Privatizing Public Health: Social Marketing for HIV Prevention in Tanzania, East Africa

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Privatizing Public Health: Social Marketing for HIV Prevention in Tanzania, East Africa

By

Erin Elizabeth Mahaffey

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Committee in charge:

Professor Cori P. Hayden, Chair
Professor Nancy Scheper-Hughes
Professor Jennifer Johnson-Hanks
Professor Stacey Langwick

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Abstract

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Erin Elizabeth Mahaffey

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This dissertation explores U.S. commercial marketing’s influence on HIV prevention programming in Tanzania, particularly the practice of social marketing. Social marketing NGOs in Tanzania uphold the goal of creating commercial markets in condoms and promoting HIV prevention behaviors among the public through commercial advertising. Their aim is to address health inequalities among urban low income communities through application of new theories regarding the “social” nature of markets to make privatized access to health goods equitable and sustainable. This dissertation analyzes and historicizes social marketing’s foundations in the presumption that humans are by nature driven to pursue pleasures which undermine their ability to make rational choices and which only markets can steer towards health and reason. By drawing on the accounts of individuals – including members of Islamic-based health NGOs, Tanzanian entrepreneurs, and individuals in impoverished neighborhoods targeted by health programs – this work describes the politics and stakes of social marketing interventions, including unanticipated economic and health marginalization. Each of these groups drew from moral understandings of the imbrication of economic, political, and social life to critique the privatization of public health. This dissertation maps these controversies not only as debates about public health and political economy grounded in terms of a critique of private property, but as entailing epistemological and ethical claims about health, markets, and human nature.
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Ch. 1: Privatizing Public Health

Introduction

This dissertation is an ethnography of social marketing for HIV prevention and the competing forms of economic thought that it encounters in Tanzania, East Africa, a former socialist state with HIV rates peaking at fourteen percent in urban and highly trafficked areas. Social marketing is the use of commercial marketing principles and techniques to address social problems like HIV. By applying marketing to public health prevention programs, social marketing professionals configure biological understandings of HIV risk in terms of how psychological desires for pleasure, fun, and ease in life motivate human behaviors, such as sexual practices and condom use, and organize humans in economic relationships, including exchanges in sex, money, and condoms. Given this understanding, social marketing interventions in HIV attempt to influence how humans make decisions about health, sex, and condom use as well as how businesses and governments make decisions about intervening in economic spheres. This research focuses specifically on U.S. led and funded social marketing programs taking place during the years of 2006-2008, which uphold the goals of creating commercial markets in condoms, coordinating these efforts with government distribution of free condoms for the poorest populations, and promoting HIV prevention behaviors among the public through commercial advertising.

In broad terms, this dissertation is an examination of what is entailed in thinking about and intervening in people’s health and sexual practices according to a marketing perspective. What is involved in thinking about citizens as consumers and public health professionals and their institutions as marketers and businesses? How does the project of public health change when public health professionals use persuasion rather than education to influence people to practice health prevention behaviors? How does public health change when health professionals consider populations to also be markets, groups of persons engaged in exchanges of materials and ideas, exchanges which influence health outcomes and yet are malleable? And what are the historical and conceptual foundations of this way of thinking about public health?

This dissertation explores these questions in the context of Tanzania, thus also addressing the issue of what actually happens in specific communities where social marketing programs take place. Where quite different presumptions and practices of government, economy, and sex are at work, is social marketing effective in the way that it claims to be? What kinds of conflicts and unexpected outcomes occur? How do people in Tanzania interact with and at times call into question social marketing and the assumptions upon which it is based? And what exactly is at stake for the multiple persons and institutions who become involved in social marketing programs?

Thus this dissertation is also an examination of politics in the health field. Politics, as contestations over the ideas, resources, and practices which influence humans and which organize society, can occur in multiple forms. The materials, ideas, or practices which become political are never straightforward or inevitable but are made so by those whose way of living is at stake. Where one might expect a dissertation on social marketing and politics to be primarily concerned with questions of access to health products, particularly whether and how governments and commercial businesses
provision or close off peoples’ opportunities to access health resources and achieve health, this research approaches these questions from a particular angle. Social marketing evaluates this question according to numerical counts of products distributed and lives saved. Instead of treating such numerical counts as resolving political questions of how government-run and market-driven health care can best promote health, this dissertation approaches ways of measuring health and health product access and ways of conceiving of public health as itself involving cultural logics and as being a political question.

Social Marketing: Interventions in Health, Rationality and Desire

Social marketing, as a field of practice and expert thought, arose in the late 1960’s and 1970’s when U.S. commercial marketing professionals began to experiment with how marketing strategies could be applied to social problems. One early application of social marketing in the late 1960’s was in family planning. At the time, governments in developing countries sought to promote the use of condoms and contraceptives among their populations. U.S. commercial marketing professionals with funding from the Ford Foundation and USAID consulted with government programs on how to use marketing strategies to persuade populations to adopt these products. One primary social marketing technique was to brand condoms and contraceptives. Where government programs had in the past distributed condoms in plain white packages, they now developed exciting and colorful packaging with clever names for condoms. This program attempted to persuade citizens to use condoms by appealing to their desire for a contemporary lifestyle and their excitement to participate as consumers in the market, rather than by provisioning citizens with information about the risks and benefits of condoms. Business professionals who developed the intervention based their approach to influencing human health on the economic logic at the heart of marketing and branding: the idea that people by nature make decisions based not on a rational pursuit of health, but rather according to an attempt to gain easy fulfillment and pleasure, to satiate desires, and to associate themselves with particular aspirations such as a “modern” way of life.

These early interventions in the problem of family planning and sexual health during the 1960’s and 1970’s initiated the establishment of several U.S.-based international non-profit and non-governmental organizations seeking to provide social marketing services to governments globally. Population Services International (PSI) was among the first. PSI’s model of conducting social marketing consisted of establishing an office of their international NGO in a targeted country. The NGO would work on behalf of the local government to brand, advertise, promote, and sell health products in the country. Essentially, PSI’s NGOs operated like commercial sector companies, but any profits which resulted from the sale of condoms were reinvested into NGO programs rather than paid to shareholders. Donor funds from USAID and European governments subsidized the price of condoms, but these social marketing programs still charged a price for condoms and distributed condoms through commercial sector outlets. This practice was based on a central tenet of social marketing theory, its theory of value which states that people are more likely to value and thus use a product if they have paid for it, no matter how little the price.

These first social marketing programs were early experiments in what today has expanded into a whole field of specialization in development aimed at creating
commercial markets which not only produce profit but also, theoretically, address problems of health and health inequality. Today qualified as “markets that work for the poor,” “creative capitalism,” or “inclusive capitalism,” these theories of capitalism promote the idea that markets contain ways of equitably distributing products according to people’s need and ability to pay. For example, social marketers in Tanzania theorize that a commercial company can subsidize lower priced brands targeted at the poor through profits gleaned from expensive brands of condoms targeted at the rich. Essentially, social marketers conceive of branding as a market-based subsidy. In theory, these schools of intervention turn central tenets of public health on its head: where the modern project of public health historically arose as a way to combat the inequalities and diseases brought about by the rise of capitalist society, industrialization, and urbanization, social marketing now poses commercial market processes and commercial profits as solutions to disease. However, while social marketing may address inequalities in health and reduce health risks by creating greater access to condoms for the poor, this dissertation demonstrates how it does little to change the class inequalities which themselves produce risk. Rather, social marketing naturalizes class differences and re-inscribes these inequalities through the terms of the brand. In other words, social marketing creates the effect that one’s class, health risks, and the kinds of products, services, and opportunities available to individuals are the outcome of people’s innate desires rather than the structural effects of capitalist markets.

In the context of Tanzania, social marketing first began in 1993 after a long period of socialism, a history that continues to inflect social marketing to this day. Leading the nation at independence in 1961, Julius Nyerere promoted philosophies which conceived of private enterprises as running counter to human rights to health and equality within society. Articulated in his 1967 “Arusha Declaration,” Nyerere outlined his conception of Ujamaa (“Familyhood”) socialism and his doctrine of self-reliance. Nyerere promoted Tanzanian socialism as a critique of capitalism, which he saw to be exploitative, as well as a critique of Marxist-Leninist ‘scientific-socialism,’ which advocated for class struggle and conflict. His philosophy drew from an ethic of communal living, familyhood, and generosity rather than greed, values which he defined as particular to African modes of existence. With the Arusha Declaration, Nyerere called on citizens to form socialist villages based on communal agriculture and he nationalized private industries. The government bought large shares in companies and in certain industries took over the management entirely. Nyerere also universalized access to education and health care throughout the country.

Tanzania’s experiment with socialism was ultimately unsuccessful. Throughout the 1970’s and 1980’s, Tanzania was unable to develop the rural socialist villages thought to create widespread agricultural stores and to lead the country towards self-reliance. While Nyerere’s government attempted forced relocations to Ujamaa villages, villagers remained resistant to the plan, and the government had to import food. Little had been invested in manufacturing to earn revenue from exports. People relied more and more on goods illicitly imported from Kenya and other nearby countries, and the informal economy arose as a resource for cushioning people from the widespread poverty. While the potential for self-reliance with Ujamaa failed, equality was the one successful outcome, although unfortunately at the level of poverty.
Due to such a dire situation, the government continually sought international loans throughout the socialist era, even more so than many other African countries. Although Tanzania took a divergent path towards socialism from those political-economic recommendations prescribed by lenders like the IMF, Tanzania was seen to be a relatively peaceful and stable country compared to others in the region. Western governments strategically hoped to position their diplomatic hub in Tanzania as settler countries like Zimbabwe were on the brink of indigenous revolt against white populations, and countries like Uganda and the Congo experienced violent repressive rulers. Despite Tanzania’s acceptance of loans, they managed to forestall the implementation of structural adjustment policies which usually precluded loan agreements (Askew 2006; Coulson 1982; Ferguson 2006; Nyerere 1968).

However, as the global economic crises of the 1970’s took its toll and the price of oil skyrocketed, Tanzania was pushed further and further towards needing sizeable loans. In 1985, when Ali Hassan Mwinyi took power after Nyerere, he accepted international loans and the structural adjustment policies that came with them. In 1993, the Tanzanian government fully liberalized the economy and media. Despite these changes in the political-economy of the country, a socialist ethic pervades Tanzanian society and a socialist commitment even remains within the Tanzanian constitution to this day.

With these events, social marketing, funded by USAID and European donors, was one of the primary practices driving the development of large scale markets for consumer goods, the privatization of government health product distribution, and use of mass media in the 1990’s. The other key players in the market who were expanding infrastructures and media outlets on a national scale included Coca-cola and cigarette companies. Even today in Tanzania, the primary advertising that one sees on major thoroughfares includes social marketing, cigarettes, phones, and Fanta soda or Coke. All of this to say, that social marketing was on par with the large multinational companies seeking to make a quick first entry into the newly liberalized Tanzanian economy.

PSI was the primary social marketing organization operating in the country during this period. PSI saw itself to be working on behalf of the Tanzanian government, branding condoms as Salama, meaning safety, security, or peace. PSI had assumed that HIV risk in Tanzania is due to couples’ development of intimate long-term relationships and thus their cessation of condom use as trust increases between them. PSI promoted the Salama brand by advertising the idea that love and romance is associated with or necessitates protecting lovers from disease through condom use.

![Salama Brand](image)

PSI’s programs also worked with commercial distribution companies to expand infrastructures for product delivery in the country, as their social marketing professionals
proudly recall today. These programs recruited individuals in targeted communities to become small-scale sellers of goods like *Salama* condoms and eventually other health products like branded mosquito nets. By uplifting products from wholesalers and subwholesalers and selling the products at a slightly higher price in their own communities, social marketing promised that individuals could eventually earn profitable returns.

In 2004, USAID set up a new social marketing project which brought with it an imperative to fully privatize health product marketing to commercial companies and to end donor subsidies for NGOs like PSI. With 23 million dollars in funding from Bush’s President’s Emergency Plan for AIDS Relief (PEPFAR), USAID awarded the contract for this new project to AED (the Academy for Educational Development). This intervention led to the proliferation of social marketing practices for HIV prevention in Tanzania including increased production of condom brands, advertising, business partnerships, and promotional events in communities. USAID’s shift in priorities also led to the question of whether PSI’s traditional model of social marketing, USAID’s new program, or an alternative model developed by commercial business professionals in Tanzania would have greater staying power in the long-term and created a heightened sense of competition among these groups.

These social marketing projects never unfolded as seamlessly as health and business professionals imagined. Individuals and groups in Tanzania articulated critiques of and alternatives to social marketing and a variety of practices emerged that creatively altered the intended outcomes of social marketing. For example, in Zanzibar, a semi-autonomous archipelago of Tanzania, an Islamic ethic dovetails with a history of socialism, informing norms about how individuals should make decisions regarding sexual and economic practices. Members of Islamic-based health NGOs defer to this ethic when they criticize social marketing’s intention of influencing economic exchanges according to peoples’ desires rather than their use of rational choice. These groups call upon the government to regulate social marketing media and the desires it promotes in citizens. Within Hyena Square, a destitute neighborhood in Dar es Salaam targeted by social marketing, illicit sales practices, including both the sale of government condoms intended for free distribution and the unlicensed sale of commercial condoms, call into question social marketing conceptions of a ‘market’ and how exactly to make such markets equitable. Among Dar es Salaam’s corporate investors, CEOs appeal to a discourse of free market economics to illustrate how donor-funded interventions in commercial markets actually undermine their ability to participate in private sector development, despite the intention of social marketing programs to establish sustainable commercial markets in health goods.

Careful attention has to be paid to the terms used by actors in Tanzania to think critically about and to interact creatively with — to politicize — social marketing programs. As illustrated in the examples above, after two decades of liberalization in Tanzania, people do not appeal to the government to intervene in social marketing practices as a

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1 PEPFAR’s contribution to Tanzania in 2004 also led to a whole shift in the Tanzanian economy and public health landscape when PEPFAR invested 70 million in HIV programming that year alone. Tanzanian commercial investors began to perceive USAID as a new customer in the Tanzanian market and they began to invest in businesses to service them, including in cement and construction, advertising and paper products, and local capacity to manufacture health goods, to name a few.
call to return to socialism, understood as public ownership of health product production and distribution. Rather, as I describe in the next section, a history of Tanzanian socialism and processes of liberalization as involving a particular ethic of market exchanges and a particular logic of privatization influences social marketing today. How can social scientists characterize the politics, politicizations, and stakes of these ideas and practices at work today, and particularly in Tanzania?

An Anthropology of Social Marketing

I argue that social marketing interventions and critiques made of them primarily entail debates about how social marketing is an intervention in measuring health. To speak of “measuring” is to point to how social marketing applies economic rubrics, particularly branding from late 20\(^{th}\) century marketing, to the question of how to value and evaluate health. Such measures are based on particular claims about human nature as driven by pleasure and the nature of markets as capable of promoting social welfare.

Social marketing can be viewed as a particular set of answers to questions that have busied social thinkers, politicians, and citizens since the 18\(^{th}\) century and that have, in many ways, come to define the very scope of the social sciences. Specifically, these questions include: through what institutions or mechanisms should contemporary society seek to create peace, prosperity, and health, particularly given the nature of man; what exactly is the nature of man; how will capitalist markets effect the wellbeing of society; and what is the role of the state and economy in ensuring welfare?

Liberal thinkers of the 18\(^{th}\) and 19\(^{th}\) centuries posed a variety of answers to these questions. The “doux-commerce” thesis, most notably articulated by Adam Smith (1994 [1776]), proposed that capitalism and people’s pursuit of private interests would create a moral order, peace, and the greatest possible public welfare for all (Hirschman 1982). Social theorists of this school reconceived of investments in private interests not as greed or anti-social behavior but rather as a contribution to the emergence of a moral capitalist society built on technical specialization. They conceived of economic interests as productively directing passions which could otherwise lead to disorder (Hirschman 1977).

Social marketing extends the doux commerce thesis but modifies it in particular ways. As described earlier, social marketing holds that commercial markets and market processes are quite capable of creating the public good through private interests, except for two issues. One is that humans do not actually always make decisions that are in their “self-interest,” in this case health. Social marketing’s second addendum is that commercial interests often make health products unaffordable for the very poor, thus deteriorating social welfare.

I argue that social marketing’s attempt to solve these downsides of market approaches to health is to “socialize” the market in condoms through branding, based on a very market-based conception of what this process entails. Branding is an attempt to qualify exchange according to how goods relate to the cultural and social identities, desires, and pleasures of consumers. In contrast to the doux commerce thesis, social marketing’s use of branding attempts to convince people to pursue their pleasures as a matter of pursuing their interests yet without having to consciously regard their own interests in health and economy. Through these interventions, social marketing treats
pleasures as a proxy for health and self-interest. Social marketing’s use of branding also entails the development of segmented markets with multiple competing brands whose interdependent pricing is thought to subsidize products for the lowest income groups. In this case, social marketing treats the pursuit of pleasures as a proxy for social welfare.

Medical anthropology, economic anthropology, Africanist ethnographies, and science and technology studies offer a critical perspective on the claims made both by social marketing and liberal forms of thought such as the doux commerce thesis and these fields provide a way to understand the unintended effects of social marketing. While medical anthropology has developed well-thought critiques detailing the structural effects of neoliberal-inspired public health, and studies of governmentality examine the political rationalities which attempt to govern citizens through markets and choice (Lupton 1995; Rose 1996, 1999; Barry et. al. 1996), these projects have focused on critiquing notions of individualism and rational choice which inform public health. Social marketing requires a different orientation, primarily because a radically different understanding of human nature as, often irrational, and pleasure-driven is its foundation.

These studies also offer contributions to the ways in which public health interventions draw lines between “the economic” and “the social.” Medical anthropology and its structural critiques have argued that public health programs have misrecognized social problems of health as discrete from economic phenomenon, essentially that neoliberal policies blame individual’s poor health on their own (often read “cultural”) choices rather than understanding how economic positions prevent people from making choices in the interests of health (Farmer 2001). Accounts of governmentality detail how understandings of and interventions in “the social” or “society” are in decline and under attack. Meanwhile the government of individuals formerly serviced by welfare and state-led projects increasingly occurs through the market (Rose 1999).

Social marketing calls for a further modification of these insights into the changing understanding of the economic and the social. In contrast to accounts of governmentality, social marketing preserves a key spot for “the social,” indicated by the field’s very name. Social marketing’s name also indicates that there is some relation to the economic at work in its theorization of health. How does social marketing revise arguments about capitalism’s ability to provision publics with health and wellbeing? To what extent is social marketing an attack on “the social” as a site of welfare, merely to remake the social as a market? To what extent does social marketing incorporate critiques of the structural inequalities of health?

I attempt to answer these questions in the context of Tanzania, a site where radically different understandings of the relation between “the social” and “the economic” have traditionally been at play. As described earlier, the socialist era influenced people in Tanzania to understand economic relations in social and moral terms. In contrast to both capitalist and “scientific-socialist” understandings of economic structures, ideologies which advocated for a particular economic system based on technical understandings of production and distribution, Tanzanian socialism called upon citizens to adopt socialist ideals in the language of committing to the values of sociality and generosity rather than greed and selfishness (Askew 2006; Coulson 1982; Ferguson 2006; Nyerere 1968).

A longer history of understandings of economic relations as social relations within the East African region informed Nyerere’s socialist discourse (Bayart 1993).
the context of social marketing in Tanzania, these understandings became relevant today in particular ways. In Zanzibar, the legacies of this history intersected with an Islamic ethic promoting decision-making based on consideration for others, reason, and the containment of desire rather than the pursuit of pleasure, what was thought to undermine public welfare. Islamic-based health groups drawing from this ethic make appeals to the Tanzanian government to be a regulator of the information made available to consumers for purchasing and health choices, information thought to be corrupted by social marketing.

In my research I also discovered that social marketing entailed treating Tanzanian citizens as desiring consumers, not producers, and not only ignoring people’s lack of economic earning opportunities as a contributor to poor health, but even at times dispossessing them of the few earnings they had. For example, in one destitute community of Dar es Salaam targeted by social marketing, called Hyena Square, social marketing’s logic of intervention transitioned subsidies for small scale sellers towards consumers and big business in the name of supporting the sustainability of condoms brands thought to lead to increased use and decreased risk of HIV. Such interventions construct the “social” as a domain of market-induced pleasure and identity creation with little consideration for the interdependent welfare of all.

In addition to lines drawn between the economic and the social, social marketing points to the re-alignment of lines between the “public” and “private,” indicated by the title of this dissertation, “Privatizing Public Health.” What does it mean to “privatize public health,” and how exactly is social marketing a project of “privatizing public health?”

Where political scientists – similar to economists’ discourse on the economy – have naturalized an understanding of “the state,” describing any state formation which departs from their normative model as “weak,” “failed,” or “corrupt,” Africanist ethnographies and critical political scientists have shown that the African state is anything but weak or failed (Hibou 1999; Mbembe 2001; Roitman 2005) and that description of it requires detailed ethnography of its production (Gupta 2006; Mitchell 2006). Africanist ethnographies indicate that “the state” in Africa takes a different form than is easily recognized by Western political scientists or diplomats. It has developed tentacles which extend into private realms thus refashioning how we understand public and private.

For example, as discussed earlier, individuals and groups often sold government condoms, products intended for free distribution, especially as social marketing effectively began to create priced value in condoms. Such practices, a legacy of people’s attempts to economically gain during a socialist period which forbid private commercial practice, call into question the presumed neat separation of public and private or “state” and “market” within liberal thought and social marketing interventions. Such outcomes also occurred at the corporate level among relations between Tanzanian investors and foreign governments. Where donors like USAID perceived the market of condoms to consist of exchanges between commercial companies and Tanzanian citizens, they saw their own place to be outside the market, despite their provisioning of financing and the maintenance of brand ownership rights over condom names. In other words, while basing their interventions on discourses about the ability of free markets to provision the public with welfare and health, in practice they persisted as a primary participant in health
markets. As Hibou et al (1999) explain of the title of their collection, *Privatizing the State*, the use of the word ‘privatization’ is ironical.

Similar borders and transgression of borders were at play in social marketing concerning the relation between “licit” and “informal” or “illicit” exchanges in the market of condoms. As the Tanzanian government forbid the development of private business in the socialist era and as state licensing today regulates who can participate in economic activity, people, particularly the poor, turn to innovative non-licensed ways to create additional income, often through the informal sale of small goods in communities. Such practices disrupt social marketing attempts to technically surveil who and what kinds of exchanges are taking place in markets. Or in other words, “the market” as social marketers and donors perceive, measure, and naturalize it entails biases about the separation of “public” from “private” as well as about the role of licit and illicit exchanges in creating markets.

Demonstrating that “the economy” and “the market” are anything other than naturally occurring phenomenon has been a project not only of critical political scientists and anthropologists, but also of science and technology scholars. Scholars in this tradition explore the performativity of economics, or in other words how the science of economics has as much influence in the creation of markets as the material exchanges which comprise them (Barry et. al. 2002; Callon et al 1998; Callon et al 2002; MacKenzie 2008). This body of literature makes a quite different intervention in understandings of nature and the nature of markets than both social constructivism as well as truth claims based in science, in this case economics. Where social constructivists would configure nature as relative to a variety of perspectives, economics would defer to natural laws or a singular truth claim about market processes. In contrast, the approach of performativity is interested neither in evaluating the truth, falsity or relativity of economic claims. Instead performativity shows how claims about economic life have effects in terms of how economic relations actually emerge. For the purposes of this study, these insights further inform my efforts to denaturalize social marketing’s markets and the claims made about human reason that serve as their basis. For example, my interviews and ethnographic research describe how the market that social marketing created looked far different from the markets described by social marketers and social marketing theories which backed these programs. However, models and measurements of market processes often had great effects. I discovered that audit-based models of markets informed decision-making about the distribution of social marketing subsidies. These subsidies served to create markets in particular ways, essentially making certain kinds of consumption and product distribution possible and not others.

Finally, I found that critiques of these projects by individuals in Tanzania point to concerns with fairness, both in terms of how social marketing influences the decisions of consumers and potential resulting health outcomes and in terms of how social marketing influences who can participate in and thus benefit from competitive commercial markets in health products. These sites of tension with social marketing provide a way of thinking about health and economy outside western post-war economics and psychology which is foundational to social marketing and outside recent attempts by development professionals to instill capitalist markets with positive effects for health and society. This dissertation maps these controversies in Tanzania not only as debates about public health
and political economy grounded in terms of a critique of private property, but as entailing epistemological and ethical questions about health, markets, and human nature.

Chapter Summary

Part I of the dissertation examines practices of branding within social marketing, the assumptions about human reason and human nature which undergird branding, how these practices have altered the field of public health, and the effects of this aspect of social marketing in Tanzania. Chapter 2, “Socializing Exchange and Rationality,” explores the history of social marketing. Specifically, this chapter examines how both public health and commercial marketing fields traditionally conceived of humans, human reason, and human motivation. Where public health education professionals perceived humans to be motivated by a rational pursuit of health, commercial marketing professionals in the post-war period argued that humans make choices based on less-than-rational decision-making processes. When social marketing emerged in the 1960’s and 1970’s, this idea of the subject as less-than-rational and as primarily driven by the pursuit of easy pleasures in life, instead of health, was the key point of influence on public health. This chapter details this history as well as the changing ways in which commercial marketing, public health education, and social marketing attempted to influence humans and their decisions about product purchases and health behaviors, given these various conceptions of the subject.

Chapter 3, “Maadili and Double Markets in Zanzibar,” investigates critiques of social marketing among Muslim communities in an archipelago region of Tanzania. Where social marketing professionals in Tanzania perceive Islamic-based criticisms as founded in moral opposition to condoms and sex outside of marriage, a closer examination reveals that these communities are exercising insightful critiques about the basis of social marketing in post-war economics and psychology. Their accounts point to an understanding of social marketing’s attempts to influence humans in their desires as unethical. Rather than provide humans with information about health risks and condom use, social marketing focuses on associating condoms with human aspirations. Muslim communities call on state institutions to regulate social marketing promotion and distribution of condoms and to provision citizens with information about the risk and benefits of condom use. This chapter details their accounts, how a local ethics of desire and reason informs their perspectives, as well as the effects of social marketing’s incompatible intersection with Muslim approaches to public health in Zanzibar.

Chapter 4, “Socializing Markets,” explores marketing and communications practices at a social marketing office in Dar es Salaam. Following from the last two chapters, this chapter details the development of commercial and social brands as kinds of measurements which social marketing proposes that citizens use to make decisions about health choices. This chapter demonstrates how social marketers attempt to create inextricable and publicly shared associations between health practices and personal desires and to tie these associations to the idea of a market run society. By outlining the everyday practices and unexpected outcomes of these techniques of equivalence, this work outlines contemporary forms of U.S. politics on the African continent.

Part II of the dissertation examines social marketing’s “market” in Tanzania. By exploring social marketing’s ways of knowing and thus creating markets, I illustrate how
social marketing produces new forms of inclusion and exclusion in economic processes through interventions conducted in the name of health. Chapter 5, “A Privatized Public,” examines the practice of social marketing in the community of Hyena Square, a destitute neighborhood in Dar es Salaam consisting of people defined as “most-at-risk” for HIV. While social marketing programs construct models of how state institutions and commercial sector businesses can most equitably coordinate the distribution of condoms to poor populations, local government and individual strategies to also profit from the privatization of condoms led to a situation of decreased access. Both social marketing programs and local government-led projects of privatizing health goods attempted to direct profits from condoms to elite spheres, not only decreasing people’s ability to protect their health but also marginalizing these populations from the very economic benefits theorized as available to them through social marketing. This chapter describes these events in relation to histories of informal economies and vigilante state practice and illustrates how social marketing’s formal conceptions of and ways of measuring “the market” participate in producing these very outcomes.

Chapter 6, “Private Sector Partners and Public Sector Competitors,” explores the accounts of Tanzanian entrepreneurs enlisted in social marketing projects. They narrate how despite the intention of social marketing programs to foster sustainable businesses in health products within the region, time and time again, commercial companies find themselves undermined by and even in competition with donors and international NGOs. This chapter details their accounts, connects their experiences to local histories of racial inequalities among commercial investors and socialist narratives of racial parasitism in colonial practices, and examines how such practices and the discourse of sustainability continues despite the reality of very unsustainable donor-led interventions in the Tanzanian economy.
Ch. 2: Socializing Exchange and Rationality: Social Marketing as a Critique of *Homo Economicus*

I. “Make it fun, easy, and popular”

Social marketing professionals in the United States trace their history to a 1951 article stating, “why can’t you sell brotherhood and rational thinking like you sell soap?” Written by G.D. Wiebe, a psychologist and communications researcher from the City College of New York, this article sparked a series of debates among commercial marketing experts during the next two and a half decades which gave rise to the contemporary field of social marketing. Wiebe’s article was a turning point in commercial marketing thought because he illustrated how some government programs resembled marketing campaigns. Prior to his article, commercial marketers conceived of their trade as applicable to priced exchanges only.

Wiebe’s primary case study consisted of the government initiative carried out by the CBS television network to sell bonds for World War II in 1943. Wiebe analyzed this campaign in contrast to several other civic duty initiatives, arguing that social campaigns which were successful in their outcomes had better reproduced attributes of commercial marketing in contrast to social campaigns which failed. So what was the difference between marketing and government-run campaigns? Wiebe’s quote illustrates the key offer that marketing made to the field of public health. Beginning in the 1960’s and continuing to the present day social marketing has attempted to convince people to act rationally in regards to their health – in this case meaning to optimize their health – without actually having to think about or care about health.

Fifty six years after the publication of Wiebe’s article in June 2007, I sat alongside participants at the University of Southern Florida’s (USF) Social Marketing in Public Health Conference in Clearwater, Florida. This conference was held each year since 1990, sponsored by USF and AED, to train public health professionals in social marketing and to exchange ideas in the field. On the last day of the conference, Bill Smith, prominent U.S. social marketer and vice president of AED, spoke about social marketing’s unique potential to improve people’s health. A charismatic figure, Smith argued that “social marketing is based on the idea that people are lazy, they like to be bad and have fun, they like to be loved – this is where social marketing is consumer oriented and where it starts from.” Smith was summarizing his so often quoted mantra of good public health practice – “make it fun, easy, and popular” – what other social marketers have argued is the translation of marketing theory into laymen’s terms.

Smith was contrasting social marketing with legal and educational interventions. Where laws use force to create public health, in the case of banning smoking in public places, educational interventions rely on health information to convince people, for

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2 See Kotler and Zaltman 1971. Interestingly, Kotler and Zaltman leave out the ‘and rational thinking’ part of the quote in their direct quotation. Kotler and Zaltman’s version of Wiebe’s statement is also quoted regularly by social marketers at national and world conferences.

3 AED stands for the Academy for Educational Development and is an international non-profit organization headquartered in Washington, D.C. AED specializes in social marketing approaches and supports the development of the field by running the field’s only peer-reviewed journal, *Social Marketing Quarterly*. AED is also the international NGO hired by USAID to establish the T-MARC project in Tanzania.
example, to stop smoking on their own accord. Like education, marketing interventions rely on individuals to improve their own health through their own choices and their own means. However, in contrast to education, marketing does not presuppose that with the correct information about the risks and benefits of disease, people will chose to act in ways that promote health. As Smith stated, “people are lazy, they like to be bad and have fun,” or in other words, they don’t always care about their health. Who, in the ideal world without consequences, wouldn’t prefer to eat cheese fries all day, drink beer like it’s water, relax by the pool rather than swim laps, and not have to think about health? Ni raha.

What are we to make of Smith’s suggestion – that public health (here think inoculations) could actually be fun? Who would have thought that our desire to have fun, relax, be cool, act on impulse, and seek pleasure could be friends with this new face of public health? And what tricks do social marketers have up their sleeves to convince people to practice health prevention behaviors without people having to think about or care about health?

I’ll give one example from Tanzania to demonstrate the shift in public health prevention practices that has and is taking place. In 2007 – 2008, T-MARC developed and aired an advertisement intended to promote HIV prevention. A man and woman, engaged in love-making, erotically cry out, “vaa, vaa, vaa, vaa…..” (“wear, wear, wear, wear…..”). The extent of their pleasure is palpable. The cries of the couple escalate into a climax and then a deep-voiced announcer says, “Vaa Kondom, tumia kondom kila mara kwa usahihi” meaning “Wear a Condom, use a condom correctly each time.” The ad’s focus is on communicating the idea that condom use is compatible with and leads to sexual pleasure. Rather than foregrounding information about the condom’s ability to reduce risk for HIV and the biological facts of the HIV virus and its transmission, the ad sought to qualify or associate the use of condoms in relation to what consumers were thought to value most, sexual pleasure. T-MARC intended the ad to work against the popular attitude that condoms reduce sexual pleasure.4

As programs like T-MARC and social marketers like Bill Smith work to convince people that public health can be fun and not just informative, they are also asking people to change their perspectives on human nature. Since the inception of health education in the U.S. in the 19th century, health education professionals (today often known as health behavior and health education specialists) have assumed that people value health and that they act rationally in regards to health, or in other words that they weigh the costs and benefits of disease when making choices in life. As a result, health education has traditionally worked to arm citizens with up-to-date information on disease, assuming that with correct information, people will make choices to ensure their own health. In contrast, social marketing doesn’t presume that with correct information people will choose to act in the interests of health. Instead, social marketing, like commercial

4 You might say, who is actually going to believe that condoms enhance rather than diminish sexual pleasure? Such a proposition is laughable, made clear in many of my conversations with men targeted by social marketing programs in Tanzania. They often referred to the hilarity and impossibility of trying to eat a banana with the peel on – that certainly isn’t pleasurable, nor, as some would say, what God intended. However, the radical challenge of social marketing programs like T-MARC is to actually make condoms into devices which enhance pleasure. How T-MARC attempted to accomplish this goal and the outcomes of its project are the focus on Chapters 3-6.
marketing, presupposes that people are more likely to pursue their own subjectively defined pleasures and values in life. As such, social marketing proposes that public health professionals should adapt their programs according to peoples’ subjectively defined interests, so as to convince people that pursuing health will also enable them to fulfill their most treasured goals.

Social marketing’s perspective on rationality is indicative of a larger movement within the social sciences to re-think *homo economicus* and the neoliberal policies founded upon this naturalized vision of humans. *Homo economicus*, rational man, is an ideal type of actor who maximizes utility and minimizes cost in his choices. Utility here can be understood as benefits, happiness, or pleasure. The idea of *homo economicus* arose in the late 19th century with neoclassical economics which treated *homo economicus* not as an ideal type, but rather took for granted that *homo economicus* accurately depicted human nature and human reasoning. This depiction of human nature informed the development of fields like modern day economics, commercial marketing and public health.

In the mid 20th century, thinkers and economists such as Frederick von Hayek (2007 [1944]) and Milton Friedman (1962) further extrapolated neoclassical thought and its presumptions of rationality as a political philosophy purported to promote, democracy, peace and human welfare, often referenced by social scientists as neoliberalism. Drawing from the premise of Adam Smith’s *The Wealth of Nations* (1994 [1776]), their accounts argued that, if rational individuals are left in a free market to pursue their own interests, then the greatest good and the greatest peace will be possible for all. Taken up as an economic and governing policy in the 1970’s and 1980’s by the Republican party, neoclassical economics and its presumptions of man’s innate rationality have come to define much of late twentieth century U.S. government interventions, including public health, both within the U.S. and imposed globally by the U.S. government. As described in this chapter, neoliberal thought influenced public health to focus on developing interventions which attribute health to the choices that people make, rather than the economic conditions of their lives which often determine choice. These behaviorist approaches to explaining disease result in particular ways of distributing resources to promote health, in this case towards educational interventions rather than towards programs which address the structural determinants of health.

Social marketing as a critique of rational actor models in neoclassical economics and neoliberal policies is not alone in the social sciences. Rather social marketing has actually drawn from the insights of other fields in the social sciences engaged in similar projects. In doing so, social marketing’s enthusiasm to find common ground with other fields has often overlooked key theoretical and ultimately political differences. For example, social marketing has drawn from and found intersection among fields as diverse as anthropology and behavioral economics. From a historical perspective such fields seem to offer antagonistic perspectives on economy and human behavior. Anthropology is all about understanding subjective perspectives, rather than presuming that all people act and think in the same way. If one telescopes one’s vision of the field to a broader political-economic orientation, one could also argue that anthropology is a project which not only denaturalizes western economic claims about human rationality, but in doing so critiques the inequalities generated by global capitalist pursuits which have been based on naturalized claims about humans and economy. In other words, anthropology describes
the myopic terms in which processes of globalization and its techniques, such as marketing, have attempted to include people in its purported benefits, but which have resulted in marginalizing people from economic well-being and health. Behavioral economics on the other hand is a field which, while critiquing rational actor models of choice, actually seeks to improve the ability of interventions, like commercial marketing, to expand commercial markets through a purportedly more precise description of human nature, a description which includes consideration for “fallible” reasoning.

Let me give some embodied examples of the contradictory perspectives that social marketing conjoins. Bill Smith, quoted above, was in the 1970’s a dedicated community organizer with experience in the Peace Corp and a promoter of Freire-inspired projects aimed at liberating the poor from economic and political oppression. Today one finds Smith speaking at social marketing conferences alongside Philip Kotler, one of the most influential thinkers and consultants in commercial marketing in the second half of the twentieth century, a profession which some might say generates the very oppressive forms which Freire hoped to liberate people from. Trained in economics and behavioral science, Kotler developed the very idea of social marketing in the 1960’s and 1970’s. I encountered Kotler at the 2008 World Social Marketing Conference in England. Kotler spoke about privatization as the key to combating terrorism, resembling Peruvian economist Hernando de Soto, and he advocated for social marketing in terms of its potential to reduce poverty and increase western security. How had Smith, a student of liberation theology and key proponent of grassroots community organizing, come to find himself a colleague to a renowned marketer who had consulted with top U.S. companies on strategic marketing like IBM and AT&T?

One more example, which is much closer to home for anthropologists, consists of the degree to which medical anthropologists have jumped on the social marketing bandwagon. Also in 2008, Jim Yong Kim, a well-respected U.S. critical medical anthropologist and co-founder of Partners in Health who at the time worked in Harvard’s social medicine department spoke at U.C. Berkeley, my alma mater. His energy peaked as he talked about the new language emerging from fields like social marketing which was allowing anthropologists engaged in structural critiques of health inequalities to find common ground with entrepreneurs turned humanitarians and others applying business solutions to problems of poverty and disease. Fellow anthropologists in the audience were shocked. How could a former neo-Marxist colleague be espousing the tactics of the very neoliberal interventions they were supposed to be critiquing? (Hodge 2011).

While social marketing argues that fields like anthropology and marketing share much in common, my critical analysis suggests that when viewed with a fine grained lens, one finds that there are quite divergent alternatives proposed. I argue that the common ground found between different academic interests consists of shared efforts to re-think presumptions of man’s innate rationality within twentieth century public health and economics. In attempting to move beyond rational actor models for conducting public health, many scholars and health practitioners have lost a critical stance towards the multiple theories of human reason which have emerged and how applications of these different theories promote different political economies and thus have different effects. The incorporation of, especially, anthropological critiques – critiques intended to de-naturalize an understanding of human subjects and their economic predicaments – has in the field of social marketing led to another process of naturalizing the subject and
This naturalization concerns a vision of humans as inherently non-rational and driven by quick fulfillment of pleasure. Where did such an idea come from, how in practice does this idea work, and what are its effects?

II. Presumptions of Rational Actors in U.S. Public Health

Public health approaches did not always take for granted the idea that peoples’ health should be dependent on their own reasoned choices. Rather modern public health derives from large-scale western European efforts to address epidemics from the 15th to the 18th century through emergency procedures. Throughout this period, contagionist, environmental, and climatic theories of disease promoted responses to epidemics through forced quarantine and the temporary establishment of health institutions.

Following these sporadic efforts at eradicating disease, the modern project of public health itself emerged in the 19th century, led by Britain and France. Social reformers or hygienists who attributed disease to the social and economic outcomes of industrialization and urbanization, not individual choice led the early modern public health movement. Known as “social medicine,” they advocated for on-going state-led projects to improve public health though means like improved water sanitation, sewerage systems, and regulation of food and drink. This early public health project advocated for health as a right of every citizen to be ensured by the state. In the view of social medicine, public health must address poverty, political oppression, and the economic conditions which lead to disease. These efforts stood in contrast to liberal inspired contenders who conceived of public health as part of the domain of medicine and individualized care. (Duffy 1992; La Berge 1992; Lupton 1995; Porter 1999).

In contrast to these approaches, the revolution in bacteriology at end of the 19th century led to a medicalized approach to public health, far from the community-based efforts of the early reformers. Now viewing the individual as the vector of disease, public health focused on the reform of individual actions. Education was one of the primary means for governments to inform citizens about issues like communicable diseases, so as to encourage preventative behaviors that would reduce illness and deaths (Bowman 1976). During the post-World War I period, health institutions such as the American Public Health Association formally created government health education departments, and universities and colleges began offering degree programs in health education (Jean 1951). Health education at that time became the domain of trained health professionals rather than social activists, and health education concentrated its efforts in clinical and educational settings (Kleinschmidt 1948).

Beginning in the 1950’s, there was a greater recognition that the field of health education had only partial impact on the health of populations. In an effort to understand these limitations, health education professionals turned to social psychology to understand why people do not always make choices that are in the interest of health (Bowman 1976). While this research led to a re-thinking of the practice of health education, it did not question the central tenets of the field: the idea that people inherently value their health and that people act rationally in the interests of health. By reproducing and formalizing these ideas, this new research sedimented the idea within public health prevention programs that public health professionals merely needed to get the right
information to citizens so as to foster human health. Several theories developed during the 1950’s to the 1970’s informed these approaches.

In the 1950’s a group of social psychologists, Godfrey Hochbaum, S. Stephen Kegeles, Howard Leventhal, and Irwin M Rosenstock, were working for the Public Health Service in the U.S. which had charged them with explaining why healthy people don’t participate in free preventative health services such as testing for tuberculosis, especially when these services are free and conveniently located (Rosenstock 1974). With little research at the time on health behaviors, this group of scientists began to explore new theoretical ground by linking public health with psychology. Drawing from social psychologist’s, Kurt Lewin’s, value expectancy theory, these scientists assumed that human behavior depends on two variables: “(1) the value placed by an individual on a particular outcome and (2) the individual’s estimate of the likelihood that a given action will result in that outcome” (Maiman and Becker 1974). These theorists asserted that the beliefs which people have about disease predict these two behavioral determinants.5

Within public health, their ideas became known as the “health belief model,” a theory of human behavior which remains influential in the field of public health today.

The health belief model presumes that individuals engage in cost-benefit analysis to determine which actions will lead to optimal health. Thus, the model also presumes that people value health (Janz et. al. 2002). Public health professionals use the model to inform educational interventions intended to alter people’s perceived risks and perceived benefits of practicing a particular behavior. One example is that people often fail to participate in cancer screenings, believing that if they are asymptomatic, then they must be healthy. Professionals use the health belief model to demonstrate that health professionals must inform people that being asymptomatic does not necessarily indicate lack of cancer in order to heighten people’s perceptions of risk and to increase prevention behaviors (Rimer 2002).

Over the next thirty years, professionals working in psychology, communication, and public health built further upon the health belief model to explain human behaviors. In the late 1960’s and 1970’s, Martin Fishbein, professor of communication for many years at the University of Pennsylvania’s Annenberg School of Communication, created the theory of reasoned action. The theory of reasoned action resembles the health belief model, but it prioritizes peoples’ intention to act as a key determinant of their behaviors, where intention is a result of people’s attitudes about a behavior and their understanding of social norms in relation to the behavior in question (Montano and Kaspryzk, 2002). Despite these slight differences, the theory of reasoned action, like the health belief model, assumes that prevention behaviors or failure to practice prevention behaviors result from the beliefs that people hold. Public health projects which adopted this theory of behavior worked to alter people’s perceptions of prevention behaviors and people’s perceptions of social norms in relation to these behaviors.

In the late 1970’s, another theory, The Transtheoretical Model, added additional weight to public health’s comprehension of rational human behavior. This model of behavior argued that people change their behavior in stages. The model outlines a series

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5 In the language of the health belief model, determinants of preventative action include individuals’ perceived risk of contracting a disease, perceived severity of a disease, perceived benefits and barriers to taking an action, and cues or calls to action (such as media programs reminding citizens to be tested for tuberculosis).
of six stages through which people pass as they make behavioral change, a model which has been applied to addiction recovery, smoking cessation, and other public health prevention programs focused on diet and exercise (Prochaska et. al. 2002). Similar to the health belief model and the theory of reasoned action, this model of behavior change assumes that humans consciously engage in cost-benefit analyses, or here called pros and cons, to weigh the risks of unhealthy behaviors versus healthy behaviors as they progress towards behavioral reform.

Central to all of these theories is the idea that health is a result of individual choice and that choice is a result of the information available to individuals and the beliefs and attitudes that individuals consciously form about health prevention behaviors. Following these ideas, health education as a field of practice intervenes in informational environments so as to shift people’s conscious ideas, beliefs, and attitudes about health.

These theories have remained central to public health education and behavior change practice, even up to the current day. Other theories of human behavior emerged in health education following these rational actor models, including theories of interpersonal, environmental, and social influences on behavior. Some of these theories served to qualify these rational actor models, such as incorporating the idea that people must have self-efficacy or confidence in their abilities to make change (Bandura 1977). However, they expanded rational actor models in limited ways and rational actor models of behavior remained stalwart in health education even up to the present day.

Beginning in the mid-1970’s, the basis of these theories, rooted in a preoccupation with individual choices and behaviors came under attack as part of a larger movement of “health promotion.” At the time, public health policy professionals in the U.S., U.K., and Canada began to rethink the efficacy of public health’s emphasis on medical and individualized care over the previous two decades (Lalonde, 1974; U.S Dept. of Health, Education, and Welfare, 1979). Their reports detailed how, since the 1950’s, public health prevention programs focused on the doctor-patient relationship as a primary site for educating citizens about health, at the expense of addressing population-level interventions. These critiques drew from works, such as Thomas McKeown’s 1976 The Role of Medicine: Dream, Mirage or Nemesis?, which remained critical of medicalized and non-preventative care and urged policy-makers to return to 19th century models of community-based health that focuses on social, economic, and environmental determinants of health (Colgrove 2002; Szreter 2001).

While these critiques and ensuing national policy reports called for a “health promotion” movement including increased community participation in public health programming, a preventative focus, and a return to socio-economic determinants of

6 In the first stage as defined by the model, precontemplation, people are defined as having no intention to change their behavior in the near future. The model asserts that people existing within this phase either do not have adequate information to understand why they should change their behavior or they have low evaluations of their own self-efficacy regarding their ability to change. In the next stage, contemplation, people are defined as being fully aware of the costs and benefits of changing behavior, but although wanting to change, they continue to deliberate these consequences. During the third stage, preparation, individuals plan to take action shortly and have prepared themselves to do so in the recent past. The fourth stage, action, individuals are defined as having made a behavioral change that reduces risk of disease. The following state, maintenance, is a period in which people are thought to work towards preventing relapse to the old behavioral patterns. In the final stage, termination, people no longer have to consciously work to maintain the healthy behaviors and are not at risk of relapse.
health, right wing politics of the 1970’s and 1980’s co-opted this discourse for its own purposes. The conservative movement utilized the call for social medicine and community participation as a way to place responsibility for health on citizens themselves and to withdrawal state support for social welfare and health care, in essence to further solidify a politics of blame (Farmer 2001; Minkler 1989; Szreter 2001). In essence, conservative politics promoted an understanding of public health which severed understandings of the relationship between political economy and individual actions. This turn of events further sedimented the idea within public health that health professionals merely needed to get the right information to people so that they could make choices in the interest of health, thus failing to consider how economic factors influence people’s ability to make choices that lead to health.

The social sciences and, particularly, medical anthropology critiqued these narrow understandings of the factors which lead to health and disease. During the late 1980’s and 1990’s, medical anthropology developed two currents of research which critiqued public health’s emphasis on rational action as a predictor of health and the politics of blaming individuals founded upon it, particularly in the realm of HIV prevention. On the one hand, social scientists and medical anthropologists demonstrated how the cultural meanings tied to sexuality, sex, and disease may make the kinds of information thought to persuade individuals to prevent disease irrelevant. Essentially these accounts argued that understandings of disease are socially constructed, and prevention thus necessitates consideration of local constructions of disease, prevention, sex, and health (Paiva 1993; Parker 2001; Pigg 2001; Treichler 1999). For health professionals to take these critiques seriously, they must consider the extent to which the experience of disease and prevention are collective phenomenon, not individual. Similar findings in family planning and demography illustrated that people’s choices about contraceptive use do not always conform to the goals or “rational” outcomes defined by policy makers, such as limiting family size. Instead of limiting number of births, many women in other contexts sought to space births or even increase them, informed by cultural values regarding honor and identity (Johnson-Hanks 2002, 2006) or radically different understandings of aging and the life course (Bledsoe 2002).

A second camp of medical anthropologists argued that both the neoliberal bias within public health that blames individuals for disease and the cultural construction approach to disease in medical anthropology overlooks the economic structures which actually produce disease. These accounts demonstrated that even if people wanted to make “rational” choices in the interest of health, their economic situations made choosing health an impossibility. These anthropologists argued that any lasting intervention in health necessitates undermining the forms of power which sustain inequalities and produce disease, including ones linked to race, class, and gender (Farmer 1992, 2001; Farmer et. al. 1996; Kim et. al. 2002; Parker 2001; Schoepf 1992a,b,c). Professionals working inside public health circles, including many professionals I encountered at social marketing conferences, have also criticized this conservative movement within public health fields, pointing to its departure from the intended project of community-based public health mapped out in the mid-1970’s by the health promotion movement (Minkler 1989).

However, what is often overlooked by these studies in their interest to improve public health through a cultural or structural critique of health promotion is the way in
which priorities and politics during this period were based on claims about human nature and the most effective way to influence human health and create social order given this nature. In contrast, studies of governmentality have effectively documented how neo-liberal theories of government conceive of humans as rational self-governing actors (Lupton 1995; Rose 1996, 1999; Barry et. al. 1996). However, these accounts overlook a field of thought and practice emerging within commercial marketing in the post-war period and within social marketing in the 1970’s. Although social marketing’s divergent train of thinking is no less based in free market ideals and the presumption that pursuit of private interests leads to public gains, social marketing runs counter to the theories of the rational subject attributed to neo-liberalism since the mid-1970’s. What exactly was this different vision of human nature, and how did it change projects of governing?

III. Critiques of Rationality

During the same years that professionals in public health theorized that human behavior is primarily rational and that promoting health necessitates distributing the right information to people, a concurrent research project in marketing led to quite different conclusions about human nature and decision-making. Richard Bagozzi (1975), a marketing expert specializing in exchange and trained in cultural anthropology, summarized this work as follows:

… we see the emergence of marketing man, perhaps based on the following assumptions: 1. Man is sometimes rational, sometimes irrational. 2. He is motivated by tangible as well as intangible rewards, by internal as well as external forces. 3. He engages in utilitarian as well as symbolic exchanges involving psychological and social aspects. 4. Although faced with incomplete information, he proceeds the best he can and makes at least rudimentary and sometimes unconscious calculations of the costs and benefits associated with social and economic exchanges. 5. Although occasionally striving to maximize his profits, marketing man often settles for less than optimum gains in his exchanges. 6. Finally, exchanges do not occur in isolation but are subject to a host of individual and social constraints: legal, ethical, normative, coercive, and the like (37).

Considering that commercial marketing arose in the late 19th and early 20th centuries, its early theories of human decision-making were first influenced by neo-classical economics. As described in the introduction to this chapter, neo-classical economics conceives of man as homo economicus, a rational actor who makes choices to maximize utility and to minimize cost. In the field of commercial marketing, this definition of man led to a specific understanding of rational choice, essentially as consumer evaluation of product purchases according to their functional utility, that is whether a product’s material features could satisfy a customer’s desire. A simple example would be consumer evaluation of soda regarding whether a soda satisfies thirst. Neoclassical economics also assumed that purchase of a product was a straight-forward reflection of a person’s self-interested desires to achieve a certain functionality, such that purchasing a Coke would be a reflection of a desire for quenching thirst.

This understanding of economic man and the material products he purchased dominated marketing in the period prior to WWII (Mittelstaedt 1990). Marketing interventions in consumer behavior up through the 1950’s occurred primarily through
finding ways to reduce costs of production, improve distribution, and manage product quality and durability (Harris 2007), making sure that consumers saw themselves to be purchasing a high value product for their money (Cochoy 1998; Lury 2004; Shaw and Jones 2005).

After the war, as new pools of labor were readily available for work, as supply of products could be rapidly met, and as businesses began to focus on production areas outside the needs of the war, American marketers began problematizing how to influence consumer demand for products. This new set of conditions led to the rise of consumer research and a marketing focus on understanding purchasing behaviors and choices. Marketers began to critique the neoclassical model for ignoring the behavioral realities of consumer decision-making. For example, they recognized that consumers often make purchasing choices without any considerable thought or cost-benefit analysis. Marketers also argued that neoclassical understandings of consumer choice ignored how consumers developed brand and product preferences. Finally, marketers realized that consumers often had very little information about products and thus didn’t always make fully informed product choices. Essentially, commercial marketers concluded that neoclassical economics provided a normative model of consumer behavior rather than a descriptive one, or in other words that *homo economicus* is an ideal construct not a true picture of human nature (Kotler 1965).

One of the first interventions in marketing’s assumptions about humans was in the field of behaviorism which argued that humans are essentially irrational and compulsive. Behaviorists perceived humans to be driven by physiological desires such as love, fear, and rage and to be motivated by compulsive and conditioned responses to stimuli. As Kotler (1965) described behaviorism, it substituted “rat psychology for a rational psychology” (40). Influenced by the work of Pavlov, John Watson, and B.F. Skinner, marketers who took up behaviorist thinking applied it to advertising by encouraging advertisers to exploit human drives such as hunger and sexual appetite. Behaviorism argued that humans have natural drives which can be ignited with “cues,” or stimuli to action, advertising being just one example. If consumers act on cues and experience satisfaction, then behaviorists theorized, such experiences will reinforce consumer behaviors and future cues will cause them to act in a similar manner.

In contrast to the behaviorist movement, cognitive psychology influenced marketing to consider the way in which perceptions of reality, rather than actual conditions in the world, determine people’s behaviors (Sheth and Gross 1988). For example, motivation research, which took influence from Freudian psychoanalysis, discarded with the behaviorist idea that humans merely respond to basic needs and could be conditioned to behave through stimuli or cues. Instead, psychoanalysis led the field of marketing to consider the unconscious, symbolic, and emotional motivations that drive human behavior. Motivation research explored a theory of repressed unconscious human desires and affects thought to direct individuals’ decision-making, and the field investigated how marketers could influence these drives. Motivation researchers used techniques like “word association, sentence completion, picture interpretation, and role-playing” in the hopes of uncovering unconscious desires (Kotler 1965: 42).

Philip Kotler (1965) provides one famous example of a marketing application of motivation research in the 1950’s. General Mills hoped to sell pre-mixed Betty Crocker cake mix. However when sales were poor, the company investigated the cause of
consumer apathy through a motivation research lens, concluding that: “a cake mix that is advertised as involving practically no labor may alienate housewives because the easy life may evoke a sense of guilt” (42). The company struggled to sell the product until they altered the recipe to require cooks to add eggs and milk to the mix. Sales supposedly sky-rocketed thereafter.

These kinds of marketing interventions were certainly not without their critiques. Feminist scholars criticized these campaigns for their manipulative character asserting that marketers “enslave women in the mindless role of housewife and consumer” (Kassarjian 1994: 305). These feminist critiques, like much of feminist scholarship, demonstrate that the roles and perspectives of women are not fixed in nature, but are influenced by social ideas generated by practices like marketing. Commercial marketers used this insight not to liberate women, but rather to experiment with how intervening in the emotional and psychological meaning tied to products and the people who use them could increase sales.

Sidney Levy, a commercial marketer trained in psychology, developed and applied these ideas from motivation research to mainstream marketing during the 1950’s and 1960’s and eventually to the development of the field of social marketing. Levy’s work explored the emotional, social, and symbolic aspects of consumer decisions. He argued that the meaning of and associations made with products configured as brands is centrally important in consumer decisions (Gardner and Levy 1955; Harris 2007; Levy 1959).

Levy re-conceptualized the object being sold as an intangible good – a brand – with emotional and psychological benefits. The brand as a textual image provided a symbol upon which reference could be made to consumer aspirations, social meanings, and the way in which consumers think of themselves as social persons. For example, the Coca-cola company treats its product not just as offering the functional benefit of a sweet fizzy drink, but also as offering a fun carefree lifestyle. Coca-cola associates its soda with this carefree lifestyle through advertising images and TV and radio commercials. These shifts in marketing thought were essentially a transition from conceiving of human decision-making as solely answering the question, “what do I need” and “what will satisfy my pleasure at the least cost,” to answering the question, “what do I want” and “who am I” or “who do I want to be.” “What does a brand say about me?” It was during this time that the figure of “marketing man” as opposed to economic man coalesced.

These shifts occurring in marketing during the post-World War II era were revolutionary in terms of how marketing reconfigured its idea of humans and human nature. To summarize, in the pre-war period, marketers conceived of subjects as actors making choices based on a cost-benefit analysis of the quality of products and their functionality, whereas in the post-war period marketers saw humans to also be motivated by the meanings attached to products in the form of a brand.

This shift from conceiving of products as brands rather than just functional things and conceiving of humans as driven by meaning rather than just materiality, was essentially the recognition by commercial marketers that people’s desires and the goods they purchase are constituted by shared social values other than purely “economic” ones as defined by neoclassical thought. As such, marketers now perceived the construction of meaning surrounding goods and peoples’ desires to be open to marketing interventions.
This shift in marketing generated not only the idea of the brand as a technique for mediating the meanings tied to consumer decision-making and the forms of reason that people use to make product purchases, but also led to the very idea of social marketing. If marketers’ primary influence on consumers now occurred through the manipulation of the meanings and symbols which purportedly determine decision-making, then why couldn’t those same techniques be applied to the decisions that people make about their health? How did the field of social marketing develop around this question, and what kinds of ideas did social marketers enlist to buttress their claims about human nature and interventions in human health?

**Branding as Socializing Exchange and Rationality: The Social Marketing Idea**

Although Wiebe, quoted at the beginning of this chapter, was primarily interested in the capacity of media technologies such as radio and television to influence civic life, several commercial marketers extended his argument in order to think about the possibilities marketing held for promoting public sector organizations in general, such as churches and government institutions. During the 1960’s and 70’s, Philip Kotler, Sidney Levy, and Gerald Zaltman all participated in theorizing how marketing techniques could be applied to practices outside commercial priced exchanges and named the practice “social marketing” (Kotler and Levy 1969a, 1969b; Kotler and Zaltman 1971).

In their articles, these marketers provided examples of how public sector organizations conduct activities which resemble commercial marketing, for example, in organizations’ efforts to increase the acceptability of ideas, products, or services among populations. Their articles led to a discipline-wide re-thinking of whether the concept of marketing itself should be broadened, resulting in the American Marketing Association (AMA) declaring this question the theme of the AMA meetings in 1970. The core of their idea was that marketing was no longer just a practice of directing the flow of priced goods and services, as it was defined by the AMA in 1948. Now, they argued, marketing is the general management of exchange. The debate between Kotler, Levy, and Zaltman on the one hand, and challengers like David Luck (1969) on the other, was how exactly to define exchange and to what kind of exchanges marketing was applicable. Kotler’s group argued that all exchanges – even gifts or charitable exchanges – resemble exchanges taking place in capitalist markets, essentially the idea that nothing is ever free and that forms of calculation, no matter how imperfect or irrational, are involved in all exchanges. Luck, on the other hand, argued that market exchanges and the subject area of marketing entails priced exchanges only, essentially the transference of material goods for money.

Similar debates about how to characterize exchange were taking place within anthropology during the post-war period, particularly within a set of discussions which founded the field of economic anthropology. Commercial marketers tapped into these conversations to buttress their claims about marketing’s new application to social issues. In the post-war period, anthropologists were split on the question of whether the attributes used to describe market exchanges – particularly presumptions of rational choice and self-interested maximization of utility – could be used to characterize exchanges in all contexts. Formalists argued that such was the case whereas substantivists argued that in non-market societies, such as those primarily organized by processes of redistribution and reciprocity, individuals make decisions about exchange based on social
values other than the individual self-interested pursuit of pleasure and happiness (Maurer 2006; Polanyi 2001 [1944]). Such values could include commitment to family, attainment of honor and prestige, and the securing of political allies and good will (Levi-Strauss 1969; Malinowski 1922; Mauss 1990 [1950]). Economic anthropology eventually extended these same arguments to market exchanges occurring in the west, demonstrating that neo-classical understandings of the division of economic from social values was in theory only (Zaloom 2005).

The post-war development of both branding and the social marketing idea entailed a seemingly similar argument, essentially characterizing all exchanges, whether charitable or priced, as entailing social and symbolic aspects. In 1975 Bagozzi, quoted at the beginning of this section, reviewed these developments within commercial marketing, and even drew on the works of anthropologists like Levi-Strauss, Malinowski, and Mauss to provide evidence for this transformation in marketing’s understandings of exchange, man’s rationality, and man’s motivations to exchange.

However, adoption of anthropological works by commercial marketers seeking to universalize their understanding of market exchanges overlooks a more critical point being made by anthropological theorizing of non-market exchanges or ‘the gift.’ Rather than to find commonality between (or even a simple inversion of (Gregory 1982)) Western notions of market exchange and other kinds of exchange, anthropologists were pointing to a crucial difference that is overlooked from the perspective of individuals in a liberal or neoliberal society. Anthropological accounts supported the idea that in many contexts, exchange and reasoning about exchange is not about the goods transferred from one person to another, but is primarily about the relationship established through the exchange. Where marketers were merely re-characterizing the goods exchanged and human reasoning about exchange as being “socially” constructed, their concern with goods itself left out more radical anthropological insights. In many Africanist accounts, anthropologists detailed how exchanges between patrons and clients entailed moral obligations as part of the “economic” choices people make, or in other words the economic decisions of individuals were not separate from social obligations to promote the welfare of all (Bayart 1993; Smith 2007). In fact to accrue individual wealth is often viewed as an anti-social practice and the result of witchcraft (Ashforth 2005; Geschiere 1997). As Marilyn Strathern has explicated in the Melanesian context, the difference between liberal market exchanges and “the gift” emerges from a different “metaphysics” of how the world works, rendering the comparability of liberal market exchanges and “the gift” impossible (Strathern 1988). Another way of putting this is that the very question of how to explain the relationship between economic (or one could substitute the word, “individual”) phenomenon in social terms is itself rooted in a western liberal history.

As many scholars of science, economy, and society have illustrated, “the economy” doesn’t naturally exist a priori as a domain separate from social values and practices. Rather western societies constructed “the economy” as a distinct domain or as an object of analysis and of political intervention beginning in the 18th century and throughout the 19th century, leading to the rise of modern day economics (Callon 1998; Foucault 1991; Mitchell 1999; Slater and Tonkiss 2001; Strathern 1988). During this time, specialized fields for analyzing problems and designing interventions around “economic” phenomenon as opposed to “social” phenomenon developed as the fields of
economics and sociology, respectively. Economics took as its starting point of analysis, individual choices, presumed to be formally rational, and “the market.” Sociology on the other hand was also concerned with the individual but primarily the extent to which the individual is formed through “social” institutions and values.

In contrast to economics, we can view anthropology, much of the social sciences, and social marketing as different attempts to re-embed the social and the economic. The social sciences and western politics have spun around this axis, the development of liberal thought, its treatment of the social, and its critique. In other words, these fields attempt to answer the question of how to understand individual economic choices, individual actions, and economic systems in social terms, with varying conceptions of what the “social” is.

What’s so important about this line between “the economic” – or presumed individual self-interested rationality – and “the social” – the shared and common space of welfare? This is one of the lines upon which social order and resulting inequalities are established and maintained and even upon which health itself is made possible or denied. For example, as described earlier, the period of neoliberal inspired public health beginning in the 1970’s was founded upon the idea that health is most available to all when rational humans are left to make choices on their own without government intervention and support. In contrast, as previously explicated, medical anthropology’s critique of this position has required detailing the relationship between economic inequalities and poor health outcomes. So what conception of “the social” did social marketing incorporate and to what extent did this new conception call into question the limitations of neoliberal inspired public health?

Constructing the Social as Perspectives on Desire and Pursuits of Pleasures: Early Social Marketing Applications

During the same years that academic marketers were redefining the very field of commercial marketing and anthropologists were debating the nature and meaning of exchange, commercial marketing practitioners were already developing projects aimed at applying marketing to ‘social’ causes, in this case family planning. As described in the introduction to the dissertation, in the mid-1960’s the Indian government, its Institute of Management, and the Ford Foundation worked together to plan the first social marketing program although the term “social marketing” did not exist at the time (Harvey 1999; Walsh et. al. 1993). The Ford Foundation and Indian government invested in this project because of a concern for encouraging family planning and limiting population growth. They believed that commercial marketing and private sector infrastructures provided an efficient and cost-effective solution to the question of how to promote family planning practice among their citizenry as well as how to coordinate the on-going distribution of donor-subsidized condoms. Although donors still subsidized the procurement of condoms under this family planning project, as they had for government-run distribution programs in the past, citizens now paid a small fee for condoms to retail owners. The planners of the India project intended this fee to reimburse the work of commercial distributors, wholesalers, and retail outlets and to provide incentives for retail owners to stock health

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7 As Strathern (1988) has shown, anthropological accounts often took for granted a notion of the individual and of society as universal phenomenon, without also realizing that these are also Western abstractions.
products in their outlets. Planners of the project also argued that people are more likely to value and thus use a product if they have paid for it (Chandy et. al. 1965).

USAID was a primary funder of these social marketing programs in the developing world among countries that had liberalized economies. Their funding enabled the development of several international non-profit NGOs specializing in social marketing services. Tim Black and Phil Harvey founded the U.S.-based Population Services International (PSI) during the 1970’s. Tim Black went on to found Marie Stopes International, a U.K. NGO that promotes family planning and sexual health in developing countries with a focus on social marketing. Phil Harvey also developed DKT International, a sexual health social marketing NGO. Other consulting development organizations, such as the Futures Group and AED (the Academy for Educational Development), began competing for USAID social marketing funds in the 1970’s and 1980’s.

While applied commercial marketers in the 60’s and 70’s were consulting in family planning and economy in the developing world, in the U.S. academic psychologists, anthropologists, and individuals working in public policy influenced the development of social marketing from another angle. Many of this group’s research interests emerged not from the desire to improve sales of companies, nor to privatize government services, but from the rising consumerist movement during the 1960’s. By understanding consumer choices and behavior and by developing the field of consumer behavior research, these scientists hoped to improve the ethics of marketing (Bartels 1988; Kassarjian 1994). Their work influenced marketing scholars not only to think of marketing exchanges as embedded in broader social and cultural worlds, but also to find ways to redefine commercial marketing itself in response to consumerist critiques, essentially to make marketing a more socially oriented and responsible field of practice. These movements were instrumental in generating the idea of social marketing and enlisting commercial marketing practitioners in non-profit and public health projects (Arnold and Fisher 1996; Kassarjian 1994; Kotler 1972).

Some of these critical thinkers emerged from the field of commercial marketing itself. In the 1970’s and 1980’s several disillusioned commercial marketing professionals sought to dedicate their lives to causes other than the pursuit of profit. They began working for government public health programs. For example, William Novelli, a former advertising executive, left commercial practice to assist the Peace Corps in promoting their programs and the National Institutes of Health in a National High Blood Pressure Education Program (Andreasen 1998). He had formerly worked as an advertising executive in New York for a company that assigned him the project of working with the Public Broadcasting Service (PBS), a project in which he realized that marketing could be used for other causes than profit (Novelli 1997).

During the 1980’s commercial sector companies also began to see how promotion of health values could support their already existing products. For example, in the 1980’s Wheaties cereal advertised its product as providing the right nutrition along with exercise to create health. This opened the door for public health education programs to use commercial media outlets and their communication strategies for health education (Ling et. al. 1992; Zaltman and Vertinsky 1971). For example, recently the American Heart Association has partnered with Campbell’s to promote awareness of heart disease in women and sales of Campbell’s low sodium and low calorie products. Such cross-
fertilizations between commercial practices and public health applications have led professionals from each of these fields to re-imagine the linkages between “social” and “economic” concerns.

Despite these developments in the 1970’s and 1980’s, Kotler and Levy’s original idea of social marketing did not enter mainstream public health prevention programming until the 1990’s. It was during the 1990’s that the few scholars of social marketing, including Philip Kotler and Alan Andreasen, began to describe social marketing practice as a way of managing civic behavior, not just promoting organizational goals and ideas (Andreasen 2003). Concurrently, many public health specialists continued to use the value expectancy theories discussed earlier to inform health interventions, but they still found problems in effecting behavioral changes. There were key populations which, despite having access to health products and services and despite being fully informed of the behaviors that produce optimal health, continued to practice behaviors that run counter to reduced health risk, such as smoking (Aggleton et. al. 1994). Defined as “hard-to-reach” populations, these groups remained outside the purview of health behavior and health education’s interventions in health and challenged their understandings of man’s innate rational pursuit of health. These challenges to public health provided an entrance point for social marketing (Lefevbre and Flora 1989).

The main critique social marketing offered public health, as described throughout this chapter, was the idea that people don’t always care to choose to be healthy, or in other words, they don’t always value the things that policy-makers construe as being objectively rational outcomes, public health. Instead they value subjectively defined pleasures. Practically this change in public health entailed the use of focus groups for public health studies (Basch 1987), a research forum borrowed from marketing that privileges consumer perspectives over quantifiable or epidemiological data. The focus group was seen as a solution to the problem of how to better incorporate the very personal and “cultural” values thought to inform the things that people care most about and to describe how those pursuits effect health choices. Other scholars began to advocate for the use of audience segmentation strategies that go beyond epidemiological and demographic analyses of risk groups by incorporating psycho-graphics information about citizens (Slater and Flora 1991). Marketing segmentation strategies offered a way to conceptualize risk groups in terms of people’s desires, and branding and marketing communications provided a way to influence consumers according to these preferences.

Social marketers further institutionalized these ideas during the 1990’s through the creation of the first peer reviewed journal, Social Marketing Quarterly, in 1994 and the establishment of a yearly conference and training retreat put on by the University of Southern Florida and AED called “Social Marketing in Public Health.” In the late 1990’s, between 1997 and 2000, many social marketing experts also noticed a rise in the use of branding within mainstream public health programming (Smith 1999). Public health professionals created the idea of the “social brand,” a practice of branding behaviors that do not necessarily require or that are not necessarily associated with a purchased product. One example of social branding is the “Vaa Kondom” program discussed at the beginning of this chapter. Another example is the “Truth” campaign in the U.S. which aimed to convince youth to reject smoking not solely by distributing information about risk for cancer, but rather by enlisting their desires to contest authority, in this case the smoking industry.
These institutionalizing processes took global stage beginning in 2004 when England established a National Social Marketing Centre (NSMC) within its Consumer Council. The NSMC held world social marketing conferences each year since 2007, uniting social marketing professionals from almost every continent.

Given all of this information, how can we then understand social marketing as a critique of presumptions of rationality in public health and as incorporating “the social” into economic depictions of choice? One clear example is how social marketing is an attempt to better serve “hard-to-reach populations.” Where social marketers perceived these hard-to-reach groups as being motivated by a different set of desires and values other than health, social marketers focused on better characterizing the preferences and pleasures which motivate these individuals and on better adapting programs to their desires. In doing so, social marketing incorporates an idea of “the social” as varied perspectives on desire, pleasure, and identity. Essentially social marketing imagines “the social” itself as a market where addressing welfare is a project of representing everyone’s desires within the marketplace. This construction of “the social” naturalizes problems of disease as resulting from peoples’ innate desires and imagines market fixes as directing desire towards healthy (read “rational”) choices via the brand. In the context of HIV in Tanzania, “hard-to-reach” denoted very poor drug users and women engaged in sex work. While social marketing programs entailed efforts to represent these groups’ purported desires and pleasures in the marketplace, as detailed in the following chapters, social marketing did nothing to address the fact that these groups are the most marginal groups to the benefits offered by capitalist economies. In other words, “the social” became “the market” for health products understood as an arena for expressing desires and pleasures, and “welfare recipients” were primarily understood as consumers not producers and individuals in need of income.

These observations then point to how social marketing could find common ground between anthropology and fields engaged in similar critiques of rational choice like behavioral economics. Behavioral economics is founded upon ideas of humans as having a “bounded rationality.” The idea originated in the post-WW II era with Herbert Simon (1969), an American economist, psychologist, and political scientist. Simon challenged rational choice theory and the construction of homo economicus as a utility maximizing being. Simon argued that neo-classical economics assumed ideal conditions for gathering and analyzing data by choosing subjects. In contrast, he argued that reality produces less than ideal conditions for rational subjects to assess data and make choices. Essentially, he argued that the amount of information available to individuals is extraordinary given the complexity of the world and that individuals’ ability to sort through this information is limited. No one person could achieve perfect or transcendent knowledge of a situation. He termed this new construction of economic man’s decision-making process, “bounded rationality.” Simon argued that actors are not “irrational,” but rather utilize a subset or bounded amount of available information to make rational decisions which produce less-than-rational outcomes. He described the process of choice among humans with bounded rationality as “satisficing” rather than “optimizing” or “utility maximizing;” people make the best, most satisfactory decision they can given a set of conditions, rather than the optimal decision if transcendent knowledge of a situation were possible. For Simon, peoples’ use of heuristic devices to make decisions is a primary contributor to their failure to practice careful lengthy calculation.
Simon’s work influenced scholars who eventually founded the field of behavioral economics. Amos Tversky and Daniel Kahnemann (1974), two Israeli psychologists, mapped the cognitive biases of humans that Simon had first pointed to, as well as the typical heuristic maneuvers utilized by the boundedly rational subject. They outlined three heuristics: anchoring; availability; and representativeness. They defined anchoring as the use of readily available information from which to estimate a decision or calculation. Essentially the idea is that humans make judgments according to the information that they presently have, which may or may not provide a reliable or accurate reference point for estimating a decision. Availability consists of assessing present risk in comparison to the available number of like examples of risky or non-risky situations. For example, people may over-estimate their risk of bird flu because of the constant media hype (Thaler and Sunstein 2008). Finally, representativeness consists of human failure to understand where chance plays a role in everyday life as opposed to patterned and predictable events. The bias of representativeness essentially means that humans may perceive likelihoods where statistical analysis would demonstrate that randomness is at work.

These ideas became foundational in the field of behavioral economics. Essentially, Tversky and Kahnemann argued not only that humans shared key biases, ones which were eventually naturalized within the neurological structures of the mind (Zaloom and Schulls, 2011), but they contended that by strategically altering informational environments such as the availability of information, anchors, or assessments of chance, professionals like economists and policy-makers could influence choice.

Their theories have had significant impact, most recently, through the work of Cass Sunstein and Richard Thaler (2008) who elaborated their ideas within a broader governing philosophy which has been taken up by the Obama administration and which they call “libertarian paternalism.” They advocate for government to structure environments and information so that people, despite their cognitive failures to practice rational action, are still caused to make choices which policymakers perceive as rational or ideal in the sense of maximizing such things as health, environmental preservation, or individual financial gain. Michael Rothschild (1999) has incorporated the language and position of libertarian paternalism into social marketing, although the term itself remains controversial in social marketing due to social marketing’s commitment to a critique of paternalistic public health programming and privileging of consumer perspectives.

Despite such hesitancy, scholars like Rothschild find common ground not only between social marketing and behavioral economics, but also between these fields and the field of anthropology as described above. While this common ground stems from a shared project of critiquing rational actor models of behavior, I argue that quite different perspectives are at stake. Where behavioral economics continues to naturalize human reason, anthropology views reason as radically open and cultural. Behavioral economics perceives of social influences on individual choice as consisting of the limitations within environmental and informational structures. In contrast, anthropological accounts point to the necessity of comprehending individual actions in relation to the broader political economies and theoretical interventions of institutions like public health, which themselves bracket our understandings of the “individual,” the “social,” and the “economic.”
IV. Conclusion

So what are we to make of these changes to the ways in which government programs promoted condoms and the ways in which public health education programs appealed to the public? These projects were based on claims about the limitations of *homo economicus* as an accurate model of human nature, essentially that this model did not consider the symbolic, emotional, and cultural motivations of consumers in their decision-making. The theory of branding provided a means for mediating decision-making based on these values, and opened the way to the social marketing idea which itself offered a way to influence health through affecting people’s pursuits of non-“economic” values and pleasures thought to drive health choices. We can view branding and social marketing as efforts to re-embed the social in the economic, a project which shares much with fields like anthropology, but in limited ways. This attempt to socialize understandings of exchange and of human rationality merely reconceived of the values that drive exchange as cultural, not just economic, rather than revolutionizing the neoclassical worldview in which exchange is self-interested and primarily about goods and their value, not the relationships forged through exchange. So what did social marketing look like in practice and how did alternative understandings of exchange and rationality in Tanzania complicate social marketing’s vision of creating public health through the market?
Ch. 3: Maadili and Double Markets in Zanzibar

I. “Maadili yetu ni kinga kubwa dhidhi ya UKIMWI”

Zanzibar, a semi-autonomous archipelago with a 99% Muslim population, lies approximately 44 miles from the coast of mainland Tanzania. For the majority of Tanzanians and most expatriate study abroad students like myself, who cannot afford the expenses of plane fare, the Stonetown ferry port in Zanzibar and the Dar es Salaam port in mainland Tanzania serve as the entry way to these two places. The experience of riding a ferry between these two places, and particularly witnessing the public media that greets newcomers at each ferry port, reflects differences in the broader cultural and political climate of each place. When one boards the ferry in Dar es Salaam, the line of passengers is a mish-mosh of men and women pushing against each other in close quarters in a culturally metered yet seemingly chaotic scramble to board the ferry. On either end when one first climbs aboard the ferry the tv screens inside the main cabin first play the call to prayer, a set of safety instructions, and then MTV music videos, usually Celine Dion seductively squatting over a bed running fingers through her hair longing for her dead lover 8 or Janet Jackson dancing and singing as half-nude men swirl their muscular physiques in silhouette across the screen. 9 These juxtapositions destabilize a sense of cultural uniformity isomorphic to geography that is often sought by many of the tourists on board. Yet all of these images flood into the background during the ride as passengers turn to newspapers, talking, and napping, and a woman circulates the cabin providing vomit bags and comfort to the seasick. When the ferry nears the Zanzibar port, the environment shifts as women start to fix their hair, re-align their wraps and scarves over their shoulders and tops, myself included. As the tree-lined island turns into the building-edged beach in Stonetown, everyone lines up to leave the ferry.

The ride from Zanzibar to Dar es Salaam is slightly different. If one arrives in Stonetown for the 7am ferry, quite early in the morning and just two hours after first prayer, the mad push for entrance onto the boat that exists in Dar es Salaam is completely absent as two lines, one for men and one for women, orderly and patiently form at the ferry entrance. The ferry ride itself is quite similar to the ride from Dar es Salaam, except that as one arrives at the Dar es Salaam port a set of visual materials that is absent in Zanzibar greets the newcomers.

A huge billboard that one cannot fail to notice as one enters the Dar es Salaam port by ferry coming from Zanzibar, but which is positioned out of view as one leaves for Zanzibar on the ferry, is a Salama 3 Bomba condom advertisement for PSI’s line of scented condoms – strawberry, chocolate, and banana. 10 A young hip couple, intended to convey a committed relationship and a cool image made available to those who purchase Salama Bomba condoms, is the focus of the billboard. Pictures of strawberry, chocolate, and banana surround the couple with the slogan, “chaguo lako,” meaning “your choice.” In contrast, when one arrives at the Stonetown port there is an absence of advertising,

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8 Celine Dion’s “It’s all coming back to me now”  
9 Janet Jackson’s “Love would never do without you”  
10 PSI developed this line of condoms in 2005 in order to create other brand offerings to the traditional Salama brand, just after T-MARC began launching the Dume brand. PSI was responding to common complaints of consumers in Tanzania, that the smell of condoms is one disincentive to use.
social marketing included. However if one walks or rides along the main thoroughfare through which the majority of ferry passengers exit the port, there is a plain white sign that reads in black lettering, “maadili yetu ni kinga kubwa dhidi ya UKIMWI”, meaning “our culture / moral-ethics is the biggest protection against AIDS.” The Zanzibar AIDS Control Programme, the local government office charged with coordinating a multi-sectoral response to HIV, with funding and support from Africare, a US-based organization with offices in Tanzania, had placed the sign there.

In contrast to social marketing media, such as the Salama Bomba ad at the Dar es Salaam port, the billboard in Zanzibar consisted of a statement only. There were no bright colors and no images. The sign was an explicit statement about a public health strategy, one that is informed by a particular Zanzibari form of Islamic ethics or maadili. The strategy of maadili itself, as this chapter describes, consists of managing one’s behavior so as not to provoke desires in others, that is, desires that run against Islamic ethics. Instead, maadili involves making choices based on reasoned arguments, information, and moral considerations.

In contrast, the Salama Bomba ad, potentially the very kind of program referenced as a failed strategy by those who erected the Zanzibar sign, intended to evoke desire in its viewers. In particular, the ad seeks to elicit aspiration to a way of life that PSI characterized in terms of individual choice, romantic love, sexual pleasure, and the use of condoms. In contrast to the sign in Zanzibar, the Salama Bomba ad communicated its message and its public health strategy through indirect means and persuasive forms. Rather than directly stating how desiring and aspiring to a particular lifestyle could lead to health and the reduction of risk for HIV, the advertisement makes this information implicit. The Salama Bomba ad also presumes that human action is and should be based on individual choice, desires, and preferences, explicitly stated in the tagline, “chaguo lako” (“your choice”). The ad implies that individual actions, particularly in the realm of romantic relations and sexual practice, are not determinant of, responsible for, or connected to others’ behaviors and health whereas the Zanzibar sign makes clear, for those who understand the meaning of maadili and what I hope to make clear in this chapter, that one’s self and one’s actions as well as the actions of businesses and governments are implicated in the well-being and actions of others.

This chapter explores understandings of maadili as an HIV prevention strategy among communities and public health workers in Zanzibar in contrast to social marketing strategies of branding and marketing developed by public health and business professionals in Dar es Salaam. I pay particular attention to Islamic perspectives of social marketing media and practices as a way of gaining ethnographic purchase on social marketing and its foundations in specific economic rationalities. While public health professionals in Dar es Salaam characterized approaches to HIV prevention in Zanzibar as “faith-based,” making a distinction between ‘economic’ rationales and ‘moral’ ones as well as drawing a line between “faith” and “science,” I argue that this understanding depoliticizes critiques of social marketing by qualifying critical accounts as based in belief or essentially irrationality. Designating criticisms from Islamic groups as “faith-based” also disregards how Islamic followers call the central economic tenets of social marketing into question. In particular, accounts from Islamic groups in Zanzibar highlight how social marketing uses desire to motivate humans rather than appeal to humans as rational actors.
Following these critiques, this chapter also describes actual practices of condom exchange and procurement in Zanzibar. I examine how the tensions between social marketing practice and the Islamic approach to HIV prevention led to a situation of what I call double markets in condoms. On the one hand, social marketing practice sought to create commercial sector markets in condoms by enlisting bars, guesthouses, and small shops to sell branded condoms. On the other hand, the failure of these strategies and the criticism of these programs exercised by Islamic leaders and individuals in Zanzibar led the local government in de-privatizing these branded condoms. The Zanzibar government introduced social marketing condoms into alternative exchange networks that included government institutions and NGOs, the very opposite strategy of social marketing’s objective to commercialize and privatize condoms.

II. History of Religion and Government in Zanzibar

The history of Zanzibar’s relationship to the mainland, including its divergent form of public health programming, is a long, controversial, and violent one. Zanzibar and the former government of Tanganyika, which governed the area of mainland Tanzania since independence in 1961, united under one government, the United Republic of Tanzania, in 1964. In late 1963 a violent revolt by self-identified African populations overthrew the landed Arab elite and the Omani sultanate who had governed the archipelago since the 1600’s. Characterized as a revolution of an underdog class against a business landed elite, the new government adopted a socialist platform. Soon after the revolution, the government of Tanganyika promised to guarantee Abeid Amani Karume and the Afro-Shirazi party who took charge in Zanzibar future protection against a potential retaliation by Omani leaders.

While remaining united as one republic since 1964, tensions between the two places have surfaced, especially since the 1990’s during the post-liberalization era and in 1995 with the introduction of multi-party elections, controversies which have called into question the legitimacy and necessity of the union government (Maliyamkono 2000). Led by party leaders of the Civic United Front (CUF) with the majority of its supporters in the archipelago, the opposition party to the ruling Chama cha Mapinduzi (CCM) (“party of the revolution”), conflicts often entail calls for secession of the archipelago from the union government, power sharing agreements between CUF and CCM in Zanzibar, accusations of electoral fraud, and contestations over the distribution of taxes gleaned from Zanzibar’s tourist industry.

Since 1995, elections in Zanzibar since 1995 have been mired by police violence and accusations of electoral fraud. While CUF maintains a minority of voter support in mainland Tanzania, estimates of party affiliation in Zanzibar are more equally divided between the two parties. Thus continual election of CCM members in the upper ranks of government raise questions among CUF loyalists and challenge their sense of self-government and sovereignty. CCM leadership often resorted to violence to contain protests against electoral fraud, a set of events which led donors in freezing aid to Zanzibar between 1995 and mid 2002 (Cameron 2002; Myers 2005:83).

Many CUF affiliates also perceive of CCM leaders as mere pawns of the Union government and CCM party, acquiescing to mainland interests in exchange for
guarantees of continued employment. One of the most controversial issues raised in accusations of nepotism is that such allegiances result in the continual extraction and redistribution of revenues gleaned from the tourist industry in Zanzibar to the mainland. CUF supporters continually cite not only their perception of the unfairness of this redistributive practice, but also point to the lack of government distribution of funding in general for programs in health and education in the archipelago region, particularly in Pemba, the northernmost island. CUF supporters and particularly those in Pemba that feel marginalized from the economic benefits of the current tourist economy, make calls for self-representation and determination in government. In 2010 these controversies led to the passing of a referendum on a power-sharing agreement between CUF and CCM after years of negotiations and to the first non-violent elections since 1995. These events will reshape politics between the archipelago and mainland but with what effects remains uncertain.

Despite calls for further autonomy in the archipelago, Zanzibar maintains a level of self-government not present in any other region of Tanzania. Zanzibar has its own set of government institutions including a House of Representatives which can legislate over non-union matters, its own independently recognized president whose position falls under the president of the Union government, and other government offices such as a Ministry of Health and a separate AIDS Control Programme. HIV/AIDS is a non-union matter, allowing Zanzibar to develop its own policies and strategies for preventing and treating the disease.

The disease and responses to it took different forms on the mainland versus Zanzibar. In mainland Tanzania, estimated prevalence rates have remained around 6% in the adult population since 1997 whereas estimated prevalence rates in Zanzibar have been around 0.6% (TACAIDS 2010). Prevalence rates in Zanzibar are also concentrated in populations defined as “most-at-risk” such as “injecting drug users,” “women engaged in sex work,” and “men who have sex with men,” with prevalence rates ranging from 10% to 15% in these populations (ZAC 2008).

Zanzibar maintains its own Zanzibar AIDS Control Programme which is in charge of coordinating the health sector response to HIV/AIDS, such as surveillance, health education, commodity distribution, prevention and treatment, as well as its own Zanzibar AIDS Commission in charge of coordinating a multi-sectoral response to HIV/AIDS. Where the mainland institutions managing HIV prevention have readily adopted and invited funding and support from international organizations, particularly social marketing and health communications programming, the Zanzibar government often maintains greater autonomy over health education programming and invites international organizations to adapt materials to Islamic approaches to HIV prevention. However, Zanzibar receives what many public health professionals referred to as “spill-over campaigns” in which mainland health programming reaches the archipelago through radio and television broadcasting. Zanzibar also has a strong grass-roots set of NGOs

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11 There has also been a consistent history of calls for secession so that Zanzibar can join the Organisation of Islamic Conferences (OIC), an inter-governmental organization seeking to promote the interests of Muslims the world over. Various interests, both religious commitment and economic incentives, encourage Zanzibar leaders to work towards incorporation into the OIC (Parkin 1995). However, mainland government representatives have long denied and contested Zanzibar’s desire to enter the OIC, citing Zanzibar’s lack of status as an independent state.
which addresses HIV, yet many of these organizations lack funding and resources to carry out large scale public health prevention operations.

The government and its policies towards HIV prevention in Zanzibar are also much more influenced by and incorporate Islam into daily practices and institutions. The Zanzibar government maintains three religious-based offices including the Waqf Commission which governs endowments and property, the Chief Kadhi’s Office which governs Islamic courts dealing in matters of marriage and divorce, and Mufti’s Office which manages Islam within the school system. These offices date back to the early 1900’s when the British oversaw Zanzibar as a protectorate. While the Omani sultan had governed Zanzibar since the late 1600’s, in the late 1800’s the British formed a protectorate with the Omani government. While the British first attempted to separate religion from government, they eventually concluded that it was in their interest to acquiesce to an Islamic influenced government, especially as people in Zanzibar began to resist their attempts to develop Christian missionary schools in the region. They allowed the above three religious offices within government, but tightly oversaw appointments. In contrast, after the revolution and in the early years of socialism, the government sought to separate religion and government and prohibited the teaching of Islam in government schools. However, in the 1970’s Karume’s government shifted their policies, arguing that Islam would be compatible with the objectives of socialism, and so his regime began to support religious institutions and religious education in government schools. International Islamic reform movements of the 1970’s also took hold in Zanzibar as the socialist government began to allow scholarly exchanges between Zanzibar, Egypt, Saudia Arabia, and Sudan. These events opened religion in Zanzibar to sects outside of Shafi Sunni Islam, and today the archipelago consists primarily of Sunni sects including Shafi, Hanafi, Maliki, and Hanbali.

This history of tensions between secularization and religious revivalism continued during the era of liberalization in the 1980’s and 1990’s. With the succession of socialist president Julius Nyerere by Ali Hassan Mwinyi, who fully adopted structural adjustment policies and accepted international loans, religious revivalism rose in Tanzania. Numerous Muslim organizations emerged in order to work against the secularization of contemporary life and politics that came with liberalization, to promote Islam, and to provide alternative discourses for national progress as the tenets of socialism no longer applied and neoliberal movements began to replace them (Ludwig 1996; Wijsen and Mfumbusa 2004). While the mainland, like Zanzibar, experienced a wave of religious revivalism beginning in the early years of liberalization, in the context of Zanzibar Islamic revivalism became a means not only of finding a set of values to aspire to but also served as a means of distinguishing “Zanzibari’s” from “mainlanders.” The rising tourist industry further exacerbated this distinction by heightening people’s perception of outside invasion, producing a sense of skepticism and wariness of foreigners that pervades the island to this day.

This kind of skepticism also pervades many CUF supporters’ assessments of how the Zanzibar government incorporates religion into government practices. Today, many religious followers in Zanzibar perceive that sheikhs working within government offices, such as Mufti, are mere pawns of CCM. As one professor at State University of Zanzibar (SUZA) in Stonetown described it, “it’s the people who are defending Islam. Mufti is
there, but in reality Mufti is there to defend the ruling party. They translate the stand of CCM into a stand that’s compatible with Islam. They aren’t defending Islam.”

Whatever the intentions of individuals within government, the influence of Islam on daily life in Zanzibar necessitated that the government and foreign public health programs design HIV policies and prevention strategies with Islamic perspectives in mind. When programs failed to do so, they encountered vocal and sometimes violent opposition by community members.

III. Social Marketing and “Faith” in Zanzibar

In 2006, this history of tensions between the mainland and archipelago and between liberalization and religious revivalism informed a controversy concerning a social marketing brand, as detailed in the introduction to the dissertation. Family Health International, a US-based and USAID-funded international NGO with offices in Dar es Salaam extended its youth HIV prevention project, branded as Ishi, to Zanzibar. Ishi, at this point in its second phase, was a behavior change project meant to encourage young women to have self-confidence and to abstain from sex until marriage. Through marketing and branding strategies focusing on the idea of “ishi” meaning “to live,” FHI hoped to promote the primary message of abstinence, although the project also mentioned “being faithful” and condoms as back-up methods of preventing HIV. The primary slogan of the project was “usione soo, sema naye” (“don’t be shy, talk with each other”). FHI intended this phrase to encourage young girls to have self-confidence, to speak up, and to talk with their partners about committing to abstinence. The phrase was popular slang among youth in Tanzania and generally connoted the idea of self-empowerment.

ZANGOC, an Unguja-based NGO, and WAMATA, a Dar es Salaam-based NGO with offices in Pemba, won the contract for implementing Ishi in the archipelago. At the outset of the project in Pemba, a WAMATA staff member began visiting villages to promote the message through community forums and through the distribution of t-shirts and posters. Well aware of Ishi’s ads which reached the island through television and radio, two villages upset with the project stoned the staff member and ran him out of the area. Village members had interpreted the Ishi campaign and its key message, “usione soo, sema naye” (“don’t be shy, talk with each other”) as actually encouraging youth to have sex. Thereafter WAMATA decided to return all project materials from their offices to FHI’s office in Dar es Salaam and to quit public promotion of Ishi. Religious and political leaders in Pemba sympathetic to the villager’s critiques organized themselves and took their concerns all the way to the national level. After winning alliances in the Tanzanian Parliament, Pemba representatives led the government in taking the Ishi project off of the national airways. However, Ishi continues to this day in mainland Tanzania through community level programming.

Given these controversies, in 2005 T-MARC staff at the outset of the T-MARC project decided that their efforts would be better concentrated on mainland Tanzania. T-MARC staff, including T-MARC’s marketing director, Hilda, carried out informal formative research in Zanzibar and they concluded that Zanzibar is “not ready for condoms” due to “religious pushback.” Similar to other professionals working in public health and social marketing organizations in Dar es Salaam, Hilda described the “push-
back” from communities as an issue of religious and moral opposition to the condom itself. She likewise assumed that Islamic approaches to HIV prevention in Zanzibar rejected the condom as a prevention option entirely. Professionals often used generalizing terms like “culture” and “religion” to explain Islamic opposition to the condom, with little explanation about what is entailed in Islamic critiques of condom social marketing other than pointing to the relationship between condom use and the prohibition of sex outside of marriage.

While in 2005 T-MARC had decided to concentrate their condom marketing efforts elsewhere, on “most-at-risk populations” in mainland Tanzania, four years prior in 2001 PSI had decided to open an office branch in Zanzibar and to begin promoting condoms in this urban center. PSI struggled for years to gain ground with its social marketing project. Many businesses in the Stonetown area refused to carry PSI’s branded and subsidized condoms, and any public advertising for these branded condoms or for the use of condoms in general, such as billboards and signs, were quickly destroyed by community members.

PSI hired Hemed, a man with a two year degree in business from a technical college in mainland Tanzania, to serve as the regional manager in Zanzibar. Originally from coastal south-western Tanzania, Hemed’s “outsider” status in Zanzibar both gave him a kind of public exemption from prohibitions on commercially promoting condoms, while at the same time further contributed to his experience of marginalization within local government and public health circles in Zanzibar. Hemed recalled the situation in 2001 in which condoms were hardly available in Zanzibar except for high priced condoms available in venues visited by tourists. These tourist condoms cost around 3,000 to 5,000 shillings or around 3 to 5 dollars, an unaffordable price for most Zanzibaris. Hemed initiated trainings with owners of bars and guesthouses to encourage them to stock lower-priced social marketing condoms. While only making headway with some of these venues, he utilized the bars of those owners who were receptive to condoms to conduct “Salama nights,” an evening event in which he distributed condoms and conducted educational activities on HIV prevention.

Hemed experienced less success with convincing pharmacies and maduka to stock condoms, an occurrence that he attributed to the fact that more conservative leaning individuals from Pemba owned the majority of dukas and pharmacies. He did make progress with kiosks, large carts that men carried to market areas to sell small consumer goods, a success he also attributed to the idea that most kiosk owners were from mainland Tanzania.

Hemed worked with Abdula, a local Zanzibari man engaged in many small entrepreneurial activities, to promote and distribute condoms to shops, bars, kiosks, and guesthouses willing to stock them, using a motorbike provided by PSI headquarters in Dar es Salaam. While seeing successes in venues like bars, kiosks, and guesthouses, Hemed and Abdula made little headway in terms of increasing condom sales and use to the levels that PSI expected for mainland areas of Tanzania.

Hemed also found challenges in enlisting public media companies to promote condoms in Zanzibar. Only one private radio station was willing to play PSI’s Salama

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12 A guesthouse is an hourly or nightly hotel. Some house women living as long-term residents who provide sexual services for clients.

13 Maduka is plural for duka, meaning small shop.
ads on airtime, and Hemed found that the use of billboards or tire covers was unacceptable in the area. If he placed media advertisements in public, they would quickly be removed by community members.

Hemed’s experiences and FHI’s trials with Ishi demonstrate instances in which Islamic individuals and organizations in Zanzibar oppose American-run public health programs. Public health professionals in Dar es Salaam diagnose these critiques as “faith-based” or belief-based opposition to the condom itself and to sex outside of marriage. In doing so, public health professionals draw lines between “moral” and “economic” practice understood as belief-based versus science or evidence-based approaches to creating population health, as though the two can be readily separated. These perspectives overlook key arguments exercised by Islamic groups regarding the application of marketing to public health, ones that I detail hereafter.

IV. Prevention versus “More Business”

In contrast to the assessments made by public health professionals in Dar es Salaam, I investigated how communities in Zanzibar who were vocal about social marketing themselves perceived marketing-based HIV prevention strategies. In June of 2008, I had the privilege of attending a week-long workshop on “Gender and Reproductive Health,” organized by the Zanzibar AIDS Commission (ZAC) and a local NGO called the Zanzibar Interfaith Alliance for Development and AIDS (ZIADA) and funded by the UNFPA. Ali, the faith-based coordinator at ZAC, had asked me to use this workshop as my entrance point to Islamic communities. He felt that it was the most appropriate and sensitive way to introduce me to individuals within this community and that it would allow me to establish the most trust possible with a group of people skeptical of outside researchers and foreigners.

Ali helped create ZIADA in 2004. ZIADA is an umbrella organization for all religious organizations working on HIV in Zanzibar and primarily consists of affiliated mosques and madrassas. Its purpose is to “reduce the prevalence of HIV/AIDS by using faith and by using spiritual books,” as Omar, the secretary to the organization described it to me. Omar described how religious leaders hoped to promote health in their communities, but usually lacked up-to-date information on HIV/AIDS. ZIADA’s goal was to provide training on information about HIV to these leaders and to have them mainstream HIV in their teachings.

In the summer of 2008, participants attending the workshop primarily consisted of twenty individuals who taught religious education to adults or children in their communities, either at their mosques or at madrasas. There were two individuals from Christian churches. Individuals had to submit a formal application to ZIADA, and those who were chosen came from all areas of Unguja and Pemba, both urban and rural, and represented a broad spectrum of Muslim sects and Christian faith in Zanzibar. Each day we met at a local school in the Michezani area of Zanzibar. The workshop consisted of formal presentations by government officials on gender, the state of HIV in Zanzibar, methods of prevention, etc., followed by opportunities for the attendants to discuss and debate how faith communities should address these challenges.
Throughout the week, I was impressed at how democratic the workshop was. Government officials, from ZAC and other ministries like the Ministry of Labor, Youth, Women, and Children’s Development, opened each session with scientific and statistical information about risk for HIV, methods of prevention, relationships between gender dynamics, disease, and poverty. After their presentations participants were given plenty of space to debate these issues, including the scientific basis of the presentations. Participants expressed a variety of opinions on topics such as the constructed versus biological nature of gender and sex, the rights of individuals versus religious institutions or government, and the effects of discrimination and social marginalization of affected individuals in communities. Despite differences in opinion on these issues, the attendants’ common point of concern was the belief that religion and religious ethics should guide public health efforts to prevent HIV in Zanzibar, not decontextualized scientific information nor foreign-operated health and business programs. Throughout the workshop, they sought to come to common understandings about how to interpret religious ethics in relation to behavioral prescriptions for preventing HIV.

The third day of the conference covered topics under the heading “reproductive health.” The session included material on what strategies were appropriate to use in preventing HIV in communities and what the role of religion and the family should be in prevention. At one point we divided into small groups to discuss what parents should do to help their children prevent HIV. My group came up with a list that included: preventing HIV at birth; following doctors’ orders; fighting poverty; teaching about HIV in the family; and teaching “maadili ya dini” or the moral-ethics of religion, which included teaching the ethic that sex should be kept inside marital relationships. When I asked the group about the meaning of maadili, they described it as “norms with the culture,” “teachings with the culture,” or “ethics.” They explained that there are maadili ya jamii (moral-ethics of society) and maadili ya dini (moral-ethics of religion) and that sometimes the two don’t agree. They perceived the workshop as an opportunity to articulate the moral-ethics of religion as a means of preventing HIV.

When the whole group reconvened, people shared their ideas about preventing HIV through the family, raising similar points to my own group. However at one point, Ahmed, a father of four, religious educator, and a reporting officer of a government-run port in Pemba, became outraged and began railing against the kinds of tv and radio advertising that disrupts the teaching of moral-ethics within the family. In particular, he referenced the Ishi campaign by pointing to the slogan, “usione soo, sema naye.” Everyone in attendance knew what ad he was referring to without him having to explain. The woman sitting next to me, a madrassa teacher living in the nearby area of Michezani, explained that the advertisement was promoting condoms to youth and encouraging youth to have sex. She interpreted the saying, “usione soo, sema naye,” literally translated as “don’t be shy, talk with each other,” as meaning “don’t be afraid to have sex.” Or as Ahmed later explained it to me, he interpreted the saying as “don’t feel shame, usione haya, that I am not able to make love unless for condoms.”

Ahmed’s outburst led to a discussion of the sense that Zanzibari communities were losing their ability to control influences on their children. People raised the issue that the government often failed to regulate advertising. Likewise, they criticized the

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14 “Don’t feel shame, usione haya, kwamba siwezi kufanya mapenzi isipokawa kwa kondom.”
government for allowing the building of bars and guesthouses in their communities. Not all attendants were against the construction of bars and guesthouses entirely; rather they hoped that these venues, seen to be a site of health risk for their communities, could be built in other locations. People expressed similar opinions about condom distribution. There was not an outright rejection of the condom and its distribution by all attendants. Rather many individuals expressed the opinion that the government should oversee the promotion and distribution of condoms. They hoped that condoms would not be made available in ways that would incite new desires in youth for sexual practices tied to HIV risk.

After the workshop, I met with many of the participants to clarify their perspectives on HIV prevention, condom use, and the approach of social marketing in contrast to their vision of public health programming informed by Islamic ethics. While most individuals prescribed to the philosophy that the best method of preventing HIV was for individuals to only have sexual intercourse within a marital relationship, participants did qualify when condoms could be used and how specifically they should be promoted and distributed. One man, Hafidh, was particularly articulate on these issues.

Hafidh is a tall slim man with a calming presence. A father and husband, he teaches biology at a secondary school and is a madrassa teacher of young pre-school children just outside Chakechake, Pemba. He explained to me the conditions under which Islam sanctions condom use. Hafidh argued that if you know one hundred percent that a condom will effectively prevent HIV, then it is okay to use it. However, Hafidh pointed to the multiple conditions in which condoms break and fail and do not successfully prevent HIV. Secondly he said that because condoms are not one hundred percent reliable, sexual intercourse and condom use should only occur in a committed marital relationship. He then used these conditions, prescribed by his faith, to comment on the negative effects of social marketing.

H: We feel maybe that these condoms are more business. More business sometime we can say that. Or not? … Okay, I mean that when I produce, I produce some things. I think I have to encourage you to use it. Or not? … Because of that they prepare since they want things to be used. Now it is, I mean, it is difficult to give a person certainty that the condom is preventing AIDS or the condom is doing what… there is not one hundred percent certainty that this thing is ****, preventing there is not one hundred percent. Even if there is .001 percent it is dangerous. It is dangerous…

E: These businesses have what kind of effect?

H: These effects come that when you emphasize a thing, and you see it to be widespread, you make an advertisement that you advertise, that people see it is a good thing… when you advertise that thing has a meaning. You build a picture for people that the thing doesn’t have problems… When you build a picture that the thing has no problems it has the meaning that

15 Sisi tunahisi labda kwamba hizi kondoms zimekuwa more business. More business sometime we can say that. Or not?!.... Okay, I mean that when I produce, I produce some things. I think I have to encourage you to use it. Or not? … Kwa maana hiyo wao waliungenezai kwa vile vitu wanataka vitu vitumiwe. Sasa ni maana kwamba ni kigumu kumpa mtu hakika kwamba kondom inazuia ukimwi au kondom inafanya nini… hakuna hakika asimilia ni hundred percent kwamba hii kitu kinaweza kukaa, kuzuia hakuna hundred percent. Hata kama kuna 0.001 percent ni hatari. Ni hatari...

16 Hizi biashara ina effect gani?
Hafidh narrated a critique which I began to hear again and again in my research – that utilizing marketing as a strategy for conducting public health programming involves packaging a recommendation in ways that isolates out the risks involved in using it. Essentially these critiques spoke to the heart of marketing’s philosophy for governing humans as consumers. As described in the last chapter, the shift that public health behavior change programs make when they adopt marketing strategies is to appeal to persons not as individuals engaged in cost-benefit analysis, but as individuals driven by pleasures and desires which preclude their ability to rationally assess risks. Therefore marketing communications often extracts explicit communication of health risks involved in a set of recommended behaviors. Many of the leaders at the ZIADA workshop found this approach to be deceitful and to impose new risks on their communities. They perceived social marketing programs to be asking individuals to make decisions based on desire and a kind of faith in the ability of condoms to prevent HIV, rather than reason and ethics. Their critiques actually flipped public health professional’s understanding of the issues in Zanzibar and the discourse of “faith” on its head: while public health professionals perceived “faith” to be the basis of HIV programs in Zanzibar, Islamic leaders saw “faith” to be at the basis of condom marketing in contrast to their own prescriptions which called for a rational weighing of the risks and benefits involved in condom use. However, religious leaders did not speak about these opposing strategies in the language of “faith.” Rather they used the terms “prevention” versus “business” to describe what they saw to be public health programs versus marketing programs.

Hafidh’s designation of social marketing as “more business” was also echoed by Kassim, the Coordinator of HIV/STI Transmission and Control at ZACP. A medical doctor, Kassim was in charge of educating health care workers on STI prevention and treatment; coordinating the distribution of STI and HIV drugs and supplies to health workers; managing educational materials through radio, tv, posters, and leaflets; and overseeing peer education programs, particularly those targeting women involved in sex work. During our meeting, Kassim drew a clear distinction between ZACP’s work at

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17 Hizi effects yake inakuja kwamba unapokitilia mkazo kitu na ukaona kupamba sana unaafanya ili advertisement kwamba unakiaidvertise, kwamba watu wanaona ni kizuri kitu... unapokiaidvertise kile kitu ina maana. Unajenga picha kwa watu kwamba kitu hakina maatatizo... unapojenga picha kwa kwamba kitu hakina maatatizo ina maana wengi watakitumia. Wakitumia kile ya maana ni matatitizo ni yake basi ina maana yale matatizo... Sasa wewe... eh?... unapata fedha yako au sivyo? Unapata fedha yako... Kwa hiyo athari ya kibiashara ni kama haya. Wewe unaadvertise kuonyesha kwamba kila kitu hakina maatatizo. Sawa? Watu wanakitumia. Si ndiyo? Watu wanapokitumia kama kina matatitizo sasa ina maana wewe unechukwa matatitizo... umewapa watu. Unafahamu sana? Ina maana wewe umepata fedha yako hii biashara kama watu wamenunua labda, si ndiyo? Lakini jamii... jamii imeathirika. Imepata matatitizo. Kwa hiyo hii ndiyo effect ya hizi business...
“prevention” in contrast to PSI’s work at “business.” Like many professionals working at ZAC and ZACP, Kassim perceived of PSI as a commercial business, not a public health NGO. He qualified PSI’s work as a business in terms of their charging a price for condoms rather than providing them for free and in terms of their use of advertising to promote sales of condoms. While Kassim, like other professionals at ZACP, did not explicitly draw from Islamic ethics in their design of government HIV prevention programs, his perspective on “prevention” versus “business” and the practical strategies that ZACP took to address HIV in Zanzibar (see section 6.0) reflect a shared orientation to the kinds of ethical concerns expressed by individuals within faith-based organizations like ZIADA.

The distinction between prevention and business also echoed larger concerns of the mainland government concerning what kinds of contraceptive devices should be considered ‘over-the-counter’ versus what should be considered in need of a prescription and regulated by trained pharmacists. Over the past five years, USAID has funded and collaborated with programs such as the Management Sciences for Health and USAID’s own Health Policy Initiative, a program run by the Futures Group in Tanzania, to deregulate the sale of contraceptive pills. Specifically these projects advocate with the Tanzanian government to allow contraceptives pills to be sold in unregulated type 2 pharmacies (duka la dawa baridi), private sector shops which are licensed to carry medicines approved for sale by the Tanzanian Food and Drug Authority (TFDA). In 2007 and 2008, these programs encountered resistance from policymakers and the TFDA because these latter groups were concerned about the safety implications of deregulating contraceptive sales. In a similar manner, Islamic leaders in Zanzibar called for treating condoms like a pharmaceutical good with its own risks and benefits that require regulation. They argued that individuals contemplating use needed to be fully aware of the risks involved in using this kind of product and with sexual practice in general, information that is not made available to consumers when marketing communications foregrounds recommended actions and omits information about risk.

Many Islamic leaders also felt that if condoms were distributed through clinic and state infrastructures, then doctors, nurses and other health professionals would better inform people about the risks of condoms as well as incorporate teachings derived from Islam regarding recommendations about how to live ethically. As Hemed explained it,

When you put them in the stores, it is business, and each person has his right to buy, but the clinic, he will be given that (the condom), he who is known by the hospital that he has the need of condom, and by the laws of Zanzibar all doctors are Muslim. Therefore they will give that condom with moral-ethics, but in the store a person follows profits and he who sells many indeed profits much.18

While this is the very kind of moralization of condoms that public health professionals working in Dar es Salaam hoped to avoid, the difference between social marketing and Islamic perspectives was not one of a moral versus amoral or technical perspective. Rather the difference was a difference of what kind of ideal moral person would prevail

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18 “Unapoweka dukani ni biashara na kila mtu ana haki ya kununua, lakini kliniki atapewa yule ambaye anatambulika kihospitali kwamba anahitaji matumizi ya kondom, na kwa sheria ya Zanzibar madaktari wote ni waislamu, hivyo watazitoa zile kondom kimaadili, lakini dukani mtu anatafuta faida na anavyouza nyingi ndivyo faida inavyokuwa kubwa.”
as the norm guiding public health interventions. Social marketing programs presume subjects to be driven by affect and the pursuit of pleasure and to possess a limited ability to reason. Social marketing thus perceives the health of individuals to be dependent on a market system for managing information in a way that highlights the relation between recommended health prevention behaviors and desires. In contrast, Islamic approaches in Zanzibar argued that humans should make decisions based not on desire and pleasures but according to a reasoned calculus that includes ethical and religious teachings.

Sheik Yusuf, a middle-aged religious leader who runs a NGO that supports orphans and community development projects in Chakechake, Pemba articulated a similar opinion.

People are afraid if they let the businesses go, they will not be committed to morals, but there will be desire. It will be like a pen. Each place it is able to be gotten. If there is a government institution, it would help to place control, otherwise each person is given because humans desire… It is not bad to be sold in certain shops like the pharmacy or stores but it is not every shop and the community is not educated. It is the reason I am saying the issue of avoiding AIDS is to preserve morals only… Without the religious leaders these condoms will continue to increase AIDS because its consumption only needs to be taught. There are styles of different types. It is possible that this youth takes it (a condom) but he doesn’t know how to use it. He was motivated only and the condom does not prevent AIDS 100 percent. Now telling people to use condoms, its meaning, they are caused to believe 100 percent. 19

Like Hafidh, Sheik Yusuf outlined the potential negative consequences of privatizing condoms, including advertising them to youth without provisioning youth with adequate information about HIV risk, rates of condom effectiveness, and moral-ethics. He articulated how condom marketing and business backgrounds the communication of risk information about the condom and foregrounds information concerning “consumption,” “motivation” or “desire,” and “types.” In contrast, if government and religious leaders are involved, Sheik Yusuf hopes that individuals will be given complete information, including information about the risks and benefits of condoms.

In contrast to their ideal prescriptions, ZIADA leaders argued that many of the businesses which are willing to carry condoms in Zanzibar are not run by followers of the Muslim faith. They perceive these business owners as stepping outside of religious ethics not only by promoting use of a product that the Muslim faith considers to have great risks, but also by secularizing business. In secularizing business, sellers perceive product purchases and use to be an act of individual choice, not an action that communities or businesses are also responsible for. As Hemed described above, when condoms are sold through businesses, sellers are concerned with profits, not with maadili. This ethic actually became the basis for bribes at the port in Pemba where one duka owner imported...

19 “Watu wanahofu wakiwaachia wafanya biashara hawatakuwa committed to morals, ila watakuwa na desire itakuwa kama kalamu, kila mahali zinapatikana. Iwaapo kungekuwa na government institution, ingesaidia kuweka control isiwe kila mtu anapewa kwasababu binadamu wanamaua… sio vibaya kuwazwa katika maduka maalumu kama pharmacy au stores lakini sio every shop na community iwe educated. Ndio maana nkasema swala la kuepuka ukimwi ni kupreserve morals tu. Bila viongozi wa dini hizi kondom zitazidi kuongeza ukimwi kwasababu matumizi yake tu inahitaji ufundishwe. Kuna style za kila aina. Inawezechana yule kijana anaichukua tu lakini hajui kuimunia, yeve kahamasishwa tu na kondom haizi anaziba ukimwi kwa asilimia 100. Sasa kuwaambia watu tumieni kondom, maana yake, wameshaamini 100%.”
condoms. Farid, a young man in his early twenties originally from Chalinze in mainland Tanzania was the only duka owner that PSI had record of carrying condoms in Pemba. Once a year he imported condoms by making a trip by ferry to Tanga and returning through a Pemban port. The police who inspected goods at the Pemban port would claim that they needed to be compensated for their sin of allowing him to commercially promote condoms. Such logic ran counter to an understanding of individuals as personally responsible for the choices that they make.

Public health professionals designing public health marketing campaigns in Dar es Salaam missed these kinds of critiques which circulated widely in Zanzibari communities. There were certainly more radical perspectives on condom use in Zanzibar, such as is represented in the pamphlets circulating in local markets claiming that the HIV virus is small enough to pass through a condom even when used correctly. And certainly, the religious leaders I spoke to supported the idea that keeping sexual relations within a committed (in this case, read ‘marital’) relationship was the most effective way to prevent HIV. This teaching was part of what it meant to approach HIV prevention through ‘moral-ethics.’ However public health professionals in Dar es Salaam tended to place greater weight on these more radical perspectives as an explanation of local critiques of social marketing and to overlook more finely articulated critiques which called into question the central tenets of social marketing practice. Islamic approaches to HIV prevention called attention to the way in which social marketing and its methods of communication background the communication of risk and foreground the communication of suggested aspirations and desires. By overlooking these critiques, organizations like PSI, FHI, and T-MARC interpreted reactions to social marketing as solely an expression of moral opposition to sex outside of marriage and to condoms themselves. This perspective has a de-politicizing effect by steering the conversation away from commentary on social marketing and towards the idea of, at best, the ‘beliefs,’ or at worse, the ‘irrationalities’ of communities in Zanzibar. This understanding of the problem, as one of ‘culture’ and ‘cultural barriers,’ is reminiscent of colonial and post-colonial discourses on the irrationalities of African populations which drew distinctions between “belief” and “science” (references). This characterization prevailed despite the fact that much of the Bush era funding for HIV prevention and sexual health at the time was based on moral and Christian ‘faith-based’ ideas such as preference for abstinence only education. However, public health professionals in Dar es Salaam, while aware and critical of PEPFAR’s programming limitations, tended to see their own programs as devoid of ‘faith’ and as providing technical, economic, de-politicized and amoral interventions in contrast to religious-based perspectives which they qualified as moralizing the issue.

Both social marketing perspectives and those represented by members of ZIADA, however, promoted a common understanding of ‘state’ and ‘market.’ On the one hand, social marketers and Islamic leaders saw government programs to be adept at providing thorough information to populations. On the other hand, both groups perceived of ‘the market’ as more skilled at provoking desire. The question for both groups concerned which approach was more effective and ethical in relation to HIV prevention.
V. **Maadili: the Ethics of Desire and Reason**

While the terms marketing versus faith, according to social marketers, or prevention versus business, according to Islamic leaders, organize the discussion of approaches to HIV prevention, these terms obscure more than illuminate the key critiques exercised by individuals in Zanzibar. In order to develop a deeper understanding of what informs Islamic critiques, one must understand the meaning of moral-ethics in Zanzibar or *maadili*.

*Maadili* was a word that circulated frequently during my time in Zanzibar, and when I would ask people about the meaning of *maadili* I would get a variety of answers. People most often translate *maadili* as “culture” or “moral-ethics.” When I probed and asked people what “culture” and “moral-ethics” mean, especially in relation to the sign described at the beginning of this chapter, people generally struggled to explain the concept, but would usually say “it’s like the way women dress.” Women’s dress was a central preoccupation among many people in Zanzibar and thus the way in which people talked about dress became a central observation of my own during my time there. Social norms based on women’s dress were tied to ideas about women’s character and dedication to or departure from Islamic teachings on correct behavior and self-composure.

Dress within Zanzibar and in other parts of the world has long been politicized as a battleground for feminists’ struggles, with contemporary controversies over veiling being a prime example. The political act of covering or not covering hair is never obvious to an uninformed observer, but rather is situated within complex meanings and histories as well as particular constructions of what constitutes feminism and political acts themselves (Mahmood 2006). In Zanzibar, people evoke women’s dress in conversations about a multitude of contemporary issues on the archipelago concerning the relationship between religion and government, the relation between the mainland and Zanzibar, gender, and the influences of conservative versus more liberal varieties of Islam as well as constructions of “western-ness” and “Arab-ness.” Laura Fair (1998; 2001) has discussed changes in the politics of women’s dress, from Swahili traditions to Arab influences in Zanzibar, particularly in relation to varying formations of race and class over the twentieth century. Thomas Burgess (2002) writes about the politicization of young people’s dress during a time when the socialist regime sought to counter the influences of consumerist culture and individualism from western countries by disciplining the appearance of youth. David Parkin (1995) has discussed debates over women’s dress as one component of young men’s turn towards Islamic fundamentalism as a search for totalizing answers, control, and empowerment during an economic climate in which their ability to provide for themselves and a family, and thus to get married and be recognized as an adult in society, has almost completely eroded. For my purposes, I’m interested in what is entailed in the way in which people enlist understandings of women’s dress to explain what it means to be a “moral-ethical” person.

The widespread use of women’s dress as a reference point for explaining “moral-ethics” in Zanzibar became clear to me one evening when I was visiting the shop of some friends, Amina and Abdula, a married couple. Abdula is the man who worked for Hemed and PSI in Zanzibar. He was in charge of distributing condoms to bars, guesthouses, and
shops that PSI’s distributor did not attend. Amina and Abdula were hard-working individuals and dedicated to the Islamic faith. They owned a small modest house but made a good enough living to be better off than many others in the area. Although they did not have children of their own, Amina often cared for her nieces in the evenings. They could be described as a more socially liberal couple in the Zanzibar context, supporting condom promotion and other contentious issues in the area such as the rights of gay individuals.

Amina and Abdula’s shop was in the Michezani area of Zanzibar just a short ride outside Stonetown, and they often invited me to sit with them in the evenings as they awaited customers. They sold clothes such as jeans, women’s dresses and scarves, as well as other items ranging from bathroom towels, make-up, and hair accessories. When I would sit with Amina and Abdula, I would ask them questions about life in Zanzibar that arose during my research. One evening we discussed women’s clothing and understandings of maadili. For awhile the conversation circled around in an endless loop, with explanations of women dress serving to explain maadili and maadili serving to explain women’s dress. Finally, Amina broke the tautology. She pointed to my handbag, a died colorful bag woven out of grass, which I had acquired at one of the tourist shops in town. The bag was an open bag, with no way of closing its top or concealing its contents. She said I have no heshima or “respect” by carrying that bag because I am displaying all of my belongings. People can easily see my cell phone inside. Taking a moment to advertise one of her faux leather handbags that closed with a snap, she explained that her handbag for sale wouldn’t invite thieves. In contrast my handbag caused me to lack respect because it would elicit desire among thieves or those in desperate need. Amina wasn’t making the point that I should purchase a closed handbag to protect my belongings. Instead her point was that I should get a closed handbag to protect others from experiencing a desire to steal. She argued that it was my responsibility to refrain from evoking bad desires in others. Making a parallel to women’s clothes, she explained that a woman with moral-ethics, a woman who has heshima, should not evoke desires in others through wearing tight clothes or showing her hair.

Amina’s comments immediately brought to mind the sign that new arrivals in Zanzibar pass by as they leave the port as well as the comments of faith-based leaders at the ZIADA workshop. All pointed to an ethic of managing one’s behaviors and comportment so as to prevent the elicitation of desire in another. One could even see the sign as a commentary on a marketing-based approach to public health by calling attention to the way in which government-run and Islamic-informed HIV prevention in Zanzibar explicitly asks people to manage desire, rather than to express and fulfill desires for pleasure as is the case with the Salama Bomba ad described at the beginning of this chapter. Similarly, calls in Zanzibar to distribute condoms through government infrastructures, rather than private sector outlets, were calls to mediate human decision-

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20 In early 2008, PSI’s distributor, Nufaika, experienced financial and management troubles. These events led them to develop new management at Nufaika and to entirely restructure their distribution strategy. Whereas in the past Abdula worked directly for PSI and procured products from Nufaika’s warehouse in Zanzibar, the new distribution model required Abdula to travel to Dar es Salaam, purchase condoms as an independent buyer from PSI, and to distribute them to all venues in Zanzibar, including those previously serviced by Nufaika such as pharmacies.
making according to reason and information, thought to be facilitated by the state, rather than the elicitation of desires thought to be facilitated by market practice.

VI. Double Morals, Double Markets: MDM and ZACP

In 2005, as the HIV/AIDS epidemic continued to persist in mainland Tanzania, public health professionals pointed to the rise in tourism and sex work on the islands, as well as the archipelago’s economic and geographic proximity to the mainland, as indications of potential epidemic vulnerability. International and local public health experts worried about people’s ability to access condoms in Zanzibar given PSI’s very minor successes since 2001.

These concerns led to a new condom distribution initiative in 2005 by the Zanzibar government and a European Union-funded Spanish NGO, Medicos del Mundo (MDM). In 2002 MDM had initiated an STI and HIV prevention program in Zanzibar in collaboration with the Zanzibar AIDS Control Programme (ZACP). This initiative included a wide range of STI prevention efforts including the expansion of health services to treat STI’s and a very successful public education program about disease prevention.

Prior to 2002 ZACP had never distributed condoms. The primary access point for condoms had remained in government-run family planning and maternal child health wards coordinated through the Zanzibar Ministry of Health. Despite this program, uptake of condoms was still low.

In response to these conditions and the failure of PSI to create widespread condom access through private outlets, MDM and ZACP began purchasing socially marketed and branded condoms from PSI in Zanzibar. In 2005 they purchased 70% of the total branded condom supply in Zanzibar for distribution through state infrastructures, condoms originally intended for distribution in the commercial sector or social marketing channels. Through this project, citizens could obtain social marketing branded condoms for free in a variety of ways. ZACP and MDM constructed plain wooden boxes with condoms which they placed in the bathrooms of government, clinic, and NGO offices. They intended these boxes, placed in discrete locations, to provide a level of anonymity for those in need. Praised as a success, MDM had a hard time keeping the boxes full. Whether this set of events reflected a clear community need for condoms or a set of actors strategically profiting from the new program was unclear. Although never confirmed, there were indications that some people who knew of the anonymous and free Salama condom distribution program uplifted the condoms for private sale to guesthouses and bars in the area.

MDM and ZACP also distributed Salama condoms through STI clinics and STI prevention community events as well as through community peer leaders who they hired and trained. They enlisted peer leaders from NGOs working on sexual health issues such as Marie Stopes Tanzania, the Raha Leo government-run Clinic in Miembeni, and ZADESA, a local NGO supporting individuals with drug addiction problems. These peer educators kept condoms at their houses, where youth and other individuals could stop by.

to access condoms, or they traveled to discos at night to distribute the condoms. However despite the intention for condoms to be distributed free of charge, many of the peer education leaders would resell these condoms to individuals in the community. This tendency was particularly the case, and still on-going in 2008, among a group of women engaged in sex work in a Miembeni guest house and several NGO members from Zadesa. The women were quite pleased with this arrangement because they could purchase a box of condoms for 1,000 shillings rather than the regular 1,500 or 2,000 per box of twenty condom packets.

These set of events led to a situation which both undermined and supported PSI’s social marketing project. ZAC and MDM created a kind of double market to social marketing’s ideal private sector market. This double market or infrastructure consisted of both free and priced exchanges. The products which circulated in this market were branded as Salama, thus enabling the Salama brand to have wider reach and circulation. In this way, ZACP and MDM potentially contributed to normalizing and increasing support for Salama condoms. While the distribution of free social marketing condoms through clinics and unmarked boxes potentially undermined the power of the brand to connote additional value by de-linking it from price, in the long run PSI hoped to capitalize on this de-privatization of their condoms. While ZACP distributed many of their branded condoms for free, in the future, as Hemed once described it to me, PSI could push commercial sales when state supplies ran out. Such was the case in 2008, after the MDM project ended and when ZACP was struggling to procure funding to purchase more condoms for distribution. Effectively, the situation in Zanzibar consisted of a government program subsidizing private sector and PSI, an international NGO, the stated intention of neither social marketing nor Islamic informed public health programming.

This need to create a parallel infrastructure or market was what the direct of ZACP called “the silence policy” and “Chinese raping.” He argued that people were so desperately in need of condoms in Zanzibar, especially most-at-risk populations, that he and his staff at ZACP had no choice but to create massive free supply, to not worry about what actually happened to products so long as they were reaching the people who needed them, and to not worry about upsetting individuals in religious communities or government by not heavily publicizing the existence of the program. Saying that it was not the most ideal solution to the problem, the director said that there was no other choice given the risks and rising incidence of HIV in Zanzibar.

This kind of doubling of infrastructure or market of condoms resembled some of the ways in which certain individuals in Zanzibar tried to negotiate their lives in terms of mediating the divergence between social norms and ethical protocols regarding self-composure and a desire to participate in activities thought to run counter to these prescriptions. This was particularly the case in regards to women’s clothing, the exemplary behavior of maadili. For example, I became friends with one of the peer educators hired to distribute Salama condoms procured by ZACP and MDM in her community. Firdaus was a young girl in her mid twenties. When I first met her in 2006 during a summer of pre-dissertation research, she was single and lived at home with her mother in a single room of a house that had a shared living space with other single-room tenents. They were quite poor. Firdaus’ father had died when she was a young girl and her mother had since struggled to provide for the family and relied on extended family

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22 1,000 shillings is approximately a little less than one US dollar.
relatives to supply her with cash. When I returned for field work in 2007 and 2008, Firdaus had married an older man in his forties who owned a *duka*, and the two lived together in another shared house while they saved money to build a house outside of town. Firdaus was a sly, witty, and calculating young woman, often making jokes and always trying to confirm and secure my friendship with her in addition to whatever economic benefits it might bring her.

One evening she invited me to the local disco. We met at her home, and she offered me a scarf which she delicately wrapped around my head and upper torso. While her husband stayed at home, he sent her brother to escort us for the evening. We made our way to the disco and upon arriving and entering, she laughed at me for not removing my scarf. The disco afforded us a kind of “private” space of young generation Zanzibaris, where expectations about self-composure were quite different than on the streets or than during the day. These kinds of experiences arose again and again in my experiences with Zanzibari women, where the logics of dress and moral-ethics never mapped onto daily life in neat fashion.

Many public health professionals who had worked in Zanzibar, both Zanzibari professionals and foreigners alike, described these kinds of practices as “double morals.” In a context where religious ethical codes strictly govern the boundaries of appropriate behavior in public contexts, individuals seeking alternative lifestyles learn to live between two worlds of sorts. While not necessarily so profound a practice, as youth all over the world learn to navigate the prescriptions of the previous generation versus the ideal lives they seek out in spaces like discos, what was interesting was how the distribution of condoms itself exemplified a similar kind of doubling as both private sector actors and government officials alike tried to adapt programming to the tensions of social marketing with the moral-ethical codes of Islam in Zanzibar.

The government distribution program was one example of market doubling and so were other numerous examples in commercial spheres, particularly the different kinds of exchanges taking place at day and at night. While shops, such as *kiosks* or *maduka*, sold condoms during the day for the standard 200-250 shillings for a 3-pack of *Salama* condoms, at night this price could be double or more depending on how late at night it was and how inaccessible alternative options for condom purchase were.

VII. Conclusion

This chapter explores controversies occurring between Islamic organizations located in a semi-autonomous archipelago region of Tanzania, Zanzibar, and U.S. funded social marketing NGOs in mainland Tanzania concerning the use of commercial advertising and branding to promote HIV prevention behaviors among citizens. Islamic leaders voice concerns with these communication techniques and argue that the government should intervene in public media to manage the transparency of risk information and the elicitation of desire.

Given these two discourses on social marketing, I outline a unique set of exchange practices taking place in Zanzibar where markets in condoms mirror people’s multiple and at times conflicting attempts to navigate the incongruence of marketing interventions in public health, the need to address HIV in Zanzibar, and an Islamic
movement seeking to recreate public life by translating Islamic ethics into daily practices and disciplines.

The Muslim perspective on social marketing has provided us a window into the alternative ethics guiding public health, government, and social life in Zanzibar. In contrast, what exactly were the logics informing the production of social marketing projects by business and public health professionals working in Dar es Salaam? How exactly did they see themselves to be influencing citizens in Tanzania?
Ch.4: Socializing the Market in Condoms

I. “And they will learn about these issues without even realizing it”

On April 8, 2008 at the Buguruni Anglican Health Center in Ilala district of Dar es Salaam, Mark Green, the U.S. ambassador to Tanzania, arrived with Sarah, the American T-MARC staff member, and other officials from the U.S. embassy. They came to the health center for the launch of the fourth season of the “Mama Ushauri” fictional radio serial drama produced by T-MARC. Mama Ushauri, translated as ‘mama advice,’ is a radio show intended to promote healthy behaviors concerning family planning, sexual health, and child survival issues related to nutrition, diarrhea, and malaria among the Tanzanian public. Mama Ushauri is the main character of the show, a woman who lives in the fictional village of Goromonzi and who counsels the town’s residents on health-related matters. The show follows plot lines concerning family and romantic relationships in Goromonzi and issues of sexual, reproductive, and children’s health that arise in these relationships. Public health professionals who work in health education and behavior change fields often refer to shows like Mama Ushauri as ‘edutainment’ because these shows combine practical information with entertaining story lines. T-MARC’s communications department, the wing of the T-MARC project concerned with health communications, manages the radio program. Although T-MARC brands the show as ‘Mama Ushauri,’ the stated purpose of Mama Ushauri is ‘selling healthy behaviors,’ not selling T-MARC’s product lines such as Dume condoms. The brand of Mama Ushauri is what social marketers call a social brand. As described in Chapter 2, the goal of social branding is to promote a particular set of health prevention behaviors as a desirable lifestyle to which citizens should aspire, signified in this case by the character, Mama Ushauri.

When the U.S. entourage arrived at the health center, Mark Green, Sarah, and the other U.S. officials stepped out of their stately SUV and were greeted by the kelele of a group of women. These women included nurses from the health center and other women who had been hired by Integrated Communications, T-MARC’s experiential marketing sub-contractor.

The women wore t-shirts sporting the Mama Ushauri logo and tagline – a generic cartoon woman with her hands up in the air and a sun shining behind her, representing a new day, with the words ‘afya bora kwa ajili ya familia yako’ (‘better health for the sake of your family’) sitting below this image. In addition to Mama Ushauri t-shirts, they

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23 As described in the introduction, T-MARC stands for the Tanzania Marketing and Communications Project for AIDS, Reproductive Health, Child Survival, and Infectious Disease. T-MARC is a social marketing project in Tanzania funded by USAID and PEPFAR.

24 At celebratory events in Tanzania, groups of women often make high pitched reverberating sounds like the ringing of bells to mark an event or moment or to escort someone along a ritualized walk.

25 Companies selling commodities hire experiential marketing firms to promote their products through one-on-one interactions with people in targeted communities. Integrated Communications uses live drama, question and answer sessions, games, and dancing to promote T-MARC’s product brands and health messages. They work for T-MARC in bars and community forums in geographic areas designated as being high risk for HIV. Essentially, experiential marketing firms attempt to create hype and excitement among consumers about a particular product or health prevention behavior through face-to-face interactions.
donned bright pink *kangas*\(^{26}\) tied around their wastes and heads. T-MARC had printed advertisements onto the *kanga*’s fabric, showcasing their line of contraceptives, Flexi-P, a brand which connotes femininity and freedom of choice. While the Tanzanian government forbid public advertising of contraceptives in the country, T-MARC cleverly circumvented this policy by making Flexi-P a sponsor of the *Mama Ushauri* show. This strategy enabled T-MARC to indirectly advertise the Flexi-P brand at community events like launches and through the announcement of Flexi-P’s sponsorship status at the beginning and end of every *Mama Ushauri* radio show. Aptly, at the launch of *Mama Ushauri* season 4, T-MARC choose the *kanga* as the clothing item to promote Flexi-P, a historical article of women’s clothing that traditionally featured political messages and provided women with a way of indirectly ‘speaking’ without directly speaking. Just as the *kanga* provided indirect forms of communication, so too did T-MARC’s continual efforts to associate Flexi-P with *Mama Ushauri* have a strategic implied message. The message conveyed that health could best be achieved through products and services rendered in commercial markets, rather than through government institutions.

By associating the social brand of *Mama Ushauri* with the commercial brand of Flexi-P, this ritualized public drama conveyed the contradictions mediated by the T-MARC project. Where socialist understandings of health had in the past characterized capitalist markets as generative of class inequality, as morally bankrupt, and as detrimental to Tanzanian national self-reliance (Nyerere 1968), T-MARC now faced the challenge of promoting an understanding of commercial markets as enabling more equitable and sustainable health product distribution systems than state-run programs. T-MARC also brought together historical contradictions of health and pleasure by promoting the idea that the achievement of health required citizens to pursue their desires, aspirations, and pleasures through the market, for such things as prosperity, love, ease and flexibility in life, rather than to tame such pleasures for the purposes of health and development. Fully decked in these symbols which represented the market as the key to health, the women clapped their hands, *keleled*, and ushered the U.S. delegation into the health center. Meanwhile cameramen from Dar es Salaam TV stations and newspapers scurried around the commotion in search of a clear shot of the events taking place.

Inside the health center, the U.S. ambassador engaged in a ritualized display of political good will. He fed vitamin A supplements to babies at the hospital, cutting open a capsule and placing the supplement on their tongues. USAID had recently begun investing in government-run vitamin A supplement programs occurring twice a year for children under five, as it had been shown to significantly reduce childhood mortality rates. The prospect of eventually transitioning vitamin A supplements into commercial markets was on T-MARC’s and USAID’s social marketing horizon. Later, on the car ride home from the event, Sarah commented that she hoped that these pictures of the

\(^{26}\) A *kanga* is a traditional piece of clothing worn by women in Tanzania, usually tied around their waste like a skirt, draped over their shoulders like a shirt, wrapped around their head, or used as a functional instrument to carry babies on their backs. The *kanga* consists of a rectangular sheet of fabric usually printed in bright colorful patterns and having a message that can be easily read when a woman wears the fabric as a skirt. In Swahili society, the *kanga* has traditionally been a means for women to ‘speak’ indirectly without speaking, and it often became a medium for communicating sensitive political issues in the community. The *kanga* also promotes messages related to spirituality, ethical principles, or hopes for a person to whom a woman gifts a *kanga* (Fair 2001).
ambassador would be the ones making it into the newspapers. This kind of representation could potentially depoliticize U.S. interventions and T-MARC’s work in Tanzania by framing their projects as ones focused primarily on health, not on politics. While I approach T-MARC’s work as a form of politics via health, Sarah hoped that the two could be separated in public discourse and opinion.

T-MARC staff recognized that one of their primary challenges in conducting their work in Tanzania was to create good public relations. T-MARC’s marketing director, Hilda, commented to me that as the wars in Iraq and Afghanistan continued, she found that many Tanzanians became increasingly skeptical of the strong U.S. presence in Tanzania, so much so that T-MARC staff made special efforts to disassociate their product brands, such as Dume condoms, from the U.S. government entirely, what she described as a hard won battle with USAID central offices in Washington, D.C. but a necessary step for the success of the T-MARC project. While much of T-MARC’s efforts went into creating associations between health products and people’s purported aspirations, as this introduction illustrates, this project of disassociation was also paramount. In this case, the disassociation of the U.S. government and T-MARC brands illustrate a further set of tensions at play in T-MARC’s work: foreign government interventions and funds were directly engaged in commercial markets in Tanzania despite the T-MARC project’s espousal of free markets as the most efficient and effective way of addressing public health in the country.27

After signing the health center’s visitor book, the officials proceeded back outside and took their place behind the podium and under tents decorated with Mama Ushauri and Flexi-P banners. One by one the U.S. officials, representatives from the Ministry of Health, and T-MARC’s managing director, Elena, made speeches about the Mama Ushauri radio program and its health benefits for Tanzanian communities. During key moments and at the end of each speech, Integrated Communications played audio recorded hand-clapping to create the appearance of a crowded audience. The Minister of Health and Social Welfare thanked the U.S. government for its sizeable donations to health causes in Tanzania. The U.S. ambassador, Mark Green, quoted the total donations of the U.S. government over the last 3 years at $84 million and qualified the implications of this funding in relation to the Mama Ushauri show. He stated that “any Tanzanian with access to a radio will now have current information about key health topics. And they will learn about these issues without even realizing it thanks to the entertaining format of the radio serial drama.”

Green’s words reflected T-MARC’s social marketing strategy which attempted to influence human behavior not through the provision of direct explicit information about disease risk, but rather through implicit means and through association. His words promoted the idea that people should integrate health behavior recommendations into their lives not through conscious rational choices but rather through unconscious thought, “without even realizing it.”

As described in Chapter 2, marketing in the post-war period critiqued neoclassical understandings of homo economicus and developed a new theory of human reason and motivation characterized by limited rationality and the pursuit of pleasure. At that time, commercial marketing shifted its understanding of consumer decision-making as based on price, risk assessment, and the evaluation of the functional utility of products, to an

27 See Chapter 7.
understanding of human decision-making as based on affect, limited reason, and the product’s association with or symbolization of particular lifestyles and ideals. When commercial marketers applied these theories of human decision-making to the field of public health, they recommended that health professionals not provide people with information about health risks, but rather demonstrate to subjects how a recommended behavior is like or will lead to fulfillment of their desires. In doing so, social marketers essentially hand people a ruler or a scale for evaluating a given choice, while black-boxing the processes that went into constructing the marks that make up the rulers’ modes of evaluation; social marketers ask people to make decisions about their behaviors based on a choice’s correspondence to a desired pleasure without asking people to evaluate the proposed correspondence between a certain behavior and a desired pleasurable outcome. In this way, social marketing attempts to implement a politics of association or equivalence, promoting association and equivalence as a normative form of reason. In this case, through branding and marketing communications, the T-MARC project specifically promoted public understandings of product use and the fulfillment of personal aspirations as not only commensurable but inextricable.

Within the Mama Ushauri show, particular characters and storylines serve to model lifestyles to which citizens are thought to aspire and to which T-MARC staff can associate and normalize health prevention practices as being an integral and necessary part. In this chapter, I examine these practices and in addition how T-MARC staff specifically reconciled and promoted understandings of the inextricabilities of positive health outcomes and health equity with profitable markets, despite historical trends which place them in opposition. However, even though T-MARC staff perceived these goals as desirable, as chapter 3 illustrated people in Tanzania did not necessarily take social marketing’s model of human reason for granted. Furthermore, as chapter 5 and 6 make clear, T-MARC’s attempts to create markets as equitable and sustainable systems for ensuring health did not unfold seamlessly in the way that they planned. Instead a variety of competing interests led to a situation in which social marketing actually further restricted access to condoms and undermined commercial companies’ ability to participate in health product marketing. Despite the outcomes of T-MARC’s social marketing project, this chapter outlines the cultural and political logic involved in branding health products and using marketing communications to promote health.

II. Scales of Incommensurability: the Politics of Equivalence

Social marketing’s use of branding and marketing communications attempts to create certain kinds of equivalence or commensurabilities between desired lifestyles, recommended health prevention practices, and in the case of health product use, price. Establishing equivalence is never a purely technical act, but is always social and political, in the sense that no objective measure of equivalence can be asserted in reference to a natural world or scale set apart from the set of alliances and agreements that sanctify commensurabilities (Harper 2000; Latour 1987, 1988, 2001; Munro et al 1996; Pels 2000; Power 1997).
Economic anthropology in Africa has been at the forefront of accounts which point to the social and political nature of equivalence, accounts which provincialize western claims to the universality of scales of measurement such as quantification and the reducibility of all scales to number (i.e., Porter 1996). For example, James Ferguson (1992) explains the failures of development programs to quantify household wealth in Lesotho by showing how conversions between categories of wealth, such as money and livestock, is not a technical question but always a cultural, moral, and political one. When people have wealth of morally incommensurable kinds, such as money, land, livestock, or persons, and when exchanges between categories of wealth entail moral and social rules, of what can and cannot be exchanged and how, a universal scale of abstraction for measuring this wealth is culturally and politically unfeasible. Ferguson provides a processual analysis of this particular regime of value (Appadurai 1986) in Lesotho by detailing the various interests by which people form and negotiate commensurabilities and incommensurabilities between these various kinds of wealth.

While Ferguson explores incommensurabilities between categories of wealth, Janet Roitman (2005: Ch. 3) investigates the political process involved when governments successfully make scales of value commensurable. She conducts a historical analysis of the French colonial government’s implementation of taxes in Cameroon. In order to impose taxes, the French government had to implement the use of French currency as a means of payment and as a benchmark of value, as opposed to stores of wealth in cattle and other material goods. Implementing tax also required the fixing of monetary prices in markets rather than bargaining and the normalization of providing change rather than rounding up so as to generate disposable taxable wealth among the population. Narrating this history, Roitman articulates how the successful implementation of taxes and fixed market prices occurred when consumers themselves took up the discourse of fixed prices as an issue of consumer protection. Like Ferguson, her account demonstrates how forms of measurement and value assignment are always a product of historical, political, and cultural struggles. In the case of Cameroon, public agreement about scales of value and equivalence, such as fixed prices and the matching of currencies to material goods, necessitated the production of fiscal subjects and the inculcation of the duties and rights involved in that position.

While Roitman narrates the French colonial government’s attempt to singularize a hegemonic scale of value in Cameroon, Jane Guyer in Marginal Gains (2004) demonstrates how in a region of multiple scales of value, politics is the ability to assert and maneuver among scales so as to produce profitable gains. In West Africa actors openly recognize the incommensurability of various monetary scales in a context of shifting registers of value spread across vast geographies. Guyer explores the strategies and rationalities involved in conversions, that is exchanges which occur across scales of value or spheres of exchange, for example among items deemed of different moral valence and thus coded as incommensurable, like livestock and money (see also Bohannan 1955; Ferguson 1992). Guyer argues that it is through conversions that actors are able to produce marginal gains in wealth when scales are incommensurable. In her account she details how power consists of the ability to “define, institutionalize, take advantage of, technically control, and symbolically represent conversions” (39).

Scholars in science and technology studies have explored technologies of commensuration, what Callon et. al. (2002) call qualification. Qualification is the practice
of characterizing a product by describing its qualities and by likening these qualities to the persons who use it (i.e., Coke is for ‘carefree’ persons). Callon et. al. (2002) describe the economy of qualities as a late 20th century process in which the associations made with or the attributes assigned to a product by producers and consumers are a primary means of asserting market value, driving exchange, and engaging in competition. Drawing from Callon’s work, Celia Lury (2004) argues that the brand is a particular technology for qualifying goods. She describes brands as an interface of communication, or a simplified way for marketers and consumers to communicate about the characterization of goods and the qualification of persons in relation to goods. The brand, as text, serves as a singular point of reference, allowing both consumers and producers to comment on the question of how to distinguish between the attributes that differentiate a particular product from otherwise similar products as well as how to distinguish between the kinds of persons who choose one product over another (for example, brands communicate about what distinguishes Coke’s soda and the persons who use Coke sodas from Pepsi’s soda and the persons who use Pepsi soda, despite the fact that both are cafffeinated cola sodas). Commercial marketers use branding in the hopes of influencing purchasing choices towards their products by finding commensurabilities between the quality of their products and the aspirations of consumers. In doing so, the brand not only reflects consumer preferences, lifestyles, commitments, and modes of evaluation but produces them (Callon 1998; Callon et. al. 2007; MacKenzie et. al. 2007).

In the case of the brands at T-MARC, staff developed these brands as technologies for creating correlations between condoms and the persons who use them, and T-MARC mediated this correspondence in affective terms by configuring brands as personae. T-MARC’s brands attempted to mediate not only relations between products and persons, but also relationships between USAID and Tanzanian citizens. The brand served as a way to create an affective relation or a potential equivalence between USAID’s goal of privatizing public health and consumer understandings of the conditions that foster public health and equity.

This kind of project necessitated that T-MARC work against a long history of socialist understandings of the relation between health and equity on the one hand, and commercial practice on the other and that T-MARC promote the market in moral terms. As James Ferguson (2006: 69-88) notes, African socialism legitimized itself not in the terms of scientific socialism and observable facts, but in a moral language. Drawing from the understanding that wealth is inextricable from the production of social relations and that there are pro-social and anti-social forms of wealth, African socialism promoted pro-social forms of production and exchange and the values of selflessness, sharing, and solidarity. Ferguson connects this understanding of African socialism to the observations of a long line of African ethnographies which detail people’s understandings of redistributive and generous forms of wealth and power versus those forms of wealth and power which “eat the people” (i.e., Bayart 1993).

This understanding of African socialism was especially promoted by Tanzania’s first president, Julius Nyerere, who articulated his socialist vision through the Arusha Declaration in 1967. Depicting capitalism as productive of inequalities, amoral, and abusive, Nyerere’s Ujamaa socialism sought to bring individuals together in communal rural agricultural villages, to nationalize industries, and to set prices for food and consumer goods (Nyerere 1968). Two primary areas in which he heavily invested
national funds were education and health. All citizens were given access to these services, and schools and clinics were erected throughout the country. Although over the near fifteen year period of Nyerere’s rule in Tanzania, he did not always hold to non-abusive and non-violent forms of power, the majority of citizens in Tanzania even today uphold him as the “father of the nation” and speak proudly of his presidency and his ideals.

This project of re-qualifying capitalism is not just particular to USAID’s objectives in Tanzania and its project of influencing a population of people formerly governed by socialist philosophies. Recently, the project of characterizing capitalism as being compatible with “doing good” and with an ethic of reducing income disparities and poverty is a primary project of professionals in business and development fields. Titled “creative capitalism” or “inclusive capitalism,” professionals promoting this reorientation of private enterprise argue that profit and poverty reduction are not incompatible but can go hand-in-hand. As discussed further in chapter 5, in the case of social marketing, business professionals theorize that commercial markets are capable of equitably provisioning the poor with health products, like condoms, despite continuing with payment of price and that the consumption of affordable condoms among low income populations can lead to better health and thus less time lost on income generating activities (Hart and London 2005; McNeil 2008; Prahalad and Hammond 2002; Prahalad 2005, 2006).

In Tanzania, these approaches in social marketing did not always generate the kinds of good work which they promised. As chapter 5 discusses, targeted communities actually experienced a decrease in access to condoms and small entrepreneurs seeking to benefit from these projects were actually pushed out of income generating projects. As chapter 6 illustrates, local corporate level partners to these projects of “inclusive capitalism” were also marginalized from profitable ventures, resulting in donor-funded non-profit organizations monopolizing health product markets.

Despite the outcomes of these programs, the goal of implementing a private sector model of distributing and promoting condoms required not only attempting to coordinate social marketing programs with local small scale sellers and large scale distribution companies, but also required trying to generate public support for the idea that market systems could more equitably provision poor populations with health goods. As science studies has demonstrated, the production of knowledge about nature involves not a simple deferment to a transparent truth, but rather entails the enlistment of allies (other scientists, ‘the public,’ non-human actors, etc.) who buttress claims about nature (Callon 1986; Latour 1987, 1988, 2001). Likewise, economics as a field of scientific practice makes claims to how its economic models represent natural truths and laws of market dynamics (Callon 1998). From a science studies perspective, asserting such claims and proving the ‘truth’ of markets similarly requires not just accurately representing markets, but producing markets according to market models and generating support for the implementation of these models from various networks (Callon et al 2007; MacKenzie 2008; MacKenzie et al 2007). In this case, re-characterizing the nature of markets not as necessarily productive of inequalities but as potentially generative of equal access required garnering support for the economic models (see chapter 5 and 6) that undergirded social marketing projects. Social marketers were very savvy in their own
work, well aware that they needed to strategically enlist the public in promoting the idea that markets can be equitable systems of public health distribution and promotion.

In Tanzania, where socialist understandings posed equity and health as necessarily antithetical to private commercial practice, social marketing worked to invert this logic and to publicly equate health and equity with a market society. To generate public support for such understandings, T-MARC used product branding, like Flexi-\textit{P}, as well as communications programming, like \textit{Mama Ushauri}, to normalize payment of price for condoms and contraceptives as an act that is in people’s and society’s interest and to promote, in moral terms, the market as a system which enables equity in health.

III. \textbf{Paying a Price as Risk Reduction}

I learned about T-MARC’s particular brands and the way that T-MARC attempted to manage people’s shared associations between persons, price, and health recommendations first-hand during the two days a week I spent at T-MARC offices. During this time I occupied a desk in a second-floor office of the T-MARC building, which in addition to myself housed desks for Edward, T-MARC’s communications director, George, his subordinate and only other staff member, and Mary, a staff member of the marketing department, which consisted of just her and her senior, Hilda. The majority of our days at T-MARC were filled with group meetings in the conference room downstairs, or with individual projects and periods of silence, working at our desks and computers, then with bursts of discussion and debates about a particular marketing-related issue or everyday event. Visitors frequently came and went, usually one of T-MARC’s contractors holding a meeting with one of the marketing or communications staff.

Staff at T-MARC consisted of both Tanzanian citizens who were hired for the five year duration of the project and American citizens with continuous salaried employment apart from the particular projects that they worked on with AED in Washington, D.C. This difference in employment status led to several tensions in the workplace. Differences in employment raised questions regarding who held sovereignty over important decisions about social marketing strategy. While the Tanzanian citizens hired to carry out the day-to-day work of the T-MARC project hoped to transition the project into a full-fledged Tanzanian-owned company where they could seek continued employment after the five years, AED was more interested in successfully accomplishing the short-term goals outlined by USAID for the five year program so as to secure their reputation for future project bids in Tanzania.\footnote{See Chapter 6 for more details.} While these goals were certainly not incompatible, there were many instances in which conflicts arose such as whether Tanzanian staff should focus their time on brand development or writing proposals for additional funding to build social marketing programs.

While this goal of establishing a “locally” owned and run social marketing program at the end of the five year period, was initially proposed by USAID, the idea was promoted more in speech than practice. In practice USAID defined “local” in very circumscribed terms, essentially meaning persons who held Tanzanian citizenship or who were born and raised as black East Africans. This understanding stood in sharp contrast
to a definition of “local” as living within the communities which the T-MARC project targeted. As such, AED hired a very elite set of Tanzanian professionals to carry out the T-MARC project, individuals who had little relation to or knowledge of the populations which they were planning to target with marketing campaigns.

This understanding of “the local” came under attack in 2005 at the launch of the T-MARC program in Dar es Salaam, when USAID received a great deal of criticism because their launch was seen to be akin to the “MTV music awards.” Held at an elite hotel in Dar es Salaam with prestigious guests and fine catering, many in the Dar es Salaam donor and government community questioned USAID’s intentions of addressing HIV among most-at-risk poor populations. Thereafter, USAID made it a policy to conduct launches within the communities which they targeted and to design them to be more “Tanzanian” in character. The 2008 launch of Mama Ushauri was just one example of the outcome of this new policy. Guests sat in plastic chairs on the sandy entrance way to the health center and were offered Fanta soda and water to drink.

Despite this change in public relations policy, the make-up of professional staff at T-MARC continued to reflect USAID’s move towards working with a new elite hired to conduct social marketing in the country. Edward, T-MARC’s director of communications, is a Kenyan citizen who had formerly worked as a media director for a Tanzanian advertising firm before taking the job at T-MARC. Prior to these work endeavors, Edward earned a bachelor’s degree in communications with an emphasis in marketing from the Catholic University of Eastern Africa in Nairobi, Kenya. Most of Edward’s family, although originally from Kenya, had migrated to the U.S. He usually spent major holidays there with them. He and his family were within the upper classes of Kenya, clearly conveyed by his car, the only Volkswagen Passat that I ever saw in Tanzania. Despite the minor repairs always being needed on the car (which could only be obtained a day’s drive away in Nairobi), it was one among many other objects demonstrating his upper class lifestyle in Dar es Salaam. Always a dedicated hard worker, Edward still had an easy-going personality. He cared greatly about marketing, HIV in East Africa, and his professional relations formed in the workplace.

Mary, the daughter of a former Tanzanian president, was twenty-something and had a young, spunky personality. She was a member of the marketing staff at T-MARC. Mary had previously attended the University of Dar es Salaam for studies in marketing and aspired to one day own her own business. Like Edward, Mary was from the upper class in Tanzania, having a personal driver who picked her up and dropped her off each day. Less interested in theorizing and teaching about marketing and communications, she usually provided jovial banter in the office to keep Edward entertained. She provoked a sibling-like relationship with him at times, resulting in arguments with each attempting to talk over the other and to get their point most forcefully across, with me serving as witness and judge.

T-MARC’s marketing director, Hilda, is a Tanzanian marketer with a graduate degree in marketing management from Middlesex University. Like most other professional staff at T-MARC, she came from an elite Tanzanian family. Hilda had worked for many years in Nairobi, Kenya for the Coca-Cola Company where she married a European man and had her first child. Returning to Dar es Salaam in order to live a more settled life near her family, she took a job with the T-MARC project in 2004. Hilda
had a driven personality, like the competitive, confident, and fear-inspiring characteristics one might imagine of a chief executive officer of a fortune five hundred company.

The “local” professional staff at T-MARC primarily had expertise in marketing and advertising, not public health. While their backgrounds and their emphasis at times on a primarily profit-driven model of marketing led to conflicts in the workplace with AED’s public health professionals hired to collaborate on the T-MARC project, their training in marketing and advertising was what, from the social marketing perspective, qualified them to work within and to represent the voice of communities which they targeted. As this chapter describes, social marketing utilizes research and intervention tools from commercial marketing which claim to accurately assess and represent people in terms of their desires and aspirations.

In contrast to the Tanzanian staff hired for the project, American AED staff were primarily trained in public health fields. Sarah, in 2007, the then AED employee charged with managing the T-MARC project was an American citizen who had earned a master’s degree in health sciences and had worked for several years for Family Health International, both in the US and in Dar es Salaam. She lived and worked in Tanzania both out of interest in life abroad and for the economic mobility it afforded her. She was a single mother of two young children, twins whom she had brought into the world through in vitro fertilization. As a single parent, she could not afford the cost of an upper middle-class lifestyle in the U.S. as a sole wage-earner and caretaker. Tanzania provided an economy offering cheap, around-the-clock childcare, house maintenance services, and drivers, essentially an automatic advancement for individuals like Sarah into a more elite class of society. Sarah was also an incredibly smart compassionate individual and she was well-connected with the Dar es Salaam professional community in public health. She served as a key contact point for my connections with numerous individuals in the public health and commercial Dar es Salaam community who provided insights into social marketing practices in Tanzania.

Sarah was the only full time staff member from AED who worked on the T-MARC project. AED occasionally flew in other employees a week at a time to consult on the project. Thomas, a Tanzanian national who had lived his adult life in the United States, was the AED-appointed director of the program. He had PhD level training in public health sciences, particularly infectious disease, but had little background in social marketing. AED brought him on the project to replace a former American director when tensions at T-MARC escalated in regards to accusations that the AED / T-MARC project reproduced colonial-like relations between U.S. staff and Tanzanian employees. Seen to be “Tanzanian,” AED hoped that Thomas could quell any questions about AED and T-MARC relations. Ironically, because Thomas was a devout public health disease specialist, who advocated for universal rights to health, he fundamentally disagreed with the entire project of social marketing which sought to charge people prices for health goods necessary to protect people’s wellbeing. My interview with Thomas actually turned into a discussion of whether I should even be studying social marketing. Thomas felt from the outset that the project was of little importance to public health and that I should direct my inquiries to areas with potentially more fruitful discoveries about how to improve human health.

Despite Thomas’ alternative ideas about the value of studying social marketing projects, I continued to study T-MARC’s marketing efforts by learning from the full-time
staff. Edward and I in particular frequently discussed T-MARC’s communications work and advertising strategies. He would often show me advertisements online or reference a piece of media research and would give me a mini lesson on marketing communication practices. In an interview with Edward when I first arrived at T-MARC in 2007, he described T-MARC’s communication strategy. “We don’t like to work with messages that are a command like, ‘don’t have sex without a condom,’ but we like to get people to reflect on themselves and to get interested.” One of the primary ways that he and others at T-MARC sought to get people to ‘reflect on themselves’ was to personify health recommendations in the figure of the brand. T-MARC staff, including Edward, treated brands as a kind of persona against which consumers could compare themselves. Edward often spoke about T-MARC’s brands as persons, by describing them as having a ‘life course’ or as entities that could be ‘killed.’ He and other staff at T-MARC also spoke about the brands as though they had first person names, including Dume (T-MARC’s male condom brand), Lady Pepeta (T-MARC’s female condom brand), and Flexi-P (T-MARC’s contraceptive line). As T-MARC’s marketing director, Hilda, asserted, “brands represent people” and good branding is a “salient positioning of yourself.”

Mary also described T-MARC’s specific brand personae to me in an early interview. “Dume is for real strong men and is centered on ideas of machismo. It’s the idea that being a man involves protecting yourself.” “Lady Pepeta stands for being a woman and coming into womanhood. It’s about being an attractive, sexy, desired woman.” Pepeta references the flat woven trays that Tanzanian women use by shaking and rotating them to sort rice from the rocks and debris that may be mixed in. This object has cultural connotations of sexiness, exemplified in the way women move and shake when they use it to sort grain and rice.

While T-MARC staff often simply described the brands in the above phrases, the process of establishing the brand as a persona required a large investment of time and effort. T-MARC staff and other members of the business community recognized the very costly upfront investment needed to develop a brand. One Tanzanian business investor quoted the initial capital needed to develop a brand at U.S. $300,000, a sum out of reach for new business investors in Tanzania. As illustrated in the introduction to this dissertation and described further in Chapter 6, the large investment required to develop a brand as persona led to brand ownership controversies, even between donor governments, private companies, and NGOs, and the monetary sum required to enter the market served as a justification for using donor funding to invest in private sector health product companies.

Due to a brand ownership controversy at the outset of the T-MARC project in 2004 between USAID and PSI,29 T-MARC staff members developed their own line of male condoms, Dume. T-MARC hired the Tanzanian research company, Steadman and Associates, to explore what characteristics its particular target group aspired to. T-MARC had decided, at PEPFAR’s request, to target a group of people which they categorized as having shared HIV risk behaviors, particularly job mobility which forced people to be away from committed and live-in sexual partners for long periods of time and which led them to engage in multiple non-committed sexual relationships. Thus Steadman and Associates’ geographically concentrated their research on major highway transportation corridors frequented by commercial truckers and key mining areas.

29 See Chapter 6.
requiring men to live apart from families. Cities and towns in these regions had the highest prevalence rates in the country.

Steadman and Associates’ research findings argued that PSI’s *Salama* brand was overly associated with romantic love and youth, such that individuals in T-MARC’s targeted group who engage in adult non-romantic and non-committed sexual relations are excluded from this brand’s persona or imagination of self (Steadman and Associates 2005). PSI’s *Salama* condom had targeted young, romantically engaged couples, whose HIV risk was thought to arise through the increasing trust that emerged between them and the related increasing failure to use a condom. The packaging and advertising for *Salama* condoms showed a young couple embraced with cheeks nuzzled close together and the phrase, “*kinga madhubuti*” (“reliable protection”). Many of *Salama’s* advertisements state, “*kama kweli unampenda utamlinda*” (“if truly you love her, you will protect her”).

![Salama condom](image)

In contrast, Steadman and Associates’ research conveyed that male workers within T-MARC’s target group – such as policemen, miners, truckers, and traveling businessmen – aspire to a prosperous life rewarded to them by their hard work and that they are driven to sexual encounters due to the pleasures, prestige, and perceived necessities of male biology for everyday sexual engagements and thus multiple sexual partnerships. Therefore T-MARC in partnership with their subcontractor, Z.K. advertising, a South African-run and Tanzanian-based advertising firm, developed the *Dume* brand. *Dume* meant “the strong macho man” or literally “male animal.” T-MARC intended this characterization to match the lifestyle aspired to by its target group. The *Dume* brand characterizes these individuals’ masculinity in terms of hard-work, job mobility, ‘coolness,’ and the responsible use of condoms. Brand images incorporate the wearing of jeans, a clothing article that’s supposedly never out of fashion, just as T-MARC recommends that condoms should be something that’s cool and never out of fashion. The image of the jeans on the packaging leads the viewer into imagining the man who is wearing the pants in front of them. Bold black and red writing make up the words on the packaging and advertising, and the brand as persona speaks saying, ‘*imetulia,*’ or ‘it’s cool.’
T-MARC staff intended this condom brand to appeal to its target group by associating the condom with a particular construction of masculinity, thought to be aspired to by this risk group, rather than to appeal to this group’s ability to reason how best to prevent HIV. The construction of Dume as a persona served as a means of proposing equivalence between this particular brand of condoms and individuals in the targeted group. This posing of the Dume brand as a persona rather than just as an abstract concept or set of qualities serves as a means of establishing an affective and self-reflective relationship between consumers and the condom.

Similarly, in early 2008, after PSI had moved away from a strategy of developing one line of condoms to developing multiple brands of condoms like T-MARC, PSI initiated a new brand of condoms targeting married couples. This condom, called Familia or “Family,” sported an orange package with a picture of a woman’s hand crossed over a man’s hand, each wearing a wedding ring to signify that these condoms were for use within committed marital relationships. The two hands created the brand persona as a married person, also indicated by PSI’s packaging of the condoms in groups of ten, rather than the traditional 3, to indicate that Familia condoms were for use within a long-term relationship over time. The orange coloring of the packaging was also significant. PSI intended the orange color to associate Familia condoms with T-MARC’s generic marketing programs that use orange in their advertising including Sikia Kengele, a program which promotes the value of faithfulness. PSI intended the Familia brand to allow couples in a committed relationship to use condoms for the stated purpose of family planning without having to explicitly recognize the condom’s ability to prevent HIV in the case of infidelity. The brand provided a way to offer risk reduction without referencing risk reduction. As PSI’s marketing manager stated, “Familia condoms are really for HIV prevention. It’s a way of going around the problem of talking about HIV, especially for discordant couples.”

The creation of these various brands as different kinds of personae was essentially a proposition to consumers to reflect on the question, “who are you, who do you want to

30 See Chapter 1.
31 Sikia Kengele was another generic marketing program run by T-MARC. The program focused on promoting values of faithfulness as a HIV prevention strategy and targeted communities defined as ‘faith-based.’ T-MARC used advertising including billboards and radio spots to promote the campaign and conducted experiential marketing events in targeted communities which featured skits about committed partnerships.
be, and do you want to be like one of these brands?” In other words, “is there an association or equivalence between you and this brand persona?” In this way, social marketing staff intended these brands as personae to establish affective relationships and commitments between individuals in Tanzania and the use of health prevention products. The social marketing brand proposed to consumers that they reflect on the use of condoms in relation to their desires and ideals, and to integrate the use of condoms into their daily practices. PSI’s marketing director described it to me in the following way, “the brand should reflect the target group, should make the target group feel that it is them, so that the product is for them, and they buy in the idea.” These branding strategies served to differentiate condoms which otherwise were exactly the same.

However, T-MARC’s strategies of branding never worked out in practice as they were theorized in the ideal. For example, T-MARC experienced unplanned distribution challenges when their commercial sector partner, Shelys Pharmaceutical, blocked them from partnering with other companies that had further distribution reach. This event resulted in Dume condoms being available at mainly higher end pharmaceutical outlets rather than small retail outlets or what marketers call ‘fast-moving-consumer-good’ outlets. This unintentional distribution strategy resulted in many low-income community members perceiving Dume condoms as a brand that is out of their price range. This outcome was the case in Uwanja wa Fisi or Hyena Square, a neighborhood in Dar es Salaam where I conducted ethnographic research. Residents in this community perceived Dume as an elite brand despite T-MARC’s effort in targeting the area as a key site housing ‘mobile at-risk populations,’ the desired Dume consumer.32

The Dume brand also misfired when instead of using packaging and branding ideas generated by targeted audiences and staff at T-MARC, USAID personnel in Washington D.C.’s office insisted that T-MARC characterize the Dume in relation to blue jeans. While T-MARC’s original ideas, focusing on sexual appeal, were deemed to risqué by USAID, T-MARC was confounded at USAID’s suggestion that blue jeans would resonate with Tanzanian populations. Among lower income populations, blue jeans are a relatively expensive luxury item, seen to be a mark of the upper class and an ‘American’ lifestyle. Staff at T-MARC were unclear whether USAID intended the blue jean imagery to represent aspiration towards an “American way of life” or whether staff at USAID’s Washington office were merely out of touch with the cultural connotations of blue jeans in Tanzania.

Despite perceptions of the Dume brand in targeted communities as not matching their own understandings of self and personal aspirations, T-MARC continued to promote the brand. T-MARC’s attempt to manage the brand as a persona included not only characterizing a particular image and name in relation to targeted consumers but also included a characterization of or foregrounding of a particular mode of reasoning or decision-making. The Dume brand foregrounds a form of reasoning based on the question, is this brand persona equivalent to my own understanding or ideal understandings of self? The Dume brand backgrounds two other forms of decision-making entirely, price and health risk, despite the fact that payment of a price and reduction of health risk are two of T-MARC’s primary goals.

32 See Chapter 5.
Social marketing’s foregrounding of the relation between persons and brand personae and the back-grounding of price and health risk as relevant information for decision-making is part of two strategies in social marketing which ideally invert historical understandings of the relationship between public health and market economies.

First, because social marketing theorizes that individuals are motivated by a pursuit of pleasure and that not all individual desires are alike, social marketing staff develop multiple brands of condoms in an attempt to appeal to everyone in a given population to use condoms. Where public health education traditionally generated a singular message for all kinds of people, social marketing seeks to target messaging and branding towards particular groups of the population. By adapting this strategy, social marketing staff assume that human desires are shared or in other words that humans can be grouped according to their desires and that desires can mark similarities and differences between persons. Essentially, the idea is that desires make people social persons.

Social marketing also conceives of these groups as having particular kinds of risk for HIV because of their shared desires. Social marketing reconfigures public health’s understanding of populations and risk according to a market-based understanding of desire. Similarly social marketing reconfigures risk as the extent to which people identify themselves with a brand or essentially whether or not people make purchases of social marketing’s brands. In this case, branding, a commercial technology intended to give companies a competitive edge in private sector markets, is reconfigured as a public health priority to effectively reduce risk among all sectors of society.

The second social marketing strategy involved in foregrounding the brand or equivalences between brand personae and persons is that marketers attribute different prices to different product brands and their corresponding categories of persons, despite the product for sale being a condom in each case. As described in the introduction, PSI and the T-MARC project sought to implement payment of a price for traditionally free services, such as condoms, for two reasons. On the one hand, social marketing theory since its inception has assumed that people naturally equate payment of a price with value of a product. Social marketing assumes that if people pay a price for condoms they are more likely to use a product. Essentially social marketing theory reduces the successful implementation of price to successful promotion of use and thus successful disease risk reduction, or in other words, social marketing treats price as a proxy for risk reduction. Social marketing, like commercial marketing, theorizes the brand as a technique for implementing price and price increases. Denoted in the concept, “brand equity,” marketing experts argue that the additional value added to a product by virtue of its brand name can be quantified in monetary terms. Marketers theorize that if a brand has enough equity, that is, personal and psychological value to a given consumer, he will be willing to pay for a product or to pay more than a standard price. Thus, the objective of branding products like condoms is to instill them with perceived value, beyond that of the functional utility of a product, so as to increase use, reflected in the act of paying a price. Interestingly, this strategy inverts commercial marketing understandings of price and use, where desire to use or have a product is what is thought to motivate consumers to pay a price. In social marketing, professionals reason that it is payment of a price that will lead to use. Social marketing promotes the idea that payment of a price is not just for the
purposes of placing financial burden for health on citizens, but is primarily a way of reducing risk.

In an interview in 2008, Hilda used the example of salt to explain the problem of promoting condom use as an issue of promoting price and the issue of promoting price as a problem of promoting qualitative value in the condom.

Salt is salt. Consumer choice is often just about the price. You buy salt in big bins at the market and it all looks the same. There is no brand and no value. You buy it for its function... Adding value or the perception of value has to do with education and how informed people are. So I will ask questions like, ‘where did this salt come from’, ‘is it refined’, etc... ‘ I know the differences in salts and so I perceive more value... But the value of condoms is not there. People want condoms for free. They’ve been given it for free and they don’t see condoms as saving their life. To get people to value condoms, you have to get people to value health and to value that condoms are protecting their health.

Hilda equates peoples’ valuation of health with willingness to pay a price for it, overlooking how people may very well value health but not have the means to pay for it. Her line of thinking presumes that the poor have disposable income, the use of which is determined by value rather than needs and limited means.

The second reason that social marketers attempt to implement price and price increases, particularly social marketers at T-MARC and similar NGOs supporting the development of segmented markets, is that they theorize that payment of a price within an economy of scale will allow for the retraction of donor funds and sustainable public health supply systems for all classes of society. As described in the introduction to the dissertation, the T-MARC project proposed to develop multiple brands of condoms for different sectors of society, sectors divided by class, risk, and lifestyle aspirations, what they call the “total market approach.” For low income groups, the model theorizes that when high enough levels of consumption are reached, profitable returns will be realized even when charging low income groups very low prices for condoms. For high income groups, the model theorizes that profitable returns will be realized by charging higher prices and that resulting profits may even be used to subsidize condom prices for low income groups. If this situation were to come to fruition, the total market approach model proposes that control of social marketing programming could be transferred to commercial companies and that competition between the various brands of multiple companies will keep prices in check and at equitable levels. Thus, the objective of implementing price under a total market approach model is also a project that social marketers theorize will lead to sustainable access to condoms.\(^3\)

These two reasons for implementing price and price increases by differentiating products according to the technology of the brand together merge or create a certain kind of commensurability between two very different understandings of the concept of “equity.” On the one hand, social marketing is interested in increasing brand equity, or the value thought to be added to a product by virtue of having a particular brand persona. In the total market approach to social marketing, the creation of brand equity is a means of implementing price so as to foster use and so as to foster conditions for sustainable supply systems. On the other hand, social marketing is interested in increasing equity of

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\(^3\) This model of social marketing is certainly not without its critics. For a further in-depth discussion and examination of how these economic models played out in practice, see Chapter 5.
access to condoms, a theory based on the idea that people should pay for health products according to their ability to pay. Within the total market approach model, it is the development of brand equity that social marketers theorize as leading to market-based forms of subsidization and thus also equity of access. In social marketing theory, these two concepts, brand equity and equity of access, become inextricable; the rising value of brand equity among multiple brands within a segmented market is theorized as allowing for increased equity among different classes of society, in that elite brands may subsidize low income brands or that volume of sales will do so. This example is just one in which social marketing, in theory, brings together concepts and practices of private interest with public interest, or commercial markets with public health, attempting to reconcile historical discordances between them. As Chapter 5 demonstrates, the ideals of equity did not always play out in practice as theorized.


Two weeks prior to the launch of Mama Ushauri season 4, I gained insight into the affective and associative means of communication through which T-MARC attempts to influence human health and to privatize public health via marketing communications. At that time I participated in a group editing session at T-MARC offices to provide feedback on the fourth season of the show. We sat in Sarah’s office. In addition to myself and Sarah, there were participants including T-MARC communications staff, professionals from Tanzanian Ministries of Health and health-related international NGOs, as well as staff from Media for Development, the media company which produced the show. Each person represented a particular health objective, whether nutrition, child survival, malaria prevention, family planning, or HIV prevention.

One-by-one we passed through the circle offering advice, critiques, and questions about the show’s fourth season. Several attendants made requests to have particular health issues more emphasized in the show. One woman affiliated with a malaria prevention NGO suggested that the show’s editors should subtly insert the sound of people slipping under their mosquito nets when they go to sleep at night, rather than leaving out any reference to mosquito nets as a form of malaria prevention. Others asked for the editors to include more comments about how birth control pills don’t cause infertility and how intra-uterine device insertion and removal is not painful. All of the comments indicated that the intention of the show was not to directly tell people what to do. Rather the intention was to create a publicly shared association between a recommended behavior or idea and characters in the Mama Ushauri show, characters who T-MARC hoped Tanzanians would aspire to be like.

Discussions also ensued about whether more mundane aspects of the show’s story line accurately represented the lives of Tanzanians. Comments like “that’s not what Tanzanians really do” were negotiated with comments that made recommendations to listeners about how to conduct their lives, such as slipping under a mosquito net when one goes to bed at night.

One of the most interesting comments at the time came from Sarah, who despite her usually very centered composure, became animated, irritated, and insistent in her
request that more messages and events be inserted which demonstrated to listeners how they could purchase products like condoms and oral re-hydration salts from their local shops, rather than traveling to the health clinic. Her outburst reflected frustration that Media for Development hadn’t already inserted these messages from the start. Explaining that we needed to create demand within communities for commercial sector health products and re-direct people to obtain health products at retail outlets rather than clinics, Sarah voiced support for T-MARC’s plan of privatizing public health services.

Sarah’s outburst surprised me at the time because T-MARC staff in the communications department spoke of the Mama Ushauri show as primarily a project in support of their health behavior change goals in Tanzania, not as a project concerned with privatization. As I learned more about the T-MARC project, I realized that T-MARC’s definition of ‘healthy behavior’ and ‘public health’ itself referred not merely to less risky sexual practices or improved biological outcomes. T-MARC framed these desired behavioral and biological outcomes as inextricable from the creation of a social order organized by market logics. In addition to the associations T-MARC promoted between payment of price, use of health products, and attaining aspirations as described in the last section, T-MARC also promoted the idea that citizens themselves should drive demand for commercial sector investments in health, and that doing so would lead to better outcomes for equity and health than relying on government institutions to dictate policies and programs.

On this day in March when I participated in editing the script of half of the show’s fourth season, this objective of associating health and equity with markets was put into stark relief by the plot lines running through the radio drama story. One story line narrates the tragic death of a young girl due to diarrhea. The story follows the regret of her parents who only after the fact learned that oral re-hydration salts (ORS) and zinc could have saved her life. These events provide listeners with embedded information on the life-saving effects of oral re-hydration salts and zinc should their children become ill. A similar plot line follows the story of another character who is told by health professionals to purchase ORS and zinc from the pharmacy to treat her children for diarrhea. When she learns that the pharmacy does not supply these products, she vows to initiate community activism to persuade small shops to carry these health products in the Goromonzi community. This plot line informs listeners not only of the necessity of obtaining ORS and zinc for child health but also promotes the idea that citizens should create demand for health products in local markets, essentially that they should be active health consumers.

Mama Ushauri, the main character of the show, also initiates community activism following the lack of ORS and zinc supplies in Goromonzi and the tragic death of the young girl. Mama Ushauri attempts to create awareness among residents about the importance of vitamin A supplements and de-worming to prevent incidents of diarrhea among children in the future. She takes her concerns to the district level medical officer and council, a group of government officials in charge of writing district financial budgets which determine funding allocations for ward and village level public health initiatives. At first, officials are resistant to her requests to prioritize child diarrhea

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34 These two products are currently being developed as commercial products by T-MARC, AED, and Shelys Pharmaceuticals through a project called the Point of Use Water Purification and Zinc Treatment (POUZN) program.
prevention within the budget, and these events send Mama Ushauri on an educational and lobbying campaign within the Goromonzzi community.

One aspect of Mama Ushauri’s activism within the story is the lead up to her confrontation with the council. The show provides embedded information on how the distribution of donor funding has changed over the years in Tanzania with the implementation of decentralization. Today UN and European donors primarily distribute their donations through basket-funding to the national government. Local governments at the district level then allocate these funds to particular projects. In T-MARC’s radio drama, Mama Ushauri learns that prior to basket-funding, when UNICEF was solely in charge of distributing money at the local level, the funds went directly to the cause of vitamin A and de-worming pill distribution in communities. In contrast she learns that today, with the local district now in charge of budget decisions, the district council does not always allocate funds to this cause and instead directs money to infrastructure development projects. Making reference to corruption, the show points out that the district council contracts these development projects to a construction company owned by the head councilor, the show’s main antagonist. In this way, the show invokes a set of issues regarding questions of decentralization, corruption, and a normative role for citizens and ‘civil society’ in establishing democratic liberal governance and funding allocation.

This plot line attempts to qualify the lifestyle to which T-MARC and USAID hopes Tanzanians will aspire. The show associates not only the use of specific health products (ORS, zinc, vitamin A, de-worming pills) with the ideal of having healthy prosperous children and a prosperous family life but also relates these potentials to an idea of the citizen as an active member of civil society making demands on government institutions and promoting consumer markets. The show constructs citizens as the driving force through which to attain liberal democratic governance and the economic promises of neo-liberalism in Tanzania, embodied in the character of Mama Ushauri.

Together, these various plotlines provide examples of how the figure of Mama Ushauri, like T-MARC’s product brands, operates as kind of persona. Mama Ushauri is meant to embody the association of a wise and secure Tanzanian woman with values, behaviors, and participation in social forms that characterize a health-informed, demanding and empowered consumer-citizen in relation to the state. The image of Mama Ushauri as a successful Tanzanian woman serves to qualify her character as one to which defined target audiences and other characters in the radio show are thought to aspire. Her character is directly opposed to the district head councilor who provides a sinister foil representing corruption of the African state. These two characters provide personae upon which to distinguish constructions of a market-driven society versus a corrupt state.

This promotion of markets as instruments for delivering health is a key objective of Mama Ushauri. Although these messages were not always first inserted by Media for Development nor seen by Media for Development as a primary goal of their own work, T-MARC staff added these associations into the show during editing sessions. These examples illustrate how T-MARC’s project of social marketing in Tanzanian entails re-characterizing the state as antithetical to achieving the goals of health and equity and the

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35 In speaking of “the state,” I am referencing the state as a constructed idea within the Mama Ushauri show.
commercial sector as the solution. The *Mama Ushauri* show was one key way in which T-MARC encouraged the idea that markets, health, and equity are inextricable.

V. **Associating Persons and Condoms, Associating Markets and Public Health**

During the 1980’s Western governments implemented political objectives in sub-Saharan Africa using contractual strategies of structural adjustment. In order to receive donor funds, recipient states had to agree to the national policy changes of privatization. Today, with critiques of structural adjustment policies well-underway and incorporated into donor states, social marketing becomes an alternative means of constituting a market-based political and social order in a world concerned with the autonomy and sovereignty of recipient states. Instead of using contractual means for implementing privatization and market policies, USAID through social marketing attempts to implement its vision of the market through citizens themselves. Using marketing communications and branding, USAID and T-MARC promote the market as a system for equitably and sustainably creating public health. They do so by associating consumer desires with their own political ideals and by attempting to create an affective relationship between citizens and USAID’s vision of a privatized order.
Ch. 5: A Privatized Public

I. Public-Private Partnerships in *Uwanja wa Fisi* (Hyena Square)

Introduction

In this chapter, I investigate the implementation of T-MARC’s public-private partnership model to develop a market in condoms and to coordinate government-run with commercially-run condom distribution in Hyena Square. After describing the distribution models and economic theories within these models, I turn towards ethnographic material documenting the actual circulation of condoms in this targeted community. I narrate how individual sellers and local government actors creatively found ways to piggy-back on social marketing’s logic of creating private benefit within the public health field by commercially selling government condoms, which were originally intended for free distribution. In doing so, these groups called into question the terms, ‘public’ versus ‘private’ and ‘state’ versus ‘market,’ at the center of T-MARC’s public-private partnership model. Their actions raised questions concerning who has the right to privately benefit from public health prevention projects and how that right is enforced and made legitimate. These events also illuminate how social marketers at T-MARC, just like local government officials, sought to control and confine private benefits earned through social marketing to elite groups. Where local government did so through practices that liberal thought deems as corrupt, I illustrate how social marketers did so through technical practices of marketing including the use of pricing subsidies and their very definitions of “the market,” “sellers,” and “consumers.” I demonstrate that economic theories and definitions of markets are not just ideological but are also productive or performative; economic theories often create the very conditions which they purport to represent.

Both social marketing practice and the informal privatization of government services led to a situation in which poor populations, intended to be public beneficiaries of public health programs, experienced decreased access to and increased pricing of condoms. Through these events, public health programs participated in constituting public beneficiaries as new sites of private economic profit for corporations and local government elite. These events illustrate the emergence of new forms of health and economic inclusion and exclusion, which are particular to the implementation of T-MARC’s public-private partnership model and Tanzania’s historical landscape. Despite social marketing’s goal of creating both economic and health benefits for low income populations, the set of practices spawned by social marketing in Hyena Square contributed to the development of a market in condoms characterized by decreased access to condoms, violent forms of private accumulation, and even the dispossession of livelihoods among small scale businesses. This chapter describes the practices through which these outcomes emerged not only in terms of the application of private property to condom distribution programs but also through particular social marketing ways of knowing – theorizing about, monitoring, and intervening in – the market in condoms.

36 See Figure 1
Uwanja wa Fisi (Hyena Square)

Uwanja wa Fisi or Hyena Square is a neighborhood in Tandale ward serving as one of the centers of land-based trade extending out from Dar es Salaam, Tanzania’s commercial capital, the seat of social marketing offices, and a city with one of the highest HIV prevalence rates in the country. The name, Hyena Square, is intended to characterize the square’s residents as desperate, willing to consume anything thrown at their feet, and points to the square’s infamy as the center of illicit activities including sex work and drug use. I was first connected to Hyena Square by T-MARC when it became the testing site for their research project on “women engaged in sex work and transactional sex.” Hyena Square was often the testing ground for numerous public health programs and disease surveillance as the area was the quintessence of neighborhoods housing what health professionals reference as “most-at-risk populations.” From the perspective of social marketers at T-MARC, most-at-risk populations include individuals working in or linked to illicit economies of sex work and transactional sex. Social marketing staff at T-MARC argue that these individuals engage in multiple concurrent sexual partnerships, a practice theorized as fuelling the HIV epidemic in sub-Saharan Africa (Epstein 2008). T-MARC’s research project sought to define and describe practices of “sex work and transactional sex” in order to inform the design of health marketing interventions aimed at promoting condom use and increasing access to condoms among these poor communities. While I provided feedback on this research project and attended many of the formative interviews in Hyena Square, I became interested in alternative questions which I outlined above.

Hyena Square, not coincidentally, lies alongside the Morogoro highway which extends to Morogoro and beyond to central and southern Tanzania. The Morogoro highway eventually connects Tanzania to countries in Southern Africa, the region hardest hit by HIV/AIDS on the continent. This transportation corridor contains cities with some of the highest prevalence rates in Tanzania, what public health experts explain as a result of multiple and concurrent partnerships occurring among individuals who work and travel along the highway.

Hyena Square, although geographically central in Dar es Salaam, houses populations marginalized from the economic benefits promised by development projects promoting capitalism and liberalization in the region. Buildings consists of simple concrete structures with mud floors and tin roofs, and winding avenues not big enough for a car to pass through provide walkways for residents. Many stores and markets offer second-hand goods and many products, whether condoms, gum, or cigarettes, are broken down and sold in pieces. For populations who live on a subsistence income, the convenience of buying items in bulk is out of reach. The Hyena Square area stands in stark contrast to the downtown section of Dar es Salaam alongside the Indian Ocean and Dar es Salaam’s commercial port. This area houses upper class businesses, restaurants, and hotels including the towering Kilimanjaro hotel where President Bush stayed on his visit in February of 2008. The downtown also houses government institutions and the specialty stores, multi-storied apartment buildings, restaurants, and religious institutions of Dar es Salaam’s Asian population. Hyena Square also contrasts with the spacious Msasani peninsula and Oyster Bay area, a fifteen minute drive from downtown, which houses expatriates and elite Tanzanians in gated complexes with manicured lawns along beautiful ocean fronts. Several foreign-owned, often South African owned, restaurants, hotels, and stores cater to Dar es Salaam’s elite and provide high-priced goods from
Europe and America. Hyena Square is also unique compared to other residential areas further out of town, like Mwenge, which house middle and lower income Tanzanians in comfortable yet moderately built homes. These areas support many locally owned businesses like *maduka*, 37 hair salons, bars, and second-hand stores.

A central economic pursuit of this area is trade. Businesses along the Morogoro highway bordering Hyena Square consist of sub-wholesalers which store and sell consumer goods. Trucks move in and out of the nearby parking area delivering corn from the country and loading boxes of detergent, soap, sodas, beer, phone cards, and other goods for the long journey out of town or to other parts of Dar es Salaam’s sprawling city. Street sellers purchase goods from these sub-wholesalers and peruse the area selling items like gum and cigarettes attached to flat slats of wood which serve as a display case.

My research began in the central square of Hyena Square which is the size of a children’s football field and is lined by bars, guesthouses, and *maduka*. When visiting the square, I would sit in plastic chairs on the porch of one of the guesthouses flanking the central square of the neighborhood. This guesthouse was essentially a brothel, offering rooms for women to entertain men by the hour. The guesthouse owners, women working there, and their clients sat on the porch as well, everyone facing the square’s center. We would watch men working in the square. They shoveled ground corn which was spread on plastic sheets used to dry the meal before bagging it and sending it out for sale. Extending from the main square are avenues lined with corn grinding shops, emitting corn particles into the air and the smell of dried out corn feed.

Hyena Square was always filled with stillness for long periods of the day, interrupted only by the metered rhythms of those working in the square. People would hang out waiting for something interesting to happen. I sat in the stillness, discussing politics and life in the square with those who sat with me, responding to requests for money, and listening to the stories of those who passed by. Inevitably an incident would erupt from the calm of the square bringing a burst of chaos and excitement for those waiting for some action. Whether it was a brothel owner chasing two male customers who had been violent with one of the women or a drunk woman taking off her clothes in the middle of the square and her partner rushing outside to beat her for humiliating him, the square always promised dramatic entertainment for those who milled about in its shaded corners. In these moments, voyeurs treated acts of violence as light-hearted scenes of laughter and comedy.

During the course of T-MARC’s formative research, I became friends with one of the hired research assistants, John, and he eventually came to work as my own research assistant. John had close friendships with many of the square’s residents and he enabled me connections, insights, and interviews that would have been difficult to achieve otherwise. John was both an insider and outsider among communities in Hyena Square. He had lived a privileged upbringing as a member of one of the families who held power during Tanzania’s socialist era. Having lived part of his childhood in the United Kingdom and having attended college in the United States, John held a worldly and critical perspective on life in the square. Yet, after the downfall of socialism and the decline of his family from economic and political power, he had become a full participant in the

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37 *Maduka* is a Swahili word that describes small shops. *Duka* is singular for *maduka*. *Maduka* generally sell small consumer items like soda, food, candy, and small household items.
nightlife and illicit activities of the square, enabling him close friendships with many in
the area.

After spending some time in the neighborhood, I began to inquire about how the
local guesthouses and its residents acquired condoms. I had already spent many months
working inside the offices of T-MARC and had listened to numerous social marketing
staff theorize about the best way to increase access to condoms among poor populations.
Their model of coordinating condom distribution included a role for the commercial
sector to distribute priced condoms to the majority of the population and for the
government to supply free condoms to the poorest of the poor populations, like many
residents living in Hyena Square. However, as I became familiar with condom exchanges
occurring in this area, I discovered that these models did not play out so neatly in
practice. For example, the guesthouse on the square where I often sat procured priced
socially marketed condoms such as Dume\textsuperscript{38} and Salama\textsuperscript{39} from maduka. They also
acquired government condoms from a man who distributed them door-to-door. This
man, like social marketing projects, also sold condoms for a price despite the national
government’s\textsuperscript{40} and T-MARC’s intentions for the condoms to be distributed free of
charge. This discovery led me to investigate how T-MARC’s public-private partnership
model and concepts of the market actually played out in practice in targeted communities
like Hyena Square.

II. “The Fortune at the Bottom of the Pyramid:” The History of Condom
Distribution in Dar es Salaam and T-MARC’s Public-Private Partnership
Model for Distribution

History of Condom Distribution Programs in Dar es Salaam

When the T-MARC project first began in Tanzania in 2005, a number of
organizations were already running projects based on behavioral approaches to HIV
prevention and improvement of condom access. The National AIDS Control Programme
(NACP), a department under the Ministry of Health and Social Welfare, coordinates the
health sector response to HIV/AIDS in Tanzania. Established in 1988, this institution is
in charge of two key areas relevant to social marketing including information, education,
and communication (IEC) programming and condom distribution for STI prevention.
Thus, social marketing programs like PSI and T-MARC report to and coordinate efforts
with NACP offices, particularly its IEC unit. NACP works with the Reproductive and
Child Health Unit of the Ministry of Health to set policies and make decisions about the
distribution of free government condoms to health centers throughout the country. Since
1993, the Medical Stores Department (MSD), another department under the Ministry of
Health, has carried out the practical work of ordering and distributing government health
products like condoms to hospitals and health centers throughout the country. The

\textsuperscript{38} The brand of social marketing condoms supported by USAID and the T-MARC project.
\textsuperscript{39} The brand of social marketing condoms supported by European donors and PSI.
\textsuperscript{40} The National AIDS Control Program, a program under the Ministry of Health and Social Welfare in
Tanzania charged with coordinating a national multi-sectoral response to the HIV/AIDS epidemic, ran this
government condom distribution program.
condoms that MSD distributes to health centers sport plain white packaging with the black letters ‘MSD’ stamped on them.

In addition to NACP’s free condom distribution programs, two social marketing programs have focused on HIV prevention and condom promotion in the country prior to T-MARC. Populations Services International (PSI) worked in the country since 1993 developing its Salama brand of condoms. In the early years of social marketing, PSI developed its own set of distributors who worked solely for PSI and promoted PSI’s brands. However, when the T-MARC project began in 2005, as a project intended to partner with commercial sector companies and distributors, PSI followed suit and began to contract their distribution work to a Tanzanian owned company, Nufaika. Established in 1993, Nufaika is the only commercial sector company in Tanzania that solely practices distribution and does not engage in product development or marketing. Nufaika supports the distribution of Salama condoms to commercial wholesalers and to some NGOs and donors.

Marie Stopes Tanzania (MST) is another non-profit organization that has engaged in social marketing of condoms. First established in 1989, MST primarily focuses on providing family planning services in Tanzania. They run several private hospitals in the country and also provide services through mobile health units in rural areas. While in recent years they developed two brands of socially marketed condoms, Raha and Lifeguard, which they have sold primarily in their hospitals and clinics, the brands were relatively unsuccessful and in 2008, MST sought to lease rights to the brands to a commercial or social marketing organization.

T-MARC, begun in 2005, supports the Dume brand of condoms and works with Shelys International, a local pharmaceutical company, to distribute products to wholesalers and pharmaceutical outlets. Shelys, like Nufaika, relies on other retail outlets such as supermarkets, maduka, kiosks (small mobile stands), maduka la dawa (small shops that carry pharmaceutical goods), guesthouses, restaurants, and bars to uplift condoms from wholesalers or subwholesalers. While both PSI and T-MARC often utilize their marketing and educational programs in communities as an opportunity to directly sell products to smaller outlets such as maduka, in the long-term, they rely on these smaller outlets to uplift products from these larger wholesalers.

Each of these condom distribution programs targets specific groups of the population. The NACP hopes to make condoms widely available to the whole population through health centers, while specifically ensuring that the poorest individuals will be able to obtain these condoms for free. Historically, PSI targeted low income youth aged 15-25 and focused their condom brands on the idea of love and romance. The Salama brand constructs HIV risk as arising from the increasing trust, love, and subsequent foregoing of condom use that is thought to result from romantic love. PSI hopes that retailers price these condoms at 200 shillings per 3 pack. T-MARC’s Dume condom targets individuals defined as “most-at-risk” which includes women engaged in sex work as well as low income mobile workers such as truckers and miners whose HIV risk is thought to arise from lengthy stays away from home and thus multiple sexual

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41 See Chapter 4 for a discussion of the Salama brand.
42 See Chapter 6 for more details. Because MST condoms did not have a significant presence in any of my field sites during 2007-2008, I will not deal in detail with their condom brand nor distribution strategy.
partnerships. Like PSI, T-MARC hopes retailers will price these condoms at 200 shillings per 3 pack. While Marie Stopes Tanzania’s brands were unsuccessful, they also used the idea of romance to promote condoms but they promoted this brand among higher income groups, charging 350 shillings for Lifeguard and 500 shillings for Raha. Full commercial, meaning non-subsidized condoms such as Durex and Ansell, can also be found in commercial specialty shops and high-end pharmacies, selling for up to twenty five times the price of socially marketed condoms. Durex and Ansell targeted higher income Tanzanians, tourists, and expatriate populations.

Each of these organizations sought to promote their brands, not only through communications and advertising as outlined in Chapter 4, but also through specific distribution strategies. Throughout social marketing’s history, the question of how best to coordinate the distribution efforts of various institutions like government, social marketing organizations, and commercial companies has been a central area of social marketing theory, a history and set of logics I outline here.

History of Social Marketing Distribution Models

i. The NGO Model

“The NGO model” of distribution, used since social marketing’s inception in the 1970’s, envisions condom distribution occurring through internationally run non-profit non-governmental organizations (NGO) in developing countries. NGOs engaging in this approach function like commercial sector entities in that they market and advertise branded and priced health products through commercial sector infrastructures. Since the 1970’s Population Services International has practiced the NGO model of social marketing. Under the NGO model, the international social marketing (today either U.S. or U.K.-based) NGO imports, brands, markets, and distributes subsidized yet priced health products. The NGO works on behalf of the government, but it creates a distribution infrastructure that parallels those of government institutions as well as the commercial sector. Proponents of the NGO model, such as professionals working at PSI-Tanzania, argue that they must utilize their own staff to facilitate sales and distribution in countries which do not have existing infrastructures for distributing health products on a national scale. Staff at social marketing NGOs work closely with commercial retailers to create a continuous supply of products at commercial outlets. In many cases, as was the case in post-socialist Tanzania, social marketing through the NGO model is the first introduction of large scale national coordination of product distribution and marketing in a country. More recently, in countries with commercial sector distribution capabilities, the NGO will contract services such as distribution, warehousing, or packaging to local businesses, but the NGO maintains local staff to promote distribution and use of products and it retains rights of ownership over the brand. PSI has followed this latter version of the NGO model since 2005. International donors (i.e., USAID, Royal Netherlands Embassy, the German Bank, etc.) subsidize the branded condoms sold by NGOs, and the NGOs sell these condoms to consumers or distributors at a very low price. As discussed in prior chapters, social marketing NGOs argue that consumers should be charged a price for condoms, reasoning that people are more likely to value, and thus use, a product if

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43 See Chapter 4 for more details on the construction of these brands and social marketing understandings of brands.
they have paid for it. The NGO reinvests any profits earned back into the NGO’s programs to procure more condoms or to conduct public health communication programs. These NGOs, such as PSI, see themselves as working on behalf of the local government, but they are owned and controlled by foreigners. Today, it is widely agreed upon in social marketing practice that one shortfall of the NGO model is that these international NGOs compete with local business investors, thus undermining the local commercial sector. In addition, these programs entrench dependencies between host country governments and international organizations, failing to foster local ownership or sustainability of programming (Futures Group 2002; Meadley et. al 2003; O’Sullivan et. al. 2007).

ii. The Manufacturer’s Model

In response to this approach, some social marketing programs have attempted to entirely support the commercial sector, a model first experimented with by The Futures Group in the 1990’s and then termed “the manufacturer’s model.” In this model an international social marketing NGO partners with one or more local commercial sector companies which have the capacity to independently run all aspects of condom marketing. In exchange for marketing support and services from the international social marketing organization, local commercial partners agree to lower or subsidize the price of the product. The manufacturer’s model addresses criticisms of the NGO model by supporting the local ownership and sustainability of condom marketing. However, it is generally accepted in social marketing thought today that these programs often have the unintended consequence of creating further inequities in health product access by not pricing products within reach of poor populations and by limiting support for the government’s free product distribution structures. Implementing organizations, such as the Futures Group, also recognize that these programs place unrealistic expectations on commercial sector companies in developing countries, a situation which often leads to the abandonment of health product marketing by the commercial sector (Futures Group 2002; Meadley et. al 2003; O’Sullivan et. al. 2007).

iii. The Total Market Approach or Full Market Impact Model

In contrast, USAID-sponsored social marketing programs began experimenting with public-private partnership models for conducting social marketing in the late 1990’s, or what they call the total market approach model. The ‘total market approach model,’ a public-private partnership model, aims to coordinate government-run condom distribution programs with commercial sector marketing of condoms. The concept of ‘total markets’ refers to all exchanges in condoms, whether among condoms provided by the commercial sector or by government, whether among branded or unbranded products, and whether among fully priced, subsidized, or free products. (Futures Group 2002; Meadley et. al 2003; O’Sullivan et. al. 2007). In social marketing language, this model of

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44 This slippage between purchase and use is a recurring feature of social marketing. See Chapter 4 for a discussion of social marketing’s promotion of price as a form of value in their advertising and branding. This idea of paying a price for social marketing products is certainly not without critique. See Kyama and McNeil 2007.

45 The Futures Group is an international development firm with specialties in social marketing since the 1970’s.
social marketing aims to realistically and sustainably strengthen the local commercial sector while maintaining equity of access to health products through continued support of targeted government services. Social marketers who use this approach, such as staff at T-MARC, view themselves as intermediaries of the government and the commercial sector and as supporting the long-term goal of privatization and targeting of government services for the poorest of the poor. T-MARC utilized an AED-produced version of this model which they called the “full market impact” model (FMI). The full market impact model has three main components or roles which are fulfilled separately by private sector companies, government, and social marketers.

The full market impact model assigns a commercial sector company the role of certain marketing activities which can include packaging, warehousing, and distribution for a specific brand of condoms. T-MARC supports the commercial company by procuring condoms, helping make decisions about pricing and distribution strategies, and providing advertising. USAID subsidizes these marketing activities in two ways which I outline below. It’s important to explicitly note that, since T-MARC and USAID make decisions about how to distribute subsidies in social marketing projects, they heavily influence who receives private benefits from condom sales. Understanding to whom T-MARC plans to distribute subsidies in the short and long term as well as how T-MARC legitimizes their control of subsidy distribution is crucial to understanding how T-MARC is able to implement its vision of creating private benefit in the health field.

First, USAID subsidizes the price of the products themselves by paying in full for procurement or importing of the condoms, as well as for the costs of packaging. Currently the end seller and consumer receives this subsidy in the price of the product, and T-MARC staff designate these groups as the current imagined beneficiaries of their social marketing project. T-MARC staff intend for this subsidy to generate sales and demand for cheaply priced products.

During 2007 – 2008 T-MARC staff planned for consumers to pay 200 shillings for a 3-pack of condoms, or approximately less than twenty cents for 3 condoms. Although many public health professionals argue that this price is out of range for low-income groups (Kyama and McNeil 2007), T-MARC staff often justified the price of condoms in relation to the price of beer. One beer in Tanzania generally costs around 800 to 1,000 shillings, or less than 80 to 100 cents in US dollars. Because T-MARC targets populations who are thought to frequent bars, staff at T-MARC perceived the price of condoms, a quarter of that of a beer, to be well within consumers’ reach. T-MARC staff also justified their pricing according to the logic that full priced commercial condoms marketed towards elite Tanzanians and tourists cost around 1,000 to 3,500 shillings for a 3-pack, a price many times that of socially marketed condoms.

T-MARC passed on this subsidy not only to the consumer, but also to the end seller. Wholesalers, such as in Hyena Square, sell a box of condoms which contains 20 3-packs of condoms for 1500 - 2000 shillings and, given that each box contains 20 packets of condoms, sellers can purchase a box, sell condoms, and make a profit of 2,000 – 2,500 shillings or just under $2.50. Sellers include people who conduct business through a duka, people working at other small licensed shops such as hair salons, or people who work as individual street sellers and carry items for sale through communities. As was often the case, if this seller could negotiate for a higher price with a consumer, then he

46 See Figure 1.
could make even higher returns. Social marketing condoms often sold much higher than the recommended 200 shilling price for a 3-pack.

The second donor subsidy provided by USAID is distributed to the commercial sector partners of the social marketing organization in the form of marketing support. By providing financial and human resource support for advertising and promotion, marketing research, and help in decision-making, social marketing enables commercial sector partners to come out even or with a slight margin after returns and costs have been calculated. In the case of the T-MARC project, T-MARC staff worked out a very particular arrangement with their commercial sector partner, Shelys Pharmaceutical.

Shelys is one of the largest pharmaceutical manufacturers and distributors in all of East Africa and is a member of the Sumaria Group, a Tanzanian-based corporate conglomerate with businesses in plastics, consumer goods, agro-processing, distribution, and pharmaceuticals. Shelys manufactures, markets, and distributes a variety of pharmaceutical goods including anti-malarials, cough and cold medicines, and sedatives, among others.

In the partnership that T-MARC arranged with Shelys, T-MARC procures condoms and conducts all research, marketing, advertising, and decision-making for Dume condoms, the primary condom brand supported by the T-MARC project. Shelys packages, warehouses, and distributes Dume and participates in decision-making about distribution, promotion, and pricing. Shelys is guaranteed at least a 10% gain on all sales and no losses. At the end of every quarter, T-MARC in coordination with USAID negotiates a final exchange of payments with Shelys. If there are losses, USAID will return the money lost to Shelys with a 10% margin on all sales. If there are gains, Shelys takes 10% of the margin on all sales and returns the remaining profits to T-MARC for reinvestment in social marketing programming. No contractual relationship exists between T-MARC and Shelys except for a mutual agreement to partner in this project, a form of partnership established by AED in order to persuade Shelys to participate in the project. Essentially, Shelys is in a “win-win” situation, as T-MARC staff described it, to participate in condom marketing.

The hope of staff at T-MARC and USAID, embedded in the full market impact model, is that there will eventually be enough volume of sales or economies of scale generated through consumer demand such that donors can remove all subsidies. Then T-MARC staff would transition all marketing work to the commercial partners, and the commercial partners will ideally continue to profitably and sustainably import and market condoms. If this goal were to come to fruition, both subsidies, being seen by the consumer / end seller and by Shelys, would be removed. The full market impact model theorizes that, with increased levels of demand, consumers will eventually agree to pay a higher price for the product and that competition between competing condom brands will keep prices in check. The theory continues that the higher price of condoms in combination with massive consumption will still bring profitable returns to Shelys, despite the withdrawal of donor subsidies.

The commercial sector component of the full market impact model is based on ‘bottom-of-the-pyramid’ theories, a concept first outlined by C.K. Prahalad, professor of business administration at the University of Michigan. His ideas, originating in the late 1990’s and culminating in his book, The Fortune at the Bottom of the Pyramid (2006), locate the new potential pool of consumers for commercial market expansion among the
four billion people living on less than two dollars a day in slums and shantytowns. Prahalad’s argument is that multi-national corporations and big businesses have long ignored the poorest populations as potential consumers, as the next site of multinational company growth, and as a solution to economic stagnation. He describes the world’s poorest as an ‘invisible’ ‘latent market.’ In this ‘latent market,’ Prahalad perceives a new site of profitability both for firms and for the world’s poor. He argues that by providing quality goods at cheap prices on a massive scale, large corporations can earn returns on their investments. Prahalad contends that the poor actually do have disposable income that they can spend on luxury items, indicated by the high interest rates which the poor often pay for access to cash from lending sharks. Prahalad envisions making products affordable to the poor particularly by selling products in small unit packages rather than in bulk, a practice indigenous to many of the low income communities he seeks to target. Prahalad argues that the lives of the poor will improve by having access to quality goods that enhance health, lifestyles, and small-scale businesses. In connection, Prahalad makes the case that the extension of corporate practice and distribution networks into poor communities can offer economic opportunities for the poor who choose to work as distributors and sellers of bottom-of-the-pyramid products. Prahalad argues that enabling the poor to become consumers is a mark of earning dignity, choices, and self-esteem, providing a moral justification for global multi-national corporate expansion into poverty-stricken populations. Finally, Prahalad also connects the development of bottom-of-the-pyramid ventures to anti-terrorism efforts claiming that multinational company ‘service’ to low income populations will lead to a reduction in anti-globalization movements (Hart and London 2005; Prahalad and Hammond 2002; Prahalad 2006).

The ‘bottom-of-the-pyramid’ references a particular conceptualization of populations as consumer markets, divided by class. Both commercial and social marketers conceive of populations as groups falling along a vertical axis running from ‘A,’ the rich, to ‘E,’ the poorest of the poor. When one maps this class distribution according to size in countries like Tanzania, the spatial configuration is a pyramid with ‘A’ at the apex and ‘E’ at the base. The full market impact model uses this conceptualization of populations to consider how different sectors should target individual consumers. For example, the model proposes that in Tanzania the commercial sector generally targets condom marketing at tourists and elite Tanzanians considered to be in classes A and B. The model illustrates how the government tends to serve middle-income groups when their services fail to reach poor populations and that social marketing often targets similar class groupings as the government. The strategy of the full market impact model, drawing from bottom-of-the-pyramid theories, is to direct commercial sector targeting of consumers down the class pyramid scale. T-MARC envisions its project as extending commercial sector reach into the lower classes, transitioning consumers away from public sector services and towards private outlets, and targeting free state products towards the most economically marginalized.

Prahalad’s ideas are present in T-MARC’s full market impact model in numerous ways. First, the full market impact model utilizes the idea of mobilizing economies of scale among the poor or the ‘bottom-of-the-pyramid’ so that Shelys can become a

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47 See Figure 2.
48 See Figure 2.
49 See Figure 3.
sustainable and profitable business in condom marketing. According to the model, if enough volume of sales are created and consumers are seeking out the product, then costs can be recovered and profit can be continually made such that USAID can pull subsidies and Shelys can continue condom marketing on its own. Second, the full market impact model draws from Prahalad’s ideas in that social marketing itself is a project of constituting the poor as consumers as an instrument of public health prevention. In exchange for paying a small price, for that of a condom, the poor can avoid unwanted disease and maintain their health and economic earning capacities, or so the logic goes. In this way the model intends for there to be returns for the poor as well for commercial companies. Finally, the full market impact model also promotes the idea of using small-scale sellers to extend product reach into communities. T-MARC often advocated for NGOs, taxi-drivers, or other people they encountered in their promotional work in communities to become sellers of condoms. Again, this aspect of the full-market impact model sought to offer economic benefits not only to big business, but to individuals as well.

Prahalad’s work and the application of his ideas to projects like social marketing is certainly not without critique in the business community. Aneel Karnani, also a professor of business at the University of Michigan, has been an outspoken critic. Karnani argues that any attempt to address global poverty must support the poor as producers and labors, not consumers. Countering Prahalad’s claim that the poor have disposable income, Karnani demonstrates that many bottom-of-the-pyramid experiments were carried out on middle income populations. In contrast, he argues that if these experiments were conducted on the poor, the only way to make products affordable would be to reduce product quality. He also critiques the idea that selling goods in small unit packages is the key to extending accessibility and increasing affordability of goods to the poor. Instead he argues that these practices actually increase consumption of goods among the poor while not making the price per amount more affordable. He writes, “by the BOP logic, an easy way to solve the problems of hunger and malnutrition might be to sell food in smaller packages and thus make it more affordable to the poor!” (Karnani 2007). Karnani essentially demonstrates that the bottom-of-the-pyramid plan asks the poor to have shared desires with higher income populations, but to satiate them less (Karnani 2006, 2007).

While Prahalad’s bottom-of-the-pyramid approach focuses purely on the private sector as a key instrument of development in poor countries, T-MARC’s full-market impact model for social marketing also includes a role for the government. The full market impact model configures government as a service provider within a “market” of exchanges, figuratively conceived. T-MARC doesn’t actually intend for individuals to pay a price for government condoms. Instead T-MARC intends for the government to provide free health products to the poorest citizens, class E, so as to maintain equity of access. In this case it is the National AIDS Control Program (NACP) that has the intention of providing free condoms to the poorest citizens through its clinic distribution networks.

The role for social marketing programs in the full market impact model is more ambiguous. T-MARC and AED staff argued that social marketers should be “disinterested players,” working on behalf of the government while executing work in
support of creating sustainable condom businesses.50 The full market impact model constructs social marketers as “brokers of privatization and human rights,”51 addressing both concerns for equity of access to health products as well as commercial sector profitability. T-MARC staff see themselves as “liaisons” of public and private interests, public health and economic benefit. This aspect of the public-private partnership, what one social marketer at Population Services International in Tanzania referenced as a “breach between public and private,” displaces concerns for uneven competition, favoritism, and corruption through social marketing’s intermediary “disinterested” role supporting “total markets.”

While the full market impact model and bottom-of-the-pyramid theories that I have outlined thus far look very neat on paper, in practice the implementation of these models encounters multiple, competing, and conflicting practices that disrupt its fluid execution on the ground. In the remaining pages of this chapter, I explore how governments, social marketers, and individuals seeking to benefit from social marketing projects produce forms of inclusion and exclusion particular to the full market impact model and Tanzania’s historical landscape in ways that seem to both undermine and sustain the project of social marketing.

Through the full market impact model, social marketers at T-MARC conceptualize public and private realms as discrete spheres marked off by the kind of product they distribute and the means through which they do so – free or priced, unbranded or branded, government or commercial infrastructures. The model constructs these spheres as separate yet ideally complementary practices. Within this model, only social marketers have privileged status to transcend the boundaries of public and private.

Social marketing staff at T-MARC also conceive of public and private realms as discrete spheres in the sense that concerns for the economic are intended to be separate from the political. In a normative stance, the full market impact model conceives of corruption as government practice which utilizes power for economic ends, and economic ends to gain power. Concern for the co-mingling of public and private have always been present within social marketing models when social marketing organizations are financially profiting, even if profits are re-invested back into health programming. The full market impact model serves to dispel concerns for corruption through the short-term and ‘disinterested’ role of social marketers.

However, public/private, state/market, and interested/disinterested never played out in practice as they are constructed in the full market impact or total market approach model, a point I will demonstrate in the next section. Interestingly, the “total market” approach or “full market” impact model literalizes in an unintended way in Tanzania, particularly in its imagining of government institutions as part of the entire “market.”

III. Economies of Risk: “Most-at-risk-populations” at the Bottom of the Pyramid

USAID’s 2004 call for proposals to establish the T-MARC project specifically asked for organizations to suggest ways to address the challenges of condom promotion among “most-at-risk-populations.” At the time, USAID imagined that the T-MARC project would adopt management responsibilities for the Salama brand and re-target this

50 In Figure 1, the middle blue arrow represents the work of social marketers.

51 Professionals working at T-MARC offices often used this phrase.
brand at “most-at-risk populations” rather than youth in general. However, when PSI refused to release rights to the brand, T-MARC developed *Dume* as a male condom for these at-risk populations.  

USAID characterized most-at-risk populations as “including specific target groups such as uniformed personnel (police and military), truck drivers, female bar workers and miners” (USAID 2004). USAID added that “it is important to recognize the high risks associated with the endemic nature of multiple partner behavior and trans-generational relationships in Tanzanian society” (USAID 2004). USAID and T-MARC’s conception of most-at-risk populations focused on the idea of men’s mobility in employment as leading to multiple partnerships, particularly with women engaged in sex work or transactional sex, what is often duly referred to as trans-generational sex. Trans-generational sex refers to the idea that older men with money provide younger women having a lower economic status with money in exchange for sex. USAID and T-MARC understood transactional forms of sex to be acts where women’s key interest in the relationship is thought to be material gain and where there are gendered and economic power differentials in the relationship. T-MARC staff associated increasing levels of this kind of “economic asymmetry” within relationships with increasing levels of risk, meaning that with greater exchange values, sexual acts were less likely to include condom use (Luke 2003).

Over the last ten years, there has been a rise in public health and social science research exploring the categories of sex work and transactional sex and its relationship to HIV transmission in sub-Saharan Africa (Luke and Kurtz 2002; Chatterji 2004). Many studies explore the relationship between the exchange of sex for money, materials, or services and the use of condoms, arguing that women’s economic dependence on transactional sex limits their power to negotiate condom use (Dunkle et al 2004; Hunter 2002; Luke 2005, 2006; Maganja 2007). Such studies call for increasing women’s economic earning ability so as to improve their negotiating powers in sexual relationships. Social science accounts provide a critical perspective on public health studies of transactional sex and sex work, arguing that the transactional nature of sex is not limited to lower classes but is an integral part of broader social norms of patron-client relations in sub-Saharan Africa, where forms of social status tied to transactional sex require public health intervention as much as women’s economic marginality (Swidler and Watkins 2007).

USAID and the T-MARC project sought to address this public health problem of transactional sex through neither of the two means described above. Instead, T-MARC’s solution was to incorporate ‘most-at-risk’ individuals into formal and mainstream economies of condoms as a strategy of risk reduction, transforming these individuals not just into condom users or into private beneficiaries as condom sellers, but primarily into consumers.  

Such a strategy entailed a particular concept of health risk as linked not only to deviant sexual practices but also deviant economic behavior, in this case sex work or transactional sex. Essentially, T-MARC perceived of risk groups as a category of

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52 PEPFAR provided 23 million US dollars in funding for the T-MARC project and thus required T-MARC to hold to their prescriptions for promoting abstinence and “being faithful” among the general population and condoms among populations deemed “most-at-risk.”

53 For more details on how social marketing poses consumption as a risk reduction strategy, see Chapters 2-4.
persons who participated in practices which transgressed liberal normative separations of public and private as economy and sex. This understanding of a kind of deviant and at-risk sexual economy overlapped with another kind of economy thought to be in need of repair, the “bottom of the pyramid.” T-MARC conceived of at-risk individuals as particular kinds of consumptive economic subjects, of the “bottom of the pyramid,” and as unable to participate as consumers of fully priced commercial condoms under current market conditions.

USAID’s narrow focus on these “most-at-risk-populations” was not without controversy. The Royal Netherlands Embassy’s First Secretary of Health and HIV/AIDS described how surprised he and others in the European donor community were at the fact that USAID had decided to narrowly focus condom promotion towards these defined groups. In contrast, he argued that Tanzania is a country in which a large majority of individuals are at risk and in need of subsidized condoms to prevent the spread of HIV, not just those categorized by USAID as “most-at-risk.” Corroborating the First Secretary’s statements is the 2007-2008 Tanzania HIV/AIDS indicator survey which found that there was no difference in HIV prevalence among various wealth categories and that higher income groups actually had slightly higher prevalence rates to the poorest groups (TACAIDS 2010).

Despite such criticism, while I worked at T-MARC offices during 2007-2008, T-MARC focused more and more on sex work and transactional sex among destitute populations as the key site of HIV risk in the country. During 2007-2008, T-MARC carried out experiential marketing events with women openly identifying themselves as “sex workers” and “bar maids” in low income communities. The purpose of the workshops was to provide information about condom use and HIV prevention, to disseminate condom negotiation skills, and to promote the Lady Pepeta (T-MARC’s female condom) and Dume brands. During this same year, T-MARC conducted the formative research on populations defined as “women engaged in sex work and transactional sex,” the research that led to my introduction to Hyena Square. The purpose of the research was to construct a social geography of the various categories of sex work and transactional sex taking place in high prevalence geographic areas of Tanzania, to map HIV risk behaviors, and to understand the motivations and aspirations of these women so that T-MARC could design communications and advertising accordingly. While T-MARC’s research included research subjects from a broad range of class status, T-MARC planned to use this information to inform a series of workshops, to be implemented by local NGOs, which would primarily concentrate on promoting HIV prevention behaviors among women in the lowest income category. T-MARC perceived of these women’s vulnerability in terms of their low earning capacities and thus their perceived susceptibility to forgo condom use for higher valued exchanges in sex. These workshops sought to provide women with information about HIV, condom negotiation skills, and awareness of social marketing brands and pricing. T-MARC would eventually target these workshops at neighborhoods like Hyena Square.

I was able to participate in many of the formative interviews of this research occurring in Hyena Square, a set of events which allowed me to gain an understanding of the lives of women targeted by T-MARC’s social marketing project. For these open-ended interviews with women, we traveled to “guesthouses,” a kind of hourly hotel, some of which women permanently lived in, or just a set of rooms housing women, where it
was generally known that one could offer money in exchange for sexual services. Most of
the women who lived in these houses did not identify as “sex workers,” although they
freely admitted that they engaged in sex on a daily basis as a means to earn money.

Many of these women, like other Hyena Square residents, came from Western
Tanzania, particularly from Bukoba, or from the Iringa region of Southern Tanzania.
Some of the women’s parents had come from these same regions, but they themselves
were born in Hyena Square. Women who came to Dar es Salaam from western or
southern regions generally did so during their teenage years in search of economic
opportunities, hoping to improve their fortunes and to send money home to families.
Some of these women arrived in Hyena Square with the help of individuals involved in
human trafficking, who would transport young women to Dar es Salaam, often selling
them to families where they would serve as “house girls” (unpaid or minimally paid
servants). Hyena Square became a site of refuge for these young women who sought to
escape this form of slavery.

Exchanges in sex for money in Hyena Square typically went for around 2,000 to
5,000 shillings. If a man could convince a woman not to use a condom or if a condom
broke and a woman could persuade a man to compensate her for this increase risk of
disease and pregnancy, the price was higher, sometimes as high as 10,000 shillings. If a
woman was in desperate need of cash, for example because of a drug habit, she would be
willing to take an even lower rate, as low as 1,000 shillings per sex act.

Women expected men to use condoms, unless a man could negotiate a high
enough price to forgo them. At guesthouses, the owner of the guesthouse would provide
each customer with one condom for free. If he needed more, he would have to pay 100
shillings for each condom. The guesthouses carried both Salama condoms and MSD
condoms, and they did not distinguish prices between them; each condom cost 100
shillings.

IV. Privatizing Public Health in Hyena Square

“Informal” Privatizations

One afternoon, John, my research assistant, and I began searching for the man
who distributed government condoms to brothels in the area. We found him at his
shoeshine business, a wooden stand on the edge of the highway with several old shoes
lying in the dirt along with some polish and rags. A long wooden bench and two run-
down plastic chairs provided seating for customers. The man – whom I’ll call Andrew –
invited us to join him and as we took seats, he pointed to the large cardboard boxes of
government condoms, sitting in the shade underneath his shoeshine stand.

Selling condoms had been Andrew’s side business for about eight years. In 2000,
the National AIDS Control Program coordinated an HIV peer education workshop for
local NGOs and made government condoms available to NGO members through the
municipal level government health centers. Andrew is a member of a NGO that supports
albino rights in Tanzania. Albinos have been consistently marginalized within Tanzania
and have in the past several years been the targets of violent and often fatal attacks.
While Andrew’s NGO works to combat the forms of discrimination and inequality faced

54 1,000 shillings at the time was approximately slightly less than 1 US dollar.
by albinos in Tanzania, his NGO also extends their organizational services to broader social issues like the prevention of HIV/AIDS. In 2000 his NGO participated in the government-run HIV prevention trainings, and Andrew began distributing condoms to his local neighborhood as part of the NGO activities. Despite the intention of the National AIDS Control Program to set up free condom distribution networks through NGOs, Andrew sold the government condoms to earn a supplemental income in addition to his shoeshine business. He obtained the condoms for free and could sell each box of 100 condoms for 400 shillings per box. In a given day, he could sell anywhere from 2 to 20 boxes. Considering that his shoe shine business brought in 5,000 shillings per week or $5.00, his condom sales were a much needed part of his income.

Andrew usually procured condoms from the municipal level health center, but five months prior to our meeting, government officials switched the condom distribution sites to the local health office in Tandale ward, where Andrew worked and lived near Hyena Square. Since the condom distribution sites shifted to the ward level, it had become increasingly difficult for Andrew to obtain condoms from the local authorities, as they often told him that their supplies had run out. He returned to the municipal health center when supplies were short at the ward offices.

Andrew only sold MSD condoms and never sold social marketing condoms because the price of procuring condoms like Dume or Salama was too expensive for him. However his sales of government condoms piggy-backed on the branding logic of the social marketing project. For example, in Hyena Square ‘MSD’ was known as a brand of condoms and people were unaware that the government provided these condoms for free. While people readily purchased these condoms because they were so cheap, people generally considered them to be of poor quality, to smell bad, and to lead to infections in women.

In contrast to Andrew’s piggy-backing on the social marketing concept, one of Andrew’s friends who worked as a seller on the sidewalk next to him was able to purchase the more expensive social marketing condoms. Andrew’s friend had a large wooden tray that he carried around which displayed condoms, gum, candy, cigarettes, and other small goods. As a street seller, he provided sales of convenience, perusing the avenues directly outside people’s home where he made sales at their doorsteps. He had been able to use his profits to purchase Salama condoms and to re-sell these condoms through his business for additional income and capital. He procured condoms from the local sub-wholesalers along the highway for around 2,000 shillings per box, a price out of reach for Andrew. Selling each condom packet for around 200 shillings, he could make a profit of 2,000 shillings per box.

Both Andrew and his friend worried about their small-scale businesses and police crackdowns on unlicensed sellers. Although Andrew was not required by the government to have a license for his shoeshine business, it was illegal for him to sell government condoms. His friend who was required by the government to obtain a license to sell small consumer goods, had not yet made payments for a license.

Economists and international organizations traditionally portrayed illicit exchange practices, often referenced by development practitioners as “the informal economy,” as

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55 Municipal level government is above ward level government in the hierarchy of product distribution and government.
56 2,000 shillings is slightly less than 2 US dollars
those exchanges which remain outside statistical and state monitoring techniques, as backward outgrowths of a declining poverty-stricken economy, and as aberrations (De Soto 1989; Hart 1973; Portes 1994; Portes et. al. 1989). Despite this depiction, informal practices in Tanzania have made up a significant portion of people’s income, where most formal wages don’t provide enough income for individuals, especially for people supporting families (Tripp 1997). In the case of condoms and social marketing, the possibility for street sellers to afford social marketing condoms given the current distribution of subsidies, or even for NGO members to sell government condoms, provided many profitable and intriguing business opportunities that supplemented local incomes.

Development economists such as Hernando de Soto (1989) traditionally posed informal practices as both a hindrance to and, with the right interventions, potential site of development. By designing strategies for formalizing these practices, these economists intended to unleash capital for investment in economies with further global reach and higher returns as well as to make these practices taxable by the state. More recently development experts perceive the informal economy as a potential of economic growth and through micro-finance programs experts work to develop the informal sector and small businesses as the basis of national economies in the developing world. However, these development strategies have at times resulted in further marginalization and dispossession of property among the poor (Elychar 2005; Mitchell 2005).

Although social marketing practice at T-MARC was not engaged in formulating problems concerning capital for poor populations, illicit exchange, or state licensing, T-MARC’s project of constructing sustainable markets in condoms interfaced with “illicit” or “informal” sales in interesting ways. Small-scale unlicensed sellers are one of the primary mechanisms through which products like condoms first conveniently and cheaply reach the end consumer. Through these exchange networks social marketing projects begin to generate the level of sales needed for creating commercial profits at the corporate level.

Likewise, the illicit sale of government condoms also came to have an unexpected role in the social marketing project. Despite the illicit sale of government condoms at the local level, the National AIDS Control Program continued to support a distribution chain that was intended to provide free supplies, a strategy which correlated well in theory with T-MARC’s public-private partnership model and goals of equity. However, in practice, professional staff at T-MARC were often well aware of the sale of public sector condoms and used it to advocate for a more committed adoption by the government of the public-private partnership model for total markets. For the marketing manager at T-MARC, it was essentially a question of creating greater access to condoms through public-private partnerships and a question of the government more accurately targeting free distribution to those most in need.

Social Marketing Privatizations

T-MARC’s Marketing Director, Hilda, is a Tanzanian marketer with a masters degree in marketing management from Middlesex University. Hilda, like most other staff at T-MARC, comes from an elite Tanzanian family. She worked for many years in Nairobi, Kenya for the Coca-cola Company where she married a European man and had her first child. Returning to Dar es Salaam in order to live a more settled life near her
family, she took a job with the T-MARC project in 2004. After my field experiences in Hyena Square, Hilda spoke to me about her assessments of the successes and failures of government-run free condom distribution programs as well as the government’s coordination with the full market impact model. In her account she speaks about interactions with individuals at the National AIDS Control Program at contraceptive security meetings in which donors, government representatives, and social marketing organizations meet to discuss their work and results in improving condom and contraceptive access.

Conceptually, they [the Tanzanian government, particularly individuals working at NACP] appreciate the PPP model. They’re just not following up with making it happen… The government has been very good in terms of getting donor funding to bring in condoms… All of a sudden they have so much commodities but they can’t get them to the population… So in condoms, I was telling them, what is your concern? Why don’t you guys embrace the commercial sector? You know, if people came and they say, ‘you know what? I want to get condoms.’ It’s such a huge red tape bureaucratic process of accessing it … even if this end user is going to sell at the end of the day people are going to be buying and that’s what we want is use. So does it matter that this person actually came and got it free and ends up selling it for 400 shillings… okay, at least I have covered my costs of provision of services. So what does it matter if the drug shops will uplift condoms from MSD and start selling them in the shops. Even if its 400 shillings. As long as we are encouraging condom use…They say ‘no, no, no cause this commercial sector is going to make a business case.’ …Why not take a risk and try it out? … Let us offer so many people to uplift from us… then lets measure the health impact… the whole issue is accessibility. Some of the condoms are going to be rotting in the store. There is the issue of expiration.

Hilda’s response essentially outlined the long-term goals of social marketing. In the ideal world of social marketing, the government would contract the majority of condom distribution to private companies, and the government’s free services would be tightly targeted at the poorest of the poor. As Hilda saw it, the government currently did a poor job not only of distributing condoms, but also of targeting the free supplies to those most in need.

Hilda’s perspective makes certain departures from the full market impact model as outlined by AED and promoted by USAID. From Hilda’s perspective, selling government condoms rather than maintaining them as free products would best lead to better health outcomes. Her personal support of full privatization policies and use of commercial marketing strategies occurred in other realms as well. For example, she encouraged the idea that T-MARC create its own fully priced product lines to fund the organization’s long-term existence after USAID’s 5 year funding cycle ended. Several other staff at T-MARC, also with business training and commercial sector backgrounds, promoted her ideas. However, they were always met with strong resistance from USAID

57 As described in Chapter 1, part of the project outlined for AED (the American NGO heading up the T-MARC project) was for it to establish T-MARC as a locally owned and run NGO, apart from AED management. The idea was that T-MARC as an NGO would graduate certain products, like condoms, from social marketing care to the commercial sector and that they would then move on to other products, like vitamin A supplements. USAID hoped that fulfillment of this goal would enable them to sponsor a non-US run NGO (in contrast to PSI and AED) in Tanzania. One problem for Tanzanian staff at T-MARC throughout T-MARC’s 5 year project though was how T-MARC as an NGO would continue to receive funding and sustain itself apart from becoming a primary contractor to USAID. See Chapter 6 for more details.
and AED staff who insisted that T-MARC refrain from engaging in commercial activities apart from those supported by the full market impact model.

Hilda’s comments about government resistance to public-private partnerships were also echoed by the Director of Programs at Population Services International (PSI) offices in Dar es Salaam. Michael is a Tanzania M.D. who left his medical practice in the 1990’s to work for PSI. Between 2000 and 2002 he worked with PSI to implement a total market approach model, a public-private partnership, for distributing mosquito nets to prevent malaria, a project also funded by USAID. Michael describes the government’s relation to social marketing through public-private partnerships,

Social marketing as an idea is supposed to be sustained and is supposed to be bought by the ministry. So what we are doing now is to always attract the ministry to make social marketing as one of their tools… The district council is going to plan for health for the year, what they call comprehensive health plan. Then they should include social marketing element, technique. And by doing so, when they get the money through general budget support, they will be able to contract. You know its not common for the government to contract NGO to do for them or the commercial sector to do for them. So you lose the PPP, public-private partnership. So through social marketing … social marketing is a breach between public and private. So we want them to buy in the idea. And we keep on working … so that when these development partners group meets with the government, they should be addressing the idea of social marketing within the government. And when it gets ripe, the governments from the central down to the district will be able to subcontract activities. They have got money, but they cannot do everything themselves… At the end of the day we need the public-private partnership which is not happening… All of that came because of the social marketing. The private getting money from the government... It was not common that kind of a ppp.

The response of the government, which both Hilda and Michael outline, is to refrain from contracting with commercial sector operators. At first glance this logic could be interpreted as the government defending the public’s rights to health, an idea also promoted by the full market impact model. However, as I spent more time in Hyena Square, I wondered if another emergent rationality was at stake. Certainly at stake was the question of whether government condoms should be a public or private product, but what public and private meant and entailed and where the line between public and private should be drawn seemed to be up for grabs, for both the government and social marketers.

**Privatizations by the Ants**

About a month after first meeting Andrew along the Morogoro highway, John and I returned to talk with him again about his condom business. We had learned from some friends in Hyena Square that someone else was now selling MSD condoms. Andrew told us that he was no longer able to procure free condoms at the ward level government nor at the municipal offices. On every attempt to procure condoms in the last several weeks, the ward executive officer and the municipal health officer had told him that all of the condoms had been distributed. We learned that the street-level security, in Swahili sungusungu, had been taking the government condoms and selling them to the local brothels. The person in charge of condom distribution at the municipal health center refused to give Andrew any more condoms and began re-directing these supplies to the local government. The village level government now held a monopoly over government
condom distribution in the area. In addition to learning that the local government authorities had displaced Andrew’s condom business originally run through his NGO, we discovered that the sungusungu now also sold MSD condoms to the local shops in addition to the brothels. However, retailers sold MSD condoms for 1,000 shillings for the box of 100 condoms, two and half times that of what Andrew sold them for and a price comparable to the price of a box of Salama condoms at particular wholesalers.

Sungusungu, which means ‘ants’ in Kiswahili, are a paramilitary troop of the Tanzania government in charge of security and law enforcement at the village or street level. The village or street level government is the lowest level government in Tanzania, falling under the ward level government which is under the municipal or district level government. Originating in west-central Tanzania, the organization of sungusungu spread throughout the country as a means of protecting and restoring individual property, especially cattle, robbed by thieves. Sungusungu as an organization sits between the ad hoc gatherings of people at the site of theft, who chase down thieves and usually burn or beat them to death, and a more formal enforcement and justice system which remains sparse and ineffectual at the village level. The government first officially recognized sungusungu in the early 1980’s, but never developed official laws to regulate or coordinate them (Tripp 1997). Fitting easily into Julius Nyerere’s Socialist villagization program, the president lauded their activities and provided political support for their continued formation. Although the government originally recognized sungusungu as a means of regulating behavior and preventing the proliferation of unchecked power at the local level, the local government eventually began to utilize sungusungu for their own purposes of tax collection, and the sungusungu developed independent decentralized autonomy (Abrahams 1987; Fleisher 2000; Paciotti et. al. 2004). In Hyena Square, the sungusungu worked for the village chief who was in charge of an area of approximately 100 households. The sungusungu consisted of community members, many of whom had family relations in the area. The majority of them were very muscular, inspiring respect among the community. Sungusungu collected money from businesses in exchange for protection from robbery. Although often diagnosed as a response by citizens to a “failed state,” the sungusungu represent a form of vigilante state practice. The sungusungu monopolize violence at the village level, with no contractual relationship to bind them in obligation to a citizenry.

Hyena Square residents feared the sungusungu who in coordination with the village chief often maintained political-economic control through seizure and violence. Although intended to be a security force to protect the residents of the village, the sungusungu often used their force and personal relations to extract payments, accumulate wealth, and re-inscribe their power. When the village chief or the sungusungu themselves were in need of finances, they would demand money from residents, often raping women engaged in sex work in the process.

The sungusungu co-optation of condom distribution had the effect of creating not only a profitable hierarchy of distribution, but also a direct link between government provision and commercial sector outlets, in some ways the very kind of privatization propositions social marketers at T-MARC were advocating for from government. In the case of the sungusungu in Hyena Square, private individuals within government were earning the returns on sales, rather than private intermediaries contracted on behalf of government, the plan advocated for by social marketers. However, both forms of
privatization work according to a similar rationality, one outlined by Mbembe (2001) and Hibou (1999) as ‘private indirect government.’

The literature on private indirect government seeks to counter normative discourse about states in Africa as weak, failed, corrupt, and in decline. Instead, ‘private indirect government’ points to the ways in which states re-orient or re-deploy power in a productive manner through private, and often illicit, means. In the case of social marketing in Hyena Square, local government utilized sungusungu as a means to extract payments for public health services, money which could be used for private means or the furtherance of political power.

In a similar way, T-MARC’s requests for the government to partner with private companies in the social marketing project also re-directed state power to the private realm. However, T-MARC legitimized these forms of governing and private accumulation through its semi-contractual relations and self-depiction as a “disinterested” player. Still, these relationships exhibited a similar kind of tightening of private accumulation to elite spheres. For example, just as the sungusungu fully transitioned local government distribution of free condoms into a profitable enterprise over which they had sole control, so did social marketers seek to constrict sites of profit for the benefit of elite corporate partners, in this case Shelys Pharmaceuticals. The T-MARC project planned to eventually withdraw subsidies now benefiting retail shops (maduka) and street sellers, what T-MARC staff call ‘supply chain intermediaries.’ T-MARC staff, as informed by the full market impact model, intend to redirect these subsidies to Shelys. The plan is to make the condom marketing project profitable and sustainable for Shelys, but in doing so, T-MARC also dispossesses local businesses of profit in areas like Hyena Square. Hilda, T-MARC’s marketing manager, summarizes their plan.

Our recommended price points are not actually reaching the end recipients. We are not pushing the envelope too high in terms of demanding that the retailers pass that on because we're still trying to develop the market. But there will come a point in which we will actually adjust that and adjust the margins that the supply chain intermediaries are making cause we’ll know that the demand will be forth-coming. We can cut back on the margins that they are making and still so, cause that is where we can cut back to address the profitability to the commercial sector partner… so that their profitability is enhanced. Cause right now we know the retailers are making a lot of profit and they’re not passing that price point advantage to the end user… But right now we're not really being hard because we want to nurture the retail support and we want to build equity and create demand. Once the demand is there and the consumer is demanding the product, trust me, the retailers will be forced to supply. And we will then have the, the muscles to adjust their margins. Other commercial sector partners have done it, that might be of interest to you. Even the pharmaceutical industry has done it. They say ‘right, you guys are making so much profit, so guess what? I’m going to take away some of these margins. So I’m going to increase my prices to you, but you are going to make sure that you maintain your price to the consumer.’ And we’re going to sensitize to the consumers the price point that they should be getting for this product. And usually you get buy-in.

In this way, although the sale of government condoms and the sungusungu monopolization of these sales called into question the normative framings of public and private within the full market impact model, the sungusungu also found common alignment with T-MARC’s project of privatizing government. Both parties, T-MARC
and sungusungu, attempted to control the flow of private benefit created by public health projects through the ambiguities of their roles as public or private actors. Where sungusungu directed private accumulation into the hands of local government, T-MARC directed profits into the hands of corporate elite businesses. Through these events, T-MARC’s conception of the ‘total market,’ as a market involving both commercial and government goods and exchanges, literalized in a way unanticipated by social marketing staff.

V. Markets as Proxies: The Performativity of Monitoring and Evaluating the Market in Condoms

The exchange practices occurring in Hyena Square not only called into question the full market impact model’s theories of public and private but also T-MARC’s understanding of the terms ‘market,’ ‘consumer,’ and ‘seller.’ Specifically, T-MARC’s monitoring and evaluation techniques predefined market, sellers, and consumers, in ways that do not conform to the practices taking place in Hyena Square. However despite these discrepancies, T-MARC used marketing technologies, particularly pricing subsidies and monitoring and evaluation data, to implement their particular vision of who counts as private beneficiaries and to actualize their definition of the market. Despite the creative attempts of individuals like Andrew and other street sellers to participate in social marketing’s market, T-MARC’s technological practices had a powerful productive or performative effect that allowed them to create the market in their own image.

Markets of commercial sector practice never emerge as raw output from the implementation of public-private partnership models or as an obvious set of social relations. Rather social marketers utilize monitoring technologies to describe the markets that they seek to intervene upon. In connection, science and technology studies’ interaction with economic sociology explores how descriptive technologies never provide pure representations of markets, but rather participate in producing, or performing, them (Callon 1998; Callon et. al. 2007; MacKenzie et. al. 2007). Market monitoring devices frame markets in particular ways and inform decision-making about pricing and distributing products. In this section I explore T-MARC’s market monitoring devices and how evidence of markets and health itself actualize social marketing’s market in condoms.

Sales as a Proxy for Health: The Retail Audit

In order to inform marketing decisions regarding distribution, promotion, and pricing and in order to report to donors (i.e., USAID and PEPFAR) on work accomplished, T-MARC used a retail audit to track product purchases and to provide indicators meant to describe the market in condoms. The retail audit measures purchases, stock levels, sales, price, and point-of-sale materials at a sample of retail outlets. These measurements provide a means of evaluating the volume of sales, market share of any particular brand, and the reach and consistency of distribution over time. T-MARC used this data to understand consumer demand and the scope of consumer markets.

T-MARC contracted retail audit research to Research International, a British international marketing research company originally begun by Unilever, with its East
African offices located in Nairobi, Kenya. Research International collects data from a sample of retail outlets in each region of the country. Research International defines a retail outlet as including any of the following: supermarkets, mini markets, petrol stations, large and small *maduka, kiosks*, pharmacies, bars, night clubs or discos, and guest houses. Retail outlet owners at sampled outlets collect data regarding sales and purchases on a daily basis through a standardized recording format. Retail audit surveyors working for Research International live in each region of Tanzania and they collect relevant information from retail outlet owners once a month. Collected data is weighted according to the number of retail outlets in a particular area so as to obtain estimates of total sales in an entire region. Data is sent to Research International offices in Nairobi, Kenya, entered in a database, and cleaned. The database is then sent to The Retail Audit Company in the U.K. for analysis. Research International delivers retail audit reports to T-MARC on a quarterly basis through meetings held at T-MARC offices in Dar es Salaam.

The retail audit is of value to T-MARC because without it, condom exchanges can only be tracked through Shelys’ distribution system to their final distribution point, wholesalers and sub-wholesalers. Beyond these points T-MARC has no idea how its products are circulating and reaching target populations. Hilda, T-MARC’s marketing manager, describes the retail audit and its purpose,

Right now the distribution model in Tanzania is very much through third party distribution strategies, structure. So it’s difficult to clearly and visibly understand, you know, where are you, where is your availability at what point, what are the trends over time. So that’s what we use the retail audit to measure… Because our direct interaction through Shelys is with wholesale agents and subwholesale agents. We’ve shown that we don’t know whose uplifting the product and where it’s getting. So that [the retail audit] gives us the measure of how well are we represented at the retail point. *Where is the consumer’s contact point.*

The retail audit provides an estimation of the extent to which goods are moving in and out of retail outlets and cannot assess the extent to which goods are actually reaching or being exchanged with T-MARC’s target populations. Although one can never know what happens with condoms once they leave the wholesaler, sub-wholesaler, or retail outlet, T-MARC marks the retail outlet as “the consumer’s contact point.”

In one incident at T-MARC, the retail audit was reporting suspiciously high sales volumes of female condoms in a southern region of Tanzania that bordered Mozambique. The sales were so high that T-MARC decided to investigate. They learned that the female condoms were being bought by a factory in Mozambique to manufacture a secondary product. The subsidized female condoms provided such cheap raw material for the factory in contrast to purchasing the material outright from a vendor in the U.S. or China that the factory sent staff across country borders to procure the condoms. T-MARC worked with retail outlets in the area to stop the sale of condoms to this factory, a move in which T-MARC claimed the right to determine the use of the condoms. Although this incident was a rare case documented at T-MARC, it points to the ways in which actual use and exchange of condoms with targeted populations is always out of reach of social marketing surveillance technologies in sites like Tanzania. It also indicates how T-MARC worked to maintain control over the constitution of sellers and consumers and the distribution of public and private benefits; when consumption was not for use in sexual practices, T-MARC attempted to control purchases.
Given these circumstances, the retail audit depicts social marketing’s market as a very particular kind of entity. The market is the set of exchanges occurring in and out of formal, measurable, registered retail outlets, and this definition of the market is set out by the terms of the retail audit. As Arnold, the retail audit manager at Research International, explained it to me, “the sampling frame for the retail audit provides the definition of the market.” By excluding exchange practices described in the previous section, T-MARC’s understanding of the market came to be a set of licit and auditable exchanges. Researchers carrying out the retail audit were very aware of this fact. However, the way in which T-MARC staff and their donors used the retail audit for decision-making tended to ignore this performative potential of sampling in several ways. On the one hand, staff at T-MARC treated the retail audit as a descriptive indicator of the market which they used to make marketing decisions about pricing, distribution, and promotion, a point I will return to. On the other hand, measures of social marketing’s market traveled discursively to USAID offices in Dar es Salaam and Washington, D.C. as well as to PEPFAR and PSP-One offices in Washington for purposes of monitoring and evaluating funded programs and for purposes of decision-making in regards to U.S policies in Tanzania.

Evidence of Markets: PEPFAR and the Evidence-based Public Health Movement

T-MARC designed their monitoring and evaluation plan with input from PSP-One and PEPFAR. The first objective measured in T-MARC’s monitoring plan which is part of USAID’s country objectives is “Health status of Tanzanian families improved” indicated by the “impact of T-MARC interventions on the ‘total market’ for family planning, child survival, and infectious disease.” T-MARC estimates their impact on the total market by measuring the size of the overall market, quantified as the number of commercial partners in the market, as well as market share. Market share is the quarterly percentage of sales volume for each brand and includes figures for the government as well. These figures are used to compare government and market shares in order to understand trends towards privatization. The second objective is the “reduced transmission and impact of HIV/AIDS in Tanzania” indicated by the “impact of T-MARC interventions on the total market for condoms.” T-MARC similarly estimates impact by the size of the overall market and market share in addition to the number of retail outlets that stock condoms, an indicator required by the PEPFAR program.

T-MARC was held accountable to the above indicators, ones which public health professionals term as “process indicators.” Traditional social marketing indicators and those adopted by PEPFAR have long been critiqued for measuring the process through which their public health programs take place, rather than the relation between programs and health outcomes. The evidence-based movement in public health emerged to counter programs like PEPFAR in which the agreed upon evidence functions more as an audit of work completed, work which is based on political ideologies, rather than as an indicator of improved health outcomes, access to condoms, and equity of access. In recent years, social marketing programs have moved beyond these traditional measures with the goal of improving the objectivity of measures and in order to measure outcomes which

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58 PSP-One is the global program of USAID focused on promoting private sector solutions to health care and public health.
indicate the extent to which their programs are actually reaching and servicing their target populations as opposed to solely measuring retail outlet delivery.

Over the last fifteen years, evidence-based medicine became a dominant paradigm not only of clinical practice, but also of public health (Lambert 2006). Social marketing in particular fully embraced an evidence-based approach to public health so much so that social marketers use the language of evidence to characterize social marketing as “what works.” Social marketing’s affinity with evidence-based approaches stems from its relation to commercial marketing where the concept of “evidence-based marketing” seems redundant. Where product sales and the drive for profit are paramount motivators for discovering effectiveness, learning what works is a hallmark of the marketing concept, and the bottom line provides a simple means of determining success.

Despite a tendency to value evidence-based approaches to programming, social marketers have long struggled and continue to struggle with the question of what constitutes evidence of success and how to measure the effects of programming. For commercial marketers concerned with making profits, sales volume is an easy indicator for project evaluation. In contrast, for social marketers who are also concerned with questions of health outcomes in addition to sales, measuring impact can be problematic. Social marketers in the context of Tanzania are often faced with the question of whether goals of public health or commercial viability of health products come first.

For social marketers problems of measurement are not only a question of what to measure, but also a question of how to measure. For social marketing programs like T-MARC which concern sexual behaviors, condom exchanges, and HIV transmission, programs target practices that remain outside the technological field of vision of monitoring and evaluation devices and exacerbate problems of measurement. The causal relationship between social marketing, sexual practice, and HIV prevalence can never be determined with any significant level of confidence for scientific communities espousing evidence-based approaches. Conducting randomized control trials – an agreed upon means of establishing causality within medicine and public health – would be unethical (and unfeasible) in the case of HIV. In regards to condom use, reported use of condoms by individuals often remains a relatively unreliable indicator of use and such data is only collected at offices like T-MARC every several years through KAPB studies.59 Professionals at T-MARC often commented that the only way in which they could assess their efforts in HIV prevention was to evaluate the Tanzanian HIV Indicator Survey estimates of HIV prevalence, a study conducted every four years. Even with this information, T-MARC could only really assess whether or not their programs were having no effect at all. Positive causation was indeterminable. Therefore in the short-term, T-MARC relied on proxy measures to determine the effects of their work where condom sales served as a proxy for use and health outcomes.

Evidence-based approaches in public health traditionally purify evidence from something called politics to the extent that professionals define evidence as an objective reference point for decision-making outside the realm of advocacy, building alliance, or ideological preference. In contrast, science and technology studies points to how scientific practice, the construction of evidence, and the establishment of facts is a social practice and always involves political work such as building alliances (Callon 1986; Latour 1987, 1988, 2001).

59 KAPB stands for knowledge, attitude, practices, and behavior study.
Many public health experts critique the Bush administration for basing their public health policy decisions upon neo-liberal, neo-conservative, or other moral-political ideologies. This observation is most certainly the case. However, I seek to explore how evidence and science—often thought to exist outside the realm of the political or to hold the possibility of purification from the political—is itself political in other multiple senses. My argument is not meant to denounce or discredit the use of evidence within public health, but rather to extend critiques made within public health to the evidence-based movement itself, so as to unsettle some taken-for-granted assumptions within public health about where the political lies. Drawing from literature within studies of science and technology, I seek to illustrate how social marketing produces its very object of intervention, the market, through the practice of measuring, while discarding and making unthinkable alternative possibilities.

**Problematicizing Evidence and Access: Geographic Information Systems and Proximity**

Social marketers and other public health professionals have criticized measurement of sales as a form of monitoring not because of the kind of market retail audit measures construct, but rather because it constructs a disembodied market in relation to the targeted population. The retail audit does not account for the level of access these retail sites create in relation to target populations. In any intervention, research project, or critical orientation, certain things must be held stable, while others are problematized. In the case of evidence in support of social marketing, definitions of the market are held stable and the question of measuring proximity to target audiences comes into question. As such many social marketing programs have shifted their monitoring efforts to a new study called GIS mapping, which takes into consideration point-of-sale outlet’s proximity to targeted consumer populations.

During 2008, T-MARC began adding this new form of surveillance which had already been used by one of their partner AED programs in Nepal as well as internationally by PSI. This new study, referenced by AED as “Mapping Condom Coverage,” by PSI as “Measuring Access and Performance,” or as “GIS mapping,” extends the retail audit study in several ways. The main purpose of what I will call GIS mapping is to measure the “coverage,” “quality of coverage,” “access” to condoms, and “equity of access” among social marketing’s target population. GIS studies estimate these indicators within areas designated as “hot spots” and “hot zones.” A hot spot is a place where sexual activity or sexual negotiation takes place among the defined target audience. A hot spot could include a nightclub, guesthouse, street, bar, etc. A hot zone is a cluster of hot spots in one contained geographic area. For T-MARC hot spots and hot zones consist of areas where sexual negotiation and practices take place for women identifying as sex workers. Coverage is “the proportion of geographically defined residential areas or hot zones in which a minimum standard of product or service

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60 GIS stands for geographic information systems. The GIS mapping studies for social marketing use GIS data to map the degree of coverage and access to condoms for populations defined as ‘most-at-risk’.

61 See Figures 4 and 5. Figure 4 is an example of a map of hot spots in the Kathmandu Valley of Nepal, generated by AED’s social marketing project in Nepal. Figure 5 depicts hot zones in the Kathmandu Valley.
availability is present." Quality of coverage measures a number of other variables including price of product, hours of operation, number of stock-outs, etc. GIS mapping also measures access, defined as “the proportion of the population segment in a geographically defined residential area or hot zone that is within the catchment area of a service delivery point” where a catchment area is the area surrounding a hot spot or hot zone for a hundred meters. Equity of access is defined as “equal access to delivery points of a minimum standard” “among populations with equal levels of need, risk, or demand” (Chapman et. al. 2005; Pant 2007; Patel et. al. 2005)

In contrast to the retail audit which takes each retail outlet as its sampling unit, the GIS mapping study takes geographic areas as the primary sampling unit, reflecting a concern with coverage and access in relation to key populations rather than with sales volumes. However, the GIS mapping study does not call into question one central feature of the retail audit study. Where the retail audit measures the extent to which sales are occurring in and out of formalized auditable retail outlets, not the extent to which products actually reach target populations, the GIS study continues to privilege and normalize the formal auditable retail outlet as the site through which target populations, procure condoms. GIS mapping thus frames social marketing’s markets as exchanges occurring at these sites and consumers as those who uplift products from these sites. The GIS study thus poses the project of social marketing and public health as one of expanding the reach of formalized measurable retail outlets into the residential spaces of most-at-risk populations.

Of course, on many levels this conclusion seems obvious. Social marketing occurs in the name of extending the capacity of private markets to serve public health – but what this market is and who is able to participate in it and benefit from it and in what form is open to question. What happens in the eyes of PEPFAR, PSP-One, and T-MARC through monitoring and evaluation is that the market becomes the set of exchanges that are auditable and licit. Those forms of exchange which may make up the extension of circulation routes through which populations procure public health goods like condoms, such as through Andrew’s business or through licensed or unlicensed street sellers, is framed outside the market that social marketers imagine themselves to intervene upon. Not only does this process result in producing a particular delimitation of exchanges as “the market,” but the relation between HIV prevention and those practices deemed economic comes to be about a particular set of relations. GIS mapping places bottom-of-the-pyramid strategies and the total market approach into better perspective in terms of who T-MARC defines as sellers and private beneficiaries, and who T-MARC defines as consumers, resources for expanding corporate profits and promoting ‘the public good’ or health.

Actualizing the Market in Condoms

Despite the fact that these programs produced a number of exchanges which many individuals in the target population relied on for their livelihoods, these practices remain outside the vision of monitoring and evaluation. This aspect of monitoring devices actualizes a particular kind of market when one considers the long-term pricing and subsidy distribution strategies of T-MARC’s social marketing project described in the last section.

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62 See Figure 6
What happens through subsidy adjustments once retail outlet sales have reached a particular volume is that the subsidy that the end seller or consumer is earning is re-directed to Shelys. As such private interests in social marketing’s market comes to be about maintaining large scale business for Shelys, and health, the public good, is sustained by turning the poor into consumers, not private beneficiaries. Although utilized as unwitting emissaries of bottom-of-the-pyramid ventures, in the long-term small scale sellers are cut from profits. Retail outlet owners with enough capital will maintain product turnover to keep customers for other more profitable sales, but will still lose the long-term profits of social marketing sales.

Three technical devices inform this long-term strategy: the retail audit; GIS mapping; and willingness to pay studies. The retail audit provides information on pricing and demand at the retail outlet point. GIS mapping provides assurance that retail outlets are within residential areas of targeted populations which consist of high-trafficked areas in which commercial sex work is happening. This information is important because social marketing’s long-term strategy is to exploit the retail outlet site; to reduce their margins significantly but to maintain sales through consumer demand. Willingness to pay studies conducted within T-MARC’s public health KAPB studies indicate the price targeted populations are willing to pay for a product as well as the discrepancies between retail outlet prices and end consumer prices. These three pieces of information taken together inform social marketing decisions regarding the distribution of subsidies to supply chain ‘intermediaries’ and to Shelys.

This process speaks to arguments about economic marginality of small sellers and poor populations to capitalist economies in interesting ways. Unlicensed sellers and small retail owners were actually providing the driving force behind the extension of a large scale pharmaceutical industry in condoms. Rather than being marginal to capitalist profits, these small sellers are central to capitalism’s promise and are made marginal through social marketing’s long-term strategic project implemented in the name of health.

VI. Conclusion: A Privatized Public

“One characteristic of the historical sequence unfolding in Africa is the direct link that now exists between, on the one hand, deregulation and the primacy of the market and, on the other, the rise of violence and the creation of private military, paramilitary, or jurisdictional organizations” – Mbembe 78-79

This chapter explores T-MARC’s public-private partnership model and the practical implementation of this model in one neighborhood of Dar es Salaam, Hyena Square. I detail how multiple competing visions of privatizing government condom distribution led to a set of circumstances that undermines social marketing’s goal of equitably increasing health product access and economic benefit among key populations. I show how the sungusungu and social marketers at T-MARC similarly attempt to direct the flow of private benefit in the realm of public health, but they do so through alternative means. Where informal contracts, property rights in a brand name, and methods of monitoring and evaluation enable T-MARC and USAID to maintain control over private accumulation, the sungusungu rely on threat of violence.
While these two approaches on the surface seem to illustrate competing rationalities for creating private benefit in the field of public health, both remained complicit with the other and shared similar logics of privatization. The sungusungu depended on community understandings of government condoms as the priced ‘MSD brand’ to sustain an interest in paying a price for these products. Likewise, social marketers experimented with the idea and even advocated for the unregulated sale of government condoms as an interim strategy to promote condom use, despite the full market impact model’s construction of government services as protecting equity of access. Both parties’ vision of privatization included economically marginalizing the very populations social marketing programs are meant to serve. By dispossessing targeted populations from productive economic activities, these groups contribute to the continued exclusion of these populations from the very means to ensure their own health. At the level of the guesthouse, social marketing did little to subsidize the price of condoms. Rather guesthouses sold one MSD or Salama condom at a similar price point, 100 shillings, despite the intention of social marketing to make MSD condoms freely available and to sell a three pack of Salama condoms for 200 shillings.

Finally, this work builds towards the argument that the total market approach’s or full market impact’s theorization of risk reduction as the creation of consumers within economies of scale entails and necessitates practices of dispossession where becoming a consumer often means losing one’s productive practices. Contemporary imperatives of creating health and creating access to health products and services often legitimize these forms of dispossession.

The total market approach model for social marketing positions the creation of markets and the careful coordination of public and private interests as a project of public health through creating greater access to health prevention products. Social marketing’s strategy is one of generating enough demand and economies of scale to such a point that profits can be re-directed up the distribution hierarchy to corporate partners, a project which provides only short-term economic benefits for those seeking incomes off of social marketing’s bottom-of-the-pyramid promises. The long-term promise of social marketing’s market is that of health outcomes, a promise wherein becoming consumer approximates health. Becoming consumer in this model, given T-MARC’s long-term strategy of subsidy distribution, is often also a movement not only of making purchases, but of having profits or business withdrawn, as is the case with small sellers and retailers. Small sellers and retailers are positioned as marginalized ‘intermediaries’ of Shelys and the end user. Often framed as a project of mobilizing private interests for the benefit of the public good or health, in Tanzania the T-MARC project became a project of utilizing health and the public good to economically re-marginalize small scale sellers and the poor and extract profits from them on a massive scale; the public good became a resource for private gain.

Similar to the sungusungu co-optation of state condom distribution sites in Hyena Square, T-MARC sought to condense and channel the distribution of condoms and the profits made through this project to corporate business partners. Just as sales and access became proxies for health outcomes, social marketers conceived of government as like businesses and businesses as like governments under the total market approach model. In Uwanja wa Fisi, the metaphor of government as business and its citizens as bottom-of-the-pyramid consumers literalized. Rather than diagnosing these events as corruption,
from a normative liberal standpoint, I argue that the events in Hyena Square co-emerged with social marketing’s own configuration of total markets. Where local authorities utilized condom distribution networks to extract payments, T-MARC also hoped to incorporate state condom distribution into their own contractual-based market relations. T-MARC’s total market approach model made assumptions about the state based on liberal theories of public and private while at the same time re-configuring the state metaphorically as a business in a market, with the strategic goal of privatization and corporate level profits. Given that this project was carried out in the name of creating financial sustainability through corporate level profits, how well did social marketing programs contribute to corporate level businesses in Tanzania?
Ch. 6: Private Sector Partners and Public Sector Competitors

I. Introduction:

Social marketing programs re-fabricated understandings of public and private not only at the local level, as Chapter 5 described, but they likewise redrew the relations and borders between foreign governments, the Tanzanian government, NGOs, and commercial sector companies in Tanzania. These changes were driven by USAID’s agenda to create financial sustainability for commercial companies and social marketing programs.

T-MARC’s goal to create a financially sustainable program in social marketing within Tanzania was two-fold. On the one hand, USAID hoped that the T-MARC project would eventually transform into a locally owned and run social marketing organization, at the very latest by the end of the 5-year project. On the other hand, in the long-term USAID hoped that T-MARC would entirely transition the marketing of condoms and contraceptives from the care of social marketers to the commercial sector. In this later case, T-MARC would continue its work as a social marketing office by adopting new products (i.e. vitamin supplements) for social marketing. Within USAID’s sight were the prospects of eventual withdrawal of donor subsidies for health products and continued product distribution thought to be stabilized through market forces, as described in Chapter 5.

While USAID had specific conceptions of what is entailed in “sustainability,” “the market,” and “local ownership,” a number of actors, including corporate level investors, the Tanzanian government, and social marketers themselves, contested these very definitions. Informed by their experiences with USAID-run social marketing programs, these groups questioned the role of the U.S. government in Tanzania and its tendency to subvert local control of public health and economy.

II. Constructions of Sustainability: From Partnership to Market Competition:

i. Partnership

USAID’s emphasis on long-term “sustainability” and “local ownership” reflect broader international efforts to make aid more effective and more empowering for targeted countries. Gaining momentum in 2002, the aid effectiveness movement first held the Monterrey Conference in order to create shared goals and consensus among multi-lateral donors concerning how to improve the long-lasting impact of aid. The movement culminated in the Paris Declaration of 2005 which defined aid effectiveness strategies around five points, three of which are of interest in this chapter: (1.) ownership, defined as allowing developing countries to set their own agendas for tackling poverty; (2.) alignment, defined as donor country utilization of local institutions and support for strategies set forth by recipient countries; and (3.) harmonisation, defined as avoiding duplication in programming.

One of USAID’s and PEPFAR’s primary strategies for implementing these goals was to focus on developing “partnerships” in their donor-funded programs. Over the last
five to ten years, the language of partnership has pervaded the field of economic and health development practice, in north as well as south. Partnership connoted equal relationships between donors and development partners, respect for the sovereignty of recipient countries, and working in collaboration with various programs rather than duplicating efforts.

The discourse of partnership had particular salience in Tanzania, and professionals at T-MARC readily embraced the idea. In the spring of 2008, I participated in an organizational planning meeting at T-MARC offices where the primary focus of the meeting was to establish the mission and values of T-MARC as a locally-owned organization separate from the USAID-funded T-MARC project. Sarah, the AED staff member working at T-MARC offices, ran the meeting. She divided all participants, including communications, marketing, and research professional staff into four groups. Our task was to present a performance on the primary values we saw to be central to T-MARC. Each of the groups that presented performed the exact same message in different ways. Some groups acted out elaborate skits about a woman in a village seeking contraceptives and the multiple partnerships implemented to provide her with the necessary drugs. In a brief two-hour workshop, it became apparent that partnership was the central value for T-MARC employees. Today their mission statement reads,

T-MARC Company’s mission is to successfully contribute to the well-being of all Tanzanians by developing effective and diverse partnerships between multiple players in the commercial, NGO, governmental, and public sectors to implement marketing and communications solutions that address key health, social, and economic challenges.

At T-MARC offices, professional staff drew a distinction between ‘partnership’ and ‘contractual relations.’ T-MARC’s managing director, Elena, spoke of partnership as those relations in which both parties will benefit either financially or through extended reach of programming created through working together. Partnerships involved mutual agreements to work together, rather than an exchange of work and payments as it is utilized in contractual relations. In the case of T-MARC’s public-private partnership, T-MARC and its commercial sector partner would both obtain more widespread reach of product distribution and marketing activities. T-MARC worked with their commercial sector partner’s (Shelys’) distribution infrastructure to extend the reach of social marketing products, and the marketing and distribution of social marketing products promoted Shelys’ other full commercial value products in addition to providing modest financial returns. The partnership relationship also allows for Shelys, with product marketing, development, distribution, and management capabilities, to one day take full ownership of social marketing brands.

In contrast to partnership models, more traditional social marketing programs tend to position commercial sector companies as ‘contractors,’ carrying out distribution work for a fee, rather than as long-term partners who may one day fully take on all aspects of product marketing. PSI’s relationship with Nufaii (their commercial sector distributor) exemplifies a contractual relationship based on Nufaii’s provision of distribution services in exchange for payments with no long-term commitment by PSI to transfer ownership and marketing of products to the commercial company. The dependency of Nufaii on PSI and of social marketing on continual donor funding is the exact issue USAID sought to remedy through the T-MARC project.
Competition

The TMA model constructs sustainability essentially as a question of public-private partnership, essentially as the careful coordination of public and private sectors. As discussed in the previous chapter, the shift in social marketing practice from the NGO model and the manufacturer’s model to the public-private partnership model or TMA is essentially a problematization of sustainability. Where critics argued that the NGO model (contractual model) created too much dependence on donor funds and that the manufacturer’s model (market competition) undermined long-term health product supply and commercial sector profitability in poor countries, the total market approach ideally addresses each of these concerns by finding a middle ground.

Within the TMA model, the commercial piece of sustainability is essentially construed as commercial sector profitability. Profitability enables the commercial sector to assume full control of product marketing and management and it allows social marketers to retract subsidized support for particular product categories. The TMA model constructs profitability, and thus sustainability, as enabled by two processes: 1. Increasing consumer demand for a product so as to create economies of scale; and 2. Competition between multiple commercial sector companies so as to keep prices low and affordable to low-income populations and so as to maintain a variety of brands and pricing points in the market. In this chapter, I am most interested in the later of these two processes and how specifically social marketers and donors managed relationships with commercial companies in order to fulfill this goal.

In order to generate competitive market relations, T-MARC intended to partner with multiple commercial companies rather than just one. The hope is that if multiple companies would eventually take over full responsibilities for competing branded products, then marketing activities, competitive pricing and profit motives in an economy of scale would displace the role of donor subsidization. As such, the TMA model intends for only one social marketing organization to partner with multiple companies and thus multiple brands, rather than to focus on a single brand. Michael, the director of programs at PSI offices in Dar es Salaam, described this new development in social marketing thought as “the time when we killed the brands.” His comments point to how this new era in social marketing brought with it the idea that social marketers were intended to be concerned equally with all commercial brands and state products and have no preference for any one brand.

As described in chapter 5, within total market approaches “the market” for social marketers and donors refers to a particular circumscribed set of exchanges between commercial sector companies, distributors, retailers, and consumers. To summarize, under the TMA “competition” refers to competitive relations among commercial sector companies and their brands, an understanding which marks particular relations as competitive and others as partnerships. Partnerships, in contrast, refer to relationships between donors and social marketers and between donors, social marketers, and private companies. When social marketers interfere in spaces they normatively describe as competitive, that is between commercial sector companies, they see their role to be one of “partnership” whether or not they are directly partnered with particular companies.

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63 Figure 1 illustrates how one of the primary desired outcomes of the full market impact model is ‘sustainability.’
Apart from the dual framing of sustainability as partnership and competition, USAID additionally constructed sustainability as a question of sovereignty over public health interventions and decision-making, in this case understood as “local ownership.” Ownership for USAID referred to the question of who was involved in managing the day-to-day programming of T-MARC (Tanzanians or Americans) as well as under whom the organization was registered. In USAID’s call for proposals for the T-MARC project, they requested that by the end of the five year program that the T-MARC project be “duly registered in Tanzania with Tanzanian nationals having control of the governance and management of the organization.” Given these ideals of sustainability construed as partnership, competition, and local ownership, how well in practice did the sustainability of commercial markets fair?

III. The Bid for the T-MARC Project:

USAID received three bids for the T-MARC project from PSI-Tanzania, the social marketing organization long supported by USAID; the Futures Group, an organization which had worked in private sector solutions to public health problems for many years in Tanzania; and AED, a Washington, D.C. based non-profit organization that had never worked in Tanzania. USAID chose the later of the three organizations to the astonishment of the Tanzanian public health community.

As described in the introduction to the dissertation, PSI was the first social marketing organization in the country in 1993 when Tanzania fully liberalized. Until 2004, they managed to continuously secure funding from USAID and other donors like the Royal Netherlands Embassy (RNE). PSI had worked closely with these donors and the Government of Tanzania to market Salama brand of condoms, SafePlan contraceptive pills, and Care female condom. PSI had been at the forefront of introducing market-based promotion and distribution of health products in Tanzania so much so that many health and economic development professionals working in Tanzania credit PSI-Tanzania with being one of the first organizations (alongside Coke) to develop large scale national commercial sector distribution infrastructures.

USAID made the call for proposals and decided to transition funding from PSI to AED without consulting donor partners and the Tanzanian government. The unilateral and opaque nature of the decision left RNE and the Tanzania government baffled, and these events have left relations between USAID, RNE, and the Tanzanian government in shaky form to this day. Many professionals in the expatriate community working for PSI and RNE as well as Tanzanian government officials attributed USAID’s decision to a premeditated desire to gain more control over social marketing programming in the country, an assessment which seemingly conflicts with USAID’s stated objectives of fostering local ownership and management. These professionals reasoned that USAID’s decision was motivated by recurrent reports of corruption at PSI-Tanzania in addition to PSI’s strong hold in Tanzania through its backing by the Tanzanian government, had led USAID towards unilateral strategies to gain more control over the program. These same professionals asserted that USAID had assumed that PSI-Tanzania would leave the country if USAID funding were not renewed, a purported prophecy which did not transpire.
In addition general suspicions of a broader “hidden agenda” permeated the donor and public health community. One representative from RNE raised questions about USAID’s intentions because the T-MARC project preserved partnerships and hiring spots for an elite class of Tanzanian businesses and individuals who had absolutely no background experience in social marketing or public health. T-MARC’s launch event, what some expatriates qualified as “un-Tanzanian” and similar to “the MTV music awards,” corroborated people’s suspicions of a change in US social marketing policy towards preference for a new elite. By 2007-2008 these critiques had made their way to USAID offices and at a spring 2008 launch event for T-MARC’s family planning radio serial drama, *Mama Ushauri*, T-MARC’s AED staff member, Sarah, commented to me that USAID had been very explicit in outlining that the event should be “Tanzanian in character” and open to all classes of society. The event was held at a local clinic in one targeted community during the afternoon and local dance troops performed songs and dances for the audiences.

USAID did have a broader agenda of privatizing public health. The money allocated for the T-MARC project was part of a USAID global initiative called PSP-One which stands for Private Sector Partnerships – One. This program sought to transform traditional social marketing programs (based on the NGO model) in countries around the world towards commercial led ventures. Essentially the goal of PSP-One was to create sustainable social marketing organizations through the theories of public – private partnerships described in the last section. The extent to which this agenda was ‘hidden’ is unclear. When I asked several Tanzanian staff members at T-MARC about PSP-One, they had no idea what the program was. USAID and PEPFAR representatives declined requests for interviews so further information was unavailable. However, one readily finds information about the program on the internet through the webpages of consultants on the program like D.C-based Abt Associates.

USAID’s agenda – to make social marketing sustainable through private sector models – while occurring in the name of fostering the sustainability and local ownership of social marketing in Tanzania, temporarily undermined the sustainability of the first and primary social marketing organization, PSI-Tanzania. Fortunately for PSI, when they lost USAID’s funding, they reached out to donors in the European community for support, and RNE, the German bank, and the Global Fund stepped in to supply additional funding so that the program could continue.

At the time, USAID’s decision was a heavy blow for PSI-Tanzania not only because of the withdrawal of funding, but also because USAID claimed rights of ownership to the social marketing brands *Salama*, *SafePlan*, and *Care*. Brand ownership was a constant question in the minds of those who collaborated in social marketing projects. Potential owners included foreign donors (i.e., USAID, RNE, KFW), the Tanzanian government (i.e., NACP), social marketing organizations (i.e., PSI), and commercial sector partners (i.e., Shelys).

Although a series of negotiations ensued over the controversy, PSI-Tanzania eventually won rights once PSI presented legal documents filed in the 1990’s to corroborate ownership. In addition the Tanzanian government stepped in to support PSI’s claims to the brand and to mediate the controversy. However, the final negotiations resulted in PSI taking rights to *Salama* condoms, the most profitable of the brands, and
USAID taking rights to Care female condoms and SafePlan contraceptives, seen at the time to be of little value.

Many health professionals working in Tanzania at the time, saw the brand ownership controversy to be representative of USAID’s operating policies more broadly within the country. Where European donors have switched to basket-funding approaches, which collectively pool donor funds and then distribute them through the Tanzanian government, USAID still holds to an older model of donor–recipient relations in which USAID contracts with individual NGOs and circumvents working with the Tanzanian government.

As stated earlier, this new European funded group (PSI, RNE, and the Government of Tanzania) believes that USAID created the T-MARC project in order to gain more control over social marketing, despite USAID’s framing of the project as one of fostering local ownership and sustainability. On learning how the T-MARC project and brand ownership played out over the next several years, particularly in regards to the kinds of relationships established with the corporate level commercial sector in Tanzania, one can understand how this group could make such an accusation. These accusations point to how USAID’s practices provide them with greater power over not only social marketing programming, but as the next section describes, the Tanzanian economy.

The Tanzanian government was well aware of the ways in which US-led projects like T-MARC circumvented traditional Tanzanian state institutions and governed through alternative means, a situation which at times led to dead-end conversations in my research with government officials. When I asked a high level direct of TACAIDS in 2008 about TACAIDS’ relationship with T-MARC he stated,

> We depend on PSI… well indeed it [PSI] would be complementing with T-MARC… but if they [T-MARC] don’t give me information how do I know it?… they report to Washington. (laugh)…

IV. Private Sector Partners, Public Sector Competitors

Due to USAID’s use of competitive RFP’s, the change in funding from PSI to T-MARC, and PSI’s persistence to remain as a social marketing organization in Tanzania, in the first years of the T-MARC project competition fell not as a dynamic between multiple commercial for-profit companies, but rather as a relationship between social marketing organizations. As described earlier, central to the total market approach model is the idea that only one social marketing organization should support multiple brands managed by multiple commercial companies. However, when PSI insisted that its program remain in the country and that it held rights to Salama condoms, T-MARC no longer existed in the ideal TMA or FMI vacuum, and the hope of a single social marketing organization working in Tanzania as a manager of condom privatization became impossible.

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64 RFP stands for request for proposals which is the call for proposals for projects like T-MARC distributed by USAID.
T-MARC also never materialized another commercial sector partner other than Shelys. T-MARC’s marketing manager, Hilda, attributed T-MARC’s failure to enlist other companies as a result of the original USAID / PSI brand ownership controversy. She argued that the time spent on establishing a new brand of products for Shelys from scratch detracted from T-MARC’s efforts to partner with additional companies. Once the brand ownership issue was settled, T-MARC quickly set to work on formative research to determine the images, names, and styles that would constitute their new condom brands.

Another reason for the T-MARC project remaining with just one partner is that by the time T-MARC had established the Dume brand and was ready to investigate other potential partners, Shelys rejected the idea of collaborating with another commercial competitor, even if through social marketing. Shelys had two sister companies under the Sumaria conglomerate, Beta Health and Sabuni, which they preferred for T-MARC to use as additional partners. By this point Shelys held great leverage with T-MARC and USAID. T-MARC’s whole project rested on Shelys’ packaging, warehousing, and distribution capabilities, and so they could not sign on to a new partnership without Shelys’ consent. T-MARC at times considered completely dropping Shelys as a partner, but USAID pressured T-MARC to remain in the partnership.

AED had originally signed on to working with Shelys prior to winning the USAID contract. AED had hoped that a large well-respected and East-African owned company like Shelys would secure the T-MARC contract, and it did. On the other hand T-MARC staff argued that Shelys agreed to the partnership not because of interests in social marketing or in the T-MARC project, but rather because they hoped to gain leverage for winning contracts with USAID’s other projects, particularly care and treatment programs requiring supplies of ARV’s or treatment of malaria requiring ACT’s (artemisinin combination therapy). East African businesses pay close attention to donor agendas and follow donor plans as they search for new business opportunities. In 2004 when PEPFAR committed 70 million dollars for HIV prevention in Tanzania, the following year Shelys opened a new pharmaceutical plant in Dar es Salaam with the hope of eventually manufacturing ARV’s.

Where Shelys’ plans have secured a strong relationship with USAID, their agenda has caused difficulties for the T-MARC project. T-MARC’s marketing manager often attributed the problems occurring among distribution of condoms to the low incentives provided to Shelys to perform well on the social marketing project. To be fair, Shelys did develop some interest in condoms as they started to increase in sales, but they weren’t concerned for creating new distribution infrastructures. Instead they continued to just follow their own infrastructures in pharmaceutical goods, and they weren’t willing to push condom sales at the expense of their own products. One of the biggest contributors to the problem is that Shelys was a poor choice for condom distribution to begin with. Their primary distribution sites are pharmacies, while the primary access point of condoms for many consumers is in fast-moving-consumer goods, such as dukas and kiosks not serviced by Shelys’ distributors. On top of these distribution problems, Shelys’ blocking of multiple partnerships left T-MARC and AED staff struggling to respond to donors who questioned their originally planned intentions for creating multiple partnerships.

Despite Shelys’ attempts to remain as the sole partner to T-MARC and USAID, there were two young Tanzanian entrepreneurs who in 2007 sought to become another...
commercial partner to T-MARC. These two businessmen, Peter and Alex, even proposed a partnership deal to T-MARC without T-MARC needing to approach them.

Peter had worked in the banking industry in Dar es Salaam, and Alex had worked for a number of years for a pharmaceutical distribution company. They were well informed of emerging economic opportunities in the country, closely followed donor agendas, and hoped to benefit from new industries in the health field. As black East Africans, they also held promise for cutting into the racial class divides in Tanzania whereby the majority of large scale distribution and consumer product marketing companies are owned by foreigners and Indian East Africans.

Peter and Alex acquired research on condom markets and profitability in Tanzania, and through Alex’s job as a pharmaceutical distributor, they learned that social marketing programs underserved many parts of Tanzania. In the Iringa region of southern Tanzania where the HIV prevalence rate is at the country’s highest at 14%, Alex’s distributors at his company relayed stories of local businesses that rented used condoms. Such news inspired Peter and Alex to explore extending condom marketing in the region. However, after collecting research on condom businesses and pricing in Tanzania, the two men still saw themselves to be limited financially by two factors. First, in geographic areas well-served by social marketing organizations, they were unable to compete on pricing. Social marketing in Tanzania currently extends donor subsidies to retailers and any new condom brands that are not able to provide profitable incentives to retailers will not be purchased by sellers. 65 As Peter explained,

> What became critical is we couldn’t price it much higher than the *Salama* which is what PSI asks … from the retail perspective as long as you can get *Salama* you probably won’t want your product [Peter’s condom] because you get 40, 50% or 60% return on selling a Salama, and from yours [Peter’s condom] you probably get 10, 20 cause I can’t take that hit… and so that’s where the competition comes in.

Essentially, Peter detailed how PSI was not so much in partnership with business investors in Tanzania, but rather their main competition. This situation was the very issue USAID sought to rectify through the T-MARC project.

The second factor limiting Peter and Alex’s investment was that the price of condoms is intimately tied to the price of petroleum, one of the raw materials used in the manufacturing of condoms in Korean and Chinese factories. As oil prices soared during 2007 – 2008, these fluctuations necessitated that Peter and Alex re-consider marketing strategies such as pricing in relation to procurement costs. They decided to focus on a condom that targeted mid-range classes in Tanzania as opposed to the lower classes targeted by social marketers. They would offer a “premium” brand costing consumers around 350-450 shillings 66 per condom, which would be much lower in price than the high class condom brands that targeted upper-class Tanzanians and tourists at 1,200 shillings or higher. 67

Apart from these two pricing limitations, one of the largest capital barriers for Peter and Alex was marketing costs. In 2007, Peter and Alex heard that T-MARC was offering money to support branded condom marketing efforts for new businesses. They

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65 See chapter 5 for a further discussion.
66 At the time 350-450 shillings was approximately 30-40 US cents.
67 At the time 1,200 shilling was approximately 1 US dollar.
approached T-MARC about gaining financial support for their new condom brand, *Romantix*. At the time T-MARC was offering $100,000 per company for marketing support. After a few talks with T-MARC staff, Peter and Alex became frustrated by the multiple donor-stipulated restrictions on elements like use of distribution companies and hierarchies of approvals which slowed processing times. In relation to the first case, Peter stated that the businesses with the best distribution infrastructures in Tanzania are: Tanzanian Breweries Limited (TBL), a subsidiary of SABBR; Tanzanian cigarette (TCC), a subsidiary of Japan Tobacco International (JTI); Coca-cola; and Mohammed Enterprises Tanzania Limited (METL), one of the largest Tanzanian-owned consumer goods manufacturers and distributors, and the largest exporter in the country. PEPFAR and USAID policies restricted Peter and Alex from partnering with beer or cigarette companies. Coke had consistently remained uninterested in social marketing requests for years, a stance T-MARC’s marketing director and former Coke employee attributed to the company’s desire to maintain their brand image apart from consumer associations with HIV/AIDS, even HIV prevention efforts. METL was the only viable option for the two entrepreneurs. In regards to the second set of donor limitations on funding use, T-MARC estimated that it would take up to six months to have the approvals and marketing funding ready. As such, Peter and Alex concluded that T-MARC wasn’t fully committed to allowing them to run their own business through a private sector model where decision-making is based on efficient processing time and consideration for profit first and foremost. They forecasted that partnering with T-MARC would do more to undermine than promote their ability to sustain a commercial sector company in the long-term.

Not long after approaching T-MARC, Peter and Alex learned that Marie Stopes Tanzania had decided to lease rights to their condom brand, *Raha* and *Lifeguard*. Marie Stopes’ condoms had long been used in their clinics and could be found in some commercial outlets, but fared poorly as a priced condom. Marie Stopes did little to increase commercial condom distribution, especially with PSI and T-MARC addressing the issue. In addition Marie Stopes had recently switched to social marketing of pregnancy test strips, and the majority of their programs in Tanzania addressed patient care in their clinics.

Peter and Alex quickly approached Marie Stopes because if they could avoid launching an entirely new brand of condoms, then they would no longer need to raise capital for marketing support. Peter estimated that successfully launching a new line of condoms in Tanzania could cost as much as $300,000. By leveraging leasing rights to Marie Stopes’ condoms, Peter and Alex would merely require capital to continue developing Marie Stopes’ pre-established marketing and distribution work. On approaching Marie Stopes Peter and Alex learned much to their surprise that their main competitor in the bid to obtain leasing rights to *Raha* and *Lifeguard* condoms was T-MARC. Like the two investors, T-MARC had been interested for some time in locating a mid-range condom brand to complete its total market approach promise to donors and to complement *Dume* which was targeted towards lower income populations.

This competitive bid necessitated that Peter and Alex raise the start-up capital to secure the brand lease and to locate a distributor as co-partner. In regards to the former Alex had worked in the pharmaceutical distribution industry for some years and could utilize his social capital to secure a bank loan. On the later of the challenges, Peter and
Alex were able to make an arrangement for distribution piggy-backing with the CEO of *Mohammed Enterprises Tanzania Limited* (METL). METL has one of the best distribution networks in the country, connecting Dar es Salaam to the very rural and street level infrastructures on a daily basis. In the arrangement made with Peter and Alex, METL had agreed to provide distribution for free for the pair of businessmen. Since condoms were a small consumer item, they filled little space on distribution trucks, and METL’s CEO was a Member of Parliament from Singida region, constantly on the lookout for opportunities to improve his political and business appeal among voting citizens. Peter and Alex now merely needed to secure the contract with Marie Stopes. Peter relayed the results of the competitive bid to me,

> Finally thank God, Marie Stopes decided to go with us, but yeah, we had to struggle to raise the cash cause we had to, to block the thing. But they [T-MARC] had the cash, and again this is donor money competing with our private sector money. Because we had to raise that actually, to acquire what we had to push it forward but they [T-MARC] were actually just sitting on cash. I have no idea why Marie Stopes made the decision they did, but it benefited us. Maybe they did the same analysis [as Peter]: ‘this is a donor organization competing with a private sector organization. We’re much better off doing this with the private sector organization’ cause maybe they went through that same framework of mind, and thought ‘why am I taking money from donor money [PEPFAR] so these guys [T-MARC] can actually go out and compete in the private sector when we have a private sector?’

Peter and Alex won the bid, but as Peter points out, they had to compete with PEPFAR money to do so. No longer was T-MARC just competing with PSI for contractual bids to USAID, another social marketing organization, but they were now also competing with a Tanzanian owned private sector business for leasing rights to brands.

Where Peter argued that T-MARC and PSI competed with his and Alex’s efforts to market condoms, Hilda, T-MARC’s marketing manager, argued that T-MARC treated all companies with condom brands as partners in the total market, not competitors. She saw Peter and Alex to be addressing a neglected sector of society by providing a much needed middle income brand of condom. Hilda even evaluated the investments being made by Peter and Alex as an indication that the T-MARC project was a success. If private investors could see the commercial value of condoms and establish functioning businesses, then she felt that she was doing her job well. In contrast Peter and Alex saw their investment opportunity to stem from the failures of social marketing to adequately address condom availability in the country.

A similar story exists for Mariam, a black Tanzania woman who owns a marketing and distribution company for feminine hygiene products in Dar es Salaam. Mariam’s story resonates with Peter and Alex’s experience, but also points to how social marketing mirrors the competitive relations and disparate access to capital existing between local Tanzanian entrepreneurs and multinational corporations, a set of relations which undermine local businesses and reproduce racialized class boundaries. Mariam first established her feminine hygiene company, Kays Hygiene Products Limited, in 1982 and began production in 1985. She recalled the difficulties in gaining access to credit as a black Tanzanian woman in order to begin her company. In 1982 when Mariam was trying to gain a business license Tanzania was still following Nyerere’s socialist program and so it was difficult to obtain a license for private business. Mariam recalls,
It was not easy at all. It’s not easy even now. Because at that time the local Tanzanians were not allowed to do business because we were just coming out of socialism. We knew we are still there during Nyerere’s time, but we kept on knocking and saying the women were suffering and eventually the government agreed to give us the license to do the business, but we were given a license with many other people…

Although banks tended to discriminate against Tanzanians without collateral, she managed to obtain business loans from the East African Development Bank and a German organization which was interested in investing in female-led industries.

Despite this success, Mariam felt continually sidelined throughout her business career. As one of the first black Tanzanian women to profitably develop and run a local product manufacturing company in the country, she was rightly proud of her successes. However as the Tanzanian economy further opened up to global businesses in the late 1980’s and early 1990’s, she was unable to compete with multinational companies like Johnson and Johnson, Proctor and Gamble, and now Chinese-led companies. Several years back Proctor and Gamble had brought in Always, a brand of feminine pads, subsidized their price to run out local businesses like her own, invested heavily in local advertising, and then later hiked prices once all competitors had been cut from the market share. Mariam was one of the few local businesses that successfully weathered these events.

Another competitive advantage multinationals have over local manufacturers and industries is the difference in raw material versus commodity import tax burdens brought about by structural adjustment policies. Mariam argues,

Our country at the moment, it doesn’t put a lot of emphasis on industry. Trading, we still do trading in Tanzania. You can prosper better than when you do industry... Particularly with sanitary pads. Right now you can import sanitary pads or baby diapers without paying duty. Right? After struggling for the women and that kind of thing, for them to make it cheaper! But if you import raw material to make the products here for which you’re going to give jobs to Tanzanians, you pay almost 50% in total of that plus import duty plus all the other taxes. And so it becomes very difficult. But again you can see we’ve invested so we have to find other ways of surviving and to continue to manufacture.

Mariam had similar experiences with social marketing organizations. She lamented that social marketing programs always chose to partner with multinational firms, even if East African-based, like Shelys Pharmaceutical. Mariam argued that she had better networks in the fast-moving-consumer goods industry through her work with sanitary pads, a separate distribution chain than pharmaceutical ones and one that more adequately matched desired condom distribution channels, but still AED choose to partner with Shelys.

However Mariam’s company had worked with multiple social marketing programs on a contractual basis since 1993 when PSI first established its program in Tanzania. She benefited economically from their business – never in the long term – but the short-term profits enabled her to survive difficult economic times such as when Proctor and Gamble brought Always to the Tanzanian market. She has thus continued to accept social marketing contractual offers. Most of Mariam’s work with social marketers consisted of warehousing and packaging social marketing products, usually condoms, on a contractual basis under the NGO model of social marketing. She worked with PSI for
eleven years since 1993 with the goals of improving social welfare, gaining company experience in marketing, and earning financial returns.

Mariam lamented PSI’s change to “all business” in 2005, the same year that the T-MARC project began, when PSI decided to drop their relationship with Kays and switch to working with Nufaika. For Mariam the terms “all business” pointed to the ways in which the growth of the capitalist economy in Tanzania had eroded previous commitments and loyalties based in shared ancestry and replaced them with relationships based on maximizing economic profitability. Where Mariam expected PSI to remain loyal to her company due to shared economic struggles and social backgrounds between PSI staff and herself, in this case African Tanzanian heritage, she was dismayed to learn that they were willing to place competitive economic edge above these values. In bitter tones Mariam recounted the financial hits that her business took by associating themselves with condoms and PSI in the 1990’s before the massive public health campaigns to de-stigmatize condoms in the country. She realized how T-MARC’s and PSI’s decision to partner with the larger Tanzanian companies left her struggling to maintain her business.

Those are big people. Those Sumaria’s are big people. They have all sorts of businesses. And the social marketing I thought would be left to the local people … because the local people are the ones who are dying. I’m sorry to use. I’m not being a racist, but those people they just don’t get this point. We cleared the way. We removed the stigma. We got all the mud thrown on us. We got all the abuses. And then, suddenly they [social marketers] removed!

Today Mariam no longer works with PSI, but T-MARC and Shelys (whom Mariam references above as Sumaria, the conglomerate of which Shelys is just one subsidiary) contract with Mariam for warehousing space. However Mariam has never been able to position herself as a partner in the way that Shelys has with T-MARC.

Together these two stories illustrate how some commercial sector actors perceive social marketing not as supporting their businesses but as being competitors to their businesses and at times undermining them. In addition, Mariam’s story points to the ways in which social marketing in Tanzania replicates a similar experience occurring among multinational and local commercial competitors in the way that these relations reproduce racialized class boundaries in the business sector.

These practices were not only taking place in the condom market, but were exactly replicated in the market in mosquito nets. In 2008, I interviewed an outraged corporate level investor who had put large sums of money into USAID’s program to create a total market in mosquito nets. For five years he worked to develop a factory to produce nets along with a handful of other Tanzanian investors. USAID promoted a voucher system whereby they gave women and children under five years of age a subsidy to purchase a net. At the end of the five years these vouchers and the widespread distribution of nets had undermined the ability of commercial companies to continue their businesses without the continuation of the voucher system. In addition, USAID devised a new set of competitive terms for the market in mosquito nets by requiring companies to invest in and for voucher purchases to apply to a new quality of net and net treatment processes promoted by the World Health Organization. USAID therefore partnered with only one Tanzanian commercial company who had managed to ready his factory for the new quality procedures. The other businesses were completely handicapped by USAID’s
decision and they were cut from being able to participate in the mosquito net market. The man that I interviewed was in the process of shutting down his factory. Meanwhile, at social marketing conferences in the U.K. that same year, I witnessed the American NGO running the implementation of these total market approaches in mosquito nets speaking of them as successes, usually in terms of numbers of mosquito nets distributed.

A long-time social marketing veteran who has worked on total market approaches for mosquito nets in Tanzania and on various social marketing projects in Africa and Asia, commented on private sector perspectives of social marketing through public-private partnerships,

If you really sit down at a public-private partnership meeting and you go in the back and you listen to people, conversation from the private sector is ‘we’re gonna get screwed, it’s just a matter of time. We’re gonna get f***ed. Can we make enough money in the short-term before these guys screw us. You never trust a donor.’ You know what? They’re absolutely right.

Similar critiques emerged among government actors working at the national level. The Director of Information, Education, and Communications at the National AIDS Control Programme (NACP) argued that the T-MARC project merely re-created the problems already existing with PSI. He saw USAID to be sponsoring the continuation of social marketing at the international level without adequately addressing local social marketing capacity, private sector growth, or a sustainable solution to condom accessibility.

What is behind, what is the main vision of the US government? Is it that T-MARC survives? Or indeed that condoms be accessible to the community? Which is it? … Now, if indeed, if the purpose is to ensure that Tanzanians access condoms, then you can collaborate with them or anybody and support them, the local organization. Yes, because these [T-MARC and PSI] are projects. T-MARC, PSI, these are projects. They have a lifetime. Tomorrow and the day after they will probably go. Or the US government will decide not to fund them. They will collapse. And then the whole system will collapse…You are developing another PSI. Now, why don’t you use the expertise of PSI and develop local companies here. Why do you have to bring another similar PSI? … That’s how they [USAID] operate. I cannot create new modalities. Whom am I? (laugh) Whom am I?

While the sustainability of commercial sector companies seemed continually to be undermined by donor projects, did the sustainability of T-MARC as an independent Tanzanian-owned social marketing NGO endure any better?

V. T-MARC and USAID Today

A sense of vulnerability and uncertainty pervades not only the accounts of commercial sector actors, but also the experiences of professionals working at T-MARC. The most common anxiety shared by professional staff at T-MARC was the question of whether the T-MARC project would continue and thus whether they would have jobs after the five year project time frame. Since 2005 and up to 2008, USAID was the sole

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68 The NACP is under the Ministry of Health and Social Welfare and is charged with managing the health sector’s response to and prevention of HIV/AIDS.
donor for the T-MARC project, and T-MARC staff worried about the long-term viability of the program if T-MARC was not able to diversify its funding sources. However, whenever opportunities for proposals arose through European donors, USAID steered T-MARC away from advancing applications, arguing that they did not want to deal with the issue of “co-mingling of funds.” T-MARC has applied for and won small packages of additional funds from USAID to participate in projects like malaria prevention, but T-MARC professionals worry that the reliance on single-donor funding undermines the long-term sustainability of their project.

T-MARC is a unique case in regards to donor funded projects in Tanzania because it is considered a “project,” “The T-MARC Project,” won and run by AED, but since 2007 it is also considered a “company,” “The T-MARC Company,” registered, owned and run by a board of directors that includes Tanzanian T-MARC staff, Tanzania professionals working outside T-MARC, as well as American professionals working for AED. This ambiguous status puts T-MARC managers in an awkward relation to AED, USAID, and the T-MARC board of directors. In an attempt to ensure the long-term viability of their company and their jobs, they have to navigate tensions between USAID and AED to micro-manage the company and insert their own agendas. These divergent interests become particularly accentuated in the relationship between AED and the new T-MARC company. AED’s reputation with USAID hinges on the success or failure of the T-MARC project in regards to developing and managing products like Dume and obtaining quantified results correlating the T-MARC project with lowered HIV rates in Tanzania. However, although T-MARC shares these goals, the long-term viability of their own company is a much more pressing issue in the short-term. T-MARC staff often lamented that AED professionals pressured them not to work on applications for outside donor funding because it detracted from their work on the already established “T-MARC project.”

Resentment grew among T-MARC staff when AED utilized T-MARC offices, funded by money from the T-MARC project, to house other Tanzanian-based projects won by AED, such as The Point-of-Use Water Disinfection and Zinc Treatment Project (POUZN), and Netmark. T-MARC professionals complained that AED used the T-MARC project as a way to “set up shop” in the country with no consideration for the long-term sustainability of the T-MARC company and local jobs. These feelings were further exacerbated among Tanzanian professionals at T-MARC because many of them had left very reputable jobs in the private sector. The marketing manager, Hilda, had formerly worked for Coke in Nairobi, and the communications director had worked for a well-respected Tanzanian advertising company. These professionals worried that their social marketing skills may not transfer back to the private sector at the end of the 5 years. Staff also sometimes expressed disappointment at leaving their commercial sector jobs, wondering if they would have had more job satisfaction in private work by having more flexibility afforded by the absence of donor stipulations and micro-management of financial opportunities and advertising ideas. In contrast, their AED colleagues held secure US-based jobs which were guaranteed to continue after the five years.

T-MARC’s concerns about the long-term sustainability of the T-MARC company brought into question the issue of brand ownership. In 2007-2008 USAID still owned the rights to T-MARC managed brands like Dume, and it was uncertain as to whether USAID would release the brand at the end of the 5 years and to whom. Dume was
generating enough revenue by that point for the product to be of interest to Shelys, so both Shelys and T-MARC had stakes in and hoped to make claims to the brand. This issue further heightened anxieties among T-MARC staff. If they were unable to maintain rights to the brand, they reasoned that they would have no resources of their own to leverage in order to win donor funds outside of USAID.

Reflecting these insights back to the Marie Stopes brand leasing story, commercial sector actors like Peter and Alex saw T-MARC to be competing with private sector, while T-MARC was struggling to maintain its image to donors as a successful implementer of total market approaches which necessitated securing multiple commercial brands apart from just Dume. Unable to maintain Peter and Adam as commercial partners due to the various donor limitations on funds and timing, and failing to convince Shelys to work outside of any sub-company under the Sumaria conglomerate, T-MARC was left to scramble for the Marie Stopes brand on their own hoping that two brands and multiple company partners (even if all under the Sumaria conglomerate) would reflect success to USAID and other potential donors. One of their primary concerns was not just the sustainability of the market in condoms but the sustainability of social marketing and its place in that market.
Chapter 7: Conclusion

This ethnography contributes to the question of how conceptions of “the economic” – “the market,” public / private distinctions, and forms of economic reasoning – matter for public health and not just in the ways that medical anthropology has traditionally formulated this argument. Structural critiques of health inequalities illustrate how public health theories of disease rooted in individual behavioral therapies fail to account for the underlying economic causes of disease (Farmer 2001; Kim et al 2002). Essentially, the idea is that these behavioral theories misrecognize economic causations of disease as “cultural” or individual problems. These accounts critique the privatization of health care and public health by detailing the inequalities generated by private property. In contrast, this dissertation examines the market-based theories which promote ways of addressing these very problems of inequality. I argue that rather than just operating ideologically or incorrectly representing economic and health processes, these social marketing theories have tangible productive effects on the economic and biological lives of citizens. My account demonstrates that preventing HIV is not just a question of whether to create public or private forms of access to health goods, but necessitates scrutinizing the effects of how we conceive of public and private, the market, the social, and human reason. In other words, the very theories of human reason, public and private relations, and the market which buttress social marketing programs participate in creating economic relations and health and disease in specific ways.

The specific goal of the total market approach model and the PSP-One program is to transition state-run condom distribution programs into the hands of commercial businesses as much as is possible without sacrificing equity of access. USAID and T-MARC base these objectives on free market discourses claiming that competitive market processes and economies of scale can themselves subsidize products for the poor rather than the state. These ideas are tempered by the recognition that establishing a “socialist market” requires, in the ideal, short-term interventions in economic processes and possibly long-term state subsidization for a very small portion of the population. Ironically, USAID’s and T-MARC’s interventions in Tanzania resulted not in the contraction of state intervention in the economy, and not in heightened competitive relations between commercial sector companies, but rather in a heavy U.S. presence in the economy and in competitive relations between social marketing programs and the very commercial companies they were intended to support. This outcome undermined the possibility of long-term financial sustainability for commercially-run social marketing programs. Despite the competitive relations existing between social marketers and corporate companies, the construction of T-MARC under the total market approach model, as being a “disinterested player” and a partner to every commercial company (whether T-MARC is directly partnered with their condom brands or not) serves to legitimize social marketing’s and USAID’s intervention in private realms despite free market ideologies which advocate otherwise.

While USAID advocated for “local ownership” of development programming, they understood ownership in terms of under whom the organization was registered and managed, not under whom the brand was registered. This construction of ownership occurred despite the fact that the brand was the primary asset of the social marketing
project. Whoever owns the brand maintains control over social marketing and considerable influence over interventions in the Tanzanian economy. We can see a kind of political battle occurring between the Tanzanian government on the one hand, and its intermediaries of PSI, and the United States government on the other hand and its intermediaries of T-MARC. Both attempted to create a monopoly status for the brands that they owned in the public health market.

The strategies used to create monopolies in health product markets made USAID an unique economic actor. They acted like both seller and consumer. They provided the capital needed for either social marketing NGOs or corporate investors to begin marketing and selling a health product. Most importantly, they maintained private ownership rights over brand names. However, USAID or their social marketing intermediaries often purchased the condoms, which USAID held brand rights to, from their own commercial partners and distributed these condoms for free at community events and at small grassroots NGOs who ran educational campaigns for HIV prevention, including USAID-funded programs like Ishi, mentioned in Chapter 3. Such was also the case in social marketing programs for malaria prevention. USAID programs distributed vouchers so that women and children could purchase the mosquito nets which USAID funded corporate investors to produce. In this way, USAID was as much a buyer as a seller, but certainly professionals at USAID nor social marketers themselves ever perceived themselves as consumers.

What does this mean, for an actor to be both a seller and a consumer in a market? Such a position is a key means of maintaining power in a post-globalized world, where the organization of life increasingly occurs through the market and territorial borders no longer mark the boundaries of sovereignty. It is the flip side of the sungisungu monopolization of the market in condoms through force described in Chapter 5. Despite these practices which served as a key mode of U.S. power in Tanzania, the imperative of health keeps our focus on the humanitarian script of generosity and the emergency status of the HIV epidemic (“President’s Emergency Plan for AIDS Relief”), making contestation of such interventions difficult.

One element of the dispossession of opportunity for local and corporate level commercial actors in Tanzania which is not thoroughly detailed in my ethnographic research is the extent to which these practices are tied to broader economies. Although implied by the stories told in Chapter 6, social marketing, as a practice which undermines Tanzanian investors’ abilities to compete in regional markets, exists alongside broader efforts to expand multinational presence in the country from afar, including pharmaceutical investments. How exactly Tanzanian corporate investors are tied to and cut off from these markets is of significance for understanding the effects of and influence of U.S. power in the region.

In Chapter 5, I concluded that instead of the sum of private interests leading to public gains, the “public good” became a resource for pursuit of private gain. Chapter 6 extends that argument illustrating that the “public good” is another proxy for U.S. influence in foreign economies. The brand itself is reconfigured in this social marketing process. The brand becomes not only a resource for private gain, a referent of desire, a medium of human reason, a measure of value, a promoter of health, but in being all of these things in the social marketing context, the brand also has the ability to create or undermine whole markets. The brand is a means of exercising political and economic
influence, just as arbitrarily as the sungusungu, in a post-globalized world. Through such processes, the outcome of social marketing programs was not just the contraction of economic opportunities for small sellers as described in Chapter 5, but the complete stripping of economic opportunities for Tanzanian corporate investors in health markets and the monopolization of those markets by foreign government agencies, primarily USAID, as described in Chapter 6.

As Chapters 2 and 4 describe, T-MARC and USAID implement these programs not through structural adjustment policies, nor by force, but through carefully plotted interventions intended to influence how everyday people understand, imagine, and act upon their most intimate and cherished desires in life. The brand as a rubric of value provided a standard for people to measure their desires in relation to the outcomes hoped for by social marketing projects. In other words, T-MARC created social marketing brands as a way for people to compare the equivalence of behaviors promoting health and allegiance to political-economic orders with peoples’ purported innate desires and ideal selves (Chapter 4). This project necessitated that T-MARC re-qualify the market itself as an arena for achieving health, fair governance, and equity in contrast to socialist informed understandings of the market as a corruptor of human welfare.

In Tanzania, these interventions call into question how people understand economic exchanges as moral relations. The social and moral aspects of exchange recognized by social marketing theory (Chapter 2) entail reductive notions of “the social” as varied perspectives on pleasures and identity, essentially as a market of desires. By qualifying products according to “cultural” values and personifying brands as persons, social marketing attempted to create a kind of moral relationship between products and persons (Chapter 4). In Zanzibar, these practices raise ethical questions for Muslim followers who understood the market as a moral relation among persons, not persons and things. Specifically, they worried about how market exchanges in health goods may not provision people with adequate information about the risks of product use, or in other words, they were concerned about how social marketing may overlook concern for the general welfare in its obsession with mediating pleasure as a way to create health and profitable markets (Chapter 3).

Finally, these accounts demonstrate that it is not just social marketing theories of and interventions in the market of condoms that have effects for economy and health in Tanzania, but also the multiple ways in which individuals in Tanzania critique and politicize social marketing’s definition of the market. Their contestations about who can participate in and benefit from “the market” actually “open” markets through unanticipated “doublings” (Chapter 3) where governments and informal sellers become primary participants in social marketing markets (Chapter 5). Interestingly, corporate CEOs turned USAID’s free market discourse back on them, as a way of demonstrating the extent of U.S. government intervention in the Tanzanian economy which cripples local private sector investors (Chapter 6).

I hope these stories have illustrated how measuring health – that is, prescriptions for individuals to weigh decisions about health, professional evaluation of public health in economic terms, and the definition of health markets themselves – is not only a technical act with unequivocal universal application but is a political and ethical question that calls for scrutiny and reflection and that has consequences for health itself.
Figures

Figure 1: “Full Market Impact™”
Figure 2: “Usual Situation: Inefficient Market Coverage”
Figure 3: “Full Market Impact through PPP”
Figure 4: “Hotspots in the Kathmandu Valley”
Figure 5: “Selected HIV Risk Zones”
Figure 6: “Coverage”
Bibliography:


Pant PD. 2007. GIS for Strategic Planning: Coverage, Quality of Coverage and Access to Condoms Among Women Working in HIV Risk Zone in Nepal (A study for AED), Mitra Samaj


--- 2006. Prahalad’s response letter to Karnani’s Mirage at the Bottom of the Pyramid.


--- 1999.


TACAIDS. 2010. UNGASS reporting for 2010 (Tanzania Mainland and Zanzibar)


USAID 2004. Statement of Work / Call for Proposals for the T-MARC Project.


