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‘Low-hanging fruit’: Counting and accounting for children in PEPFAR-funded HIV/AIDS programmes in South Africa

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Abstract

The article traces the social life of a policy that aimed to define and circumscribe the ambiguous and contested category of the ‘orphaned and vulnerable children’ (OVC) in South Africa at the height of the ‘emergency response’ to HIV/AIDS. Drawing on several months of institutional ethnographic research conducted over the course of five years with South African organisations receiving funding from the US President’s Emergency Plan for AIDS Relief to provide services to ‘OVC’, the project interrogates the influence of governmental forms of counting and accounting on health policy and practice in South Africa. Focusing on the experiences of one organisation, the article describes a process of policy ‘translation’ typified by a series of disconnects between the intentions of a policy and the exigencies of implementation, structured by the ambiguous and flexible nature of the category of the ‘orphaned and vulnerable child’. In this context, the article argues, the uncertainty produced by the implementation of the guidelines was not simply an artifact of a poorly designed policy, but rather signals an underlying epistemological tension in the practice of ‘global health’, in which quantitative metrics designed for monitoring and evaluation are often incapable of approximating the complexities of everyday life.

Keywords

HIV/AIDS; orphanhood; vulnerability; PEPFAR; global health; measurement

In 2008, five years after the passage of legislation authorising the President’s Emergency Plan for AIDS Relief (PEPFAR), President George W. Bush hosted an event at the Smithsonian National Museum of African Art to highlight the important effects of the initiative. ‘This work of health and redemption’, he proclaimed in his introductory speech, ‘is both a matter of conscience and a wise exercise of American influence’ (Wolfe, 2008). In a film produced for the occasion, President Bush narrated, ‘This is really a story of the human spirit, one of the great untold stories of our time’ (US President’s Emergency Plan for AIDS Relief, 2008). In the film, impact numbers were set to dramatic music and combined with images of African children, poor neighbourhoods, and US-funded HIV clinics: 1.73 million people treated, two billion condoms distributed, 33 million voluntary counselling and testing sessions completed, 2.7 million orphans and vulnerable children ‘cared for’ (US President’s Emergency Plan for AIDS Relief, 2008).

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Such outcome statistics were celebrated as a sign of PEPFAR's significance and success. With other impact numbers for treatment, prevention, and care, the statistics became important tools for policy-makers and advocates in debates around the reauthorisation of the legislation, and were cited as a justification for increased funding for PEPFAR in its second five years. In introducing the legislation, the chairman of the House Committee on Foreign Affairs commented, 'Every dollar saves lives. I don't know of any other legislation that is this direct' (House Committee on Foreign Affairs, 2007). 'PEPFAR has succeeded', a *Wall Street Journal* editorial claimed, 'precisely because it is the one foreign-aid program that channels money toward specific targets. The statistics are astounding: Since 2004, the program has provided counseling and testing for more than 33 million people, and administered care to nearly seven million, including more than 2.7 million children and orphans' (Editorial Staff, 2008, p. A10).

Nearly five years later, on 1 December 2012, World AIDS Day, the US Secretary of State Hillary Clinton officially released a new report entitled PEPFAR Blueprint: Creating an AIDS-Free Generation. The report opens with the following description:

'What a difference a decade makes. Ten years ago, AIDS was wiping out a generation of individuals and reversing important health and development gains being made in Africa. [...] AIDS threatened the very foundations of societies. It took people in the prime of their lives when they should have been caring for their families. It created millions of orphans, unable to attend school without the support provided by their parents' (US Department of State, 2012, p. 2).

By 2012, the report contrasts, citing 2012 programme outcome statistics, AIDS was no longer a certain death sentence and important steps had been made in prevention and control. 'These results are not just numbers', the report went on:

'They represent lives saved and infections averted—and that is the true test of success. For PEPFAR, it is all about results. By adopting a targeted approach to address one of the most complex global health issues in modern history, and by then taking it to scale with urgency and commitment, the U.S. has helped demonstrate what is possible with focus, resources and science' (US Department of State, 2012, p. 2).

On the occasion of the tenth anniversary of PEPFAR, this article explores the multiple impacts of the programme through an in-depth examination of the effects of the implementation of one set of PEPFAR guidelines in South Africa. While the majority of research and media attention on PEPFAR, and on 'HIV scale-up' more broadly, has focused on prevention and treatment programmes, my research has centred on programmes for 'orphans and vulnerable children' (OVC)—the smallest and, in many respects, least controversial of PEPFAR's programmatic initiatives. By tracing the effects of OVC policies and programmes, the aim of the project has been to highlight how frameworks and models of intervention drawn from the world of public health have increasingly been inscribed onto what would generally be considered 'social' concerns—the raising of children, the functioning of families, and the structure of social relations.

Rather than interrogating the effects of these technologies on young people and families, a concern I take up elsewhere, I take the entry of PEPFAR guidelines as a site for examining how the creation and implementation of such categories is shaped by negotiations between forms of knowledge, expert discourses, and local, national, and international politics. More specifically, the article is concerned with the production and management of epistemological uncertainty surrounding the deployment of enumerative technologies required to produce metrics of PEPFAR programme 'success'. Focusing on the experiences of staff at one PEPFAR-funded organisation in South Africa, I describe a process of policy 'translation' typified by a series of disconnects between the intentions of a policy, designed to satisfy the requirements of a system of assistance dependent on the production of evidence and accountability, and the exigencies of implementation, structured by the complex dynamics of local relations and lived experience and which come together in the ambiguous and flexible nature of the category of the 'orphaned and vulnerable child'.

Through this analysis, I show how the uncertainty produced by PEPFAR OVC guidelines was not simply an artefact of a poorly designed policy, but rather signalled an underlying epistemological tension in the practice of 'global health', in which quantitative metrics designed for monitoring and evaluation are often incapable of approximating the complexities of everyday life. This challenge was readily acknowledged by policy-makers, who highlighted the need to maintain a clear distinction between so-called 'operational' and 'programmatic' definitions and encouraged programme implementers to 'be flexible' or 'use their common sense' to deal with the incommensurability of such categories. Nonetheless, the contradictions between the sedimented notions of such categories spelled out in policy and the flexibility encouraged by programme officers created powerful uncertainties and fears for those who were dependent on the beneficence of strangers to secure their own livelihoods and provide care for children in need. In this context, measures of programme 'success' did not in fact stand simply for effective programming, but rather signalled the ability of actors to negotiate deeply contradictory mandates and fraught relationship across multiple levels of authority.

PEPFAR and technologies of global health

In 2003, one week before the declaration of war against Iraq, President George W. Bush made a pledge in his State of the Union address to commit US\$15 billion over five years to the US President's Emergency Plan for AIDS Relief (PEPFAR), a new initiative in the global fight against HIV/AIDS (Bush, 2003). Further, he pledged that by the end of 2008, PEPFAR-funded programmes would have supported treatment for two million people living with HIV/AIDS; prevented seven million new HIV infections; and supported care for ten million people infected with and affected by the disease, including two million 'orphans and vulnerable children'. On 27 May 2003, the US Congress passed the US Leadership against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 with strong bipartisan support, authorising the requested \$15 billion for global AIDS programmes and establishing the new Office of the Global AIDS Coordinator (OGAC) to oversee the plan. In 2005, Congress passed an additional law, the Assistance for Orphans and Other Vulnerable Children in Developing Countries Act, which called for increased attention and funding for programmes for 'orphans and vulnerable children affected by HIV/AIDS', mandating that at least 10% of

PEPFAR funds be disbursed to OVC programmes, and created an additional set of oversight and reporting requirements for these programmes.

As the flagship programme of President George W. Bush's 'compassionate conservatism' agenda,¹ PEPFAR was significant not only for its immense monetary commitment, but also for its targeted and strictly regulated approach. The PEPFAR legislation mandated specific funding and outcome targets for different elements of the programme, enshrining President Bush's pledge into law, and required the submission of annual reports to Congress to document progress toward these goals. To reach these goals and document impacts across programmes implemented by thousands of partners and sub-partners across many countries, strict monitoring and evaluation became a central component of the PEPFAR approach. By mandating quantitative funding and outcome targets for specific categories of individuals perceived to be in need of intervention, the legislation mobilised a series of estimations and assumptions regarding the number of individuals in specific target groups in need of intervention and necessitated the production of definitions of each of these categories, a point I take up below.

Because of its regulated approach and focus on results, as the second director of the programme recalled in a 2009 article entitled 'How to Save Lives by Breaking all the Rules', PEPFAR was seen as a fundamentally different kind of development initiative. 'The idea', he described, 'was to favour personal and national responsibility, rethinking the traditional roles of "donor" and "recipient"' (Dybul, 2009). To this end, he went on:

'Bush called for local problems to be solved by local governments and people; for good governance and an end to corruption; for accountability that focused on results rather than how much money was committed; for people from every sector of society— government and nongovernment alike—to contribute to the effort; and for an emphasis on trade and economic best practices as the ultimate engine of sustainable growth' (Dybul, 2009).

Through its massive financial investment—the 'largest commitment ever by any nation for an international health initiative dedicated to a single disease' (White House Press Office, 2007)—and its strictly regulated approach, PEPFAR has played a major role in shaping an expanding form of development and philanthropic aid structured around global public health initiatives (Oomman, Bernstein, & Rosenzweig, 2007). In the new approach to 'global health', health programmes and development funds have shifted toward the free market, and into the control of donor nations and private industries, thus creating a series of 'vertical', technical interventions framed by, as Brown describes, 'the new international political economy structured around neoliberal approaches to economics, trade, and politics' (Brown, Cueto, & Fee, 2006, p. 68).

¹ 'Despite charges of simplistic militarism', *Washington Post* columnist Mike Gerson wrote in 2008, 'the Bush Doctrine actually includes three elements: the pre-emption of emerging threats, the encouragement of responsible self-government, and the promotion of development and health as alternatives to despair and bitterness' (Gerson, 2008). 'Government cannot solve every problem', President Bush explained in a 2002 speech, 'but it can encourage people and communities to help themselves and to help one another. It is compassionate to actively help our fellow citizens in need. It is conservative to insist on responsibility and on results' (Bush, 2002). The same principles of compassion and conservatism applied, he stated, when the US offered assistance to developing nations.

In this new approach, as many have argued, forms of surveillance and control have shifted from the state's regulation of individual bodies and populations to globalised forms of sovereignty mediated through biomedical technologies (Biehl, 2004; King, 2002; Nguyen, 2005; Redfield, 2012). Funding agencies, donors, and public-private partnerships declare a need to intervene and set strict conditions for their assistance and support, compelling recipients to comply in order to access support. Citizenship is thus reconfigured in biological terms, and distributed through complex relations between donors, states, and non-governmental organisations (NGOs).

Through their particular focus on children impacted by one disease, PEPFAR OVC policies and programmes can be seen to represent the apex of this expanding biopolitical imaginary. This discursive terrain can be framed in reference to the work of medical anthropologists who have espoused ideas about health, biological, or therapeutic citizenship to understand the increasing medicalisation of individuals' lives and the ways in which they adapt (Biehl, 2004, 2007; Lakoff, 2005; Nguyen, 2005; Petryna, 2002; Robins, 2004; Rose, 2005). Like the radiation exposure in Adriana Petryna's work, the OVC category cannot easily be defined by, nor reduced to, a definitive biomedical dichotomy but is still placed in a biomedically-oriented classificatory system framed around a single disease. Because of this ambiguity, individuals (policy-makers, NGO officers, and families) negotiate their own uses of the category. For the child affected by HIV/AIDS, however, it is hard to imagine that the market-based modes of biological citizenship described in the work of others could operate. Children, when they are discussed at all in this literature, are seen as something other than a patient-citizen or an advocate. They are painted as the victim, the recipient of support, or the surrogate for someone else's claims to biological citizenship. Thus, to complicate the biological citizenship literature, the larger project from which this paper is drawn has attempted to explore the dynamics of citizenship for young people classified as 'OVC' and to explore more seriously other forms of belonging that hold great importance in the lives of these children. This article, however, is not focused on interrogating the effects of these technologies on programme recipients. Instead, the article examines their effects on the 'middle figures', to use Nancy Hunt's term (1999), who are forced to negotiate divergent forms of knowledge; local, national, and international politics; and complex everyday encounters in the implementation of public health policies and programmes.

Documenting the 'local' lives of a policy

The research was initially organised around the implementation of the 2006 US PEPFAR guidelines for programmes for 'OVC' in South Africa. The project has taken the entry of the guidelines as a site for examining the effects of policy and programmatic definitions of vulnerable children on governmental techniques, NGO practices, and the experiences of children and families in rural South Africa. Drawing from this frame, I structured my project around two guiding questions. The first sought to comprehend how definitions of the OVC category and understandings of child vulnerability move through donor and policy domains and through implementing organisations to service provision in local communities, and then how they penetrate individuals' lives. The second has explored forms of vulnerability and structures of care for children in rural KwaZulu-Natal in order to identify points of

divergence between programmatic approaches and paradigms of policy-makers and programme implementers and the experiences of children and families.

Following these guiding questions, the project was framed around two distinct, though overlapping, methodological approaches or phases: a multi-site, institutional ethnography of PEPFAR-funded care programmes in South Africa and an in-depth study of the experiences of 20 young people and families in one area of northern KwaZulu-Natal, chosen based on their reported membership in this category of vulnerability. The research did not simply proceed from one phase to the other, however, but rather moved back and forth between them. To study such processes of power and governance, Michel Foucault suggests, we must not begin at the centre looking for homogeneous domination, but rather look towards power's extremities, its capillaries (Foucault, 1975, p. 30). Thus, while the temporal unfolding of the project necessarily proceeded from policy-makers to children, I attempted to complicate this temporality by moving back and forth between spaces in each phase. In the end, the looping and folding between these 'sites' become in itself a central focus of the research. This paper draws primarily on material from the first of these methodological approaches.

The institutional research drew primarily on techniques of archival research, discourse analysis, participant observation, and key informant interviews. First, to understand the formation of categories of vulnerability and eligibility in global health programmes oriented around children affected by HIV, I reviewed US government documents, including transcripts of congressional hearings and PEPFAR programme documents, and tracked media representations of PEPFAR and of OVC programmes over several years. Second, to explore the ways in which PEPFAR policies were translated, adapted, and co-opted in South Africa, I conducted several months of institutional ethnographic research between 2006 and 2010 with PEPFAR-funded OVC programmes in South Africa, the country with the highest number of HIV-infected individuals and 'AIDS orphans' in the world (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2011; United Nations Children's Fund [UNICEF], 2010) and the largest recipient of PEPFAR funds (PEPFAR, 2012). I conducted interviews with staff members at all levels of the PEPFAR structure of implementation within South Africa (policy-makers, programme directors, and local implementers) and extensive documentary record of e-mail communications, meeting minutes, and inter-organisational memos involved in the development and dissemination of PEPFAR guidelines.

One South African NGO providing services for children affected by HIV/AIDS, whom I call Orphan Care, served as the focal point of this institutional research. I interviewed staff at head offices in Durban and Johannesburg, pored over the organisation's records and informational materials, travelled with area managers to visit project sites in rural KwaZulu-Natal, and spent time with project staff at local programme sites. In all of these settings, I was given free access to talk to staff, attend meetings, sit in on daily activities, and study reports, correspondence, child monitoring forms, and data collected for reporting purposes. Through these diverse sources, I have been able to piece together a detailed account of the organisation's experience with PEPFAR.

When I began the research, Orphan Care was generally considered one of PEPFAR's 'poster child NGOs', as one staff member put it. By the end of 2007, however, the organisation appeared to have fallen entirely out of the favour of PEPFAR programme officers and seemed to be at risk of losing their PEPFAR funding. Staff at the organisation traced this shift to the vocal concerns they had raised about the new PEPFAR guidelines and their active role in the debates that ensued. Thus, the organisation offers an interesting study of the complex effects of policy for organisations charged with implementing programmes in South Africa and of the sometimes fraught relationships between global health policy-makers and programme officers and those who must implement programmes and policies in locality.

Categorising the 'children of AIDS'

Despite the focus on numerical targets, neither the Leadership Act nor the Assistance for OVC Act defined the term 'orphans and vulnerable children' or set specific programming requirements for OVC programmes. The 2006 Orphans and Other Vulnerable Children Programming Guidance represented the programme's first attempt to formalise its use of the 'OVC' term. The new guidelines explicitly restricted the use of the term in programmes supported by PEPFAR funds, defining an 'OVC' as 'a child, 0–17 years old, who is either orphaned or made more vulnerable *because of HIV/AIDS*' (Office of the Global AIDS Coordinator [OGAC], 2006), p. 2. The language of the *Guidance* thus excluded as beneficiaries other children living in high HIV prevalence areas, stating in several places that funds could not be given to any programme 'not directly supporting HIV/AIDS-affected OVCs' or to any child who did not fit the definition (OGAC, 2006, p. 19).

The restrictive focus was in direct contradiction with dominant international opinion and research on the subject at the time. The 2004 Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS, a document authored by UNICEF, UNAIDS, and the United States Agency for International Development (USAID), stated clearly that 'programmes should not single out children orphaned by HIV/AIDS' as 'targeting specific categories of children can lead to increased stigmatization, discrimination and harm to those children while, at the same, denying support to other children in the community whose needs may be profound' (UNICEF, UNAIDS, & USAID, 2004, p. 28). Further, a large body of quantitative and qualitative evidence published before the release of the guidelines offered contradictory results as to whether this category of children constituted a high-risk population that should be targeted for particular interventions.²

²Studies had not been able to clearly show whether orphans in fact suffered higher rates of morbidity and mortality than non-orphaned children living in the same communities. Similarly, studies published before the release of the *Guidance* that attempted to assess the effects of orphanhood on factors such as relative socio-economic situation or educational outcomes (e.g. Ainsworth & Filmer, 2002; Case, 2004; Foster & Williamson, 2000; Monasch, 2007) had not shown conclusive results. The most conclusive evidence of increased vulnerability of orphaned children could be drawn from psychological studies, in which orphans have been shown to have higher levels of psychosocial distress than non-orphans (Atwine, Cantor-Graae, & Bajunirwe, 2005; Cluver & Gardner, 2007; Cluver, Gardner, & Operario, 2007). Similarly, much work in the social sciences has questioned the assumptions made about the special vulnerability of orphans of AIDS and those made vulnerable because of the illness of their parents and has identified a vast overlap between the difficult experiences of orphans and the large numbers of other poor children in communities affected by HIV (e.g. Bray, 2004; Henderson, 2006; Meintjes & Bray, 2005; Meintjes & Giese, 2006).

Despite its bounded definition of the OVC category, the *Guidance* itself also openly acknowledged the limitations of the definition it used, providing the following clarification:

‘The above operational definition identifies those who are potentially eligible for PEPFAR supported services, but does not identify those most in need of services. For programmatic decisions, each community will need to prioritize those children most vulnerable and in need of further care’ (OGAC, 2006, p. 4).

The tension between the need for a clearly quantifiable indicator to measure the number of children served with PEPFAR funds and the practicalities of effective programme implementation was clearly of major concern from the early years of PEPFAR. A 2004 USAID report, for example, described how the terms ‘orphan’ and ‘vulnerable children’ could take on different meanings when developed for the purpose of gathering and presenting quantitative data (an ‘operational’ definition) or for the purpose of designing and implementing policies and programmes (a ‘programmatic’ definition). It was essential, the report suggested, to establish a ‘firewall’ between these two kinds of definitions:

‘Problems occur in the field when definitions established for quantitative purposes are picked up and used for program targeting or eligibility criteria in policy and program implementation. The quantitative process must have clear boundaries and allow for absolute distinctions. In contrast, developing and implementing policies have to take into account local variations in what factors cause or constitute vulnerability. In the latter case, no one prescriptive notion will suffice for every occasion’ (Williamson, Cox, & Johnston, 2004, p. 1).

The ambiguity introduced by the distinction between operational definitions and the necessities of programmatic decision-making became a central component in the debates and disagreements the guidelines inspired as they were disseminated to local organisations in South Africa. Further, the tension between these concepts underscores exactly the epistemological challenge the paper attempts to elucidate. By establishing a ‘firewall’ between these two fundamentally different kinds of definitions but expecting individuals in the field to be able to negotiate both of them in their everyday experiences, policy-makers forced NGO staff to find ways of reconciling these seemingly irreconcilable imperatives.

Resistance and accommodation: The implementation of PEPFAR OVC policy in South Africa

As I walked off the plane in Durban, South Africa in 2006 and entered the international arrivals terminal, I was greeted by an enormous lighted sign advertising the services of a South African company specialising in the creation of data management systems for HIV/AIDS programmes. The sign highlighted in bold, red letters that the company’s software was designed to generate reports specifically tailored to PEPFAR reporting requirements. The presence of this lighted billboard was an immediate and powerful signal of the expanding importance of HIV/AIDS programmes, international donors, and the ‘audit cultures’ (Strathern, 2000) they bring with them in this landscape. Since the early 2000s, when I began to conduct research on HIV/AIDS in South Africa, the humanitarian concern, media attention, and donor funding the epidemic generated had increased by several orders

of magnitude. As a result of this expanding concern, from the early 2000s, many existing South African organisations began to shift their programming to focus on HIV/AIDS and numerous new organisations were formed, particularly after the arrival of funds from PEPFAR in 2004. From a list of a few hundred organisations when it was founded in 2003, by 2012, the Centre for HIV/AIDS Networking's directory of HIV/AIDS organisations in South Africa listed more than 12,000 organisations that provided HIV-related health and social welfare services.

Orphan Care was one of these vast numbers of new organisations founded in the early 2000s to address the effects of the rapidly expanding epidemic. The goal of Orphan Care was to 'franchise', as the organisation's advertising materials termed it, a community-based model of care for orphans that could be implemented sustainably throughout the country. Since it began offering services to children in early 2003, the organisation had garnered increasing support and had started to expand, growing from 12 centres in 2003 to more than 100 sites across KwaZulu-Natal and Gauteng by 2006. Staff members at other organisations labelled Orphan Care 'PEPFAR's darling' because its business-based model of programming was highly respected by PEPFAR programme officers. By the time the guidelines were rolled out, Orphan Care was one of the largest recipients of PEPFAR OVC funding and had a strong track record of success.

Shortly after the release of the *Guidance* in South Africa, however, Orphan Care staff were informed that their funding for certain services would be cut because they could not identify which children in the services fit within the new PEPFAR definition. Despite the necessary reallocations and programmatic changes, it was repeatedly emphasised that Orphan Care's reported target numbers could not 'under any circumstances' go down. Senior Orphan Care staff resisted these new requirements, insisting that it was both unethical and unfeasible to track HIV status of children or parents and that their inclusive approach was appropriate in a context where the overwhelming majority of children were affected by HIV/AIDS.

Orphan Care staff members were not alone in their objections to the new guidelines. In interviews conducted in December and January 2006, NGO officers at several of the major PEPFAR-funded organisations in South Africa expressed profound frustration about the problematic nature of the OVC definition as well as other restrictions on services, arguing that the guidelines were misguided, potentially stigmatising, and impossible to implement in many communities. Further, as several individuals highlighted, the guidelines were in direct contradiction with South African government policy, which emphasised that the definition of orphanhood and vulnerability should make 'no reference to the causes of orphanhood' (South African Government, 2005, p. 4), making the situation even more difficult for South African organisations.

For Orphan Care, their insistence that their existing eligibility criteria and service models were effective, and that they were not willing to change them in the face of PEPFAR demands, became a constant source of tension in discussions with PEPFAR programme officers. Rather than accepting what they saw as an unethical and impossible policy, Orphan Care staff began to work with their counterparts at 11 other major PEPFAR-funded

organisations affected by the *Guidance* to put together a formal complaint and advocate for a change in the *Guidance* itself.

Outside of this process, prominent Orphan Care board members decided to pursue their concerns regarding the *Guidance* through political and diplomatic avenues, expressing their frustrations to colleagues in high-level positions in government and industry. Further, at the international level, Orphan Care joined a larger collective effort to develop a report advocating for change in the policy. In the report, organisations highlighted a series of concerns regarding the restricted OVC definition, concluding, 'We see the restriction of the term OVC as a dangerous step in the wrong direction, which seemingly overwrites years of research illustrating that NGOs should not limit themselves to serving only those children affected by HIV/AIDS.' In addition to specific concerns about the content of the *Guidance*, the report also raised a general issue with the frequent changes in OVC indicators and guidelines and the significant challenges this had created for organisations.

In response to the pressure being put on them, in early 2007, USAID staff called all of the organisations receiving PEPFAR OVC funds to a meeting to clarify their expectations regarding the new *Guidance*. In the meeting, according to the official minutes, programme officers stated explicitly that PEPFAR would not be requiring verification of the HIV status of individual children or parents to justify 'the provision of OVC support or the selection of sites', but that PEPFAR did expect that organisations could confirm the eligibility of supported OVC 'through viable monitoring and evaluation systems and processes' and that these 'should provide an adequate audit trail that can sufficiently answer the question of "why" any particular OVC was enrolled into the program' (United States Agency for International Development, 2007). While the explanation was intended to clarify matters, it amplified the existing ambiguity and tension between flexible selection criteria and strict audit requirements.

Shortly thereafter, at a meeting held in Washington, DC to discuss concerns regarding the *Guidance*, the Senior Technical Officer for OVC Programs acknowledged the challenges presented by implementing the new OVC definition in explicit terms. 'We do *not* want to have a situation that requires people to exclude orphans that are not vulnerable because of AIDS', he stated strongly, 'but we don't want to lose our focus on HIV/AIDS. This requirement is a part of the legislation that governs PEPFAR' (Global Action for Children, 2007, p. 10). To address this tension, he suggested, 'We need to rely on common sense and find a balance that provides guidance without being so restrictive that we undermine or constrain creative programming in the field' (Global Action for Children, 2007, p. 3). Implementing organisations need not show proof but 'only a possibility' that children are directly affected by HIV/AIDS, such as 'a parent who is chronically ill'. Organisations should 'be flexible' and use their 'common sense', he reiterated several times, in order to do the best they could in applying the *Guidance*.

While they had not managed to incite any real change in the OVC *Guidance*, Orphan Care and other PEPFAR-funded organisations had succeeded, it seemed, in swaying how the *Guidance* would affect their programmes. They had largely avoided having to implement major programmatic changes and had maintained their PEPFAR funding. However, the

institutional effects of the contestations over the *Guidance* were more difficult to gauge. As these conversations came to an end, the new CEO of Orphan Care was called to another meeting with PEPFAR programme officers, where she was told in no uncertain terms that there was a need to move on from the debates about the *Guidance* now that it had become clear that organisations were largely going to be able to adapt the *Guidance* to suit their own programme directives. ‘They would like to see us being more positive’, she reported to staff, ‘about a situation that was a directive out of Washington’. There was a possibility of new funds in the near future, she was told, and Orphan Care would be recommended. However, she reported, ‘it was noted that [Orphan Care] was a very vocal antagonist about American funding and it was hoped that [Orphan Care] would understand that an aggressive public approach would give us negative press’ (Internal communication, 2007). Speaking to senior staff after the meeting, she explained what she had taken away from the conversation:

‘Personally, I think we will get more money and politically I think we need to deliver as best as we can under their new guidelines to ensure this...If we raise money in the future that can replace PEPFAR then we would rethink our approach but at present we need them and so we walk cautiously’ (Internal communication, 2007).

Because of the inherent ambiguity of the category and the clearly articulated ‘flexibility’ given to programmes in terms of implementation, organisations had a great deal of space in the end to adapt the provisions of PEPFAR policy to suit their needs. However, because they were dependent on donors, organisations like Orphan Care were still forced to ‘walk cautiously’ to satisfy the ambiguous and shifting expectations of PEPFAR and to try to implement the forms of monitoring and reporting they required. In the next section, I take this account further to examine how the OVC definition, and the bureaucratic requirements of PEPFAR programming, were interpreted by mid-level managers responsible for programme oversight and reporting.

Documenting the child and implementing ‘common sense’

In 2007 and 2008, in the midst of the debates regarding the OVC *Guidance*, I spent time working with the coordinator of one of Orphan Care’s areas of service on the north coast of KwaZulu-Natal. Prudence was in charge of managing the operations of a number of local care sites spread across northern KwaZulu-Natal. Travelling each day between far-flung projects, she visited local programme offices to check on the status of operations, help resolve issues, and provide advice. The central element of her work seemed to be the supervision and oversight of the data collection process. On numerous occasions, I sat with her in cramped project offices as she went about the task of checking the forms and attendance registers filled out by local staff to confirm that they were conducting their programmes appropriately and to verify the numbers being reported to her. ‘We must be in a position to explain every number’, Prudence told me on several occasions.

In early 2007, in response to a concern expressed by senior staff about eligibility of children in programmes, Prudence began to review every child registration form collected by staff at project sites. ‘We’ve got to be very careful’, Prudence asserted, ‘because once the donors hear that [there is a concern regarding whether children are eligible], they can come down to

the sites and check the forms. So if I am not making sure, if the manager is not making sure, then we are in for it!’ Reviewing each line of the form, she pressed local staff to justify the eligibility of each child they were enrolling, asking for more details about illness status, employment, resident relatives, social grants, and other forms of support. For more than half of the registration forms she reviewed, Prudence returned the form to the site manager, telling them that they should not enrol the child until they had more information. Interestingly, while the concern had been motivated by fears about the consequences of not following the PEPFAR OVC definition, the decisions being made by Prudence and her staff in reviewing the enrolment forms were not based strictly on the definition of OVC formalised by the PEPFAR *Guidance*. Instead, Prudence had clearly adapted her own definition of what orphanhood and vulnerability meant in her community. When I asked her to define the term, she explained:

‘An OVC is a child between the ages of 0 and 18. It’s the child that doesn’t have both parents or one parent. But the condition is that that child must be vulnerable, that the child is not having a primary caregiver. But there are also children who don’t have both parents who are not vulnerable. Like if my sister and her husband died and I am available to look after their children, they aren’t vulnerable as long as I am playing the role of being a parent and doing everything that the parents would have done... But if the primary caregiver has no money—they don’t have money to go to school, for food—then the child is vulnerable. He or she gets in’.

In a later conversation, I asked Prudence if she had been told about the new PEPFAR guidelines and the focus on children directly affected by HIV. ‘Yes, I’ve heard all about it’, she responded, ‘but it really is not easy to identify if a person has died of AIDS, and that would stigmatise the child’.

Prudence’s definition clearly referenced important notions of kinship and family amongst isiZulu-speaking individuals in the region, where children are generally understood to belong not only to a nuclear family but to a broader extended kin structure, in which care for children is often more distributed.³ In this context, to call a child an *intandane*, the term most frequently employed to describe an orphan, carries with it a sense of neglect, of lack of care, not simply of loss of a biological parent. As one of the volunteers working for Orphan Care explained to me, a child who had lost their mother and father would no longer be referred to as an *intandane* if a family member took them in, as was most often the case after parental death. ‘This name no longer works well’, she explained, ‘if she is looked after because now she would be getting full support’.

In a small survey I conducted in 2007 of a random sample of 200 child registration forms from 10 randomly selected Orphan Care programme sites, only one form referenced HIV/AIDS as a cause of parental death or child vulnerability, while 24 referenced deaths due to ‘natural causes’. Further, 142 of the 200 registration forms left the location or status of one or both parents (primarily fathers) blank or listed the parental status as ‘unknown’. In reality, these forms rarely contained sufficient information to be able to assess whether children fit

³This is admittedly a reductive description of a complex field of experience and understanding. I explore the dynamics of kinship and care amongst isiZulu-speaking individuals in post-apartheid South Africa in much more depth elsewhere.

within the PEPFAR OVC definition—or even enough information to categorise the children within the kinds of alternate definitions put forward by Prudence and other programme staff. While these forms were religiously stored, counted, and photocopied and their information entered in Orphan Care's databases, many of the forms had more questions left blank than completed. In practice, decisions about which children to enrol drew on much more personal, emotional registers, a point I take up in detail elsewhere.

While registration forms may have said little about whether each child was 'an OVC', government identification numbers for the children and their caregivers were almost always included, and many care centres required copies of children's birth certificates and death certificates for their parents. In addition, programme staff were expected to take attendance each day at care sites to document children's participation in different activities and to complete forms for each home visit or other service offered. Despite the large numbers of forms collected by staff to record services received by enrolled children and document their ongoing needs and submitted each month to Orphan Care, copies of these forms were generally not included in children's records at the programme sites, making it impossible for staff and volunteers to refer back to them to follow up on concerns and monitor young people's progress and needs over time. Rather, the aim of these extensive record-keeping systems was clearly to document the number of services provided, and to create the requisite paper-based 'audit trail' to back up service counts reported to PEPFAR each month. Further, because enrolment figures were used to make budget allocations, it was very important to centres to report as many children as possible.

To track and collect these figures, Orphan Care area coordinators like Prudence called together the local project managers once each month to collect data for the monthly reports required by PEPFAR. Early in the morning, local programme managers, nearly all women, would converge on a hotel in the largest town of the region, each bearing carefully sorted stacks of forms to be reviewed, including attendance registers for daycare, aftercare, and nutrition programmes; committee, staff, and volunteer meeting minutes; clinic referral forms and forms documenting bereavement counselling; registration and deregistration forms; and tally sheets of children served for the month. At each meeting, programme staff carefully distilled the many forms and tick marks on daily attendance registers into overall service counts in a spreadsheet on the area coordinator's laptop. As one staff member entered the data, another would double-check the counts to ensure that the numbers were accurate. While the numbers were entered for one project, the other project managers sat sorting and resorting their stacks of forms into plastic sleeves and folders and checking the counts on their attendance forms. Even if a child was listed as having received a service only once during the month (e.g., attended after-school care one out of 31 days), the child would be counted as a full recipient of PEPFAR services. Thus, service counts were based on the number of children visited, not on the depth or quality of engagements. Staff members at Orphan Care and other PEPFAR-funded organisations frequently expressed concern that the over-focus on counting and on formal bureaucratic procedures undermined the quality of services being offered. 'It doesn't matter how well you reach 64 children', one programme officer stated bluntly, 'if you didn't reach your target of 600'.

At most monthly meetings, there was also one or more new forms distributed to be completed for the next month's meeting, accompanied by a long explanation as to how they were to be used. The constant stream of forms and changes in reporting systems inspired frequent complaints from project managers. Over the years since the start of PEPFAR funding, organisations had been required to change the way they reported on services to children several times. Reporting demands had shifted from raw counts of children served to a 'service-based model', first based on a rubric of six different kinds of services, then eight, and then expanded to 11 categories. Each of these changes required the development of costly new systems of monitoring and reporting. In 2007, the director of one of the largest international children's organisations operating in South Africa told me that they were spending nearly half of their PEPFAR funding on database development and monitoring and evaluation. A staff member at another organisation described the situation thus: 'The level of detail that we have to report on is so great that it can take five months of intensive work to prepare and submit a report on PEPFAR expenditure and impact'.

By the end of 2008, though the PEPFAR *Guidance* still stood as the official policy document governing practices of PEPFAR-funded OVC organisations, most organisations I worked with reported that they were 'getting used to the *Guidance*'. Most had found ways to work around its strictures, to be 'flexible', as they had been advised, but there had been no official change in the language of the guidelines. 'There's been all of this talk of "being reasonable"', one staff member complained, 'and they are not going to penalise you for being reasonable, but they're also not going to change the policy to make it reasonable'.

In this context, organisations continued to struggle with the tension between the flexibility advocated by PEPFAR officials and the oftentimes more literal interpretations of PEPFAR 'prime partners', who were tasked with disbursing and overseeing funds, and external auditors, who could arrive without warning to review programme documentation, looking for reporting errors and omissions. These audits inspired such levels of fear, a former PEPFAR auditor told me, that it was not uncommon for NGO staff to break into tears during the audit process. PEPFAR reporting requirements had created a management style governed through fear, staff members at several organisations told me—fear that the numbers weren't right, that indicators were wrong, that funding would be lost. 'The stress and fear is created at the top and moves all the way down', an Orphan Care staff member explained, 'and the competition with the organisation next to you makes sure you keep it going'.

A central element of the tension inherent in these processes derived from a basic fact about the structure of PEPFAR programmes in South Africa and elsewhere. The companies charged with monitoring and evaluation were generally large, international corporations with strong ties to the US government, while programmes were implemented by local organisations with predominantly local staff. One of the major critiques of PEPFAR and other US bilateral programmes has been the large percentage of funds spent on overhead, travel, equipment, and salary and benefit packages for expatriate staff tasked with evaluation activities (see, for example, Epstein, 2005; Redfield, 2012). As a result, there were often powerful barriers of socioeconomic status, education, experience, and race between local programme staff who implemented programmes on the ground and those charged with the

oversight of many PEPFAR-funded projects, a point that was articulated in quite powerful terms by the director of Orphan Care:

‘As with all USG-funded initiatives, the expenditure of the funding is reported against a set of indicators that are rational, measurable and generally make sense, especially to those that set the indicators. The recipients of funding often find the indicators rather confusing, as they are the poor, the mostly illiterate, the vulnerable, the marginalised and the desperate people of the developing world’.

In reality, many local organisations in South Africa relied quite heavily on voluntary labour for the implementation of programmes. At one Orphan Care local site where I spent a good deal of time in 2009 and 2010, PEPFAR reporting forms were completed almost entirely by local volunteers. In many senses, the local volunteers I came to know experienced similar challenges to those whom they ‘served.’ Often without any other source of income, volunteers relied on small contributions from individual donors and the occasional ‘transport money’ offered by Orphan Care to attend trainings to get by. In this context, despite the distancing practices of form filling, service provision was shaped by complex interpersonal relationships defined by the complexities of dependence and historical inequalities, a concern I take up more fully elsewhere.

The production of PEPFAR ‘success’

While PEPFAR programme officers emphasised the importance of tracking systems for children to ensure quality service provision, the end point of these complex networks of data collection and reporting was in fact the production of raw counts of individuals given assistance for reports to the US Congress. To reach global targets and collapse complex data into digestible statistics for public dissemination, PEPFAR officials were compelled to implement generic guidelines and reporting requirements that allowed for the comparison of standardised data across diverse countries. Despite the ambiguities of the OVC category and the clearly divergent understandings of eligibility criteria, numbers continued to be counted and services summed in quarterly reports for PEPFAR. The questions raised about which children were to be included and what services they received faded as reports were collected, collated, and entered into national data banks. As Andrew Lakoff suggests in his study of pharmaceutical systems in Latin America, the need for ‘liquidity’ or ‘universality’ often trumps individual complexities and needs and requires the standardisation of knowledge and forms of practice across institutions, cities, and countries (Lakoff, 2005).

Because of concerns regarding audits and accountability, however, numbers of children reported as enrolled in PEPFAR-funded OVC programmes dropped drastically in the first reporting periods after the dissemination of the *Guidance*. The problem of low numbers was a concern from the level of the local service providers, whose annual funding was directly related to the number of children they could report, to that of the Office of the Global AIDS Coordinator, which was responsible for ensuring that PEPFAR programmes were making satisfactory progress toward global prevention, treatment, and care targets set by the US Congress. The resultant push for numbers created even greater pressure and competition within and between organisations for children to count.

In addition to the pressure on partner organisations to produce higher service counts, the need for high service numbers was also addressed at the aggregate level through changes in counting and reporting practices. Along with its revised OVC definition and restrictions on services, the *OVC Guidance* had also shifted how organisations were intended to measure the number of OVC served through their programmes. Previously, to count a child as ‘directly served’, an organisation had to document that they had provided the child with at least three services from a list of ‘essential’ categories of support. Under the new rules, the category of children ‘directly served’ was divided into two subcategories: (1) ‘primary direct’, defined as children receiving three or more services and (2) ‘supplementary direct’, children who received only one or two services (OGAC, 2006). When the numbers were reported to Congress in the 2007 annual report, however, the subcategories ‘primary direct’ and ‘supplementary direct’ were added together and reported as a total number of children ‘served’ through PEPFAR programmes. Thus, through the change in counting practices, which effectively reduced the depth of support programmes had to provide to children, PEPFAR programmes were not only able to meet their 2007 targets but were able to report significant increases in the number of ‘orphans and vulnerable children’ served, despite the important challenges faced on the ground.

By 2008, numbers of children served, summed and summed again over the preceding four years, resulted in the impressive statistic of 2.7 million children ‘supported’ by US government funds, as stated in PEPFAR’s annual report to Congress (OGAC, 2008). The number was well above the target of two million orphans and vulnerable children set by President Bush and the US Congress for PEPFAR’s five-year plan. According to the PEPFAR annual report, all of the numerical targets—treat two million HIV-positive individuals, prevent seven million infections, and provide care for 10 million individuals affected by AIDS, including two million orphans and vulnerable children—had been met and surpassed.

These outcome statistics were celebrated as a sign of PEPFAR’s significance and success. As Mark Dybul wrote in a piece reflecting on the success of PEPFAR’s programmes, ‘Over time, people came together, and as a result, lives were literally saved... PEPFAR met its ambitious goals early and on budget’ (Dybul, 2009, p. 2). With other impact numbers for treatment, prevention, and care, the figure of 2.7 million ‘OVCs served’ became an important tool for policy-makers and advocates and was cited as a justification for increased funding for PEPFAR. When the PEPFAR legislation was reauthorised in 2008 for another five years with a budget of \$50 billion, the final legislation included a specific new target for OVC programming the next five years of PEPFAR funding: five million OVCs served (Tom Lantos Reauthorization Act, 2008).

‘From emergency to sustainability’: The new era of PEPFAR programming

The entry of PEPFAR II (as the second five years of PEPFAR programming has been called) in 2009 coincided with a political transition in the United States and with major shifts in the global economic climate. After flattening in 2009, donor government funding for HIV/AIDS fell by 10% between 2009 and 2010, the first decline in more than a decade (Kates, Wexler, Lief, Avila, & Gobet, 2011). Similarly, growth in global health funding

overall fell to 4% in 2010, and in 2011 and 2012 appeared to have stopped completely (Garrett, 2012). In this new climate of fiscal austerity, a series of reforms were implemented with the aim of shifting PEPFAR programming and other initiatives away from ‘emergency’ response and toward a more ‘sustainable’ model framed around collaboration with recipient governments and evidence-based programming.

A central element of the new PEPFAR approach was a renewed focus on monitoring and evaluation and on research, structured by a new framework of ‘implementation science’ (IS) (OGAC, 2009; Padian et al., 2011a). In an article intended to explain and advocate for the new approach, PEPFAR leadership conceded that monitoring and evaluation activities in the first ‘emergency’ phase of PEPFAR had functioned solely to ‘monitor progress and report to Congress’, rather than to improve quality of services (Padian et al., 2011b, p. 200). In a later article, OGAC programme officers openly acknowledged the problems with these initial emphases: ‘High targets provided some motivation to offer the most affordable and feasible services rather than the most needed’, to reach for the ‘low-hanging fruit’ (Nyberg et al., 2012, p. S129). Because of this overemphasis on numerical targets, an external review of PEPFAR-funded programmes concluded, the majority of PEPFAR-funded interventions seemed to have had no measurable effect on the young people they were intended to serve (Bryant et al., 2012, p. 1513). To address these concerns, emphasis began to shift from a focus on efficient, inexpensive forms of service provision to an interest in interventions that could be shown to have *measurable* impacts. As PEPFAR leadership argued, ‘programs must demonstrate value and impact to be prioritized within complex and resource-constrained environments. In this context, there is a greater demand to causally attribute outcomes to programs’ (Padian et al., 2011a, p. 199). To realise these objectives, though the next phase of PEPFAR was framed around a new era of country ownership and a discourse of development, programmes could in fact be subject to more techniques of measurement.

Such shifts in programmatic imperatives could be seen to be part of a broader bureaucratic process of circumscription, framed around appeals to science, truth, and bureaucratic efficiency. In a recent analysis of the shifting discourses of global HIV/AIDS funding over the last decade, Alan Ingram describes what he sees as a shift from a ‘rationality of salvation (premised upon exception from the neoliberal norm of scarcity)’, which defined the early years of global HIV/AIDS intervention, to ‘one of administration (premised upon the subsumption of HIV/AIDS back within a discourse of scarcity)’. In these circumstances, he suggests, ‘the need for greater visibility, calculability and attributability of all aspects of the response is intensified by a discourse of scarcity (often rendered as “sustainability”)’ (Ingram, 2012, p. 3).

In August 2012, Secretary Hillary Clinton announced that South Africa was to become the first country to ‘nationalize’ its PEPFAR programme, as funds would be scaled back and ‘responsibility’ handed over to the South African government (Govender, 2012). One of the first programmes to lose funding under the new, scaled-back PEPFAR mandate was Orphan Care, which had continued to struggle to keep up with the changing requirements of PEPFAR reporting and the need to demonstrate programme impact. In early September 2012, Orphan Care officially announced that they would be closing down 67 of their 90 centres across the country as a result of their loss of PEPFAR funding (Nkosi, 2012). These

closures represented, according to an Orphan Care staff member, ‘nearly 11,000 AIDS orphans left out in the cold and over 300 jobs retrenched’ (Nkosi, 2012). ‘Though [Orphan Care] has been viewed as a model partner of PEPFAR’, the organisation’s CEO was quoted as stating in a news article, ‘the current service offering does not fit the eligibility criteria of this new Partnership Framework’ (Nkosi, 2012).

Conclusion

The article has described the ways in which the category of the ‘OVC’ (or ‘orphaned and vulnerable children’) was circumscribed through particular political and bureaucratic procedures in the US and in South Africa, and how this bureaucratisation of the category was translated into an overwhelming imperative to produce counts of children served and ‘lives saved’. In the emphasis on a restricted definition of the ambiguous category of the OVC, the *Guidance* aimed to bound notions of risk, create certainty, and limit the scope of intervention by identifying a circumscribed, apolitical group of ‘vulnerable’ young people for whom bounded services could be offered and ‘results’ measured. However, in the context of programme implementation in locality, it quickly became evident that the circumscribed definition was of little use, particularly in the context of programmes designed to provide ‘care’ for children, and programme officers began to encourage a certain amount of negotiation and adaptation to suit the needs of service providers.

This flexibility was productive in some senses, allowing programme officers and policy-makers to satisfy political agendas and show programme ‘success’, while still enabling negotiations and adaptations to suit the needs of programme implementers. In the background, however, the production of this coherent narrative of programme ‘success’ required a great deal of material, intellectual, and emotional labour on the part of programme staff and diluted the effectiveness of interventions as resources were expended on negotiating the requirements of an unimplementable policy and programming decisions were made in order to facilitate a numerical imperative. In this context, measures of programme ‘success’ did not necessarily stand for effective programming but, rather, signalled the ability of actors to negotiate deeply contradictory mandates and fraught relationships across multiple levels of authority.

More broadly, by channelling its resources through ‘civil society’, setting strict conditions for its assistance and support, deploying new biomedical technologies, and requiring complex forms of accounting, PEPFAR has reconfigured forms of governance in the areas where it has intervened beyond the reach or impact of actual funding dollars. As the prominent sign in the Durban airport advertising data management services suggested, the bureaucratic procedures required by PEPFAR and other donors in the HIV/AIDS ‘industry’ have reshaped the practices of powerful organisations across South Africa, who have implemented new technologies of counting and accounting in order to satisfy PEPFAR requirements, and of the South African National Government, which has begun to take over these programmes and practices in the new era of PEPFAR and HIV/AIDS programming in South Africa.

This phenomenon is not isolated to PEPFAR in South Africa, but rather represents a broader trend in global health and development programmes in which a renewed concern with cost, impact, and efficiency is driving global health and development policy and practice more generally towards an ever-greater focus on counting and accounting, on metrics and quantitative forms of evidence, and on the categorisation and circumscription of forms of suffering and of everyday life. Faced with this expanding emphasis on evidence and accountability, policy-makers and programme officers intending to make a difference in the lives of young people and families must continue to struggle to define and delimit a target population for their interventions. Through these processes, epistemological tensions are produced that create powerful uncertainties in the everyday practice of public health. There is a need for greater attention to the long-term effects of such uncertainties on the experiences of both the individuals tasked with delivering services and their intended beneficiaries.

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