of civil society organizations and provincial authorities is an important element in efforts to reach the underserved populations. Therefore, the main implementers of activities in this proposal are exclusively nongovernmental organizations” (South Africa, 2006, p. 37). At another point in the proposal:

The objective of strengthening capacity of civil society organizations contributes to the prevention goal because civil society organizations provide a wide range of prevention services and often reach populations that might be out of reach of public or private services. However, this objective also has wider system strengthening implications that address other priority areas such as care and treatment. (South Africa, 2006, p. 58).

What is striking is the descriptive nature of the statements related to the state:

“The public health sector is the lifeline on which 80% of South Africans depend. About 40 million people are cared for through some 4100 clinics and 400 hospitals, receiving services ranging from community-based and primary health care to highly specialized treatment” (p. 59). And even then, the proposal states:

In South Africa while the infrastructure is excellent in some places in others it needs urgent attention with communities remaining vulnerable and having reduced access to HIV and AIDS services. Both public and private health facilities are highly concentrated in urban areas and are less well distributed in rural areas. (p. 42).

And to reach the rural areas, NGOs are invoked as having advantage over the state and the private sector. Thus, even the proposal that makes explicit claims about the advantages of the civil society does not do the same about the state.

From the above examples it becomes very evident that the government is reluctant to provide services that are accessible to the people in need, cannot reach areas or regions where poor and vulnerable live, nor can it provide complete services to people

who have been historically underserved by the public health system. With marginal modifications to the public health system run by the government, majority of these needs are handed over to the civil society, and to a lesser extent to the private sector, without calling into question the failure of government in meeting the needs of the citizens. The sustainability of the support provided by the non-governmental sectors that depend on external funds is not discussed, nor the accountability of these sectors to the people taken care of. Thus, the proposals discourage involvement of the state in areas that can be better dealt by the NGOs. We do know from the proposals what are the benefits of including NGOs but we are at loss for knowing what the benefits are of the state in providing health care. Therefore, we could safely assume that the state is talked about without drawing attention to itself.

Government and Reforms

The state can show its commitment to a cause by providing financial support for the cause. In all the proposals, the claim that the government is serious about dealing with the health of its people is substantiated by statements that reveal the commitment of the government. Most of these are factual in nature, and the reader is left to assume whether the government doing its job or not: “According to a 2003 report on Selected World Development Indicators, India is spending under the public sector, 0.9% of its GDP on health care. An additional 4% is spent in the private sector” (India, 2006, p. 39). In the case of Eritrea: “The total estimated expenditure on health as a percentage of GDP has grown from 3.4% in 1995 to 4.3% in the year 2000. On average government expenditures on health as a percentage of total government expenditures was 4.5% for

the period between 1995 and the year 2000” (Eritrea, 2006, p. 41). The public health system is supported by the government. Also, the Global Fund likes to know how much money is committed by the countries for the health. Thus, funding is equated to political commitment for the most part.

With lines like these it is hard to form an opinion about the state; all we do know is that the state is committed to the health of its citizens. There is no way to know how this funding corresponds to reality of the situation, although all the proposals request funds because the government funding is inadequate. The reason why the government can or cannot increase funds, are not provided: Only in the proposals where the case was to be made for the government commitment, we find the increase in budget spending highlighted to draw attention to it:

The South African Government has dramatically increased its resource allocation to tackling the HIV and AIDS challenge from R264 million during 2001/02 to R1,5 billion in 2005/06 financial years. During this Medium Term Expenditure Framework period, government spending is projected to increase by 78% in real terms. (South Africa, 2006, p. 44).

The rationale for seeking more funds stems from the above: the spending by the government is not sufficient to address the problems posed by these diseases. This means that the government, if it could spend enough money, would be able to solve all the problems. The existence of these diseases is reduced to the lack of financial resources alone. The political, historical, social and economical aspects of the prevalence of the problem is not discussed: “Despite the fact that the Ministry of Health has been allocating substantial funds from its annual budget, there still exist resource gaps in

various areas of the fight against this disease” (Bulgaria, 2006, p. 49). The money that the government spends is used for immediate needs:

Of the total of all necessary resources, the state budget for the five-year period will provide approximately 60% or 23 100 784 EUR. Domestic resources will be used to meet urgent needs related to treatment: first-line drug, including chemoprophylaxis; vaccines and diagnostics, as well as subsidies for hospital treatment of TB patients. (Bulgaria, 2006, p. 49).

The funds needed by the proposal are for activities not covered by the public funds.

Although these activities are important, due to financial constraints the state cannot provide support. We are not told why the health of so many thousands of people is not a priority for a few countries; the proposal application does not encourage those details.

The failure of the government, in a few proposals, has been imputed to macro changes. We are left with an impression that the government is unable to take care of its populations because of conditions beyond its control. In the case of Guatemala, the lack of funds is due to change in external support: “Even though the Guatemalan government has been responsible for financing this sector, the percentage decrease of external cooperation support towards the health sector during the 1996-2001 period, has created problems and funding is still insufficient” (Guatemala, 2006, p. 44). This shows that the government priorities are influenced by forces outside the border and within. In case of Bulgaria:

The transitional circumstances of the last decade affected all fields of development in the country including provision of basic health and social services. Public health services were affected through extreme financial austerity resulting in deterioration of the service quality and decreased accessibility to basic social services by the population. Since mid 1990s GDP per capita share allocated for public health services decreased from 4% to 0.5 % in 1998 yielding 6-7 USD per person. (Georgia, 2006, p. 42)

And this has effect on the health sector:

The severe financial constraints prevented anti malaria activities at a sufficient scale and contributed to reduction of the surveillance, of vector control activities and to no full-fledged epidemiological control, destruction of the public health services, a shortage of insecticides, drugs, equipment and consumables necessary for malaria surveillance and control in the country. The public health services were under staffed and under equipped. (Georgia, 2006, p. 42)

This creates a need for funds to address the problems. The proposal does not include any of the above mentioned indicators in the proposal. The external situation is left to the government and the proposal is implemented without addressing important aspects that influence the health of the population. Addressing just the treatment without addressing the issues that cause the need for treatment makes these interventions lopsided. And the role of the state in this is marginalized although the macroeconomic situation created by the state is the primary reason why the proposal was needed in the first place.

In a similar vein, the reforms of the health care sector are also a prerogative of the government, which influences the health of the population. Health reforms have had mixed results on the health systems in the countries where they were implemented, and the reforms have got a bad reputation among scholars who see them as imbued with neo-liberal ideology. Only one proposal talks about the structural adjustments that have been the characteristics of the neo-liberal era:

The hiring freeze affecting permanent public employees of the government which has been in effect for years due to various structural adjustment programs has contributed to the growth of the private sector and especially to the shortage of qualified personnel in public healthcare facilities where the high average age among doctors and paramedics is signaling that substantial losses to retirement are coming in the next few years. (Benin, 2006, p. 44)

In the case of Bulgaria, the impact of reforms is explicitly acknowledged:

From a state-funded system under the Soviet ‘Semashko’ model, in 2000 the healthcare system started operating under the principles of health insurance... The intentions of health reform include gradually reducing the share of budget funding, particularly starting from 2006, and transition to funding from health insurance. (Bulgaria, 2006, p. 52)

Elsewhere in the proposal, it is mentioned that “People from vulnerable groups have no health insurance” (p. 43) and that 46% of the main target group of the proposal, the Roma community, has no health insurance as well. And in other instances, we find that they are embarking on health reforms, like Guatemala:

The Government of Guatemala, through its MinHealth is carrying out political, technical and legal mechanisms for the transformation of the health system through an integral reform. As the implementation of this reform will take time, progressive changes at medium and long term have started, together with others changes of rapid to medium impact. (Guatemala, 2006, p. 56)

The reforms do not happen in a vacuum and the state plays an important role in implementing these reforms. Despite this, the state’s responsibility is never discussed, and the ways to deal with the reforms, to mitigate the effects is never discussed. All the proposal focuses is on providing the treatment to the people who cannot afford the treatment. This leaves the reforms, and the government that promotes it, untouched.

In other proposals, reforms are talked in neutral if not positive terms. The implication is that the reforms would better the health system and would cure the problems that plague the system currently: “In the mid-90s, a number of reforms were undertaken in the public sector. The following were adopted for the purpose of establishing adequate health-related legislation... This established the legislative base needed to carry on with healthcare reforms” (Bulgaria, 2006, p. 54). The proposals never talk about the implications of these reforms but just that the reforms are in progress:

“The activities in this proposal align with the health sector reforms in strengthening health resources, are congruent with the national development control strategy and build on the national strategy on DOTS expansion” (Lesotho, 2006, p. 57). As far as the impact of reforms in these proposals is concerned, the jury is still out.

From the above evidence we can conclude that the importance of the state can be understood based on the financial commitment it has towards the health of its citizens. The need for funds stems from the fact that the government’s money is not sufficient to address the problems, reducing the prevalence of the diseases to monetary aspects. Added to this, we are told that health reforms will have positive impact, or at least the governments are working towards it, but we are not told if the reforms have beneficial effects on the people. The macroeconomic conditions can have a decisive effect on people’s access to health care but the government’s role in shaping the macro economic conditions is made marginal to discussion. Therefore, we are left with a state that is struggling for the betterment of its citizens and if not for the lack of funds people would be leading healthy and happy lives.

Poverty and the State

Like discussed in the chapter on framing of the diseases, all these three diseases affect the poor people disproportionately. Poverty can clearly be seen as the root cause of all the three diseases. Also as discussed in the chapter how poverty is framed as the effect of the disease rather than the cause. Therefore, the proposals see the government role as the provider of services to people who are poor and cannot afford them. By doing so, the state does not have to deal with the issue of poverty explicitly in any of the

proposals. The structural causes of poverty, the marginalization of segments of population that requires treatment based on their socio-economic condition is treated tangential and marginal to the discussion about their health. Despite all this, the state is seen as the only entity that can address the issue better than other sectors. This is done through the route of policy.

Poverty reduction is talked about in the larger framework of development. The proposal application requires the CCM to mention the development initiatives that are related to the diseases, thus bringing out the aspects of poverty and disease. Most proposals mention poverty reduction programs or papers that the state is undertaking to address the issue:

In response to such a complex development problem, the Government of Burkina developed a Strategic Framework for Poverty Reduction (CLSP) in 2000, reviewed in 2003, whose main ambition is to promote human security. Health and the struggle against HIV/AIDS are top priorities in this national strategy. (Burkina Faso, 2006, p. 48).

The World Bank has come under strong criticism for its structural adjustment policies that promoted neo-liberal view of the world under the guise of development. This led the Bank to come up with Poverty Reduction Papers (PRSPs as they are now called) that a country has to have before getting aid from the Bank. Although this has been treated by critics of the bank as old wine in new bottle, most countries have mentioned these papers as the evidence to show that the government is committed to reducing poverty:

A Poverty Reduction Strategy Paper (PRSP) has been formulated and endorsed by the government to address the broader context of economic development, equity and reduction of poverty. GoB endorses priority on control of Malaria, TB

and other major communicable diseases as a means of poverty reduction in the broader framework of national development. (Bangladesh, 2006, p. 45).

Even here we find the disease “as a means to poverty reduction” and not the other way round. By addressing the disease, the proposals claim that the poverty levels will be improved. While this is partially true, what is assumed in the process is that there exist plenty of opportunities that healthy population can use to be gainfully employed and better their living standard. The underlying notion is that the conditions exist in the job market that are not utilized by people who are sick. Therefore, poverty never becomes an indicator for the success of these proposals, but rather a by product:

The government, with the support of its key development partners, is in the process of finalizing Eritrea’s Poverty Reduction Strategy Paper (PRSP8). The paper ranks inadequate health services as well as low accessibility to health services as the third most important cause of poverty. It is well established that addressing the disease burden of a country will reduce the vulnerability of the population to poverty. Morbidity and mortality caused by malaria are significant obstacles to achieving delivery of this poverty reduction strategy. (Eritrea, 2006, p. 40)

Despite this claim, none of the indicators in the evaluation of the interventions have socio-economic levels of the targeted population as an indicator of the success of the proposal. Only the utilization of services, treatment and quantitative expansion of services is taken into consideration while measuring the changes brought about by the activities proposed in the proposals.

Only the proposals from South Africa for HIV explicitly states the importance of the government in linking poverty to the disease:

The Government’s Comprehensive HIV and AIDS management programme is firmly located within and aligned to developmental interventions referred to above. The country has mounted a comprehensive multisectoral response to the HIV and AIDS challenge, seeking to address the socio-economic determinants

and drivers of the disease through a range of programmes that address poverty reduction and improved access to basic services such as water, housing and sanitation. The national response to this challenge is articulated in two major policy documents: the 'HIV, AIDS and STI Strategic Plan for South Africa, 2000-2005' and the 'Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa' (South Africa, 2006, p. 51).

The proposal foregrounds the socio-economic aspects of the disease and describes how the government is planning on dealing with the issues to address the problem. Even here, the proposal does not mention the activities of the government in the interventions planned by the proposal but mentions that these issues have been addressed elsewhere. The proposal, for most part, focuses just on the access to treatment and expansion of services, the bio-medical aspect of the diseases.

Therefore, the root cause of all these diseases is pushed to the margins of the discussion in these proposals and the poverty reduction aspect is relegated to the policies of the government that are not part of these particular interventions. Thus, the role of the state in the most important aspect of public health is subverted from being discussed, and the funds given by the Global Fund are not used for poverty reduction even though it is the most determining factor in predicting who is vulnerable to these diseases and who are not vulnerable.

Government in a Leadership Role

The government is featured prominently in discussing the policies that address these issues. The drift is that the important role of the government is to make policies, guidelines and framework. These activities are never handed over to other sectors but more importantly, the other sectors are not invoked while talking about the making of policies that affect their working. Once the policies are framed, the non-governmental

sector is called upon to implement part of these policies. It is hard to say with certainty that other sectors are not consulted in the process, but the evidence points to the fact that the other sectors are not needed to be named when talking about the policies. The impression the reader gets is that the government is the only player in the field and these policies are unanimously accepted across the board.

Government can systematically respond to the problems posed by these diseases by creating policies. The mentioning of policies created by the government is treated as the evidence that the government is active in responding to the diseases. How these policies play out on the ground, to what effect, are not mentioned in the proposal, just the existence of the policies. The state authority and legitimacy is revealed through these policies: “Seeing the need for a comprehensive national policy to tackle tuberculosis, as early as 1994 Bulgaria developed its first National TB Programme, and in 1997 an Expert Council on TB was set up under the Ministry of Health” (Bulgaria, 2006, p. 50). The policies by the government also seem to take on the partnership rhetoric that was not around until early 90s. Partnership need not always be initiated by the government, but in the proposals we get a distinct drift on the government being at the vanguard of partnerships: “The government of Burkina committed itself to a national policy of global care (medical, preventive and psychosocial) for people living with HIV/AIDS and their families by establishing a close partnership with association actors and health professionals.” (Burkina Faso, 2006, p. 60).

The policies create a leadership role for the government by giving it the authority to oversee projects, specify roles for various sectors and shape the activities and expectation of various sectors in responding to the diseases:

The NHP 2002 also emphasis leadership role of the Central Government in provision of resources, technical support, M&E etc relating to the priority diseases control programmes, to the state governments, especially to the focus states. The Policy document envisages larger role of local self governments and civil society in health care which has been also addressed in the national TB control policy. (India, 2006, p. 48).

Within the policy framework the other sectors have to operate, and these policies work as the guiding principles for the work taking place within the borders:

National Health Policy, which is in print, will give direction to public and private sectors, NGOs and partners and establish boundaries for public/private mix options. For the past decade, health care in the country was generally free of charge, however, cost recovery has started. (India, 2006, p. 48)

Thus, the government has the power over other sectors and it wields its influence through various policies, as mentioned in these proposals.

If not policies, the other terms that are used in relation to the influence of state on other sectors are through 'framework' and 'guidelines': "The Ministry of Health is the body responsible for implementing health initiatives of the country as one of the main agents and executors. This body sets guidelines for action against HIV/AIDS, which are used to regulate the activity of other subsectors" (Peru, 2006: 40). Also, government is invoked when it comes to the legal system because it is the only entity that can create a conducive environment for the activities mentioned in the proposal to take place:

In order to meet these commitments, the Peruvian government is trying to create alliances with private companies and the community within the legal framework of Law 26626, "ANTI AIDS Law", and its modification Law 28243, which

introduced HAART as an obligation of the state in the comprehensive care of people with HIV. (Peru, 2006, p. 76).

Or in the case of Georgia, the government creates decrees:

The Government of Georgia through issuance of the Presidential Decree N17 'On strengthening Malaria control and prevention activities in Georgia' has emphasized the urgency of the problem and expressed the high political commitment to implementation of NMCP. Through the decree all state authorities and executive institutions are obliged to ensure inter-sectoral collaboration for effective coordination and implementation of anti-malaria programmes. (Georgia, 2006, p. 72).

The other aspect of the state other than creating policies and frameworks are the guidelines:

The aim is to consolidate and expand interventions of the present major strategic directions. The NMCP is based on the existing regulations and a guideline developed and approved by the Ministry of Health, and is responsible for technical guidance, planning, monitoring and evaluation of malaria control in the country. (Georgia, 2006, p. 72).

The following quote neatly sums up the importance of the government to the proposal:

“The framework, which has been developed in accessing and using donor funds, is based on a principle that allows government to define priorities and identify gaps where support should be provided” (South Africa, 2006, p. 18). All these lines say that the state is important and its authority is influential. As most of the activities take place within this, it is implied that the effects of such acts by the government have positive effect on the health of the people, if not on the implementation of the activities mentioned in the proposal.

The government also takes on the leader role in the projects by monitoring and evaluating the projects or overseeing the implementation of it by other bodies:

The government has developed an extensive framework for monitoring and evaluating existing programmes and resources committed to address the challenge. This framework includes a comprehensive set of indicators for measuring the impact of conditional grant funded programmes. (South Africa, 2006, p. 82).

The proposals aim at strengthening the leadership and managerial aspects of the government in most instances. The usage of the word ‘management’ is found with the terms related to the state:

During grant implementation, the Ministry of Health’s (MOH) technical and management capabilities (especially in the three programs to control AIDS, Malaria and Tuberculosis) were strengthened in order to implement the projects financed by the Global Fund in the areas of program management, administrative and financial management, procurement and monitoring-evaluation. (Benin, 2006, p. 78)

Therefore, when the government’s capacity is discussed, it is discussed in managerial terms and the focus of most of the proposals was on strengthening this managerial aspects of the state:

Strengthening the management capacity of the National Programme for the Prevention and Control of Tuberculosis in Bulgaria by expanding the existing structure to a programme management unit at the Ministry of Health is the measure required to achieve the national objectives regarding this disease, as well as to achieve good coordination among all interventions and partners on national and international level. (Bulgaria, 2006, p. 67)

From the examples above, it become clear that the state is treated as a leader or manager of the activities related to the diseases, and although it is not mentioned, given the discussion about the comparative advantages of the state and the civil society, one could assume that these are the strengths of the state because the non-governmental organizations are not mentioned in relation to the above mentioned activities. It is hard to know from these lines alone if the government’s involvement even in these areas is

positive or negative, but given the uniform acceptance of government's policies, frameworks, laws and guidelines in all the proposals, we are left with the feeling that the government does a good job in this particular role. Like the proposal from Bulgaria goes to show, the government can gain legitimacy, for the most, part by just coming up with a set of policies and documents: "A number of political documents emphasise the concern and political will of the Government about alleviating the disadvantaged situation of the Roma population" (Bulgaria, 2006, p. 74).

Conclusion

Based on the statements about the state in the proposals studied, one can reach the following conclusions:

1. The state is described largely in factual terms and to an extent in descriptive terms. The proposals do not take a clear stance on the state, by given the ambiguity, the proposals see the role of the state as a positive force in the health of the citizens. If we compare this with the statements made about the civil society, the differences are glaring. While the proposals wholeheartedly claim that the civil society is integral to the success of the proposals, we are forced to make such statements about the state, mainly because of the lack of evidence to the contrary and not otherwise.
2. The proposals do not talk about the state despite the fact that the largest representation in the CCM which writes proposals is from the state entities. Also, the state places calls for the civil society to join the CCM, giving an idea of the

role of the state as a leader. The state never addresses itself clearly in these proposals.

3. By being very vague about the role of the government, and framing the need for funds as lack of funds from the government, the diseases is problem is primarily reduced to a monetary one. This leaves the state off the hook by not making it accountable for the state of affairs that have led to these diseases being such sever public health problems. Also, by reducing the shortcomings of the state to lack of funds the proposals leave very little room to reform the state or make the state more responsible for its citizens' health. The spaces to work against the state, to talk about political and structural changes that impede welfare are completely marginalized, if not subverted, by framing the problems of the state in this fashion.
4. By deploying the civil society in the places and processes that are hard to reach or hard to implement, the state is treated as inflexible and the scope for reforming the public health system is minimized. While it is true that these are the strengths of the civil society, the non-governmental structures are not sustainable or can be made accountable like the ones related to the state, so the inflexibility of the state system is acknowledged and normalized while the strengths of the civil society are emphasized, and its unsustainability is underplayed.
5. Despite the repeated assertion that poverty is intricately related to disease, poverty is never addressed in these proposals. The role of the state in addressing poverty, the real importance of the state, is relegated to policy documents

addressed by the state itself (through PRSPs, for example) whereas the funds from the proposal are used exclusively to address the problems posed by the diseases through bio-medical interventions. The root cause of the problems is largely left at the periphery.

6. Health reforms, despite the bad rap they received in the scholarly community as promoting neoliberal ideas, are seen as benign if not helpful. The role of the state in the implementation of these reforms, or in dealing with macroeconomic issues, is never discussed. These proposals are implemented in the backdrop of larger economic changes brought about by the state but are never addressed in the proposals.
7. Through policies, guidelines, frameworks, laws, and decrees, the state has a great control over the environment in which these proposals are implemented. To a large extent it is the state that dictates the rules of the game. Despite all this, the state role is portrayed as that of a leader or a manager, overseeing various projects while the implementation and engagement with the public is largely left to other sectors.

In conclusion, based on the statements found in the proposals about the state, one cannot really reach any major conclusions without a leap of faith. By being purposefully ambiguous despite a great deal of room to discuss the role of the state, the proposals manage to deflect the attention away from the state to the civil society and the activities implemented rather than politicizing the health of the citizens. The implications of these

findings in the larger debates surrounding the role of the state, the market and the civil society, in relation to development, will be discussed in detail in the next chapter.

CHAPTER VI

CONCLUSIONS

The objective of the present study was to see what roles do the public and the private sectors play in the partnerships promoted by the Global Fund through the proposals they approve for funding. By knowing the roles, it was hoped that the Global Fund could be situated in the larger debates taking place in the field of international development as well as in the realm of public-private partnerships that have become the mainstay of development strategies, including global health. As described in the first chapter, the state has been central to most of the controversies surrounding development: one on side are actors who favor the state in providing welfare to people to counter the unpredictable market forces in assuring security to the majority of populations, and on the other side are actors, mainly the neoliberals, who favor market mechanisms based on the belief that the logic of the market leads to efficient distribution of resources. Due to international political changes in the early 1980s, there was an upsurge in neoliberal thought that permeated the economic thinking of the present times and the workings of development agencies. Because of mounting evidence that showed the failures of markets in providing basic security to the public all across the globe, by late 1980s there was a change in neoliberal as well as social democrat thinking that focused on the liberating aspects of civil society as a solution to societal problems. This manifested in public-private partnerships where actors from various sectors came together to share resources and strengths to create synergies in their work towards a common cause. With passing time, these partnerships have become central to various public projects, mainly

in urban planning but later included development and health projects in the international arena. Lately, there has been a growing criticism in the scholarly community on purported benefits of partnerships, and given the hegemonic influence of neoliberal ideology in economic thinking (and development being all about economic growth, like Rist (2001) contends), these scholars find a distinct neoliberal strand of politics hidden in partnerships that, they contend, could lead to disastrous effect on the well being of society, let alone the health of poor people.

At the beginning of twenty first century, it was unanimously agreed upon that there is a need for a new form of organizing that can address growing health disparities at the global level. The burden posed by three deadly diseases in history – TB, Malaria, and HIV—on the developing countries and their economies led to a global consensus on forming a global fund that could funnel the development aid to areas where it is needed the most. Thus, the Global Fund came into being as the most important force in addressing the problems posed by these three diseases that kill nearly six million people each year. The unique aspect of the Global Fund is the popularity it gained among actors from various political backgrounds – for the World Bank to Oxfam, from the President of US to rock star Bono – and also the success it had in collecting funds from different entities, including multinational corporations and philanthropic foundations. The Global Fund claims that it does not shape the programs it funds, and leaves the ownership of the projects, from writing proposals to implementation to evaluation, to the sectors working in cohesion in the country the funds are given to. Thus, the organization claims that it acts only as a funding mechanism that funds proposals based solely on their technical

merit. This study was conducted to see if the proposals that describe the partnerships in detail lend themselves to analysis in a way that they can be situated in the larger debates surrounding development and health. The literature reviewed, and the scholarly work this dissertation depends on, provides a rationale to pursue this line of thought to see what a researcher could come up with by studying these proposals.

Findings

The findings related to the framing of the diseases show that the diseases have socio-economic origins. Poverty can be seen as all pervasive factor in predicting who is vulnerable to disease and who is not. It is not just the biological and environmental factors that contribute to the disease spread but the larger economic conditions and macro social forces decisively shape the trajectory of these diseases. Diseases also are gendered and spatial in nature, and are worsened by lack of funds, infrastructures and equality in the societies they prevail. Framing diseases in this fashion opens up spaces for various actors to step in, and based on the strengths of each actor the division of labor takes place so that positive change can be brought about in the lives of the targeted people. Despite this kind of framing, issues like social injustice, powerlessness, macroeconomic factors, access to livelihood, which have bearing upon the health of an individual, but are not easily quantifiable, are left out of the interventions proposed. (One could surmise that issues or diseases that do not fit this mold, like hunger, diarrhea, environmental problems, might not receive the same kind of attention these diseases do). More importantly, the most influential aspects on the health of the public – poverty and marco-economic issues – are not discussed when it comes to designing programs that

address the problems. By not addressing the root causes of the diseases, one could question the long term effectiveness of such interventions. If poverty is at the root of many societal problems in developing countries, which can also cause new diseases to emerge, will more partnerships be created to address these problems without dealing with poverty in a direct way?

The findings related to the private sector provide a different set of insights. What becomes obvious by reading the proposals is that the for-profit sector is marginalized in the entire discourse surrounding these diseases. While the importance of this sector is acknowledged in almost all the proposals, the for-profit sector is seen as mainly catering to the needs of people who can afford the services, and these services are expensive, curative in nature, and are available only in particular geographical regions. Based on the framing of the diseases, we notice that the private sector addresses mainly the biomedical aspect of the problem. This sector is not regulated or encouraged to expand its reach by providing services to the poor or people living in remote areas. Instead, other sectors are called to take up these roles.

This brings one to the civil society and community participation. Based on the framing of the diseases, one could conclude that of all the spaces opened by the framing of the diseases, the civil society is given the task of addressing the spatial, ignorance, gendered and biomedical aspects of the diseases. Civil society becomes accessible in these proposals through non-governmental organizations. This sector is invoked to perform multiple tasks that are not performed by the for-profit sector, or cannot be performed efficiently by the public sector. From community mobilization to provision of

services to empowerment to burden sharing, community and community based organizations (NGOs) are seen as solutions to most of the problems posed by these diseases. Community participation is promoted as the most effective solution, despite the fact that there is a growing body of literature on the “tyranny of participation” (see Cooke & Kothari, 2001; and Hickey & Mohan, 2004 for a thorough overview of the debates).

This can be linked to the discussion about the civil society in the first chapter in which I discuss how the concept of civil society has become appealing to people at both ends of the political spectrum: the neoliberals see it as a means to create a free-market society, and neo Marxists view it as brimming with radical possibilities for participatory democracy. Civil society, unlike the state, was never caught in the cross fire between the above mentioned actors who submerged themselves in the discussions about the importance of the state and the market (mainly evidenced in the workings of advanced capitalism) in the welfare of citizens. Thus, by taking a clear and positive stance on the virtues of civil society these proposals do not risk criticism from people at the either end of the political spectrum. As the concept of civil society is one of the least controversial yet confusing areas in development literature, the findings about the roles of the civil society in partnerships do not allow one to align these proposals, and in turn the workings of the Global Fund, with a particular ideological camp.

All the aspects of the civil society highlighted in the proposals fit the values of both the right and the left. Even in these aspects, as we have noticed, empowerment is depoliticized by reducing it to information and behavioral aspects, structural aspects that

influence the behavior and information are removed from the reach of the civil society; and the duty of the state in service provision is shared with the NGOs and community volunteers. Added to this, we can find evidence to the fact that the civil society is taught market values by encouraging it to take ownership and responsibility of the citizens health without properly explaining why this should be the case. The traditional strengths of the civil society, like making the state accountable, reforming the welfare state to make it more accessible and accountable to the public, working on political and institutional changes, lending voice in policy and market reforms, and importantly, dealing with causes of poverty are marginalized in the discourse surrounding the diseases in these proposals. Also, the role of civil society as a countervailing force for the state's negligence of its welfare commitments, or the political character of the NGO sector is never talked about, or even mentioned. This makes the proposals apolitical and "technical" (to use the Global Fund term).

The role of the state is perhaps the most controversial topic in development literature and in debates about economic growth. Perhaps this is the most interesting finding in the present study. The state is not talked in enough detail to draw any major conclusion. Most statements are factual, and do not lend themselves to in-depth analysis. The roles of the state are obfuscated by invocations of other sectors, and only in reference to other sectors can we understand the limitations of the state. The state is not made marginal to the discussion, on contrary the state exist by default in these proposals while other sectors are described and justified in relation to the working of the state. The state is treated as important, its ability to create conducive environment for the proposals

to be implemented is acknowledged, and its role as a policy-maker to coordinate and maintain programs is stated as given.

Yet, in all the proposals, the state is made neutral and ambiguous. No normative statements related to the state (like stated in relation to civil society) can be found in the entire data set. While the partnerships are promoted as drawing on the collaborative strengths of each sector, the strengths of the state are not discussed. Essentially, the state is left with no accountability to the public in these proposals. Moreover, it is treated as inflexible and discouraged from expanding its reach to hard-to-reach populations. Thus, the welfare state is not reformed in the process. Even when discussing poverty, the role of the government is made tangential to the funding of the proposals. Like the critics of partnerships contend, the main role the state can be seen as being that of leadership and managerial responsibility. It is hard to claim that the welfare state is being whittled away, as many fear, but it is also hard to claim that the roles of the state are being expanded as needed through these proposals.

From analyzing the proposals, we are left with a feeling that the only reason why these diseases are serious public health problems is because of the lack of funds by the government to implement projects. This takes away spaces for political reformation of the state, leaving one wanting to know if the government is as neutral as the proposals make it sound to be. Given the fact that majority of the funding (two-thirds) in the proposals under study was given to government entities (and two-thirds of total funds ever distributed by the Global Fund till date was given to the government-related actors), one would expect more in-depth description of the role of the state in the health of the

populations as well as in implementing the programs funded by the Global Fund. Alas, that is not the case. The absence of clear discussion about the state, like it can be found about the civil society, almost made me quit this project. How does one place these proposals, or the organization that funds these proposals, in the larger debates surrounding development when they do not talk clearly about the state, an entity that has been so central to all the discussions surrounding economic growth and public welfare? How does one situate a set of documents that talk about public-private partnerships in the larger debates surrounding partnerships when the roles of one sector are not clearly delineated? How do we know if there is a neoliberal ideology at work if there is no clear stance on the role of the state in these proposals?

Strategic Ambiguity

Here, I relied on the concept put forth by Eisenberg (1984) while talking about people in organizations that have to deal with multiple and conflicting goals, and have to come up with a communicative strategy to handle the situation. He calls it “strategic ambiguity”. He theorized in relation to people in organizations who, when confronted with multiple and often conflicting goals, “respond with communicative strategies which do not always minimize ambiguity, but may nonetheless be effective” (p.232). He claims that “strategic ambiguity promotes unified diversity” because it “fosters the existence of multiple viewpoints in organizations” (p. 239). This ambiguity helps in people interpreting the message in a way they feel comfortable, thus helping multiple actors reach multiple conclusions based on the same message. “It is a political necessity to

engage in strategic ambiguity so that different constituent groups may apply different interpretations to the symbol” (p. 239).

As an example, take the following line:

The objective of strengthening capacity of civil society organizations contributes to the prevention goal because civil society organizations provide a wide range of prevention services and often reach populations that might be out of reach of public or private services. (South Africa, 2006, p. 58)

This line can be interpreted by the people on the left as strengthening the civil society which could lead to empowerment of people, and can be interpreted by the people on the right as a way of discouraging the state from expanding its welfare commitments, letting private sector expands its reach. But this line can also be interpreted in a different way: people on the left can view this as an assault on the welfare state but it is hard to reach this conclusion because people who dislike the corrosive effects of markets on public welfare, mainly on the left, also like civil society that is being promoted by these proposals, creating a contradiction. To further elaborate my point, imagine the above statement rewritten in the following form:

Because the public services cannot be expanded to reach populations that are hard to reach because of their location, and because the private sector does not find incentive in providing services to these people, the capacity of the civil society organizations need to be strengthened to contribute to the prevention goal so that they can provide a wide range of prevention services.

By reframing the above statement, the limitations of the public sector, according to the proposal, are made explicit, and the failure of the private sector in meeting the needs of the poor and marginalized people is also made known, making it easier for readers to question “Why the public services cannot be expanded to reach these people?”

or “Why are these people so poor that they cannot afford services of the private sector?” Thus, the statement, by explicitly talking about the limitations of the state and the market can become controversial. This line of discussion is avoided in all the proposals, highlighting the ‘strategic ambiguity’ used by the proposal writers in deflecting attention from the state.

Eisenberg (1984) goes on to explain that “Ambiguity is used strategically to foster agreement on abstractions without limiting specific interpretations” (p.234). He provides an explanation:

The writing of group documents provides a final example of how unified diversity can be promoted through the use of strategic ambiguity. When a group composed of individuals with divergent perspectives on a topic convenes to author a document collectively, the final product is presumed to represent the will of the group. Strategic ambiguity is often employed to make the group appear to speak in a single voice. Group members appeal to a repertoire of increasingly ambiguous legitimations which both retain the appearance of unity and reasonably represent the opinions of the group (p. 234).

Based on the above statement, we can safely assume that the Country Coordinating Mechanism (composed of representatives from various sectors of a country), which writes and submits proposals to the Global Fund, can be seen as a group with divergent viewpoints. Yet the proposal needs to come across as if it is written in a single voice, but leave enough room for representing the views of the members. Let us look at another quotation related to poverty and disease in the previous chapter:

The government, with the support of its key development partners, is in the process of finalizing Eritrea’s Poverty Reduction Strategy Paper. The paper ranks inadequate health services as well as low accessibility to health services as the third most important cause of poverty. It is well established that addressing the disease burden of a country will reduce the vulnerability of the population to poverty. Morbidity and mortality caused by malaria are significant obstacles to achieving delivery of this poverty reduction strategy. (Eritrea, 2006, p. 46)

The above statement is framed in a way that seems to be conveying the view of the entire group, and that all the 'development partners' support the finalizing of poverty reduction strategy. Then the proposal claims that reduction of disease would lead to reduction of poverty. This is just one way of looking at the link between poverty and disease. The other way to look at it is that poverty causes disease and make a claim that says: "Because the reduction of poverty has potential to reduce the incidence and burden of the disease, the poverty reduction strategy focuses on the raising the living standard of the poor as a means to reducing the incidence of the disease." None of the proposals make a claim to this effect. All the sectors will agree to the fact that the reduction of disease can have effect on the reduction of poverty, so that idea is foregrounded to keep the group consensus in tact. Is there evidence to the fact that reduction of disease would help in reduction of poverty? At least there is no substantial literature to back this claim, although there is literature on the positive effects of reduction of poverty on the well being of people. This is what Eisenberg would term as "ambiguous legitimation".

Lastly, Eisenberg claims that strategically ambiguous communication is deniable:

The use of strategic ambiguity complicates the task of interpretation for the receiver. For example, an individual can disclose an important piece of information ambiguously ("I feel uncomfortable in this job") and then deny specific interpretations should they arise ("You mean you can't get along with the boss?"). (p. 236)

Even this can be evidenced in the talk about the state in the proposals. Like we have seen, the claim that the state is interested in the welfare of its citizens is repeatedly made through the lines that talk about money the state spends on health. For instance,

The total estimated expenditure on health as a percentage of GDP has grown from 3.4% in 1995 to 4.3% in the year 2000. On average government expenditures on health as a percentage of total government expenditures was 4.5% for the period between 1995 and the year 2000. (Eritrea, 2006, p. 41)

The above line does not say much about the state of affairs in a country. There is no rule of thumb on how much a government should spend on the health of its citizens, and it varies from country to country. Unless we know in detail the budget allocation and what is given priority over health, the above statement is just a number. Yes, it does show that the government increased its spending and if neoliberals were to interpret this as “the government is expanding its welfare commitments”, one could deny it by pointing to the fact that the people are still dying, which could mean that the state is not expanding its welfare commitments. But at the same time we are left wondering why so many lives are lost despite government spending, and if the state is ineffective in living up to its welfare expectations and therefore, should be devolved. Because there is not enough information on the subject, it becomes easy to deny a particular interpretation in this context. As another example:

The NHP [National Health Plan] 2002 also emphasis leadership role of the Central Government in provision of resources, technical support, M&E etc relating to the priority diseases control programmes, to the state governments, especially to the focus states. The Policy document envisages larger role of local self governments and civil society in health care which has been also addressed in the national TB control policy. (India, 2006, p. 48).

Here, we see the central government taking on the role of a leader and devolving its work to the local governments and civil society. We do not know the actors who have to take up the provider roles of the central government. More importantly, we do not know how these policies came into being. Did the civil society have a say in the framing

of this policy? If one were to interpret this as the rise of neoliberal ideas because “the policy makers and the people who get affected by the policy are separated leading to depoliticization of policy”, or another contention that “government is primarily taking on a leadership role” (an argument put forth by Evans and Shield (2005) in the first chapter), for instance, it can be denied because the quote above is ambiguous about the participants involved in making the policy.

The above examples by no means imply that all the statements about the state are ambiguous and all the statements about civil society are crystal clear. What the above explanations show is that compared to the description of civil society in the proposals, the description of the roles of the state are treated very ambiguously and in uncertain terms, to an extent where it is hard to draw major conclusions on the role of the state in these proposals. Like Eisenberg (1984) cautions towards the end of his article: “Strategic ambiguity must be viewed as a continuum, from most clear to most ambiguous; the more ambiguous the communication, the easier it is to deny specific interpretations” (p. 238) Based on this we can see that the civil society falls towards the most clear end of the continuum and the state tends to fall towards the other end of the continuum, with a few statements related to both the sectors interspersed in between; a few statements on the state are as clear as a few statements on civil society are ambiguous.

Given this, one could hypothesize that the reason why the Global Fund is able to garner support from people at both ends of the political spectrum is due to the fact that the proposals it funds do not take a clear stance on the state but take a clear positive stance on civil society as being essential to the success of the programs. As civil society

has followers on both ends of the political spectrum and the state have critics at both ends, by being clear about civil society and ambiguous about the state, the proposals funded by the Global Fund give the organization a neutral look and feel despite the fact that the majority of the funding goes to the state.

Different Readings of the Data

To continue the line of thought, it is hard to place the Global Fund in the debates discussed in the first chapter because one can read the same proposals in two different ways. The anti-Partnerships reading would highlight the following aspects in the proposals: the civil society is taking the traditional roles of the state like service provision, empowering people, addressing poverty and ignorance among the public. Also, the market is unregulated, uninvolved and is treated as unimportant when it comes to the health of the citizens, at least in relation to these diseases. Like Miraftab (2004) and Linder (1999) contend, the roles of the state, the market and the civil society are progressively getting blurred in these partnerships. To add to Linder (1999) critique, the diseases are talked in specific economic terms, substantiating the claim that the diseases are commercialized. By making the NGOs do the labor with its workforce, one could contend that it creates a large unorganized labor in society that do not have similar kind of benefits provided in the public sector. Also the state can be seen as taking on the steering role and not the rowing role. In Evans and Shields (2005) view, the “state has become a service manager and a policy director.” On similar lines, based on the lack of references to the inclusion of civil society in policy making, one could contend that the people are distant from policy, reducing the spaces for political involvement by the

public, not to mention the silencing of voices in the processes. This could be one possible way of doing an anti-partnership reading of the proposals.

But on the other hand, same data can be read in a pro-partnership way. The Global Fund claims that roughly 66% of the total funds ever distributed by the organization go to the state, only 2% goes to the private sector, and the rest to the civil society. This shows that the state has an important role to play in the health of its citizens (although it is not discussed clearly in the proposals). This is also seen in the composition of CCMs, in which majority of members are from the state. Moreover, the focus of the proposals is on strengthening the public health infrastructure. Given the importance of civil society in the changes brought about around the globe, we find that the involvement of the civil society is made central in all the proposals. This could be seen as an effective way in lowering the cost and increasing the efficiency of the programs sponsored by the funds. Also, people taking ownership and responsibility of their health in itself can be seen as a positive move by many. As an increasing evidence points to the fact that no single sector can solve huge problems posed by these diseases, collaborative advantage can be seen as the best way out. Given the positive track record of civil society in providing better service delivery in areas neglected by the state and the market, one could say that there is not inherent harm in handing over this work to the NGO sector. Based on the pro-partnership literature cited in the first chapter, we could see the civil society involvement as leading to better sharing of power and checking the domination of one sector over other sectors, leading to lasting positive outcomes from

the proposals. This could be one possible way to do a pro-partnership reading of the proposals.

That being said, the limitations of civil society are clearly overlooked in these proposals. For instance, as discussed in the first chapter, studies show that the civil society organizations cannot provide welfare in the long run, especially in relation to issues of poverty and income generation. These organizations, with no elected representatives, are not accountable to the public like the state is or can be accountable. Also is evidenced from the literature, the NGOs are not effective in dealing with the root causes of poverty or poverty alleviation. Moreover, long term impacts of NGOs have been mixed; there is a potential for these organizations to pander to donor agencies' needs and ideologies; and in the long run the sector is vulnerable to influences of the market forces. To take this argument forward, even though the proposals value civil society, they do not do in the same spirit found in the scholarship of the left. The following aspects of the civil society upheld by scholars on the left are not foregrounded in the proposals: the political role of the civil society, the empowerment brought about by social movements, the issues of labor and employment, the spaces for radical changes and reforming capitalism.

Other important finding that needs to be considered in detail by scholars working at the intersection of the state, the market and the civil society is the idea promoted by the concept of "public-private partnerships." While the concept seems egalitarian on the surface, as we have noticed, majority of the funding goes to the state and only 2% goes to the private sector (understood as for-profit sector). By giving negligible role to the

for-profit sector and putting the civil society under the private sector side of public-private partnerships, are we not running the risk of conflating civil society with the private sector? What are the ramifications of calling the civil society as the private sector? Is this a part of neoliberal vocabulary?

Recommendations:

Based on the findings one could propose the following recommendations:

1. Roles of the actors in partnerships need to be clearly defined in the proposals as it helps scholars working on the development issues to understand which sector is good at implementing what program in what regions and in what capacity. By doing so, not only one could understand what persuasion these proposals follow but also it helps in forming better partnerships gleaned from the experiences based on the advantages of each sector. Also, given the debates surrounding the state and the market, especially in the realm of neoliberal politics, it will help scholars in understanding the general drift of development programs supported by the Global Fund.
2. Poverty needs to be made central in all the programs dealing with the diseases. The proposals clearly show that the poverty issues are addressed in a lopsided fashion, without considering the negative effects of poverty on the health of its people. By coming up with programs that address poverty in relation to health, these interventions could mitigate the long term ill-effects of poverty, and stem the causation and spread of new diseases that poverty can engender.

3. Macroeconomic issues should be given consideration as well in these proposals. As there is a clear link between the macro economic conditions in a country and the provision of public health services, by taking these aspects into consideration a more holistic approach to public health problems can be promoted.
4. Sustainability of the civil society should be considered while including NGOs and community in these programs. Although the immediate effects of NGO involvement has been shown to be positive, the diseases caused by poverty require long term involvement which can only happen if the state takes an active role in all the aspects of addressing the diseases. While the civil society should not be discouraged in involving, it should be acknowledged that the state plays the most important role in sustainability of any project that deals with the health of large segments of poor populations.

Contributions, Limitations, and Suggestions

The present study makes the following contributions to the literature and scholarship: First, the roles of various sectors as constructed in the proposals have not been studied by scholars, both in development literature as well as outside the field despite abundance of literature taking both pro and anti partnerships stance. Without understanding the roles played by various actors, it is hard to understand the implications of projects funded by an organization. Secondly, although there are a great number of studies done on policy documents and organizational literature (discourse analysis being a popular method), no major study has been done on the proposals as rhetorical texts that construct various sectors' involvement as essential for the success of development

projects. This study addresses that gap. Thirdly, the present study proposes a hypothesis for the popularity of an organization to people from different backgrounds based on Eisenberg's "strategic ambiguity" surrounding controversial issues. This hypothesis can be used to test and see if it holds good for other organizations or other texts in relation to partnerships and development. Fourthly, the study adds to the literature on ideologies of organizations (like neo-liberal ideology of the World Bank and IMF) and shows that it is not always possible to unearth the ideological underpinnings of an organization as evidenced through studying the proposals, despite the fact that the organization, as it is claimed, can be very successful in reaching the goals espoused. The multiple readings of the texts reveal the ambiguity in reaching a conclusion about the dominant ideology that drives an institution. Fifthly, the study contributes to the literature on the framing of diseases and how diseases are constructed as public health problems. The study also shows how the framing can be used to understand the various actors are involved in addressing the diseases. Also, the framing of diseases as developmental problems has been understudied in development literature, to which this study contributes by trying to fill the gap. Moreover, the present study focuses on the new trends in international development – public private partnerships – and by doing so, contributes to the discussion of new strategies in deployment of international aid. Lastly, it is a unique study located at the intersection of the scholarship related to the state, the market and the civil society, and how all these actors are related in the field of global health, development and partnerships.

The limitations of the present study are: the present study relies on documents without taking the context of their production and consumption into account. This can have affect on the outcomes but given the fact that these proposals are persuasive texts that convince the technical review board at the Global Fund to provide funds, the study focused just on texts as received by the organization and approved. Another limitation of the study is the number of proposals under study. Till date, 450 proposals were funded by the Global Fund, of which only 15 were chosen for study due to the issues of manageability. Therefore drawing any major conclusion should be done with caution. Also, only the proposals were studied without taking the organizational rhetoric, policies and literature into consideration. This does not provide a comprehensive picture of the organization or the work it supports. The study does not compare the findings with the literature on similar organizations. A comparative study would provide more insights.

Future researchers can use the concept of ‘strategic ambiguity’ to see if other proposals use similar approach. If resources allow, studying the proposals over a period of time can give insights into how the Global Fund changed its funding preferences, if any. Or use the concept to see if other organizations fund proposals that take a similar approach. Other way of understanding the kind of work supported by the Global Fund is to look at the publications and press releases of the organization. These documents might contain the ideology that the organizations supports or promotes. Also, one could focus on organizational rhetoric in the press releases, or just focus on how the media deploys partnerships in relation to the Global Fund or other organizations to see if there is a discontinuity in what the organizations funds and the public perception of the

organizational work. To get an in-depth understanding of the working of an organization like the Global Fund, it would be useful to interview the technical review board that selects proposals for funding. This will provide insights to what these people really look for into the proposals, what they mean by 'technical merit', and how do they view the role of the public and private sector in partnerships. If one could do an ethnography of how the programs funded by the Global Fund play out in the field and how various actors come together to discuss these issues, it could lead to a better understanding of partnerships and what they stand for in relation to development and welfare. Or one could do a comparative study of the proposals funded by the Global Fund and the proposals funded by international institutions like the WB, IMF, the WHO, or the UNAIDS to see how these organizations frame the diseases and roles of various sectors in relation to the problems posed by the diseases.

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