The ‘Politics of the Queue’: The Politicization of People Living with HIV/AIDS in Tanzania

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ABSTRACT

Starting from a body of literature on movements around ‘biological citizenship’, this article analyses the political significance of HIV-positive people’s collective action in Tanzania. We explore reasons for the limited impact of Tanzanian AIDS activism on the wider political scene, concluding that the formation of a ‘movement’ is still in its infancy and faces many constraints, though some breakthroughs had been made. Participation in PLHA groups in Tanzania encourages politicizing struggles over representation, democratic forms and gender that can lead to a process of political socialization in which members learn to recognize and confront abuses of power. It is in such low-level, less visible social transformations that the greatest potential of participation in collective action around HIV/AIDS in Tanzania lies.

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INTRODUCTION

> *'We have risen from our beds, we have regained strength, and we have shown the world that we are still here' (member of a group for AIDS widows following the introduction of ARVs).*

Within the last fifteen years, People Living with HIV and AIDS (PLHA) in Tanzania have increasingly organized themselves in support groups and networks, somewhat resembling the phenomenon of movements around what has been called 'biological citizenship' (Nguyen, 2005; Petryna, 2002; Rose, 2007; Rose and Novas, 2003). This article is based on research into the emergence of PLHA collective action in Tanzania; despite some breakthroughs, we argue that the formation of a 'movement' is still in its infancy and faces many constraints. A better characterization of the key role played by PLHA groups might be the 'politics of the queue'. This captures the contradiction that the groups' main activity is not challenging authority but marshalling people for treatment and facilitating service delivery. Nevertheless, in the queues for treatment, dialogue and discussion generate questioning and mobilization. Within PLHA groups politicizing struggles take place over representation and democratic forms, petty corruption and, more than anything, over gender inequities. We are witnessing a process of political socialization, faltering and weak perhaps, but not without potential.

Our investigation into PLHA activism looked mainly at grassroots organizations, but collective action here occurs in a context which extends beyond the local to the national and the global, in an era when the roll-out of antiretroviral treatments, through international funding, promises to transform a deadly epidemic into a manageable disease. This far-reaching development followed a global social movement of AIDS activists, including a mass protest movement in South Africa which challenged both the local state and the global pharmaceutical industry, and has strong links to international advocacy groups. The South African movement is claimed by Robins (2004, 2008) as an example not only of 'biological citizenship' but of 'global civil society' in action. That such a characterization cannot (yet) be applied to Tanzania, or most of the rest of Africa, suggests that such outcomes cannot be taken for granted. Nevertheless the debate raises significant questions about the defining rights of ‘citizens’, especially those who live with and may die from a stigmatizing disease, how they struggle to gain recognition by powerful state and other interests, and how they engage with the hierarchical nature of global interactions.

Whilst our research focused on the view from grassroots PLHA organizations (in Dar es Salaam, Zanzibar, Kigoma and Morogoro), we also looked at their links with higher level networks, with government-sponsored umbrella organizations and state institutions, foreign donors and international agencies. Material was collected through qualitative methodology, using participant observation — a method resting on the in-depth study of social contexts and critical events particularly appropriate to a setting where shame and danger dominate people’s lives. Fieldwork in Tanzania was carried out over a total period of twenty-three months (July 2004 to October 2005, July/August 2007, May to October 2008) and included regular participation in the daily activities of three grassroots PLHA groups, numerous visits to other PLHA groups at local, district and national level, as well as visiting members’ homes and accompanying them to events and group activities, hospitals, relatives and friends. We also joined the queues of patients waiting for testing and treatment in HIV clinics and used personal networks to capture those who do not join PLHA groups. Ethnographic fieldwork was followed up by discussions with two international PLHA networks in Europe.

BACKGROUND DEBATES

Recent debates have drawn on Foucault to explore the phenomenon of people organizing collectively on the basis of their biomedical status, and have conceptualized this as ‘biological citizenship’. The phenomenon itself can be traced back to 1970s feminist challenges to medical expertise and their revaluation of women’s own knowledge. By the late 1980s an emergent movement of patients demanding inclusion in decision making had recast thinking in relation to life-threatening illnesses in the developed world (Diedrich, 2007; Petryna, 2002; Rose, 2007). The movement represented people positively transforming themselves from ‘victims’ to ‘survivors’ and becoming active agents in their own recovery. This experience could be interpreted as depoliticizing, diverting people into a ‘therapeutic culture’ and personalized responsibility (Diedrich, 2007);[1] conversely these developments have led patients and their supporters to become a collective force, informed and organized to challenge the state and the medical establishment, both public and private. According to Rose (2007), the very terms of what the state owed to citizens around ‘life itself’ were challenged in a novel ‘politics of embodied individuals’ (Rose and Novas, 2003: 7). Whereas in the past citizenship was a collective identity conferred from above, in this formulation it is a demand for inclusion from below. To join medical support groups could be a learning process in ‘becoming political’ (Rose and Novas, 2003), through engaging, challenging and negotiating with authorities and creating alliances of solidarity with like-minded groups. In the process, collective action extends beyond the nation state and becomes a globalizing force, a process sometimes referred to as ‘globalization from below’ (Appadurai, 2002).

While some scholars, such as Rose and Novas (2003), Biehl (2007) and Kistner (2009) point to the disciplining features of biopolitics as a model of biological self-governance promoted under contemporary liberal governments in the West, others celebrate the phenomenon as one of positive resistance to bureaucracy and coercion, facilitating the empowerment of the disempowered. AIDS activists have demanded involvement in scientific research on HIV/AIDS, access to treatment and protection from discrimination and stigmatization. Initially, campaigns were most vocal and visible in the global North, but powerful movements soon emerged in settings lacking the affluence, literacy and accessible electronic communication networks found in the developed world, including Brazil and South Africa. The South African Treatment Action Campaign (TAC) analysed by Steven Robins (2004), for example, mobilized PLHA into a powerful political force, challenging not only the government’s rejection of the way ‘Western science’ linked HIV with AIDS and its resistance to making treatment available, but also big pharmaceutical companies eager to protect patents and profits. Combining a leadership of globally connected intellectuals and

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[1] For Nguyen the term ‘therapeutic’ is used almost interchangeably with ‘biomedical’ as ‘a form of stateless citizenship whereby claims are made on a global order on the basis of one’s biomedical condition, and responsibility worked out in the context of local moral economies’ (Nguyen, 2005:142).

professionals with a social base of urban township dwellers (mostly women), it allied with the union movement, gay activism and the South African Communist Party to achieve its goals, using diverse and often unorthodox methods. Movements like TAC were a powerful force in converting donor perceptions of universal access to treatment in less-developed countries from a utopian dream to a moral imperative (Smith and Siplon, 2006: 73). Since 2005, free treatment (funded largely by the USA) is available in a large number of developing countries, giving those who were dying a new lease of life. TAC's achievements lead Robins to argue that 'politicising the right to health care has empowered citizens' and generated forms of 'grassroots globalisation' (2004: 670, 664).

TAC's success may lead to the assumption that confrontational politics against those in power is the main catalyst for change 'from below'. Our research project looks at Tanzania, one of the early epicentres of HIV/AIDS, where we found that despite many similarities to the South African case, non-governmental public action by PLHA had little impact on national policy formulation, legislation or strategic planning, but that less visible, yet significant social transformations at the local level are generated through coming together as PLHA. HIV-positive people in Tanzania were beneficiaries of global AIDS activism's successes. The burgeoning of PLHA groups here began when AIDS was still a death sentence and their major concern was coping with the terrible consequences of the disease, rather than confronting the state or the medical establishment. Some could afford to access anti-retrovirals (ARVs) privately and thereby avoid disclosure of their condition, but this was beyond the means of the majority, whose poverty was deepened by their illness and whose mobilization was a plea for survival. When ARVs were rolled out for all, it was not in consequence of local unrest, but because battles around treatment access had already been won elsewhere. PLHA in Tanzania were not drawn into this decisive politicizing moment.

This absence might be understood (following Tarrow, 1998), in terms of the limited 'political opportunity structure' for contentious politics in Tanzania in this period (Mbilinyi, 2007: 10). In South Africa TAC borrowed from previous political struggles against apartheid and involved political parties, organized unions and gay activism. There was already a 'repertoire of contention' on which to build — politically conscious subjects, ways of organizing and building alliances, political space for popular unrest. TAC claimed adherents across the lines of race, occupation and ethnicity. Certain kinds of class relations might be considered part of the political opportunity structure for such collective action. Robins argues that it was 'class-based mobilisation' that 'created political space for the articulation of radical forms of "health citizenship"' (2004: 663).[2] South Africa, with a high proportion of its population in wage labour and a long history of organized unions, contrasts strongly with Tanzania, where only a minority is in wage employment and unions were co-opted by the state after independence and are only now emerging from that stranglehold (Shivji, 2007: 63). Tanzanian unions have played only a minor role in campaigns against HIV.[3] Moreover, in both cases, the social base of activism seems not to be organized wage-labourers but poverty-stricken women (and to a lesser extent men) eking out an existence in the informal economy of petty commodity production, and, in Tanzania, mostly first time activists. While more confrontational strategies were used in past struggles in Tanzania (in the fight for independence, or the extensive wild cat strikes of the 1960s), most PLHA are reluctant to resort to such tactics, for fear of losing the limited amount of support they enjoy. Tanzanian grassroots PLHA groupings exhibit a patron–client mode of politics rather than one based on the solidarity of common interests or organizational capacity developed through past struggles. In contrast, the extremely repressive nature of the South African state under apartheid made confrontational political mobilization one of the only avenues for change.

There is another contrast with the South African case. If poor women from the townships are the social base of TAC, educated intellectuals and business elements are very much a part of its leadership and explain its capacity to surf the internet and engage in effective legal and media interventions. The movement in South Africa bridges the class divides, with action and ideology focused on broad themes of socio-

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[2] The Congress of South African Trade Unions is cited as a key partner in the enterprise, but the socio-economic location and organizational affiliations of those who formed the base of TAC's membership are not revealed.

[3] In the 1990s the Organization of Tanzanian Trade Unions (still under state co-option) was active in peer education and treatment of infected employees, distributing more than a million condoms (AIDSCAP, 2009). In 2004, now the independent Trade Union Congress of Tanzania, their political weakness was apparent in complaints about failure to consult with them about the national Poverty Reduction Strategy, and their comment on: 'the pathetic illness situation facing the poor'; see TUCT (2004).

economic transformation. In Tanzania the well-off are largely in denial, the stigma of the disease reinforced by its popular moral diagnosis and association with death. No public figures in Tanzania have identified themselves as HIV positive. Very few members of grassroots PLHA groups are aware of the broader picture of global struggles around HIV/AIDS prevention, treatment and care. Even amongst national leaders few are connected to movements and organizations outside the country; and rarely are claims made that go beyond issues of coping with HIV/AIDS to demanding social justice. Rather, the potential of PLHA organizing at grassroots level comes out of the anguish of survival under conditions of stark economic insecurity, physical illness and social exclusion, which lends it some political force.

The question we want to examine here concerns the political significance of collective action amongst PLHA in Tanzania. We will argue, first, that it does not represent a depoliticizing therapeutic turn towards personalized responsibility. Second, dependency on donor funding and patronage politics has led to factionalism and infighting within the PLHA community, which thus largely fails to provide the supportive environment considered necessary for the transformation of identities into empowered, active citizens who are able to make claims on the state; instead, PLHA organizations play a very minor role in decision making and rarely challenge the state or other authorities (although there have been some successful examples such as the Emtri affair described below). They may become mere facilitators of service delivery, marshalling the infected for treatment. Third, despite its limited direct impact on political decision making, such action has made significant contributions to political discourse around AIDS, by socializing the response, questioning the silences and challenging stigma. It is significant enough for the state, donors and medical authorities to see PLHA as agents in the take-up of life-restoring drugs.

The politicization of AIDS which is manifested in the proliferation of grassroots PLHA groups is not understood simply in terms of their impact on the wider political scene. The mobilization of Tanzanian men and women from diverse origins and different generations who share both harsh material circumstances and life threatening illness is unusual in itself. They forge novel solidarities through identifying as a stigmatized category, they learn how to organize, to confront power and to recognize its abuse. In the process they create, enlarge and occupy popular political space (Cornwall, 2004).

THE ROLE OF PLHA IN THE NATIONAL RESPONSE TO AIDS IN TANZANIA

The small and localized PLHA groups which we investigated are a recent phenomenon, many less than a decade old, and emerged long after the first cases of AIDS were reported in the country in the early 1980s (Baylies and Bujra, 2000: 27). The eruption of AIDS in Tanzania coincided with severe economic crisis, followed by the imposition of IMF Structural Adjustment, a harsh sentence of neoliberal economic reform. With the contraction of state services as one ingredient in the recipe, social welfare deficiencies were to be made up by the voluntary sector.[4] Out of the urgent need for solidarity, in the face of disintegrating social support networks collapsing under the pressure of caring for people suffering from a deadly and stigmatized condition, campaigning groups to support those living with AIDS emerged[5] and global funding flowed in to sustain them. However, attempts to unite these groups into a powerful political movement have largely failed and today the PLHA sector in Tanzania is heterogeneous and fragmented.

The first national group set up specifically by and for PLHA was SHEDEPHA (Service, Health and Development for People Living with HIV and AIDS) in 1993. Stigmatization was then so potent that it took great courage to disclose HIV status in public, so the formation of SHEDEPHA by Joseph Katto, an ex-oil company employee with partial primary education, and a few other HIV-positive people who met at the hospital, was a breakthrough. For several years, SHEDEPHA was the only PLHA group in the country, going on to establish district branches. In 1999, however, twelve women members started their own group, TAWOLIHA (Tanzanian Women Living with HIV and AIDS), because, it was said, women did not feel comfortable

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[4] See the World Bank (1992: xxxvii) for the way that this endeavour was framed in neoliberal terms.

[5] The key example is WAMATA (Walio katika Mapambano wa AIDS, Tanzania: ‘those who are in the struggle against AIDS’), founded in 1989 (Bujra and Mokake, 2000).

disclosing in front of men. Widows within TAWOLIHA, in turn, claimed the mutual understanding of others who had experienced the loss of a husband, and another group, AWITA (AIDS Widows Tanzania), was formed. This kind of segmentation allowed at first for extending the reach of PLHA mobilization by addressing the interests of narrower groups, even whilst all shared the stigmatizing burden of HIV infection.

As global funding increased, many new PLHA groups sought registration as NGOs in order to become eligible. Under surveillance from IMF, the World Bank and the UN, the government formulated strategic plans, initially through a National AIDS Control Programme and subsequently through the Tanzania Commission for AIDS (TACAIDS). In the first National Multi-Sectoral Framework on HIV/AIDS (2003–2007), the UN strategy for 'greater involvement of people living with AIDS' (GIPA, formalized at the 1994 AIDS Summit in Paris) was acknowledged, and support programmes for PLHA at community level were promoted in principle. People living with HIV and AIDS were encouraged to form groups and to organize these into networks at district, national and regional levels to promote the efficient coordination of activities. Such networks would also serve the need of international organizations for official channels to ensure funding accountability. However, resources for 'PLHA activities' were never sufficient to offer members a sustainable livelihood, or even reimburse their most basic expenses. Today there are seven national networks, all of which compete for prominence in the eyes of donors. Far from reinforcing a community of equals, the embrace of the state and donors created a political space within which patron–client relations were extended down through national networks to grassroots associations, sometimes composed of a mere handful of activists operating out of 'offices' in back streets.

The first generation of national PLHA leaders tended to come from the middle sections of society, rather than the poorest. They were from various ethnic origins, with some education, and with livelihoods based on small businesses or wage-labour, even white collar jobs. Like the South African activists described by Robins, they turned experiences of near fatal illness and crushing stigmatization and discrimination into an empowering force by seeking the solidarity of fellow sufferers and establishing new support networks where traditional ones had fallen apart. Given the promise of donor interest, leadership of such organizations also offered a route to modest social advancement, with remuneration, influence, opportunities for further education and foreign travel. Participation in international workshops and conferences on HIV/AIDS broadened their understanding of the 'AIDS industry' and offered the skills to navigate it.[6] In so doing some lost their close ties with their local social base. As a fellow activist said of one of them, 'if you go to their office, there's no-one there, it's closed, it's just a "briefcase association" (*jumuiya ya mfuko*). There is no place even to keep the files and they never had an annual general meeting'. Between the lines of this dismissive remark is a set of defining characteristics of what is taken to be a legitimate organization, which some of the networks strive to be.

The internal politics of PLHA networks vary considerably, from autocracy ('one-man shows') to a limited democracy with leaders elected for fixed terms. One such leader, facing the end of his two terms, expressed broader political ambitions of building on his PLHA networks to found an oppositional political party. His story illustrates the kind of 'career' such activists carve out. After the death of his wife and child and testing HIV-positive himself, he joined an East African association of PLHA. Despite limited schooling (Form 1) he was then able to make a small income from workshop and seminar attendance allowances and from providing testimonies to a donor magazine. Eventually he was appointed as a commissioner on TACAIDS, the government umbrella body. By 2000 he decided to use this experience to start his own organization, TANOPHA (Tanzanian Network of Organizations for PLHA), though it took a year to achieve registration. Pursuing the interests of his PLHA members as well as his class and personal ambition, he made links with people in high places. As he said 'I know several members of parliament who are HIV positive, but the system doesn't allow them to admit it'.[7] He also brought in some high level advisors with government or donor affiliations and thereby built up a successful advocacy network with many affiliate grassroots associations. TANOPHA participates in HIV awareness campaigns, assists member organizations to gain registration and trains their volunteers in 'capacity building', including transparency in doing accounts and writing proposals for donor funding.

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[6] To use the phraseology of Jelke Boesten, a researcher on the project.

[7] Wealthy HIV positive people use expensive 'fast-track' options in special 'VIP rooms' in private hospitals beyond the gaze of other patients and even hospital staff.

Donor support has led to the competitive creation of PLHA groups at all levels: as the same leader said, ‘everyone wants their own’. Infighting for limited opportunities leads to factionalism. Some groups which claim a national profile are largely inactive and at any one time some groups are expanding their reach, whilst others fail. One example is MMAAT (the Movement of Men Against AIDS, Tanzania) which claimed over a thousand members spread across several branches. Its main office was completely empty: no files, documents, leaflets, nothing that could point to active engagement. Neither elections for officers, nor regular meetings for members were held, due, according to its Chair and founder, to lack of funds to pay for members’ travel expenses. When its leaders attend workshops run by other groups, they receive the allowances commonly disbursed. Despite a lack of collective activity, the association claims a donor-friendly gender remit, as we shall see later.

Recently TACAIDS encouraged the revival of a national council for PLHA, NACOPHA (National Council of People Living with HIV/AIDS), to become the principal recipient of all funding for PLHA work in Tanzania. PLHA national networks view this as a threatening move towards centralized control and containment, and one which would interrupt what can be seen as a process of class mobility or consolidation for their leaders. As one leader put it, ‘they don’t want me to have that 45 acre farm I own … In their eyes we shouldn’t be active and we should be poor’. From a weak base, their politics *vis-à-vis* the state are only moderately challenging. Although they may present this as a national characteristic (‘our Tanzanian culture is not one of confrontation’) it is most evidently a response to the limited political opportunity structure within which they must operate, where state and donors call the shots. The networks complain that the government ‘doesn’t hear us at all’. It stereotypes the members as ‘sick people’ or includes them tokenistically, choosing its own nominees for ‘consultation’ whilst excluding them from decision making. They are only ‘to be there and listen’. When the government produced an AIDS bill in 2007 the PLHA organizations had little say in its formulation. This leader added that ‘the large donor organizations are no better’ and claimed that they too expected them to be poor and deserving. Given this context, claims to biological citizenship are unlikely to generate powerful counter-politics, but rather resemble a form of ‘neoliberal governmentality’ (Kistner, 2009).

MUTUALITY AND CYNICISM: PLHA AT THE GRASSROOTS

The grassroots groups we investigated included a successful organization in Zanzibar (ZAPHA+),[8] an organization led by women in Kigoma, the widows' organization AWITA, and three groups of the most needy in Dar es Salaam. Few join such groups with the intention of becoming political actors; most arrive in despair, overcoming their fears of exposure and resulting discrimination, and with no options left. Nowadays they often encounter others like them in the queues for ARV treatment at government clinics. To attract members, one group (Wahanga) established itself precisely on this terrain. Its members offer advice on coping with the disease and getting treatment, and act as intermediaries between medical staff and people with little knowledge of medical terminology or practice, who are frightened or angry at the way they are treated. They channel patients' complaints and monitor the quality of service delivery. Increasingly clinics refer those who test positive to a local PLHA group for support. Such groups reach out to those who are too sick to work, or have been dismissed from work or abandoned by marriage partners and families, and whose most pressing need is for immediate, practical support in the face of recurring and debilitating illness and socio-economic exclusion. In groups people find relief from their isolation: as a ZAPHA+ member said, 'There I saw all these other people … with AIDS! And I realized that I was not alone, that there are fellow sufferers. From that day I have been coming'. Others might become involved as a result of destitution.

Most of the groups we investigated had formal lists of 'members', but few could afford subscriptions. Rather than the groups being funded by their members, the situation was often reversed, with adherents hoping for, or even expecting, some succour from membership. The majority were people whose livelihoods were in the informal economy — petty trading, selling food, commercial sex or casual work for others with small businesses. Appadurai (2002: 26) borrows the term 'toilers' from Sandeep Pendse to describe the class positioning of such people. Marx would have described them with the imprecise concept 'lumpen proletariat', as those beyond wage

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[8] The full name of this organization is Zanzibar Association for People Living with HIV/AIDS. Data are drawn from Nadine Beckmann's PhD research (2004–8).

work, politically unreliable and volatile. The devastation of HIV infection has undermined even their insecure hold on a livelihood. Responding to members' need to build a sustainable livelihood and donors' demands for entrepreneurial spirit and self-empowerment, groups have sought external funding to start income-generation activities, in addition to providing peer counselling, education and awareness-raising, and home-based care to sick members.

The politics of such groups revolve around two aspects which could potentially be at odds with one another. The first involves the building of solidarity and a democratic consensus around the aims and practice of the group. The second involves leadership; this may be rule-governed and representative or it may serve to build personal fiefdoms which do not reflect the interests of the members. Even the most cynical members recognize the value of mutuality derived from joining a group. This may be embodied in their relations with each other rather than with the leader. As one woman said:

> I don't come to the monthly meetings in order to listen to the chairman — I don't even care what he says. I only come because I know there is today and tomorrow. Today we give a bit of money to help those who are sick, and somebody goes and visits. I am fine now, but I can get sick too, and then they will help me. That's why I force myself to go to the meetings.

People also gain in non-material ways, through learning about the disease and about the latest treatments. An AWITA member explained: 'at first I didn't know what AIDS is, but when I got here I received so much education about [it]… how to live with it, and how to protect my children'.

At the lowest level, people who aspire to be leaders must first create a following of loyal members. If they cannot deliver, then their members desert them. As one leader said, 'members only come when something is given out for free; food or money — then they're all there'. Given the sheer need of those who seek assistance, this cannot usually be achieved without external support, so the leaders must learn how to attract donors and get state support. Few are educated beyond primary level, and their access to facilities is meagre. The grassroots offices that we visited were without telephones, though many leaders had mobiles. Some had been helped to acquire an email address, but none had a computer and they could rarely afford an internet café. Surfing the net was problematic for those who could barely speak English. Creating transnational alliances and mobilizing support globally on the basis of their shared ‘AIDS citizenship’ was nearly impossible for these groups. Members, however, expect returns whilst regarding success with some suspicion and envy, unless mechanisms are in place to share the proceeds. There is tension between voluntary activism and the need of all to make a living.

Critical views are particularly potent in Dar es Salaam, where PLHA groups have mushroomed, although many have a nebulous existence. Members are often fickle in their attachment. As one leader in Dar said: ‘We used to be seventy up to ninety people in the group, but now, since they saw there is no money, they don’t come any more’. This is confirmed by supporters who say, ‘we are tired of coming — you always hear the same old stuff and there are so many groups now’. Leaders meanwhile can get impatient and speak disparagingly of their followers: as one said, ‘they don’t know anything, they just come to ask for help’.

Whatever their origins and mode of livelihood, leaders of PLHA groups sooner or later look to making a living through their organization. They do this through access to donor funding, through attendance allowances, or by capitalizing on contacts built with patrons higher up the system, though only those with some English can make real progress. The names of some leaders may become known through radio or even television and some imagine futures as politicians. ‘People know me now’, said the leader of one group; ‘If I put up for election here I could win’.

The politics of mutuality can lose out to cynicism, especially when people see NGO workers and government officials (and indeed some national PLHA leaders) in big cars, while they are still struggling to survive. That their anger and disappointment is not translated into collective action to protest the injustices, is partly because their own leaders often aspire to climb the ladder of patronage and join the privileged. Such leaders are unlikely to call for long-term social transformation or serious challenge to the state, even where their members may demand it. At one heated meeting a woman spoke angrily about the gap between what is promised and what is delivered: ‘We’re tired of hearing there is no money! The government keeps saying that… But when we ask for some food because the medicines are hurting us, they say they don’t have any.

Let’s go to the parliament and ask for our share!’. Such militancy was not supported by leaders. Some members blamed their own lack of solidarity as well as the instrumentality of their leaders. ‘We don’t stick together… if one succeeds he forgets where he came from’. Messages, targets and strategies for mobilization are often unclear. Rather than building a movement, PLHA collective action more often feeds into compliance with state and donor agendas.

The Faces of Dependency

‘Grassroots globalization’ can mean that local people grasp that their struggles are shared across the globe and that their own political action can contribute to transforming the global context in which AIDS is managed; or it can mean that global advocacy networks, often unwittingly, set agendas and develop scripts by which people at the grassroots are to be enlightened. The South African case shows that a movement in one country — and in the South — can have a global impact; but more often the arena of global politics around AIDS is marked by relations of dependency. This is evidenced most strongly in the direction of funding flows, but is also reflected in the whole culture of coping with HIV and modes of self-organization.

Tanzania does not lack a history of grassroots and national political organization. Nationalist politics and wage labour conflicts were a marked feature of the struggle for independence. Such organization was funded by local people out of their meagre incomes (in the same way they still contribute to ethnic burial societies, rotating credit associations or funeral expenses, with meticulous accounts kept in exercise books). The period of socialism under Nyerere allowed for some contention to be expressed, but the growth of state power gradually co-opted or repressed alternative voices. Limited industrial development also restricted the emergence of a large wage labour sector. When Tanzania shifted to multi-partyism in the early 1990s, it was as a culmination of neoliberal reforms imposed by the IMF under structural adjustment. ‘Civil society’ was now privileged, but as a partner in a ‘neo-liberal offensive’ (Shivji, 2007: 29). The burgeoning of NGOs did not create much space for struggles for change, as they derived ‘not only their sustenance but also their legitimacy from the donor community’ (ibid.: 31). Over time the state also reasserted its surveillance over non-state actors' activities, most notably in the NGO Bill of 2000 which restricted NGOs to a 'non-partisan' role (LEAT, 2009; Shivji, 2007: 61).

Donors arrived from many different directions,[9] but they all assumed they were operating on a *tabula rasa* rather than building on existing or historical examples of organization. This led to a 'capacity-building' phase, in which new civil society organizations were taught how to establish themselves, keep accounts and provide evidence of their probity to those who fed them. Benchmarks for action reflected current debates in the development field — empowerment, gender equity, democratization and so on. Similar pressures were brought to bear on emergent PLHA organizations, limiting their autonomy.

The tiny office of Chakupau, a neighbourhood PLHA organization in Dar es Salaam, illustrates the outcomes of this process. On the walls are displayed the results of the capacity-building workshops that small NGOs are funded to attend: charts, neatly drawn, of the organizational structure, mission statement and objectives of the group, their accounts and expenditures, and pictures of their activities. There is also a diagram depicting their network: Chakupau is in the centre; in the next circle are those Tanzanian organizations who have provided funding in the past (TACAIDS, the Human Development Trust and TANOPHA); and in the outer circle are others they collaborate with (AWITA, etc.). On another wall, a big painting illustrates the famous ship of hope inspired by Fr Joinet in the early years of HIV/AIDS in Tanzania (Joinet, 1984): it shows a boat called 'G8 summit' (the developed countries of the North) from which people throw life-belts in the form of ARVs and condoms to save drowning Tanzanians. The secretary and chair of the association are busy writing letters and funding proposals to donors.

The dependency of grassroots associations on national, state and international bodies is underlined here, but national PLHA networks also rely heavily on donors. The donor community not only provides sustenance, it also demands new ways of thinking — for example on gender. It is said that MMAAT was originally founded in line with current international thinking that men should take more responsibility for the

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[9] UN and US donors predominate amongst the major funders for PLHA in Tanzania, with lesser funding from Europe, South Africa and the Tanzanian government.

transmission of HIV (Foreman, 1999). One of its members laid claim to ‘progressive’ thinking. ‘Men must change’, he insisted, they must see their wives as partners; ‘instead of only telling them what to do, they must also listen’. A discussion with the chair and founder, however, suggested that these worthy goals had been translated into more self-serving arguments: the association aimed to ensure men got their fair share of donor funds since much more came in to fund women’s groups, whilst men also had heavy burdens. Only when pressed did he add that they also want to abolish ‘male rule’ and unite men to fight against AIDS and get tested so that they do not infect their partners. Throughout he referred to men as family heads and sole breadwinners. In the event, the emptiness of MMAAT’s office, described earlier, suggested that they have been unable to effectively engage in this cause.

Global discourse on AIDS also underlines the value of openness, breaking the silences around sex and sexuality. It promotes disclosure by individuals of their status, encouraging them to ‘own’ their illness in order to confront and overcome it. In South Africa TAC members wear t-shirts proclaiming their HIV status to emphasize that they are not ashamed and to make common cause with fellow PLHA. Illness narratives and treatment testimonies have served as powerful vehicles in transforming sufferers’ subjectivities and shaping new identities as empowered and ‘responsibilized’ survivors (Robins, 2004, 2008). In Tanzania, too, it is common for AIDS campaigns to invite those who have suffered to offer testimony of their personal journeys — though they expect to be paid to perform in this way. A PLHA activist in Kigoma complained about how little the national network was paying her from donor funds for testimony delivered at workshops. It would seem that it is not a new ‘identity’, whether of victim or survivor, that is being claimed here; it is simply one more way for desperate people to eke out a living.

While the framework for engaging with global players is certainly constrained by structural forces, this does not mean that grassroots members are merely passive victims; they creatively manipulate global discourses to fit their own needs. We observed an AIDS widows group (AWITA) in Magomeni, Dar es Salaam, for example, mobilizing their members to display their main income-generating activities for a group of young white fundraisers who were looking for potential beneficiaries. In a strikingly scripted way, each member introduced herself, using the confessionary formula introduced long ago by the American association Alcoholics Anonymous: ‘My name is Tuma’ said the first. ‘I am a widow and I am living with HIV/AIDS.’ They endeavoured to convey a positive, energetic atmosphere, while simultaneously highlighting their lack of resources to fulfil all their commitments, including mutual support and counselling, raising awareness of HIV among their fellow citizens, and providing psychological care and quality time for the many orphans of the group. Clearly, they had learnt how to present their suffering in a way that will open Western people’s purses.

The widows in this localized group struggle to create a financial support system to alleviate their members’ most severe impoverishment, despite the fact that AWITA is a well-established group, formed by the thirteen women who started TAWOLIHA, as a daughter organization specifically for HIV positive widows. Only four of the original founders are still alive. The organization has never become a national network in its own right, though it has spawned several autonomous widows’ groups in other parts of the country. It currently claims forty members. It enjoys some prominence in the media after initiating and participating in several notable campaigns to demand widows’ inheritance rights and to challenge stigmatizing images of PLHA manifested in awareness programmes.

AWITA is known to most development partners working in the field of HIV/AIDS and has received limited funding, but few donors are willing to meet with groups working at the grassroots level. The widows are bitter about the pittances they receive despite all their patient hard work, especially when they hear about the large sums of money which enter the country for HIV/AIDS. Overseas development aid for HIV/AIDS was projected to be more than TSh 500bn (well over US$ 332 m at today’s exchange rate) per annum for the year 2007/8 — ‘a staggering one third’ of all aid flowing into the country (TACAIDS, 2007: 8). The focus of such a large share of donor resources on this single disease seems increasingly disproportionate. Even the government recognizes the huge risks of establishing expectations that will not be sustainable if support is withdrawn (ibid.: 12). Meanwhile, very little of this funding reaches those most in need — people living with the virus as well as facing grinding poverty.

What then is the significance of their confessional introductions? Testimonies and confessions have been ascribed a cathartic power in therapeutic approaches to dealing with trauma and mental health problems. Alcoholics Anonymous, drawing on biblical sources and social psychology, popularized the techniques of confession and disclosure as integral steps to recovery from alcoholism in the 1930s. Applied to a range of different ailments and combined with local forms of community organizing around the world, they can be described as 'travelling technologies', which have come to be part of what Nguyen (2005) refers to as global HIV assemblages. Nguyen recounts how external agencies promoted self disclosure of HIV status as a form of personal therapy in French West Africa. Local PLHA resisted, and refashioned this new space into one for discussion of 'the problems of material subsistence' (ibid.: 131). The AWITA women's strategy seems altogether more instrumental, even political, a scripted performance for an external audience of potential benefactors, similar to the commodification of stories of suffering among South African victims of Apartheid analysed by Colvin (2000). Creatively playing on the victim-turned-entrepreneurial actor narrative, they perform a script that resonates with the foundations of neoliberal governmentality, involving the transformation of passive sufferers into active and engaged patient-citizens. While this may be regarded as an empowering claim to ownership of their stories, it rarely involves a transformation of subjectivities into empowered AIDS citizens. Though disclosure to each other is implicit in their acceptance of new members, like other PLHA they often avoid naming themselves in public, to their neighbours and even sometimes within their families (cf. Boesten, 2009: 78). The 'silences' are broken only in safe contexts.

Global discourse and advocacy on AIDS is echoed in PLHA activism in Tanzania but it is a distorted echo. Scripts are reworked in local circumstances through local cultural norms and practices. And whereas stratagems like 'capacity building' eventuate in organizational structures that superficially mirror those proposed by donors, the actual life of groups may diverge considerably.

ARVs: A Depoliticizing Moment?

Access to treatment has been at the core of the struggle — and success — of the TAC in South Africa. TAC was able to form a convincing moral cause, draw clear enemy lines and routes for alliances, and create unambiguous messages and strategies. Simultaneously, powerful treatment narratives helped to transform patients' experiences of near death into an enhanced awareness of their human rights in the face of global dependencies, creating active and responsibilized citizens, empowered to make claims against the authorities. In Tanzania, there was a series of mass rallies on the city streets around HIV/AIDS in 2003–4, sponsored not by PLHA networks (though they did participate) but notably by a gender networking group, TGNP (Tanzania Gender Networking Programme), with the support of other civil society organizations. Representatives of TACAIDS and some politicians also took part, but active involvement by grassroots PLHA was limited. These rallies demanded the rights of PLHAs to ARVs, quality treatment and food security, a role in policy formulation, and the recognition of home-based care as unpaid household work. Media publicity was sought and won (Mbilinyi, 2007: 12–16). This spurt of political action was short-lived. Tanzanian PLHA quickly took access to ARVs for granted, neither having had active involvement in the struggle for their availability, nor mobilizing to protect access.

Undoubtedly, free access to anti-retroviral treatment, provided since 2005 through governmental and some NGO-run clinics, has brought massive relief in Tanzania, restoring people's health, enabling them to care for families, providing hope for the future and allowing PLHA to participate again. However, as treatment recipients 'recover', turning from 'patients' back into 'persons', the solidarity of a community of sufferers fades. Our observations showed that numbers attending PLHA group meetings have declined since treatment was introduced, suggesting that transformations from sufferers into active AIDS-citizens cannot be taken for granted.

The focus of debate among PLHA has shifted from physical survival in the face of fatal illness to economic survival and reintegration into society. Anti-retroviral treatment allows people to hide their HIV status and avoid stigmatization. This facilitates their new quest for work, partners and a 'normal life'. Rallying for the rights of PLHAs does not now make much sense to these people, as they may no longer define themselves as HIV positive. The impact of this may be felt most by those whose effort has gone into setting up PLHA groups. As one said bitterly:

> ARVs have changed things, a new stage in AIDS has arrived: we don't die anymore. Now we need to know how to take care of ourselves. I'm so sick of being asked to do home-based care… I told them [donors, state] I don't do it anymore. I don't understand why all the money that goes into AIDS always only goes to those who are already sick, or to the children of those who have already died... we should invest more in people like me, who are still going strong, so that they don't ever reach that stage and can help themselves.

These concerns acutely highlight the ambiguities inherent in the concept of biological citizenship, which in Biehl's view signifies a new form of governmentality, rather than a democratic extension of rights. Biehl sees them as mobilized individuals who 'articulate a novel concept of patient-citizenship' (2007: 94) within a global politics of survival that combines the struggle for food, housing and social security with a new political economy of pharmaceuticals, thus realizing a reforming state's vision of scientifically based and cost-effective social action.

The introduction of antiretroviral treatment has also rendered the state less obviously a target for PLHA political action. Government assistance extends to free treatment for opportunistic infections, thereby privileging PLHA compared with sufferers of other life-threatening illnesses, and providing one reason why they do not receive whole-hearted support from the general public. Given that the government now provides free treatment based on international funding, the state and donors are both friend and foe: without them, PLHA would have no support at all, neither medical nor socio-economic.

Conversely, due to CD4-based treatment initiation guidelines[10], only a few of the infected are admitted to the queues for treatment, and some die waiting, or die because they cannot feed themselves properly. Amongst these are widows ejected after husbands die of AIDS, those whose families beat and reject them when they test

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[10] The CD4 count measures disease progression by establishing the number of the remaining T-helper-cells in the patient's blood. A person whose CD4 count is below 200 cells/mm^3 considered to have AIDS, and WHO guidelines classify these patients, and those showing AIDS-defining conditions and a CD4 count below 350, as eligible for antiretroviral treatment.

positive, and all those who already struggle to survive in an economy which does not provide work. PLHA also have reason to protest against being used as voluntary labour to service home-based care and support for orphans when donor aid is coming into the country to support such services. As one poor woman cried out in despair, ‘Give us jobs! I don’t see why PLHAs couldn’t sweep the floors in the clinics… just give us a chance!’. Another reason to organize is to get the voices of PLHA heard in places where decisions are made about medical and service provision.

Where politics in general is based in patron–client mode, clients are inhibited from making common cause. PLHA groups waste energy competing with each other for different patrons (the state, INGOs bearing funding, or other ‘benefactors’) and fulfilling patrons’ criteria for acceptability to win success. This can mean echoing patrons’ scripts of ‘coming out’ and ‘testimony’, which in turn inhibits the development of an indigenous language of protest. It means accepting the kind of ‘capacity building’ that serves donors and the state, directed at creating obedient patients and an efficient voluntary labour force that works within the rules of accountability and transparency. It rarely means building people’s capacity to mount strategies of political mobilization, negotiation with authority, or the forging of political alliances.

While in South Africa alliances with trade unions and with the gay movement strengthened the power of TAC, in Tanzania the unions are weak and gay people do not organize openly. Homosexuality is technically illegal and carries a stigma almost as harsh as being infected with HIV. Grassroots PLHA tend towards homophobic views which rebuff assumptions about the source of their infection. Similarly there is no attempt to recruit from or campaign with sex workers who display a high incidence of HIV, even though many women in PLHA groups engage in transactional sex simply in order to survive. And there is little support here from wealthy or politically powerful allies who have disclosed their own status.

Despite these constraints, events in 2007 suggest that PLHA organizations may have some political impact. Emtri, an ARV generic medicine from India, was supplied to PLHA via government outlets. Patients began to notice excessive side effects and a declining CD4 count — the opposite of what ARVs are supposed to achieve.

TANOPHA attempted to put a formal complaint to the Ministry of Health, and to the National AIDS Control Programme (NACP), but they were rebuffed. The Minister issued statements to the press insisting on the drug's safety. Meanwhile a local World Health Organization representative insisted they had advised the government against this non-approved generic. TANOPHA then submitted formal legal representations and called a news conference, where they used medical evidence to testify to the dangers of Emtri. Responding to the anger of their supporters TANOPHA and other PLHA organizations marched to the Parliament buildings to submit a petition, though they failed to get press coverage of this event. Eventually the government ordered the NACP to investigate and the drug was banned. Finally the Minister was reprimanded and accusations of corrupt practice were levelled against ministry officials who were said to have promoted the drug against medical advice.

These events showed that PLHA collective action can have a remarkable political impact, despite the fear that political visibility may heighten their stigmatization. Although it did not draw attention to their small demonstration, it is notable that press coverage was favourable to their plight. Indeed one report (*ThisDay*, 10 March 2007) asked critically: 'Does President Kikwete care about Tanzanians' health?', thus posing the issue at a general level, of relevance to the health of all citizens. Following this episode, the Tanzanian producers of another ARV which was also said to cause undesirable side effects approached the leader of TANOPHA for discussions, showing that even limited confrontation can enhance the longer-term standing of PLHA. Nevertheless this case contrasts with the general lack of involvement of PLHA networks in decision making around AIDS. To go public in this way is seen as threatening the meagre recognition that government pays to PLHA organizations.

Gender Politics and Democracy in Action

Despite the limited impact on national and global decision making, in-depth ethnographic research that captures the unintended consequences of participation in PLHA groups reveals significant transformative potential to inspire political awakening at the local level, particularly around gender and generational politics and the democratization of leadership and management practices. A particularly successful grassroots group was ZAPHA+ in Zanzibar, established in 1995. With a large following, drawn largely from the most disadvantaged, they ran weekly meetings, for which Africare, their main donor, gave a grant to cover members' transport. The meetings brought together a majority of the members on a regular basis and served as a vital forum for discussing issues around organizing and managing life with HIV/AIDS, making the association a rare example of grassroots democracy.

Normally, Saturday meetings gave a respectful ear to the long-standing chairman of ZAPHA+ (re-elected some three years before the incident reported here). The first in Zanzibar to publicly disclose his HIV-positive status, he has dedicated his life to the organization. On this occasion, however, Tausi, a young woman, dared to challenge his authority by questioning what is normally taken for granted — male prerogatives to demand sexual favours. She complained that the chair had tried to seduce her and continued to harass her after she refused. 'We are many women', she said, 'but the leaders are all men'. With the room in uproar the Chair tried to silence her by invoking the Qur'an and men's 'natural' leadership and protective role towards women. In the following weeks it became evident that Tausi's experience was not uncommon, though many of the older women members insisted she should have kept quiet. In a separate women's meeting she was heavily criticized for bringing shame on the whole organization and it was suggested that the easy familiarity of the meetings subverted moral relations between the sexes. Fear was expressed that if such an abuse of leadership became known to international donors they would withdraw their financial support. Indeed, when some complained that he and other leaders were also engaged in petty corruption over donor funding, Africare did reduce its contribution.

The unquestioning respect which the Chair had enjoyed was now lost, and several executive committee members resigned. When the Chair tried to reassert his authority he inadvertently riled another member whose wife he had also seduced. This accusation carried more weight, coming from a male, a policeman, who had standing after coming back to life through ARV treatment. Calls for 'demokrasia' and for the Chair's resignation now became deafening and the Chair stepped down.

Elections followed. A respectable but weak male candidate was nominated against the current Chair, whilst an active, calm and respected woman, experienced in public speaking and AIDS education put herself forward as vice-Chair (she was also a Christian where the majority of members are Muslims). But after other women pointed out that the majority of ZAPHA+ members are women, she was encouraged to stand as Chair in her own right. At the election, overseen by donors and state officials, and through secret ballot, the woman was elected by a large margin.

This case illustrates how pre-existing social inequalities — and especially those which mark the relations between men and women — are exposed in PLHA groups. Campaigns against AIDS have opened up the topic of sexuality to public discussion. In ZAPHA+ some members had already transgressed the rule of silence about sexual matters between adjacent generations in deciding to educate their children about AIDS. Talking about ways to protect themselves from HIV infection meant discussion of condoms, of casual sex and of multiple partners. More remarkably, this was happening in a mixed group of males and females of different ages, coming together on the basis of their shared stigma and suffering. The normal rules of social engagement were already broken; Tausi’s accusation did not cause surprise.

Donor support was vital to ZAPHA+’s success, and yet here the struggles for greater democracy and gender equity were pursued despite a possible threat to funding. In long-standing groups like this, a measure of confidence in their own capacity to deal with internal conflicts is evident. They already had processes for electing leaders, an open forum in which members could voice concerns, and sanctions for misdemeanours. Despite the conflict, which left its scars, some solidarity was reasserted.

Leadership is a source of contention in most groups as those who founded them may be seen as self-interested and prone to corruption or worse. Male sexual prerogatives are not suspended simply because the people involved are HIV positive or even because they are drawn into collective action. As a sexually transmitted disease, AIDS has always raised questions of gender and it is therefore unsurprising that many of the conflicts in PLHA groups revolve around gender inequities. Many groups have a predominance of women members, as women are more likely to be subject to infection, blamed and rejected by family members, and in need of material and emotional support. A predominantly male leadership, however, reflects the prevailing patriarchal order. Conversely the ZAPHA+ case showed that PLHA groups can open up a political space in which normally buried issues of power — and confronting the abuses of power — are opened up. In the process male leadership is questioned and it is no longer unthinkable that women might become leaders. Indeed in Dar es Salaam many newer groups are led by women. Generational differences are also on display, with older people often blaming the young for their immoral ways, whilst younger people chafe at being disregarded.

An example from Kigoma shows that it is not merely sexual misbehaviour which sets gender politics in train. Here, allegations about the embezzlement of donor funds in the SHEDEPHA branch led to a breakaway group being formed. The SHEDEPHA leaders threatened the breakaways and scared away their main patron, but they persevered and registered their group in 2005. They decided to form a women's group because of their negative encounters with the male leaders of SHEDEPHA and their shared experiences of husbands' violence and abandonment when they disclosed their HIV status. The secretary and founder explained that 'Men are not trustworthy'. However, the group decided to admit some male members — four out of sixty — but specified that 'men can only be ordinary members, they cannot be elected onto the executive committee and we don't give any of the positions to men, especially not that of a treasurer'. Thus it was out of extreme experiences of loss of male support that these women learned that they can manage their lives themselves and organize on their own account. They were prepared to admit men, but on their own terms. However, female leadership faces the same challenges that all PLHA leaders confront, including the need to reconcile conflicting expectations, envy and accusations of abuses of power.

Despite their power in the group, and their knowledge of 'their rights', learnt through a workshop on HIV legislation, the Kigoma women felt socially vulnerable. Many had been chased away by husbands; one recounted how her husband threatened to kill her when she suggested he be tested. Now he wants to marry a second wife, and she cannot protect the girl from being infected in her turn. Still their group is strong and active: local hospitals pass on to them newly diagnosed people for follow-up and they visit homes to educate people about AIDS and care of the sick. Deeply engrained gender roles and hierarchies do not change overnight, but the song they sing about their struggle indicates that in these groups processes have been set in train that are difficult to reverse: ‘We’re moving forward; we will never go back’.

CONCLUSION

As compared to South Africa, the political conditions for the emergence of a social movement around ‘biological citizenship’ are limited in Tanzania. State surveillance of PLHA collective action and a heavy dependence on donors inhibit what could be a political expression of claims for the right to life and livelihoods to which all Tanzanian citizens are entitled by the Bill of Rights of 1984. As Tanzania’s Lawyers Environmental Action Team commented on the NGO Bill of 2002, ‘NGOs will never be able to participate in social, economic and political transformation … if their role in politics continues to be denied’ (LEAT, 2009). Although mobilization has created a critical mass of organized PLHA, they are divided into competitive factions scrambling for favours. Mostly first-time activists and ‘toilers’ in the informal economy, they lack experience of collective struggle. They avoid confrontation with the state, fearing it will entail stigmatizing disclosure and threaten their access to patronage.

The tendency of government to blame the behaviour of individuals and communities for HIV transmission deflects attention away from state responsibility for addressing socio-economic inequality and access to essential goods and services. These play a major role in the spread of infectious diseases, as has repeatedly been emphasized by epidemiologists (Stillwaggon, 2006). Consequently PLHA efforts focus on their own individual needs and the avoidance of stigma rather than demanding radical social change (such as a redistribution of power and wealth). Indeed in Tanzania, all are superficially on the same side, with state and donor guarantees of access to ARVs for which PLHAs have barely struggled, and whose withdrawal they cannot conceive. (The contrast with South Africa where both state and multinational pharmaceuticals stood in the way of effective treatment is marked.) The most significant role that PLHA groups play here is to marshal people into queues for treatment and to monitor that treatment so that their members can live. Despite the social value of this activity it affords little political leverage.

The same unfavourable political conditions create opportunities for some PLHA at the expense of others. Leadership of a group can deliver a modest livelihood and chances for social advancement, especially for those who already have some education or a middle-class background. At one time such a category would have enjoyed easy entry into state employment; now they pursue class mobility via NGOs, some with an eye to translating this into political careers. Their striving can serve the interests of their members when they bring in funding for projects or casual work. But it can also lead to petty corruption, instrumentality and ‘briefcase NGOs’. Few leaders are wedded to a politics of social transformation or prioritizing the very poorest — they benefit by working within the system rather than challenging it. The poverty-stricken and desperate who form the majority amongst members struggle to hold their leaders to account.

Some transformations are taking place through PLHA extension of popular political space. Within PLHA groups gender inequalities are exposed and often challenged, with men learning to work with, rather than dominate women, and women finding that they too can acquire organizational skills and exercise leadership, holding men to account both for sexual predation and petty corruption. Whilst formal organizational structures and procedures can appear as arid and empty formalism, they can be used to good effect by those who have little social power. And they provide a framework within which men and women of different generations, ethnic and religious backgrounds can work together.

People Living with HIV/AIDS in Tanzania are part of a global network through which resources and discursive framing of their situation flow, but very few have an active global engagement through communication or travel. From their perspective the global network is a hierarchical system in which clients cannot afford to challenge patrons. This is a kind of politics, but not one which allows for much autonomous action. It compares unfavourably with colonial and immediate post-colonial political modes which were self-sustaining and independent. And whilst many of those living with HIV still die because they cannot afford to eat adequately, whilst orphans suffer sexual abuse or widows are left destitute, delivery on the political promise of citizenship still needs to be claimed locally before a more globalized solidarity can be envisioned.

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