Chapter 4
Socializing norms at domestic levels

Based on the explanatory model I just outlined in the preceding chapter, this chapter will focus on the processes through which behavior change took place in the domestic institutional practices in India. In this chapter I will first examine to what extent the principled ideas and norms promoted by the international HIV/AIDS regimes were adopted and implemented in the Indian state’s domestic practices. This part will critically review the existing Indian policies, programs, and institutions on HIV/AIDS, and their degree of compliance with the norms of prevention, treatment, and care and support promoted by the AIDS regimes. Hence, I will examine the degree of socialization of norms at three levels — 1) at the level of existing HIV/AIDS policies and legislations; 2) at the level of AIDS prevention and care programs for vulnerable groups and affected communities; and 3) at the level of existing institutions. In the second part, I will then explore what were the mechanisms through which this adaptation and norm socialization took place in the Indian state’s domestic practices. This part will focus on the processes, and how various actors reshaped/ reconstituted the Indian state’s preferences and behavior by influencing it “from above,” “from below” and “from within.”

I

How do we measure the degree of compliance with a regime? A good starting point is to examine if the international agenda is being upheld in the domestic policies, programs and institutions. For the purpose of this study, compliance is understood in terms of the degree to which domestic/national agendas comply with the principles, norms and rules of the regimes’ agenda. This does not imply that it is solely the regime that has brought about this change, but only to say that a regime can be effective and successful in establishing an international legal norm and framework for action.
4.1. Socializing norms at the policy level

Incorporating the norms of the international AIDS–regimes in India’s domestic policies was often the first step towards norm socialization. Once the domestic policies acknowledged the norms of the regimes, appropriate program strategies for prevention (and care) usually followed. Deodhar (2003: p. 159) noted that in India, the major policies for HIV/AIDS control were not only adopted from the experiences of the Western countries, but also the norms and principles of prevention, treatment, and care were adopted from that of the various HIV/AIDS regimes without much considering the plethora of the major public health problems and diverse cultural predicaments. Form conservative, repressive, draconian, and anti-human rights based policies and strategies for prevention and control of HIV/AIDS, India has transitioned to a liberal, democratic, and human rights based AIDS policy-regime within a very short time. Policies that are directly related to address the HIV/AIDS problem were instituted only in response to the epidemic (such as National AIDS Control Policy, National Blood Policy, etc.). Other “related” but overlapping policies (such as National Youth Policy, or National Health Policy, etc.) having widespread effects on domains other than AIDS were only reoriented/ reconstituted to address the emerging AIDS problem by incorporating specific change within the policy-provision. These changes were to reflect the principled ideas and norms of the various AIDS regimes that India adopted over the years.

India’s adoption of norms of various AIDS regimes at the policy level provided a major disjuncture with its domestic policies. One of the first major disjunctures was that, in India, in accordance with the National Health Policy Statement (1982), new vertical programs for disease control were not to be introduced, approaches were to be broad-based and comprehensive, planning and services were to be decentralized,

138 For example, India’s National Youth Policy (NYP) of 2003 incorporated a statement (albeit in passing) on the need to prevent HIV infection among youth by appropriate education and awareness on reproductive health and sexuality issues; and proper treatment and counseling for care and rehabilitation (NYP, 2003: p. 6, 8), which was absent in its earlier version of 1988. Similarly, National Population Policy (NPP) of 2000 stated to include/integrate the STD/RTI and HIV/AIDS prevention, screening and management in maternal and child health services (NPP, 2000: p. 5, 21). Part of these changes was to reflect the norms of HIV/AIDS prevention that India was adopting.
people’s health was to be kept in their hands, and interventions were to be integrated. The National HIV/AIDS control established as a vertical program disregarded all these principles\(^{139}\) (Deodhar, 2003: p. 160). India’s AIDS control program has passed through three phases, while the planning for the fourth phase is currently underway. Phase 1 of the NACP lasted from 1992-97 (extended to 1999). Phase 2 of the program lasted from 2000-2007, whereas phase 3 was 2007-2012. Based on the experience gained in Tamil Nadu and a few other states along with the evolving trends of the HIV/AIDS epidemic, the focus shifted from raising awareness and changing behavior, to decentralization of program implementation at the state level and greater involvement of NGOs.

**Compliance at the policy level**

As a signatory to the UNGASS Declaration of Commitment on HIV/AIDS, 2001 and the UN General Assembly Political Declaration on HIV/AIDS, 2006, India remains committed to the AIDS prevention and reaching the targets of “universal access” to antiretroviral drugs. India has methodically developed its HIV/AIDS program according to the epidemic’s current pattern taking reference of an emerging evidence base — and in collaboration with a broad range of stakeholders.

Some of the regimes and international treaties that India is a signatory of wherein HIV/AIDS is found to be a common theme are: UN Millennium Declaration of 8 September 2000; World Summit for Social Development of 1 July 2000; Beijing Declaration and Platform for Action of 10 June 2000; Program of Action of the International Conference on Population and Development of 2 July 1999; UNAIDS Global Strategy Framework on HIV/AIDS\(^{140}\) of June 2001; UNGASS Declaration of

\(^{139}\) However the revised National Health Policy (NHP) of 2002 though acknowledge that vertical programs are “extremely expensive and difficult to sustain,” (NHP 2002: p. 9), it justifies continuing the vertical program structures for diseases like AIDS, TB, malaria, universal immunization, etc. until “moderate levels of prevalence are reached” (**ibid.**, p. 25). All these four diseases are heavily funded by international donors. This revised health policy statement (2002) justifying the maintenance of vertical program structures (a change from the 1982 statement), therefore, could be interpreted as India’s adaptation of norms of regimes like Global Fund at its domestic policy level.

\(^{140}\) The Global Strategy Framework puts forward a set of guiding principles and leadership commitments that together form the basis for a successful response to the epidemic. Global, national and community bodies will still need to formulate their own specific strategies concerning particular themes or regions. The Global Strategy Framework is designed to help in setting priorities and in achieving harmony and
Commitment on HIV/AIDS, June 2001; UN General Assembly Political Declaration on HIV/AIDS, June 2006 among many others. As far as HIV/AIDS is concerned, a great degree of overlapping themes and common strategies/norms exist across all these regimes.

I have summarized the key norm socialization at the policy level in a detailed table that appears later in this section (see Table 4.1). Below, I only describe some of the processes that could not be captured in a table format. Only important issue areas where India’s compliance remained good or excellent are examined here.

**Adopting the UNGASS Declaration of Commitment**

India adopted the Declaration of Commitment on HIV/AIDS in the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001. The Country Progress Report (CPR) that India prepares to present before the UNGASS reflects India’s commitment to that Declaration. As part of the World Bank’s “good governance” agenda, the country (NACO) solicits inputs of various stakeholders in this reporting process consisting of key government officials, NGOs, PLHIV groups, the UN and other multilateral organizations, bilateral donors, and international aid agencies. India’s compliance with the norms of the UNGASS-regime is reflected in the policy framework and approaches of the National AIDS Control Program. As a commitment to the Declaration, some of the policy initiatives that India took include a revision of the National AIDS Prevention and Control Policy (2002); National Blood Policy (2003; Rev. 2007); Policy for Greater Involvement of People with HIV/AIDS (2009); launching of the National Rural Health Mission (2005); launching of the National Adolescent Education Program (2005); provision of free Anti-Retroviral Therapy (2004); formation of an inter-ministerial group for mainstreaming; and setting up of the National Council on AIDS (2006) chaired by the Prime Minister of India.

**Policy framework and response**

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The policy framework for the NACP is anchored in the National AIDS Prevention and Control Policy of 2002. India has a well-articulated national strategy and approach which is described in the *NACP-3 Strategy and Implementation Plan*.\(^{141}\) To comply with the Millennium Development Goal (6a) of “halting and reversing the spread of the epidemic,” India started the Phase-3 of the program in 2007 with a new vigor. In compliance with the regimes’ norms, the focus has shifted from raising awareness to behavior change; from a national response to a more decentralized response; and to increasing involvement of NGOs and networks of PLHIVs in delivering the program. With the planning for NACP Phase-4 (2012-2017) underway, the NACO is actively seeking inputs from various stakeholders and integrating experiences from the past implementation to build upon a robust Phase–4 of the program. Bearing in mind that over 99.7 percent of India’s population is free from infection, NACP–3 places the highest priority on preventive efforts while also integrating prevention services with care, support, and treatment.

NACP–3 has well-defined strategies for implementing the national program with an implementation plan guided by various policy frameworks. The program places the highest priority for preventing HIV proliferation from high-risk groups (sex workers, drug users, MSMs, etc.) to the bridge populations\(^{142}\) (clients of sex workers, truckers, migrant laborers, partners of drug users, etc.), who then infect the population at the lowest risk. To achieve this goal, a plan of action is developed based on the experiences of NACP–1 and 2. The plan of action rests on four fundamental principles:

1. Prevent infection by 100% coverage of risk-groups through targeted intervention and scaled up interventions in the general population.

2. Provide greater care, support and treatment to larger numbers of PLHIVs.

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\(^{142}\) They are called “bridge population” because they (male clients, partners) serve as a “bridge” (transporter) of HIV infection from high-risk groups (sex workers, drug users, MSMs) to the general population (non-infected wives and children) at the lowest risk.
3. Strengthen the infrastructure, systems and human resources in prevention, care, support and treatment program at district, state and national levels; and

4. Strengthen the nationwide strategic information management system (UNGASS CPR, 2010: p. 27).

India shows signs of compliance with Millennium Development Goal #6 (halting and reversing the spread of the epidemic by 2015). With the most recent estimates showing a declining trend, India has started to halt and reverse the spread of the epidemic. HIV prevalence among adult population has declined from 0.45 percent in 2002 to 0.29 percent in 2008 (NACO AR, 2010: p. 4). There is also a declining number of PLHIV in the country, with an estimated number of 2.2 million in 2008, down from 2.7 million in 2002 (ibid.).

Though India’s achievement still falls short of expectation (as the following indicators reveal, Table 4.1), she is committed to achieve the goal of UNGASS. India reported the following key indicators of her “achievement” in the latest (2010) UNGASS report:
<table>
<thead>
<tr>
<th>Indicator</th>
<th>As reported in last UNGASS Report 2008</th>
<th>Current Status, 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total domestic and international AIDS spending (last one year)</td>
<td>US$ 171 million during 2006-2007</td>
<td>US$ 140 million (April 2009 to January 2010)</td>
</tr>
<tr>
<td>Percentage of donated blood units screened for HIV in a quality assured manner</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy (ART)</td>
<td>20% adults 35% children</td>
<td>45% adults (15+) No data on children</td>
</tr>
<tr>
<td>Percentage of HIV infected pregnant women who received ART to reduce the risk of mother to child transmission</td>
<td>8% in 2007</td>
<td>17%</td>
</tr>
<tr>
<td>Percentage of most at risk populations who received an HIV test in the last 12 months, and who know their results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female sex workers</td>
<td>34%</td>
<td>32% (national avg.)</td>
</tr>
<tr>
<td>Men who have sex with men (MSMs)</td>
<td>3 to 67% across survey locations</td>
<td>17% (national avg.)</td>
</tr>
<tr>
<td>Injecting drug users (IDUs)</td>
<td>3 to 70% across locations</td>
<td>21% (national avg.)</td>
</tr>
<tr>
<td>Percentage of most at risk populations reached with HIV prevention programs*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female sex workers</td>
<td>56%</td>
<td>82% *</td>
</tr>
<tr>
<td>Men who have sex with men (MSMs)</td>
<td>17–97% across locations</td>
<td>69% *</td>
</tr>
<tr>
<td>Injecting drug users</td>
<td>10–83 across locations</td>
<td>76% *</td>
</tr>
<tr>
<td>Percentage of female and male sex workers reporting the use of a condom with their most recent client</td>
<td>88% (national avg.)</td>
<td>No national data: Manipur: 83% Andhra Pradesh: 100% Karnataka: 99% Tamil Nadu: 93% Uttar Pradesh: 85%</td>
</tr>
<tr>
<td>Percentage of most at risk populations who are HIV infected</td>
<td>Female sex workers 5% Injecting drug users 7% MSMs 6%</td>
<td>Female sex workers 5% Injecting drug users 9% MSMs 7%</td>
</tr>
</tbody>
</table>


**Note:** Figures for the following three indicators are from NACO. (2011). *Annual Report, 2010–11.* New Delhi: Govt. of India, which is based on 1631 targeted interventions in the country, of which 454 was for female sex workers; 155 for MSMS; and 261 for IDUs. See NACO (2011). p. 13.
**HIV in workplace**

Government of India has ratified the ILO Convention No. 111 on Discrimination (Employment and Occupation) 1958. Therefore, a policy statement creating a framework for non-discrimination of workers on the basis of their real or perceived HIV status was essential. In 2001, the ILO with support from the US Department of Labor developed a three-phased program with NACO that aimed at establishing a sustainable national action on HIV/AIDS prevention, care and support in the world of work. The program is currently in its second phase. It started getting additional support from the United States President’s Emergency Fund for AIDS Relief (PEPFAR) since 2006. Based on the experiences, India adopted a *National policy on HIV/AIDS and the world of work* 143 (2009). The policy adopts the key principles of the *ILO Code of practice on HIV/AIDS and the world of work* 144. The policy, based on the principles of human rights, aims to guide the national response to HIV/AIDS of all the key actors and suggest a mechanism for effective collaboration and implementation to protect the Indian working population, and mitigate the social and economic impact of HIV/AIDS. The 10 basic principles the guide the policy are: HIV/AIDS is a workplace issue; non-discrimination or stigmatization of workers; ensuring gender equality; providing healthy work environment; social dialog between employers, workers and government; no screening for the purpose of employment; maintaining confidentiality; HIV is not a cause for termination; prevention at workplace; and provision of care and support (Ministry of Labor and Employment, undated: pp. 8-10).

In compliance with the norms, the Indian workplace policy (signed by all major employers, Chambers of Commerce, industry and business associations, and central trade unions) emphasizes the following key strategies (reproduced here from the policy statement):

a) Prevention of HIV transmission at workplace.

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b) Provide education and training at all levels in workplaces, set up interventions for behavior change through peer educators, integrate HIV in the existing programs at workplaces like the training of the human resource department.

c) Set up interventions for unorganized/informal sector workers and migrant workers, based on vulnerability studies and risk assessment.

d) Enhance access to condoms, treatment of STIs, universal precaution and post–exposure prophylaxis.

e) Widen scope of social security coverage to include HIV in employee and family assistance programs, health insurance etc.

f) Undertake vulnerability studies/epidemiological surveillance at the workplace to gather data/information for taking informed policy and programmatic decisions (Ministry of Labor and Employment, undated, p. 10).

By adopting this official policy, India joined the groups of most liberal, democratic nation–states in the world with a commitment to following good human rights practices endorsed by the international community and mitigate the impact of HIV/AIDS epidemic.

Mainstreaming as a norm

Another policy response has been to “mainstream” the HIV/AIDS based on the idea that “AIDS is everyone’s problem.” Hence all sections of the society must be targeted by all ministries and government departments through a multisectoral approach.145 To comply with this norm, NACO has so far mainstreamed 31 Union Ministries and Departments of the Government of India to include HIV/AIDS

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145 This vision contradicts with NACO’s own assertion in statements like, “99.7% population is infection–free”; or epidemic is “concentrated” in high–risk groups of sex workers, drug users and MSMs, etc. (NACO AR, 2010). The correct epistemology, indeed, should be “AIDS is a problem of sex and drugs,” but if you say this, you may face resistance from the cultural nationalists or religious fundamentalists. Instead, “AIDS is everyone’s problem” serves a strategic purpose: simultaneously, it destigmatizes the problem, and pulls-in resources from all sectors. Pisani (2008) noted part of the politics that went in labeling “AIDS as a development problem” myth because leaders in Africa and Asia did not want to talk about anal sex, prostitution and drug abuse (p. 158).
prevention in their day-to-day functioning\textsuperscript{146}. NACO maps and identifies priority organizations/ministries within the government that have direct or indirect relevance to the HIV/AIDS response. Each of these ministries has one dedicated AIDS unit with at least one focal person from staff. All these organizations have developed a situation assessment report and five-year HIV/AIDS action plan covering critical elements, including, internal budgetary allocation; cost-benefit analysis of measures taken for HIV/AIDS prevention; rights-based workplace policy; workplace interventions for care, support and treatment; and reporting of core indicators to the National Council on AIDS, etc. NACO conducts advocacy with 13 focus (key) Ministries to integrate HIV prevention in their larger mission and achieve the goal of HIV prevention in the country.

The following table (Table 4.2) summarizes the norms of the major regimes and their degree of socialization at the policy level. I have only tabulated some important issue areas where India’s compliance remained good or excellent. There are other less important issue areas where India tends to comply, which are discussed in the above text.

Table 4.2. Summary table: Compliance at the policy level (next page):

<table>
<thead>
<tr>
<th>Issue area</th>
<th>Regime’s norms</th>
<th>Degree of compliance (as reflected in existing domestic policies/ programs/ institutional structures)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human rights</td>
<td>* <strong>Norms:</strong></td>
<td>* <strong>Compliance:</strong></td>
</tr>
<tr>
<td></td>
<td>* By 2003, enact, strengthen or enforce as appropriate legislation, regulations and other measures to eliminate all forms of discrimination against and ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups (UNGASS DoC, 2001: para 58, p. 24).</td>
<td>* Recognizes the fundamental rights of all sexual minorities and gender orientations, female sex workers, and drug users by supporting “targeted interventions,” and their state and national level networks -- Indian Network for Sexual Minorities (INFOSEM), the Indian Harm reduction Network (IHRN); and National Network of Sex Workers.</td>
</tr>
<tr>
<td></td>
<td>* Uphold the principles of human dignity, equality and equity at the global level (UN Millennium Declaration, para 2). Reaffirm, promote and strive to ensure the realization of the rights set out in relevant international instruments and</td>
<td>* A detail Operational Guidelines for Targeted Intervention is in place based on the basic principles of human rights and dignity.</td>
</tr>
</tbody>
</table>

declarations (World Summit for Social Development, 2000: Part c(f))

* Non-discrimination in employment is upheld by instituting *National Policy on HIV/AIDS and the World of Work.  

* *Guidelines for HIV Testing* (Rev. March 2007) in place. NACO upholds complete voluntary, confidential and non-discriminatory free HIV testing with pre-and post-test counseling services.

* Section 377 of the Indian Penal Code criminalizing homosexuality was decriminalized by Delhi High Court in November 2007.

* NACO Ethical Guidelines for Operational Research is in place to protect the rights of human subjects in social, medical research, drug testing, or publication.

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<table>
<thead>
<tr>
<th>Civil society involvement</th>
<th>Norms:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Compliance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>* “Mobilizing support of a large number of NGOs/CBOs for expanded community initiative for prevention of HIV/AIDS” is stated as one of the objectives in National AIDS Control Policy (NACP, 2002: Sec. 3(iii), p. 6).</td>
</tr>
</tbody>
</table>

149 See *NACO Policies and Guidelines Table for Download* at NACO website: National AIDS Control Organization: http://www.nacoonline.org/
<table>
<thead>
<tr>
<th>Workplace intervention</th>
<th>Norms:</th>
<th>Compliance:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>* Full involvement and participation of people living with HIV/AIDS, young people and civil society actors in the design, planning, implementation and evaluation of programs is crucial to the development of effective responses to the HIV/AIDS epidemic. (UNGASS DoC, 2001: para 33, p. 14)</td>
<td>* India’s Country Coordinating Mechanism for Global Fund process includes NGOs, civil society representatives, PLHIV networks, and private sector enterprises among the top decision makers.</td>
</tr>
<tr>
<td></td>
<td>* India’s Country Coordinating Mechanism for Global Fund process includes NGOs, civil society representatives, PLHIV networks, and private sector enterprises among the top decision makers.</td>
<td>* All national/state/regional policies, programs and operational guidelines are prepared through a consultative process involving NGOs/CBOs, PLHIV groups, key stakeholders and vulnerable population.</td>
</tr>
<tr>
<td></td>
<td>* NGOs deliver nearly 50% of information, education, prevention, treatment, care and counseling and testing services on HIV/AIDS and sexuality across India.</td>
<td>* NGOs deliver nearly 50% of information, education, prevention, treatment, care and counseling and testing services on HIV/AIDS and sexuality across India.</td>
</tr>
<tr>
<td></td>
<td>* By 2003, develop a national legal and policy framework that protects in the workplace the rights and dignity of persons living with and affected by HIV/AIDS in consultation with representatives of employers and workers, taking account of established international guidelines on HIV/AIDS in workplace (UNGASS DoC, 2001: para 69, p. 32).</td>
<td>* India has adopted the National policy on HIV/AIDS and the World of work based on code of conduct prescribed by the International Labor Organization to reduce stigma and discrimination of PLHIVs at workplace.</td>
</tr>
<tr>
<td></td>
<td>* India has adopted the National policy on HIV/AIDS and the World of work based on code of conduct prescribed by the International Labor Organization to reduce stigma and discrimination of PLHIVs at workplace.</td>
<td>* NACO is partnering with Confederation of Indian Industries (CII), Indian Business Trust for HIV/AIDS, Federation of Indian Chambers of Commerce and Industries, The Associated</td>
</tr>
<tr>
<td>Greater involvement of people living with HIV/AIDS (GIPA principle)</td>
<td></td>
<td></td>
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</tbody>
</table>
| **Norms:**  
  
* [We, the Heads of States] acknowledge the particular role and significant contribution of people living with HIV/AIDS, young people and civil society actors in addressing the problem of HIV/AIDS in all its aspects; and recognize that their full involvement and participation in the design, planning, implementation and evaluation of programs is crucial to the development of effective responses to the HIV/AIDS epidemic (UNGASS DoC, 2001: para 33, p. 14). |
| **Compliance:**  
* NACO has actively supported the formation, and maintenance of district, state and national level network of PLHIVs. NACO supported Indian Network for People living with HIV/AIDS (INP+) in establishing and strengthening 22 state level networks and 221 district level networks of PLHIV for mobilizing communities and ensuring their access to services (UNGASS CPR, 2010: p. 56).  
  
* PLHIV networks are actively consulted in the policy process, development of guidelines, program design, implementation, and monitoring and evaluation. NACO encourages (and recruits) qualified HIV-positive people to apply for jobs and vacancies when they come up. |

* By 2005, strengthen the response to HIV/AIDS in the world of work by establishing and implementing prevention and care programs in public, private and Informal sectors, and take measures to provide a supportive workplace environment for people living with HIV/AIDS (UNGASS DoC, 2001: para 49, p. 20) | Chambers of Commerce and Industry of India (ASSOCHAM) and other corporate sectors on workplace intervention and providing of care, treatment and other support services to people living with HIV/AIDS. |
India CCM has two representatives from PLHIV networks to voice the concerns of PLHIVs in the Global Fund proposals.

* NACO has developed the *GIPA Policy* through a consultative process, which will be adopted soon (UNGASS *CPR*, 2010: p. 58).

* The State AIDS Control Societies in West Bengal and Andhra Pradesh include PLHIVs in the Executive Committee of the quasi-government society (ibid.: p. 59).

**Mainstreaming**

**Norms:**
* By 2003, ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS (UNGASS *DoC*, 2001: para 37, p. 15)

* By 2003, integrate HIV/AIDS prevention, treatment, care and support, and impact mitigation priorities into the mainstream of development planning, including in poverty eradication strategies, national budget allocations and sectoral development plans (UNGASS *DoC*, 2001: para 38, p. 16).

**Compliance:**

* Management of STDs/RTIs through NHRM.

* Finalized Tribal Action Plan with the Tribal Welfare Department to reduce the vulnerability of tribal population.

* NACO has crucial multisectoral collaboration across various Ministries including Women and Child Development, Labor and Employment,
| India has incorporated HIV-AIDS issues in the National Policy on Children, 2007 and social welfare schemes. |
| Certain states such as Orissa have issued Below Poverty Line (BPL) cards to PLHIVs as a mechanism for ensuring access to free/ subsidized food and housing facilities. |
| In Tamil Nadu and Andhra Pradesh, 10 legal aid centers are established in each state. |
4.2. Socializing norms at the program level

The creation of NACO in 1992 with the World Bank funding support represented a landmark in Indian AIDS history. Since the AIDS control program was primarily funded by the Bank with minimal government of India’s contribution, India complied with the “conditions” (norms) of loan. Primarily, the norms were to institute a human rights of based policy, program, strategy for HIV prevention, care and support services; setting up of infrastructure in line with the WHO recommendation; adopt strategies from experiences of other countries that work; institute appropriate monitoring, evaluation, reporting and surveillance mechanism for tracking the course of the epidemic, etc.

Complying with the regimes’ norms, NACP acknowledged the need to focus on human rights based prevention strategies, as well as counseling, treatment and care. To this end, the NACP encouraged safer sexual practices and condom use amongst the general public, as well as vulnerable groups; prevention and control of sexually transmitted diseases; providing treatment, care, counseling and psychosocial support to the AIDS infected people to live with dignity; and integrate AIDS information, education and communication (IEC) programs within the existing health programs. In order to implement this comprehensive approach, NACO explicitly called for intersectoral collaboration and public private partnership, together with greater NGO-participation.

Treatment, care, and support

One of the major areas of compliance was ensuring the provision of free antiretroviral therapy for all (universal access). India being a resource–constrained country with many other competing health priorities, were to assess the economic implication of launching a program that was being pushed through by powerful international AIDS regimes, lobbyists, and activist networks. Since ARV therapy must
be taken for the whole lifespan of an individual, without interruption, and in case of drug toxicity or drug resistance (because HIV mutates very fast), a second line of ARV regimens must be made available, it implied huge expenditure on the government’s exchequer. On top of that, after adopting the WTO/TRIPS–regime from January 2005, Indian manufacturers can no longer produce generic version of the patented drugs, which saved million of lives in India, Africa and other resource poor countries in Asia. So patented ARV drugs must be imported from abroad, which is 20–50 times more expensive than Indian generic drugs depending on the brand and the manufacturer. Currently, the cost of drugs is supported by the Global Fund grant.

The implementation of the ART program remained very successful. Barring a few NGOs that have the organizational capacity to deliver ART (such as YRG care in Chennai), majority of the NGOs provide home and community based care, psychosocial support, counseling, and treatment adherence services to people living with HIV/AIDS. The ART centers are linked to the community care centers that are run by the NGOs. The supply chain management of ARV drugs is managed through a dedicated Logistic Coordinator appointed at the NACO. Though NACO claims that because of a well monitored system, “there has been regular and uninterrupted supply of ARV drugs without any stock-out situation” (UNGASS CPR, 2010: p. 14, 55), recent reports indicate that drugs do go out of stock periodically and PLHIVs have to wait for several months or (years) without hearing a word from the government.150 During this period, one must continue taking the drugs so that virus do not mutate to a different strain or become drug resistant due to periodic non–intake. One can afford to do so if rich, but majority of the patients who are on free–ARV at the first place, is because they are poor. Non–availability of drugs therefore sets a potentially harmful and dangerous trend for the program.

Other instance of compliance can be observed in the provision of second–line ARV treatment in the national program.\textsuperscript{151} The program initially started on a pilot basis at two centers in January 2009, was upscalled across 10 Centers of Excellence in the country. There is also provision of prophylaxis and treatment of opportunistic infections at tertiary and district hospitals. A system for cross–referral and linkage has been established between HIV and TB (RNTCP) programs, ensuring fast tracking of patients with co-infection. Guidelines are in place for the intensified HIV/TB package in 9 states which includes routine offer of HIV counseling and testing for all TB patients, and linking all the identified HIV/TB patients to care and support services (UNGASS CPR, 2010: p. 7, 54). Other program level compliance could be observed in ongoing research and clinical trial with the Indian Council of Medical Research for developing safe, effective, and affordable microbicides; integrating prevention, counseling, testing, and care in defense hospitals; and extending social security support to PLHIVs.

While condom use in India was promoted since 1960s under the National Family Planning Program for prevention of unwanted pregnancies, its promotion received a major impetus with the outbreak of HIV epidemic. During the 1970s, when the emphasis of development was on population “control,” condom was viewed only as a tool/ device for avoiding pregnancy. Even the mass media campaigns depicted the use of condoms only in limiting the family size with the slogan, “small family, happy family”. With the advent of HIV/AIDS, and changing norms for condom based programming, the discourse on condom shifted to “dual protection,” i.e., at the same time, it protects against HIV while avoiding pregnancy. Apparently when this did not change people’s attitude significantly (only about 60 percent Indian males reported to have used condom with a non-regular sexual partner\textsuperscript{152}), the discourse has now shifted

\textsuperscript{151} Though the decision to make the second line ARVs available free of cost to those who need it came after a Supreme Court Order in August 2008 at the behest of the Sanlaap Rehabilitation Trust, Sahara House, and Voluntary Health Association of Punjab, who jointly filed a public interest litigation on the ground that denying treatment to PLHIVs is unconstitutional and illegal. In this case, the NGOs promoted the norm which was upheld by the court of law and legally instituted by the Indian state. Symington, A. (2008). Supreme Court of India approves government commitment… HIV/AIDS Policy and Law Review 13(2/3), pp. 40–41.

to the aspects of “pleasure,” i.e., condoms can be more, or equally pleasing as having sex without it. Hence the media advertisements and manufacturing companies now heavily focus on the “pleasure” aspect by making myriad range of products available — throbbing condom, ribbed condom, dotted condom, colored condom, scented condom, pan (beetle leaf) flavored condom, which one could not imagine in the 1970–80s. In 2007, India’s Ministry of Health and Family Welfare in association with USAID and other private sector partnerships entered into a media campaign (condom bindas bol, say condom freely) in which people were encouraged to say the word “condom” loudly in public\textsuperscript{153}, so that it removes the stigma and increases its popularity. Similarly, jo bola wohi sikander (those who talk are winners) was another mass media campaign developed by BBC World Service Trust to remove embarrassment about buying condom and establishing a social norm for condom use.\textsuperscript{154}

In the following table (Table 4.3), I present a detailed summary of the norms that were institutionalized at the level of program implementation.

Table 4.3. Summary table: Socializing norms at the program Level (next page):

\textsuperscript{154} Condomcondom.org is a mass media condom campaign developed and maintained by BBC World Service Trust to prevent transmission of HIV in India. The campaign aims to make condoms more acceptable by highly innovative media advertisements and socially relevant messages to prevent HIV transmission in the high–prevalence states of Andhra Pradesh, Kamataka, Maharashtra and Tamil Nadu. Retrieved August 12, 2011: http://condomcondom.org/
Table 4.3. Socializing norms at the program Level:

<table>
<thead>
<tr>
<th>Treatment and care</th>
<th>Norms:</th>
<th>Compliance:</th>
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<tbody>
<tr>
<td>Access to medication is one of the fundamental elements to achieve the full realization of right of everyone to the enjoyment of the highest attainable standard of physical and mental health (UNGASS DoC 2001: para 15, p. 9).</td>
<td>* By 2003 ensure that national strategies are developed in close collaboration with the international community including governments and intergovernmental organizations civil society and business sector to provide progressively in a sustainable manner, the highest attainable standard of treatment for HIV/AIDS (UNGASS DoC, 2001: para 55, p. 22).</td>
<td>* India adopted free universal access to HIV/AIDS treatment and care since April 2004. All eligible HIV-positive individuals are currently provided free antiretroviral therapy (ART), prevention and treatment of opportunistic infections, psychosocial support, home-based care, treatment and follow-up services from government hospital and ART centers. As of January 2010, there were 239 fully functional ART centers in the country (NACO AR, 2010: p. 53).</td>
</tr>
<tr>
<td>* Pledge to promote, at the international, regional, national and local levels, access to HIV/AIDS education, information, voluntary counseling and testing and related services, with full protection of confidentiality and informed consent, and to promote a social and legal environment that is supportive of and safe for voluntary disclosure of</td>
<td>* India also provides highly expensive second line ART regimen to those eligible PLHIVs experiencing drug toxicities and treatment resistance/failure (ibid., p. 55).</td>
<td></td>
</tr>
<tr>
<td>* NACO has developed an extensive network of Integrated Counseling and Testing Centers (ICTCs) with over 5,000 such centers across the country (NACO AR, 2010: p. 47). Testing is completely voluntary, confidential and protects the rights of the individuals. Screening for STDs, and</td>
<td></td>
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</tr>
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</table>
| HIV status (UNGA Political Declaration on HIV/AIDS, 2006: p. 4). | prevention of mother to child transmission are integrated at the counseling and testing levels.

* Pursue an integrated and balanced approach to prevention and treatment to ensure that appropriate care and support services are available and accessible to those affected by HIV/AIDS, World Summit for Social Development, 2000: p. 16)

<table>
<thead>
<tr>
<th>Building enabling environment</th>
<th>Norms:</th>
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<tbody>
<tr>
<td>* Create an enabling and supportive environment free from stigma and discrimination by raising awareness, providing care treatment and psychosocial support for people living with and affected by HIV/AIDS (UNGASS DoC, 2001; UNICEF, 2005(^{155})).</td>
<td></td>
</tr>
</tbody>
</table>

* Create an enabling economic environment aimed at promoting more equitable access for all to income, resources and social services (World Summit for Social Development, 2000, part C(b)).

* Develop sustainable communities and community organizations, and enable them to contribute to the long-term sustainability of health and other interventions at community level (Global Fund, 2010. *Community system strengthening note*).

* Provide special assistance to children orphaned by HIV/AIDS (UN Millennium Declaration, 2000)

<table>
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<tr>
<th>Compliance:</th>
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<tbody>
<tr>
<td>* NACO has undertaken training and sensitization in stigma and discrimination of its staff at national and state levels as well as of personnel who will directly interact with individuals accessing services under the NACP.</td>
</tr>
</tbody>
</table>

* Established targeted intervention programs through community based organizations to ensure peer support, learning, and building a supportive community environment in high prevalence states.

* NACO is actively supporting the Indian Network for People living with HIV/AIDS (INP\(^{+}\)); strengthening 22 similar PLHIV networks at the state level; and helping to establish 221 district level networks (UNGASS CPR, 2010: p. 7).

* In November 2008, the Press Council of India issued a new set of media guidelines (revised from 1993) for reporting on HIV/AIDS setting a benchmark for qualitative, sensitive, and responsible media coverage of HIV-related issues.

* Develop the roles of key affected populations and communities, community organizations and networks in the design, delivery, monitoring and evaluation of services and activities aimed at improving health outcomes (Global Fund, 2010, *Community system strengthening framework*, p. v).

* The *Greater Involvement of People Living with HIV/AIDS — GIPA Policy* (2010) has been developed through a consultative process and is likely to be adopted soon.

* Hindu faith leaders have signed a joint declaration at the Art of Living International Centre to work with the Department of AIDS Control to spread awareness among youth and to end stigma and discrimination against people affected by HIV.

* In February 2008, the Ministry of Railways announced a 50% waiver on train fare for PLHIVs accessing ART services. This concession is also extended to an escort of PLHIV.

* In July 2009, the Government of India decided to provide *Antyodaya Annayojna* cards to poor PLHIVs, making them eligible for getting subsidized food from public distribution system.

* Both the railway ministry and the food ministry have also agreed not to refer to such persons as
| **HIV/TB collaborative activities** | **Norms:**
* Emphasize the need for accelerated scale-up of collaborative activities on tuberculosis and HIV, in line with the *Global Plan to Stop TB 2006–2015*, and for investment in new drugs, diagnostics and vaccines that are appropriate for people with TB-HIV co-infection; (UN Political Declaration, 2006: para 33, p. 5).

* The Global Fund Board in its November 2008 meeting recommended that TB/HIV collaborative activities be included in both HIV and tuberculosis country proposals (Decision point, GF/B18/DP12). | **Compliance:**
* NACO and Revised National TB Control Program (RNTCP) have jointly developed the *National Framework for Joint HIV/TB Collaborative Activities* for strengthening HIV-TB collaborative activities across the country.

* A *National Technical Working Group for HIV/TB* is in place comprising of key officials from NACO and the Central TB Division to ensure tracking of co-infected patients, and adherence to treatment guidelines, etc.

* India has established strong cross-referrals and linkages between the existing service delivery sites of NACP and RNTCP at Microscopy Centers, ART centers, Community care centers and Integrated counseling and testing centers.

* Guidelines are in place for the intensified HIV/TB package in nine states which includes...
routine offer of HIV counseling and testing for all TB patients (and *vice versa*); and linking all the identified HIV/TB patients to care, support and treatment centers.

* Operational Guidelines and Training Modules on HIV-TB Co-infection are in place.

<table>
<thead>
<tr>
<th>Public private partnership (PPP)</th>
<th>Norms:</th>
<th>Compliance:</th>
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<tbody>
<tr>
<td></td>
<td>* Seek out actively and support the development of partnerships required to address the epidemic among the public sector and civil society, including the private sector. In particular, foster those alliances required to improve access to essential information, services and commodities – including access to condoms, care and treatment and to the technical and financial resources required to support prevention, care and treatment programs (UNAIDS Global Strategy Framework for HIV/AIDS, 2001: p. 15). * The Global Fund is supportive of proposals that focus on the creation, development and expansion of government/private/NGO partnerships, also</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Compliance:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>* India’s Global Fund country proposals in successive Rounds have incorporated both the government and private sectors, corporate business including NGOs in planning, design, service delivery, and monitoring of all Global Fund projects. * India’s Country Coordinating Mechanism (CCM) is composed of representatives from both public and private sectors, where members from other than government comprise more than 60%. * India’s private sectors including business and industries are actively engaged in delivering both workplace prevention, and care, treatment and supply chain management of ARV drugs.</td>
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known as Public-Private-Partnerships — PPPs (Global Fund guidelines for proposals, 2011).

* NACO has partnered with Confederation of Indian Industries (Indian Business Trust for HIV/AIDS); Federation of Indian chamber of Commerce and Industries (FICCI) and other corporate sectors on workplace intervention and providing of care, treatment and other support to people living with HIV/AIDS. Memorandum of Understanding was signed with ACC Cement, Ballarpur Industries Ltd., Bajaj Auto Ltd., Larsen and Toubro Ltd., and Godrej Ltd., and ART centers have been set up.

* NACO is developing partnership with Indian Army, Railways, Steel Authority of India Ltd., paramilitary forces, and NGOs like YRG Care, Freedom Foundation, Swami Vivekananda Youth Movement, private medical colleges, etc. for strengthening care and support activities including provisioning of ART.

* In a unique PPP model, India is setting up the Indian Institute of Advanced Nursing as the first postgraduate nursing institute specializing in HIV/AIDS in the world in partnership with Central
<table>
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<tr>
<th>Research</th>
<th>Norms:</th>
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<tbody>
<tr>
<td>* Increase investment in and accelerate research on the development of HIV vaccines while building national research capacity…, support and encourage increased national and international investment in HIV/AIDS related research and development including biomedical, operations, social, cultural and behavioral research…, including female-controlled methods and microbicides, and in particular, appropriate, safe and affordable HIV vaccines and their delivery… (UNGASS DoC, 2001: para 70, pp. 33-34).</td>
<td></td>
</tr>
<tr>
<td>* By 2003, ensure that all research protocols for the investigation of HIV-related treatment, including antiretroviral therapies and vaccines, based on international guidelines and best practices are evaluated by independent committees of ethics, in which persons living with HIV/AIDS and caregivers for ARV therapy participate (ibid.: para 74, p. 35).</td>
<td></td>
</tr>
<tr>
<td>Compliance:</td>
<td></td>
</tr>
<tr>
<td>* NACO has collaborated with National AIDS Research Institute, Pune for conducting cutting-edge research, training, surveillance and capacity building of staffs.</td>
<td></td>
</tr>
<tr>
<td>* NACO has constituted Network of Indian Institutions for HIV/AIDS Research (NIIHAR) for undertaking operational, epidemiological and biomedical research in the field of HIV/AIDS. This consortium has linkages with universities, Indian Council for Medical research, Council of Scientific and Industrial Research, Department of Science and Technology, Indian Council for Social Science Research and others stakeholders including donor organizations engaged in the HIV/AIDS response.</td>
<td></td>
</tr>
<tr>
<td>* In collaboration with International AIDS Vaccine Initiative and Indian Council for Medical Research, NACO has entered into HIV/AIDS vaccine trial on Indian subjects since 2006. Though further research is necessary to come to any conclusion, government, Tamil Nadu State Government, the Indian Nursing Council, and the Clinton HIV/AIDS Foundation (UNGASS CPR, 2010: p. 69).</td>
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</table>
Phase I and Phase II of the clinical trial shows impressive results.

* NACO awards 20 research fellowships per year to MD/PhD scholars to carry out research relevant to HIV/AIDS in bio-medical, clinical, epidemiological, behavioral, and social science disciplines and helps build their capacity as young scientists.

* The development of a safe, effective and affordable microbicides research is under way by Microbicides Society of India in collaboration with Indian Council for Medical Research.

* NACO in collaboration with Hindustan Latex Family Planning Promotion Trust is socially marketing Female Condom (FC), and pilot testing the feasibility in 8 targeted intervention sites by making FC available free of cost.

* India established *NACO Ethics Committee* in 2008 to consider and provide ethical clearance for research proposals and projects that involve participation and experimentation on human subjects.
4.3. Socializing norms at the level of institutions

The creation of NACO with a huge vertical program structure, and its nationwide subsidiaries in 35 states and union territories (State AIDS Control Societies) was, in fact, a part of the regime’s norm that India fully institutionalized. Despite several other competing diseases and health priorities that required urgent attention of the Indian government, AIDS was established as a vertical disease control program to give the highest priority. However, in recent years, criticisms were leveled from various quarters including activists, policy makers, and national governments against the suitability of a vertical program for AIDS. They argued that AIDS program being the largest vertical program in history is inefficient, expensive, and difficult to sustain (England, 2007, 2008). Realizing the mistake, international donors started promoting “mainstreaming,” as a norm by proposing to integrate AIDS program within the existing health infrastructure and argued for an overall health system strengthening. However, the damages were already done in the last 20 years of activism and lobbying that advocated AIDS as an exceptional disease that required exceptional political attention, funding, and manpower (and hence a vertical program). Infrastructures that were thus erected in the past 20 years, will now require skilled manpower, high operational cost, and huge resources for maintenance placing a severe strain on the national budget.

At the national level, NACO is responsible for the country’s response to the HIV epidemic, and is the equivalent of the National AIDS Commissions of other countries. It is responsible for implementing the policy framework through strategies set out in the NACP–3 strategy and implementation plan. NACO is assisted by the National Technical Support Unit for implementing targeted interventions; and by the Technical Resource Groups that advise on specific intervention areas such as blood safety, laboratory services, ART etc.
At the institution level, India’s NACP–3 complies with UNAIDS’ *Three Ones’ Principles*[^156], i.e., one agreed HIV/AIDS action framework, one national HIV/AIDS coordinating authority, and one agreed national monitoring and evaluation system. Administratively, NACO depends on the State AIDS Control Societies (SACS) in each state to perform its mandate. SACS are supported by Technical Support Unit in most states which are primarily responsible for supporting the targeted intervention component of the program. District AIDS Prevention and Control Units are set up in some of the most vulnerable districts to provide management oversight of HIV/AIDS activities in the districts. Thus, though NACO relies on a decentralized responsibility for prevention, support and supervision at the state and district levels, it still remains the highest AIDS coordinating authority in the country.

Another compliance with *Three Ones’ Principle* is observed in the development of a nationwide framework for monitoring and evaluation. NACO has developed a Strategic Information Management Unit, a web–based central server capable of integrating data from different sources, to gather quality information on the epidemic and strengthen the national monitoring and evaluation system. NACP collects routine information on program components from all states and union territories including blood banks, counseling and testing centers, STD clinics, ART centers, and NGOs implementing targeted interventions. This information is collected monthly through the software, Computerized Management Information System (CMIS) which is installed in all SACS (UNGASS *CPR*, 2010: p. 78). NACO has also constituted an Ethics Committee to consider and provide ethical clearance for research proposals that involve participation and experimentation on human subjects.

The following table (Table 4.4) summarizes the regimes’ norms and the degree of compliance at the institution level:

Table 4.4. Socializing norms at the institution level:

<table>
<thead>
<tr>
<th><strong>Political commitment</strong></th>
<th><strong>Norms:</strong></th>
<th><strong>Compliance:</strong></th>
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<tbody>
<tr>
<td></td>
<td>* Engagement of top level leaders; measurable goals and targets; adequate and sustained financial resources; and integration of HIV/AIDS prevention and care strategies into mainstream planning and development efforts (UNAIDS Global Strategy Framework on HIV/AIDS, 2001: p. 14).</td>
<td>* India has a National Council on AIDS headed by the Prime Minister and comprised of Ministers from 31 Ministries, and 9 Chief Ministers of various states to give the highest political priority to HIV/AIDS (UNGASS CPR, 2010: p. 48).</td>
</tr>
<tr>
<td></td>
<td>* Increase and prioritize national budgetary allocations for HIV/AIDS programs as required and ensure that adequate allocations are made by all ministries and other relevant stakeholders (UNGASS DoC, 2001: para 82, p. 39).</td>
<td>* India has a Parliamentary Forum on HIV/AIDS (PFA) consisting of elected representatives in the Parliament; and an inter–ministerial group for mainstreaming.</td>
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<tr>
<td></td>
<td></td>
<td>* State Councils on AIDS were formed in 25 states following the national model (UNGASS CPR, 2010: p. 48); and State Legislators Forums on AIDS were also formed in 9 states similar to the PFA.</td>
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<tr>
<td></td>
<td></td>
<td>* Despite relying on external aid, India’s domestic budget for HIV/AIDS has increased steadily over the years. During NACP 3 (2007–2012), India’s</td>
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domestic budgetary allocation was 26% ($622 million) of total funding.\(^{157}\) ($2.3 billion).

* Elected Legislators in Manipur and Nagaland decided to contribute `100,000 each from the Local Area Development Fund to support AIDS effort. All 120 Legislators from Manipur (60) and Nagaland (60) are members of Legislators Forum on AIDS in their respective states (UNGASS CPR, 2010: p. 57).

* Over 100 elected state Legislators from 15 major political parties in Andhra Pradesh signed a joint declaration to incorporate the goal of Universal Access to HIV services in their official election campaign manifestos (UNGASS CPR, 2010: p. 60).

* NACO conducts advocacy and coordination with 11 key ministries including Ministry of Home, Panchayati Raj, Women and Child Development, Rural Development, Labor and Employment, Housing and Poverty Alleviation, Surface Transport, Defense, Tourism, Youth and Sports,

\(^{157}\) Calculated from “Table 7.1, Sources of NACP 3 budget” as reported in UNGASS CPR, 2010: p. 72.
| **Legal environment** | **Norms:**  
* By 2003, strengthen the legal system capacity (UNGASS *DoC*, 2001: para 37, p. 16); ensure legal protection while respecting privacy and confidentiality (*ibid.*: para 58, p. 24); develop national legal and policy framework for protection of rights and dignity at workplace… (*ibid.*: para 69, p. 32).  
* We [the Heads of States], pledge to promote a social and legal environment that is supportive of and safe for voluntary disclosure of HIV status (Political Declaration on HIV/AIDS, 2006: p. 4). | **Social Justice and Empowerment, and Science and Technology.**  
* In January 2009, the Andhra Pradesh state cabinet approved a monthly pension of `200 for each person living with HIV from below-poverty line (BPL) and undergoing ARV treatment for a minimum of six months. About 40,000 people living with HIV from BPL families are expected to benefit from this scheme.  
**Compliance:**  
* The Draft HIV/AIDS Bill, 2006 was approved by the Union Law Ministry and is currently being considered in the Indian Parliament for making it a law. The Bill covers legislations on areas such as discrimination, informed consent, confidentiality, access to treatment, right to safe working environment, promotion of risk–reduction strategies, etc. for improving the quality of life of PLHIVs. |
<table>
<thead>
<tr>
<th><strong>Three Ones Principle</strong></th>
<th><strong>Norms:</strong></th>
<th><strong>Compliance:</strong></th>
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</table>
| **Norms:**               | * At the International Conference on AIDS and STIs in Africa held in Nairobi, Kenya, a strong consensus was arrived at on three principles applicable to all stakeholders in the country-level HIV/AIDS response:  
  * **One** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.  
  * **One** National AIDS Coordinating Authority, with a broad based multi-sector mandate.  
  * **One** agreed country level Monitoring and Evaluation System\(^\text{158}\). | * NACO is the only AIDS coordinating authority in India with a broad multisectoral mandate.  
  * NACO has developed one agreed action framework for coordinating AIDS work with appropriate policies, guidelines, and protocols in place.  
  * NACO has established Strategic Information Management Unit as the only country–level monitoring and evaluation agency. |

<table>
<thead>
<tr>
<th><strong>Country Coordinating Mechanism (CCM)</strong></th>
<th><strong>Norms:</strong></th>
<th><strong>Compliance:</strong></th>
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<tbody>
<tr>
<td><strong>Norms:</strong></td>
<td>* All proposals must be submitted through the CCM that includes NGOs/CBOs, government agencies, and commercial sector organizations, UN agencies, bilateral donors and foundations.(^\text{159})</td>
<td>* The India Country Coordinating Mechanism (CCM) for the Global Fund was established in accordance with the mandate laid out by the GFATM board since 2001. “The structure and the concept of the CCM is intended to reflect the</td>
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principles of national ownership and participatory
decision making. This unique public-private
partnership at the national level represents the
governing body for the use of Global Fund
resources in the recipient countries. The CCM is
responsible for coordinating submission of fresh
proposals, process requests for continued funding,
selecting principal recipients as well as oversight
on all GFATM grants. The current India CCM has
40 members” (Retrieved August 2, 2011 from:
http://www.india-ccm.org/).

| **World Trade Organization (WTO)/Trade Related Aspects of Intellectual Property Rights (TRIPS)** | **Norms:** | **Compliance:** (The stated norm in this area is contradictory to the practice allowed and followed by States in the international system).

* [We, the Heads of State] Reaffirm that the WTO agreement on TRIPS does not and should not prevent members from taking measures now and in the future to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, reaffirm that the Agreement can and should be interpreted and implemented in a manner supportive of the right to protect public health and, in particular, to promote access to medicines for all including the production of generic antiretroviral drugs and other essential drugs for AIDS-related

* WTO intellectual property rules, known as the TRIPS agreement, oblige India to grant 20-year patents on pharmaceutical products from 1st January 2005, so generic production of new medicines is illegal. Indian companies can no longer produce HIV drugs that are patented after 2005 which they were doing until TRIPS came into effect in 2005. This increased the procurement cost of ARV drugs for India’s national AIDS program,
infections. In this connection, we reaffirm the right to use, to the full, the provisions in the TRIPS Agreement, the Doha Declaration on the TRIPS Agreement and Public Health, and the World Trade Organization’s General Council Decision of 2003 and amendments to Article 31, which provide flexibilities for this purpose (Political Declarations on HIV/AIDS, 2006: p. 7).

| especially second-line regimen and consideration for free provision of second line of ARV therapy in case of drug resistance and toxicity. 

* To comply with WTO/TRIPS India amended its Patent Act in March 2005, Indian patent law requires that, aside from national emergencies, Indian generic manufacturers must wait for 3 years after a patent is granted to a medicine before they are authorized to apply for a compulsory license to generically produce it\(^\text{160}\).

* India is currently negotiating a free trade agreement with European Union comprising much of the TRIPS agreement with adverse effect on generic production of HIV and cancer drugs affecting the health of millions. Activists have already showed concerns that India should not give up its right to produce cheap generic ARVs for trade (ibid.).

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<thead>
<tr>
<th><strong>Gender Equality</strong></th>
<th><strong>Norms:</strong></th>
<th><strong>Compliance:</strong></th>
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<tbody>
<tr>
<td>* Promote gender equality (with a focus on women and girls) and equity in relation to sexual orientation and gender identities (with a focus on men who have sex with men, transgender populations, and male, female and transgender sex workers) (World Summit for Social Development, Commitment 5: 2000).</td>
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<tr>
<td>* Gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS; (UNGASS DoC, 2001: para 14, p. 9).</td>
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<tr>
<td>* Pledge to eliminate gender inequalities, gender-based abuse and violence; increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection (Political Declarations on HIV/AIDS, 2006: para 30, p. 5).</td>
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<tr>
<td>* NACP 3 has identified men and women as equal stakeholders in the national response and has committed to gender sensitive programming as a central and cross cutting theme. NACO has a policy guideline in place — <em>Policy Guideline: Mainstreaming Gender in HIV Program</em> (2008).</td>
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<tr>
<td>* India has developed a <em>National Policy on Gender and HIV</em> in the women empowerment framework.</td>
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<tr>
<td>* India is a signatory of CEDAW (1993) and follows commitments therein to promote gender equity and women’s empowerment in general.</td>
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<td>* UNDP and UNIFEM have helped to set up a gender desk at NACO.</td>
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<tr>
<td>* India’s <em>National Policy for the Empowerment of Women 2001</em> includes a statement “to tackle social, developmental and health consequences of</td>
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136
HIV/AIDS and other sexually transmitted diseases from a gender perspective.  

* To ensure and monitor progress on gender equity in HIV–programs, data on prevention, treatment, care and support services are disaggregated by gender and sex (NACO AR, 2010: p. 2).

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161 Ministry of Women and Child Development. (2001). *National policy for the empowerment of women.* Govt. of India.  
http://wcd.nic.in/empwomen.htm
4.3. Processes of norm socialization

After reviewing the degree of norm socialization in the Indian state’s domestic practices, I now come to examine the mechanisms through which this norm socialization and norm adaptation took place. This part is based on the explanatory model I have outlined at the end of the Chapter 3 (see Fig. 3.1). I contend that the Indian state and its preferences/interests were reshaped/reconstituted from three directions: “from above,” “from below,” and “from within,” each with several important actors and agents working simultaneously. At the end of Chapter 3, I have explained my theoretical model in detail, and have identified important actors and agents that reshaped/reconstituted the state interests. In this section, using my theoretical model, I examine the linkages between various actors and international norms, and how they led to behavior change in the domestic institutional practices in India.

Reshaping the state “from below”

The interests and preferences of the modern state are constantly being reshaped/reconstituted by multiple forces acting simultaneously from different directions (Reich, 2002). Some of these forces do actively constrain the state, while others redefine and reconstitute the state interests through a highly malleable process of socialization. In my theoretical model, the group of actors that reshape the state interests “from below” consists of the grassroots NGOs/CBOs that work with people living with HIV/AIDS; collectives of sex workers, queers, and drug users; protests and resistance movements led by the NGOs; and advocacy, pursuance by civil society and other domestic non-state actors. There is a highly complex mechanism through which these actors, their networks among themselves and with others pursue the state in redefining its interest and adopt the norms they are promoting in its domestic institutional structures. In the following section, I explain part of the processes that lead to this change.
NGOs and civil society as pressure group

How many NGOs are there in India? Well over two million162... While the figure is astonishing, not all NGOs are functional. Even if I assume that only 50 percent of these NGOs actually work, this gives us 1 million NGOs in a country of one billion population, i.e., one NGO per thousand population. While the spatial distribution of NGOs across Indian states remain a matter of concern (in that most populous states like Uttar Pradesh and Bihar have the least number of NGOs163), NGOs in India have increasingly taken over new roles where state has largely failed to perform. As Fisher (1997) pointed out that NGOs have become the “favored child” of official development agencies that will cure the ills of befallen development process and imagined as a “magic bullet” that will mysteriously (but effectively) hit the target (Dichter, 1993: p. vii, in Fisher).

In the last two decades, thousands of new international actors, donors and private foundations have emerged on the international development scene that led to an “explosion of funding164” giving rise to a new generation of Southern NGOs, mostly based in urban areas employing middle-class, educated, men and women (Mawdsley et.al., 2005). This meteoric rise in the number of NGOs in India has been variously called the “NGO-industry,” which (Kamat, 2002) called as “development hegemony,” and “NGO-ization of the grassroots.” Dip Kapoor (2005) called it as “taming of the grassroots.” During their process of growth, they have forged innovative and increasingly complex linkages (both formal and informal) with one another, with government agencies, with social movements, with international development agencies, and transnational issue networks that have profound impacts on local lives. They have

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163 Sooryamurthy and Gangrade (2001), ibid., p. 2.

164 Catherine (2006) reported that the not-for-profit sector is currently worth over $1 trillion a year globally, ranking as the world’s eighth largest economy. This places them in powerful position. The UK Department for International Development (DFID) notes that the world’s largest NGOs now have incomes “several times larger than several bilateral donors, are active in more countries and are certainly as influential in their ability to command public and political attention” (p. 5).
also become extremely successful in pressurizing the national governments to conform to the international norms promoted by specific development regimes by linking with actors from above and exerting their influence through the “boomerang effect.165"

**History of NGO movement in India**

To better conceptualize state–NGO relations, a brief history of NGO movement in India does not seem to be out of context here. Tandon (2002) viewed NGO movement is deeply rooted in the Hindu concept of *dana* (voluntary giving) wherein serving the poor (*daridra narayana*) was treated as equivalent to serving the God (*narayan sewa*). Though voluntary action in India evolved during the British colonial rule (mostly around issues of reform, independence, and modernity), actual boost to the NGO movement came in the 1970s after it was realized that the central dirigiste planning has failed to deliver the benefits of development to the poor. In the mid-1970s, the development of NGOs were influenced by Jai Prakash Narain’s (JP) ideology of “total revolution” that attracted mostly youth from all over India posing a new threat to the political power structure at the center. This led Mrs Indira Gandhi, the then Prime Minister to declare a state of national emergency. NGO movement was crushed to a great extent using brutal state power and police apparatus.

During the emergency period, the parliament enacted Foreign Contribution Regulation Act (FCRA) to regulate and monitor the activities of NGOs in the country. The interaction with foreign donors was a major reason for growing tension with State. As per this act, every NGO was required to set up a separate bank account and report the amount of funds received and the purpose yearly to the Ministry of Home Affairs. During the 1980s, the Government of India made concerted efforts to control NGO activity, particularly in the arena of political organization. During this decade, over 900 organizations were monitored for suspected subversive activities, their bank accounts were scrutinized, and tax exemption laws governing contributions to NGOs were tightened (Sen, 1999). Whereas getting an FCRA account has not been easy which requires political and bureaucratic patronage including bribery, it has become an

165 See Chapter 3 for definition.
effective tool to control the voluntary movement in India. In short, while the state welcomed NGOs and foreign funding for purposes of advancing state objectives of welfare and service delivery, it increased control over all other types of activities.

State-NGO relation in India took a new form with the emergence of issue oriented NGOs such as Narmada Bachao Andolon in the 1980s, or AIDS prevention program among sex workers during early 1990s. During the period 1980-90, the state always wanted to increase its control over the NGO sector. One such proposal which raged strong anti-state sentiments among NGOs was that establishing National and State Councils which would serve as an umbrella organization wherein NGOs could later join (Sen, 1999). The proposed policy framework was finally not adopted due to increased lobbying undertaken by certain officials within established NGO–sector. The Seventh Five Year Plan document defined NGOs as “politically neutral development organizations that would help the government in its rural development programs.”

The attempt to gain tighter control over NGO sector started in 1980 when Indira Gandhi’s government appointed a major commission of inquiry, Kudal Commission to look into the activities, sources, misuse of funds of some well known NGOs in the country that were associated with JP movement. Sen (1999) reported that during the span of commission’s life from 1982-87, about 900 Gandhian NGOs were accused of subversion; the leaders were harassed or jailed. The FCRA Act was amended several times (1983, 1985, 2004) with the latest revision in 2010, that came into effect from May 2011, which some activists say is a new instrument to curb the donor-NGO interaction in India.166

The NGO–movement got a boost after economic liberalization of 1991. The states’ well-defined roles for NGOs were observed in the Eighth Five Year Plan document (1992-97) which identified NGOs as “change–agents” and called for increased participation of NGOs in rural development. In the Ninth Five-Year Plan (1997-2002), Department of Health and Family Welfare introduced the “Mother NGO scheme” under the Reproductive and Child Health Program. Under this scheme, one

NGO was selected as “Mother NGO” in each district, who in turn, would provide support and grants to the smaller NGOs at the field level. In May 2007, the Union Cabinet gave its approval for a new *National Policy on the Voluntary Sector* with the objective of creating an “enabling environment” for voluntary organizations that not only stimulates their effectiveness but also protects their identity and safeguards their autonomy.

Thus whereas in its initial avatar, the Indian state took the responsibility of fulfilling most of the welfare and development functions for its citizens, in its more recent form, the onset of the free market and liberalization has encouraged NGOs to delegate these tasks (Kamat, 2001). Under pressure from the global economic and political order, the national government has come to cooperate increasingly with the non-governmental sector to achieve goals of development. The neoliberal agenda of “rolling back the state” (and World Bank’s good governance agenda) pushed the norm of diverting funds away from government control. And in many cases, the Left movement (such as the Naxalites, and Maoists) supported the idea of NGO–sector as it viewed the discourse of participation and empowerment as a potential tool for social change (Catherine, 2006). For example, National AIDS Control Organization (NACO) now has a database of over 10,000 NGOs to whom it funds for HIV/AIDS prevention and care activities.

**NGOs and AIDS**

From the onset of the HIV/AIDS epidemic in India (and abroad), NGOs and formal and informal community-based organizations (CBOs) have been at the forefront of promoting prevention, care and support services (Joseph & Rau, 2005). For example, in six hard-hit states of India (Maharastra, Tamil Nadu, Karnataka, Andhra Pradesh, Manipur, and Nagaland) a large part of the AIDS prevention, care and support services is delivered by NGOs. They have adopted innovative strategies to reach the community using culturally sensitive tools for communication, though political structure and local

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bureaucracy has often viewed their activities as a threat to “national culture” or political power.

The human rights of PLHIVs is largely a contribution of the NGOs. For example, organizations like Lawyers Collective, Human Rights Law Network, People’s Union for Civil Liberties, etc. have been relentlessly working on this aspect. Some of the important initiatives these NGOs took include drafting of India’s HIV/AIDS Bill 2007; organizing Affordable Medicine and Treatment Campaign; challenging the legal provision on homosexuality (IPC 377) in the Supreme Court; drafting amendments of Immoral Trafficking and Prevention Act 2006; challenging the patent laws on AIDS drugs in courts; and filing various public interest litigations on discrimination across Indian courts\textsuperscript{168}. At another level, other NGOs (Freedom Foundation, Sharan, Calcutta Samaritan, etc.) provide “harm reduction” services by distributing clean needles and syringes among drug users; condoms and lubricants among MSMs (Naz Foundation); or educate the sex workers and their clients to minimize the risk of infection (Durbar, Sangram, etc.). At the third level, NGOs (like YRG-Care, Freedom Foundation, etc.) are also providing direct anti-retroviral treatment and palliative care services in small 20-50 bed hospital settings, and training the family members of the infected people for home based care. Their program is extremely popular as it is viewed by the client as free from stigma and discrimination since it provides a supporting environment for physical and psychosocial recovery, and easy to access their services (Solomon and Ganesh, 2000).

\textbf{How the actors from below reshaped the state?}

Having reviewed the state NGO relationship, one may ask, how these actors from below influenced reshaping the state interest and catalyzed the process of norm socialization? What factors were responsible and through what processes the Indian state socialized regime’s norms in its domestic institutional structures? I briefly outline

\textsuperscript{168} A myriad of such legal issues across various parts of the country that reached the court have been described in detail in a recent book, \textit{HIV/AIDS and the Law}, Human Rights Law Network (2006), New Delhi.
below some of the factors and linkages between civil society pressure and norm socialization.

**A. Unity and network building among actors**

The degree of cohesion among the national NGO community, civil society and other non-state actors was a critical factor in their success. They were united in terms of their vision and agenda, and to carry that forward, they built networks, sites of resistances and horizontal integration of power, in the same way as a state relies on its own power structure. This cohesion resulted from NGOs being part of the same donors in different Indian states; or different donors adopting the same regimes’ norms in various states. This ideological assimilation, learning from each other, best practices and experience sharing brought the NGOs on a common platform. They were therefore getting a uniform message about the norms, principles and strategies to adopt for HIV prevention in the country. Contradictory messages usually impede the speed of norm adaptation — but in case of AIDS, the international actors promoted the established regime’s norms so there was less possibility of distortion. Issue based NGO networks were then established to promote a particular ideological orientation — networks of high-risk groups, such as INFOSEM (Indian Network for Sexual Minorities), NNSW (National Network of Sex Workers), IHRN (Indian Harm Reduction Network); networks of NGOs, such as INN (Indian Network for NGOs Working on AIDS), Voluntary Action Network India, All India Association of Voluntary Agencies, etc.; networks of campaigns and resistance movements such as Affordable Medicine and Treatment Campaign, Voices Against 377; Campaign for Sex Workers’ Rights, etc. — were all instituted to promote the norms. These networks offered united resistance against the state’s anti-human rights stance. They conducted advocacy at the state/national level to sensitize the policy makers about the situation.

**B. Evidence based advocacy**

An important objective of this network building was to reshape the national policy framework by conducting policy advocacy and sensitization programs for/with
the policy makers and top-level bureaucrats (to absorb the regime’s norms). These advocacy initiatives were based on scientific, evidence-based facts, accurate information, testimonies, life-histories, and results from well-conducted research to demonstrate that a particular strategy worked. Therefore, by giving scientific information and an alternative framework, they tried to alter the background/premise under which the state makes policies. The availability of clear indicators to demonstrate the existence of a problem and back up the claim that a particular strategy worked was vital in gaining support of the policymakers. For example, in the early days of AIDS epidemic (1992), the Sonagachi project in Kolkata for prevention of HIV/AIDS by empowering sex workers with knowledge and tools gained international reputation as a model for women’s empowerment program globally by community mobilization, rights-based approach, advocacy, and micro-finance. The availability of clear evidence from Sonagachi project that the above strategies have worked in Indian context was a crucial factor in gaining support for integrating these principles in operational guidelines for targeted intervention developed by NACO in later years. Similarly, the Humsafar Trust in Mumbai promoted safe behavior among MSM and transgender (TG) communities by giving them information, condoms and lubricants, forming support groups, etc., which was instrumental in keeping the infection rate relatively low among them (Kole, 2007). The same principles of human rights and “harm reduction” were adopted by the Freedom Foundation in Bangalore to work with drug users. All these programs demonstrated that a human rights-based strategy and involving the key population in planning, designing and implementing the program is the only way to effectively control HIV epidemic in India. In later years, these evidence

169 Keck and Sikkink (1998) called this process “information politics,” in which the NGOs (transnational activist networks) use the power of ideas, and scientific information to pursue the state by altering the context within which States make policies. Though part of this process is discursive, “information politics” has important bearing on the production of knowledge and construction of reality/interests.

170 See, for example, Swendeman, D. et al. (2009). Empowering sex workers in India to reduce vulnerability to HIV and sexually transmitted diseases. Social Science and Medicine. 69(8). pp. 1157–66.

171 See for example, NACO. (2007). Targeted interventions under NACP 3: Operational guidelines. Volume I, Core high risk groups. New Delhi: Ministry of Health and Family Welfare. This elaborate document going well over 500 pages provides guidelines for operationalizing targeted interventions for MSMs, female sex workers, transgenders, and injecting drug users at three levels: at the state level, at the NGO–level and, and for community based organizations (CBOs) for developing community led responses.
based advocacy became the benchmark for developing nationwide “targeted interventions” launched by NACO; and in the preparation of operational guidelines for NGOs and State AIDS Control Societies implementing the program.

C. Organizing large scale focusing events

The organization of large-scale focusing events such as, World AIDS Day (December 1), International Sex Workers’ Rights Day (3 March), gay pride parades, international conference on queer rights, HIV treatment, seminars, protest marches, and rallies, etc. drew tremendous media attention and public interest on the issue. In many such public events, celebrities, dignitaries, film stars (like Priety Zinta, Nafisa Ali, Shilpa Shetty, Richard Gere), cricketers (Rahul Dravid, Virendra Shewag), who acted as AIDS champions and UN AIDS ambassadors were invited to champion the cause. The presence of dignitaries and celebrities, in turn, drew wide media attention. Free media in India have generally represented these events in a positive light (without perpetuating discriminatory or stigmatizing messages), which was helpful in garnering support from part of the policymaking community and general public.

Events such as international conferences or UN high level meetings have invited India’s top political leaders. For example, Sonia Gandhi (Leader of the Congress party), represented India at the UNGASS in 2001. Following the Special Session, she personally took initiative to write letters to all the State Congress Committees urging them to play an active role in reducing HIV/AIDS in India and requesting the Chief Ministers to lead the efforts to curtail the epidemic in locations where the party holds power (Policy Project, 2005: p. 11). In addition, in 2004, Mrs. Gandhi delivered a

keynote address at the closing session of the 15th International AIDS Conference in Bangkok, along with world leaders such as Nelson Mandela. Other leaders like Prime Minister Atal Bihari Vajpayee in the opening of Business Coalition on HIV/AIDS Meeting in December 2001 emphasized the importance of developing a workplace policy for PLHIVs. Similarly, Prime Minister Manmohan Singh in his addresses to the United Nations General Assembly in September 2004 and to the National Students and Youth Parliament Special Session on HIV/AIDS in India in November 2004 also mentioned the importance of combating AIDS.

Highly publicized events such as launching of Red Ribbon Express by NACO in 2007 (a specially designed train with decorative HIV/AIDS awareness messages painted on its body to travel throughout India) inaugurated by Sonia Gandhi and Railway Ministers drew widespread media attention (NACO AR, various years). In these events, prominent political leaders like Sonia Gandhi (leader of the ruling party) or Mamta Banerjee (Union Railway Minister) made public speeches, and commitments to give AIDS the highest priority. Once the statements were made in public and were widely distributed through print and electronic media, it was difficult to backtrack, especially in a vibrant democracy like India. It was therefore wise to embrace the norms even for instrumental reasons. This instrumental adaptation had set in a process of identity formation which was later retained for reasons of belief and identity.

D. Offering pragmatic policy solution

Another key to success of the actors from below was because they offered/proposed clear policy alternatives and solutions based on evidence-based programming.\textsuperscript{173} The proposed policy solution was pragmatic and in a language that policymakers could understand. Specialized communications experts, India’s leading advertising agencies like Hindustan Thompson Associates, and advocacy groups and

\textsuperscript{173} Shiffman (2007) observed from his study of five developing countries in India, Indonesia, Nigeria, Honduras, and Guatemala that proposing pragmatic policy solution was one of the reasons for success of the NGOs in promoting global norm for safe motherhood in those counties. Shiffman, J. (2007). Generating political priority for maternal mortality reduction in five developing countries. \textit{American Journal of Public Health}, 97(5). pp. 796-803.
organizations specializing in population and health communication, like BBC World Service Trust, were contracted to develop well–designed communication programs for policymakers. Through these specially designed communication programs, they were able to convince the policymakers that something could be done to improve the situation by altering the context. Pick up any NGO advocacy report and you will typically find a set of “recommendations” for the government at the end, often based on the experiences of the program implementation. Just offering recommendations does not ensure that they will be integrated in the national planning. A state must weigh several factors for its adoption that not only include feasibility, pragmatism, cost–effectiveness, the larger socio–cultural context, and the domestic “constituency” that elect them in power to make policies; but also the larger international context, reputations abroad, and setting a precedence. A careful calculation of cost–benefit thus goes on for the adoption of norms (described in detail in Chapter 3). Nonetheless, having a clear set of alternative policy solutions provided a favorable ground for norm socialization.

E. Linkage with actors “from above”

This is called the boomerang effect, described in Chapter 3. When domestic NGOs failed to pursue the state with their demands, they usually formed linkages with the organizations “from above”. The organizations “from above” included UN bodies, transnational activist networks, international NGOs and multilateral donors, who, in turn, pressurize the state to adopt the norms. Domestic NGOs thus bypassing the state and exerting their pressure “from above” is called the “boomerang effect” (Keck and Sikkink, 1998). For example, drug substitution and needle syringe exchange programs to prevent HIV infection among drug users were always received with strong disapproval at the policy level. Domestic NGOs working with drug users like Sharan in Delhi; Freedom Foundation in Bangalore, etc., used their linkages with International Harm Reduction Network, and UNODC (United Nations Office on Drugs and Crime) who, in turn, influenced the Indian government and NACO officials to support targeted
intervention with drug users, and condone the “harm reduction” strategy and drug substitution therapy (instead of viewing them as criminals).\(^\text{174}\)

**F. Advocating AIDS as an exceptional disease**

This stance originated as a Western response to the epidemic was advocated by AIDS-and-gay-rights activists, and supported and promoted by the international donors to establish the norm that AIDS is an exceptional disease requiring an exceptional national response (Smith and Whiteside, 2010). In the early years of the HIV epidemic, this exceptionalism claimed that, HIV was different — so “exceptional” in comparison to other communicable diseases that public health officials should make HIV-policies that cater to the uniqueness of the epidemic, rather than treat it like all other communicable diseases. As Lazzarini (2001) noted that in the US, “public fear was so great, the political power of gay men so substantial, and concern over stigmatization so real, that public health authorities abandoned traditional approaches to communicable disease control in favor of a civil liberties approach\(^\text{175}\)”. The exceptionalists view resulted in an unprecedented international response, as the commitment of resources from various donors far exceeded any other health cause (see the formation of AIDS-regimes and its impact on global health in Chapter 3). International organizations, such as the UNAIDS, the Global Fund, PEPFAR, UNITAID, etc., were especially formed to address the “uniqueness” of HIV epidemic.

This “exceptionalist” stand was promoted by the international organizations and powerful AIDS regimes. For example, UNAIDS Executive Director, Peter Piot has always advocated the AIDS-exceptionalism idea.\(^\text{176}\) This idea that AIDS is an

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\(^{175}\) Lazzarini, Z. (2001). What lessons can we learn from the exceptionalism debate (finally)? *Journal of Medicine and Ethics* 29. p. 149, original emphasis added.

exceptional disease was later picked up by the domestic grassroots level NGOs and AIDS activists in India and elsewhere. For example, as early as in 1991, AIDS Bhedbhav Virodhi Andolon (ABVA, or anti-AIDS discrimination movement) prepared a Citizen’s Report on the status of homosexuality in India, through which they tried to sensitize the policymakers about the need to adopt human rights based policies in AIDS prevention.\footnote{I have dealt with this aspect in detail in Chapter 6 while examining the early history of queer mobilization in India. See Chapter 6 for details.} Activist groups and NGOs generally magnified the nature and extent of the HIV/AIDS problem\footnote{See for example, Pisani, E. (2008), \textit{Wisdom of whores...}, Chapter 1, \textit{Cooking up an epidemic}. Also, Ramachandran, S. (2003). Disease as development: Marketing HIV/AIDS for NGO profit, \textit{Times of India}, August 30.} through reports, seminars and press release, that too, in a fear-mongering language to sensationalize the policymakers and general public (I have dealt with this in detail in Chapter 1). This exceptionalism advocated by activists and championed by international AIDS regimes motivated the policymakers to absorb the regimes’ norms, especially in a political-economic environment where the financial support came from abroad.

\textbf{G. NGO-ization of the grassroots}

And finally, the sheer numbers of NGOs is one important factor as a pressure group for norm socialization. In the later part of the 1990s, following the global trend, India experienced a meteoric rise in the number of NGOs. For example, in the beginning of 1951, there were only 955 NGOs in the world, whose numbers had reached to 25,000 by 1990, and over 50,000 by 1999 — meaning, their numbers doubled only in less than a decade\footnote{Union of international Associations. (undated). Statistics: International organizations by year and type 1909-1999. Table 2. \textit{Yearbook of International Organizations}. Retrieved August 22, 2011: http://www.uia.be/statistics-international-organizations-year-and-type-1909-1999.} (1990–99). In India, similar doubling-trend is observed. In 1985, there were 5,099 FCRA registered NGOs, whose number reached to over 16,000 by 1995 and over 35,000 by 2007.\footnote{Ministry of Home Affairs. (undated). \textit{FCRA Annual Report: Receipt and utilization of foreign contribution by voluntary associations} (various years). New Delhi: FCRA Wing.} The explosion of NGOs drew huge amount of foreign funds into the country, which led to a growing professionalization of grassroots development business. As Mawdsley et.al. (2005) noted, that this
professionalization involved organizational development, capacity building, accountability, financial transparency, etc., that gave rise to a new “support industry” around capacity building and training of the Southern NGOs, and a growing need of skilled, educated manpower. India’s elite education system provided that skilled workforce required for NGO-ization and grassroots professionalization. India produces millions of graduate students (MA degree and above) every year generating a huge labor surplus. At the beginning of the academic year 2009-2010, the total number of students enrolled, in the formal system, in the Universities and Colleges was reported at 13.6 million, of which 1.6 million (12%) in university departments and nearly 12 million (88%) in affiliated colleges (MHRD Annual Report, p. 108). India produces over two million Bachelors degrees per year. With this one would add more than half a million graduate degrees (Masters degree); and about 13,000 PhDs in addition to 19,000 M.Phil degrees (UGC Annual Report, 2008-09, p. 284). Part of this huge educated workforce remain otherwise unemployed in a highly labor surplus society. Mushrooming NGO-business in every part of the country offered them an easy way out – by recruiting them as a cheap wage labor. This skilled workforce and professionalism, in turn, produced new knowledge and truths about the epidemic, something that one could not conceive a decade earlier because NGOs tended to recruit primarily grassroots level, less-skilled workers. Today, about 35,000 domestic NGOs receiving foreign funding, nearly 150 international NGOs, about 20 bilateral donors, and the same number of international organizations (IMF, World Bank) are active in India acting as a huge force of social change. It is no exaggeration to say, as Jessica Matthews did in Foreign Affairs, “Increasingly, NGOs are able to push around even the largest governments” (1997, p. 53).

**Reshaping the state “from above”**

In this group of actors, I have identified organizations of the UN system (like UNAIDS, WHO, World Bank, IMF); bilaterals (SIDA, USAID); and multilateral donors (Global Fund); international NGOs (Gates Foundation); transnational activist networks (Global Network of PLHIVs); and multinational corporations

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(GlaxoSmithKline, Pfizer). In addition to the rise of various regimes and international treaties on AIDS in recent years (discussed in Chapter 3), these actors from above have also introduced formal conditionalities for loans and grants. This has constrained the actions and directions of states through a combination of incentives and disincentives, through a mixture of rewards and threats (Reich, 2002). For example, Martha Finnmore (1994) from her study of science policy in developing countries demonstrated that UNESCO acted to promote the acceptance of certain state policies in those countries, instead of having those policies emerge from specific social processes and demands within the state itself. Finnmore’s example represents a generalized pattern of international agency-driven policy reform, in which states are pushed to comply with the policy directives issued by multilateral/multinational organizations. The following key processes from above were instrumental in reshaping the state interest to embrace global norms.

A. Promoting global norms

First, the actors from above promoted global norms that stigma, discrimination, and deaths from AIDS were unacceptable, and they pursued the governments to embrace these norms\(^ {181}\). They pursued the governments to adopt appropriate strategies for HIV prevention, and to ensure treatment and care of the infected people so that deaths from AIDS could be minimized. These norms were backed-up by consensus of various states arrived at high-level international meetings, and regional cooperation agreements. In case of India, some norms were instituted as part of the loan conditions – for example, World Bank’s loan to withdraw the AIDS Prevention Bill of 1989 and adopt a rights based policy for AIDS prevention (Dube, 2000: p. 86); or Global Fund’s grant to provide universal ARV treatment and care. Other norms, such as ensuring non-discrimination at workplace were instituted as part of the commitment/signatory to a treaty/regime. Campaigns by transnational activist networks like International Treatment Preparedness Coalition, Global Network of People Living with HIV/AIDS,

World AIDS Campaign, etc., also contributed to the promotion of norms by linking with UN bodies and multilateral donors. At another level, as a member of the WTO, India complied with enacting the provisions (and norms) of the TRIPS agreement (2005). Indian manufacturers can no longer produce generic versions of cheap anti-AIDS drugs patented after 2005, which kept millions of people alive in large parts of Africa and Asia.182

**B. Providing sufficient resources**

In addition to the active pursuance of the agenda, the international advocates provided sufficient resources for other actors to pursue that agenda. The actors from above backed up the efforts of, say, International Treatment Preparedness Coalition, or International AIDS Vaccine Initiative with provision of financial and technical resources. In Chapter 3, I have outlined the total volume of resource-flow for AIDS compared to other diseases. The amount of resources available for HIV/AIDS grew from $300 million in 1996 to about $14 billion in 2008. A large part of this funding came from PEPFAR, GFATM and World Bank’s MAP program. However, about one-third (33%) of all AIDS spending in low-and middle-income countries in 2005 also came from the developing countries themselves (UNAIDS, 2008: p. 181), which reflect some degree of norm socialization. Global Fund has already received a commitment of $11.7 billion from it donors for the years 2011-2013, the largest ever financial pledge for the collective international effort to fight AIDS, TB and malaria.183

**C. Linking with actors “from below” and “from within”**

The international organizations provided direct financial and technical support to the NGOs to implement AIDS-programs. They funded well-designed operations

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research in target communities to demonstrate that a particular program/strategy works. For example, Bill and Melinda Gates’ $338 million Avahan program in India\textsuperscript{184} provided most of its grants to the NGOs in six high prevalence states to work with sex workers, truckers, MSMs and drug users. These NGOs in turn, conducted advocacy and sensitization programs with the policy makers to integrate the norms.

**Establishing international reward system**

At another level, the international organizations established linkages with actors “from within” comprising the bureaucracy, the political class, and decision makers. They established a system of rewards and incentives in which the bureaucrats were rewarded with a high-level position in the organization after their retirement from the government, which is usually 60 years in India. For example, influential bureaucrat and Secretary in the Ministry of Health, JVR Prasada Rao was recruited by UNAIDS as the Director of Regional Support Team for Asia and Pacific after his retirement. Similarly, A.R. Nanda, Secretary of Health and Family Welfare served the David and Lucile Packard Foundation in its International Advisory Board in addition to holding the Executive Director’s position with the Population Foundation of India after his retirement. This type of “connection” demonstrates that as long as they are serving the Ministry, they work in favor of these organizations with an implicit expectation to get an asylum after their retirement. Once they are out of the Ministry and with the INGOs, they exert their influence on the Ministry from outside by acquaintance, friendship, and rewards to perform the function for the INGOs and push the norms that they are promoting.

Other types of reward system, for example, giving fellowships/scholarships to the bureaucrats, journalists, policymakers, etc. to study abroad in American universities of repute, created “docile bodies,\textsuperscript{185}” through which highly docile and “sensitized”

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\textsuperscript{185} This is a Foucauldian concept. Foucault defined docile bodies as the “one that may be subjected, used, transformed, and improved; and that this docile body can only be achieved through strict regiment of disciplinary acts” (1995: p. 136). In this case, the scholarship recipients are used, transformed and
During their study abroad, they absorbed the norms, which they implemented in their domestic practices when they returned. For example, until recently, WHO in collaboration with Ministry of Health and Family Welfare in India offered fellowships to candidates nominated by the Ministry to pursue a Masters’ degree in public health abroad. Some bureaucrats work with the government and WHO simultaneously; whereas others, take a leave, work with the WHO for five years, return to the government, and then come back to WHO again after their retirement. It seems as if there is a revolving door between the WHO headquarter in Geneva and the Ministry of Health in New Delhi through which the national policies enter and exit!

Reshaping the state “from within”

While the international actors had put the issue on the global agenda, and the actors from below readily adopted the norms for domestic adaptation/implementation, without a change from within the system, sustained institutionalization of the norm in the overall structure of the Indian state was not possible. National adoption of norms requires sustained advocacy and willingness of the state to change “from within.” By embracing and upholding the norms, the states develop and reaffirm their identity in the international society. Some of the most important factors from within that affected the norm socialization included, political and bureaucratic change; structural/institutional reform; globalization/ liberalization; (and media attention and international reward system just described above).

A. Political and bureaucratic change:

The success of norm adaptation also depended on the existence of public health leaders who were willing to make AIDS as their personal priority. Health minister such as Ambumani Ramadoss is popularly believed as the minister who personally supported

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...subjects were produced.\textsuperscript{186} During their study abroad, they absorbed the norms, which they implemented in their domestic practices when they returned. For example, until recently, WHO in collaboration with Ministry of Health and Family Welfare in India offered fellowships to candidates nominated by the Ministry to pursue a Masters’ degree in public health abroad. Some bureaucrats work with the government and WHO simultaneously; whereas others, take a leave, work with the WHO for five years, return to the government, and then come back to WHO again after their retirement. It seems as if there is a revolving door between the WHO headquarter in Geneva and the Ministry of Health in New Delhi through which the national policies enter and exit!

Reshaping the state “from within”

While the international actors had put the issue on the global agenda, and the actors from below readily adopted the norms for domestic adaptation/implementation, without a change from within the system, sustained institutionalization of the norm in the overall structure of the Indian state was not possible. National adoption of norms requires sustained advocacy and willingness of the state to change “from within.” By embracing and upholding the norms, the states develop and reaffirm their identity in the international society. Some of the most important factors from within that affected the norm socialization included, political and bureaucratic change; structural/institutional reform; globalization/ liberalization; (and media attention and international reward system just described above).

A. Political and bureaucratic change:

The success of norm adaptation also depended on the existence of public health leaders who were willing to make AIDS as their personal priority. Health minister such as Ambumani Ramadoss is popularly believed as the minister who personally supported

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\textsuperscript{186} This is what Gramsci called, creating “organic intellectuals,” a system of ideological control and domination that is achieved by producing “intellectuals” using the educational system to perform a specific function for the dominant social group (Gramsci, 1971, 1985). It is by using this group, the ruling class maintains its hegemony. Gramsci, A. (1985). \textit{Selection from cultural writings}. Tr. by William Boelhower. Cambridge, Mass: Harvard University Press; and Gramsci, A. (1971). \textit{Selections from the prison notebooks}. London: Lawrence and Wishart.
the AIDS agenda. On the contrary, Satrughna Sinha, a Bollywood film personality despite attending 2002 Barcelona AIDS conference with his crew, did not show much activism in this field. On the contrary, Union Health Minister in the current Congress led regime (2011), Ghulam Nabi Azad, made homophobic statements in the media saying homosexuality as *unnatural* and a *disease*\(^{187}\) (despite Delhi High Court ruling decriminalizing homosexuality) raising a national uproar among the AIDS community about the suitability of a homophobic minister the lead the Health Ministry and AIDS control program. Union Ministers thus come from all ideological backgrounds, with their own personal baggage about the immorality of prostitution, drug use, and homosexuality, which impedes or accelerates the process of norm socialization.

Ministers may also get constrained by a particular ideological strand that their party tends to promote. For example, if *swadeshi* (nationalism) is the official position of a political party (say BJP), the Union Ministers are most likely to comply with the party–position by resisting the norms promoted by the NGOs/INGOs as “foreign,” “un–Indian,” “corrupt,” and “cultural imperialism” of the West. In contrast, if the official position of a particular party (say Congress) is *liberalism*, then the Ministers are most likely to follow and adopt liberal policies. I say “most likely,” because in a multi–party coalition government as in India, the coalition/government may be led by the majority party (Congress), but the cabinet health minister may be from a different (minority) party (BJP) who is ideologically opposite to the dominant party leading the coalition. This is indeed the present case (15\(^{th}\) Lok Sabha, 2009–2014) with Manmohan Singh (Congress) leading the coalition government, while Ghulam Nabi Azad is a BJP health minister. It’s not to argue that BJP is less liberal than Congress (which, as a matter of fact, may be true), but *swadeshi* was the official BJP position and economic philosophy in the early days of economic liberalization, which was pursued through the 1990s until early 2000s.\(^{188}\)

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Political transition is therefore important in giving new actors the agenda–setting power. Ideological transition impedes or accelerates the absorption of norms by the state. With respect to health (and HIV/AIDS), there is insufficient evidence to conclude that Congress and BJP’s ideological differences have resulted in different degrees of norm socialization in two different political regimes. Because, overall, both Congress and BJP pursued the broad liberalization measures to maintain the coalition politics, and both remained engaged for the most part in saving a fragile coalition (Corbridge and Harriss, 2000), and hence, health took a backseat. Political transition is nonetheless helpful to explain the norm socialization because if the performance of health sector remains bad in one political regime (as measured by high infection rates, non-availability of drugs, stigma and discrimination, etc.), the new political regime is most likely to adopt measures that improve the situation. After all, they came to power by promising their constituency a better future. Therefore, political transition brings with it an internal urge for reform, which accelerates norm absorption.

India’s bureaucratic apparatus is the means of attaining the goals prescribed by the political leadership. As Singh (2000) observed, “Like Alladin’s lamp, it serves the interest of whosoever wields it. Those at the helm of affairs exercise apical dominance by dint of their political legitimacy... The Ministers make strategic decision. The officers have to act upon instructions from above without creating a fuss about it.” However, this relationship is a little overstated and is not always one way as Singh has conceived. There is a both-way relationship, as the bureaucracy also possesses the capacity of advising, appraising, and giving recommendations to the political leadership. Bureaucracy can thus influence the political leaders and decision makers. Bureaucrats who are connected to the INGOs, or who keeps an interest to serve the INGOs after retirement, or was in a WHO fellowship at Washington DC, are more likely to influence the national political leader for absorption of norms. Many political

swadeshi as the economic philosophy for the country. In a recent statement, BJP General Secretary Arun Jaitley said the BJP is committed to the reform process, which should have ideally begun in the 70s. Jaitley accused that the continuity in the reforms process, witnessed in the 1991-2004 period, had been broken by the UPA(Congress led) Government because of lack of political will. See, “No fixation with Swadeshi, BJP for reforms: Jaitley.” Indian Express, May 2, 2009. Retrieved: http://www.indianexpress.com/news/no-fixation-with-swadeshi-bjp-for-reforms/453574/

leaders also bring with them a change in bureaucracy. For example, with changing health ministers, the health secretaries get changed; or the same secretary serving two successive health ministers from two completely different ideological orientations.

Depending on the issue, some degree of political maneuvering is required to absorb the norm at the policy level. In many cases, overseas donors or domestic health activists do not have the legitimacy or expertise to pursue such political maneuvering successfully (Shiffman, 2007). That capability, almost always resides with the domestic bureaucrats and political officials. Hence bureaucratic change and advocacy with the bureaucrats, provide a crucial entry point for norm socialization.

B. Structural change

Indian industries, corporate business, private foundations and other non-state actors (NGOs, trusts, charities, art, theater, and media organizations) acted as a catalyst for change from within. As pointed out in earlier, following the economic liberalization of 1991, India’s economy was rapidly restructuring. In the neoliberal mantra of minimalist state, the new policies actively promoted private sector involvement and public-private partnership in the delivery of services. The new economic environment thus resulted in an NGO-boom in the country. As Swidler (2006) has observed from Africa, a number of diverse organizational interests from deforestation, dam development, energy/power, natural resource, disaster management, poverty alleviation, agriculture, nutrition, transport, urban pollution, waste management, to health, environment, education, sexuality, women, drugs, microfinance, faith, religion, culture, media and all other bizarre organizations had some kind of HIV/AIDS component built into their programs. For example, The Energy and Resources Institute (formerly Tata Energy Research Institute, TERI) with its 30 year’s of history in conducting research on

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190 This is consistent with Elizabeth Pisani’s (2008, Chapter 8) observation, where she compared the HIV industry with “Ants in the sugar bowl”. The sugar bowl of AIDS funding has increased so big in its size that diverse species of ants have crawled into the sugar bowl to get their share. So there is culture and AIDS, children and AIDS, fisheries and AIDS, environment and AIDS, flood management and AIDS, but in most countries the problem is “sex and AIDS,” or “drugs and AIDS” (p. 271). The wisdom of whores: Bureaucrats, brothels and the business of AIDS. New York, London: W. W. Norton.
conventional energy, solar energy, nuclear energy, hydroelectricity, hydrocarbons, sustainable development, etc., started working on HIV/AIDS in 2005. In collaboration with Business Council for Sustainable Development, TERI–BCSD began mainstreaming efforts to educate its member companies on the business risk associated with HIV/AIDS through a series of dialogue and research.\footnote{World economic Forum. (2007). \textit{TERI–BCSD India profile}. December. Retrieved August 7, 2011: https://members.weforum.org/pdf/GHI/India.pdf} It has also instituted a \textit{Corporate Award for Business Response to HIV/AIDS} (which is usually presented by the President of India or a Union Minister) for innovative initiatives undertaken by the corporate sector to combat the HIV/AIDS.

Thus following liberalization, most corporate sectors and Indian businesses established their own NGOs (non-profit) as a commitment to “corporate social responsibility” through which they delivered various workers’ welfare programs (some included HIV/AIDS). After the establishment of Indian Business Council on AIDS (with influence from ILO and UNAIDS), corporate giants like Tatas, Birlas, DCM Shriram, Hindustan Lever, Reliance, Bharti, Wipro, and Infosys, including the smaller ones like Dr. Reddy’s Laboratories, Lakshmi Cement, or Ballarpur Paper Mills started delivering HIV prevention services at workplace. For the corporate sector, however, “non-profit” remains a profitable proposition where they could divert a part of their earning to minimize income tax burden, while at the same time they act as leaders and “lords” of people’s needs.

This structural change from within and decreasing government control enabled the Indian business to form partnerships with organizations “from above.” For example, Indian Business Trust for HIV/AIDS and Confederation of Indian Industry went in partnership with Global Fund to do an advocacy program with its member industries for implementing workplace prevention, which is ongoing since 2004. Indian government has worked very closely with the private sector. The growing public–private partnership as outlined in the UNGASS Declaration of Commitment paved the way for norm socialization.
Table 4.5. Summary table: Factors for norm socialization

<table>
<thead>
<tr>
<th>Factors</th>
<th>Category</th>
<th>Description</th>
<th>Influence on norm socialization: Positive or negative?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transnational influence: Influence from INGOs, IOs, TANs, Bi–and multilaterals</td>
<td>From Above</td>
<td>Efforts by international state and non-state actors to establish a global norm that AIDS is a human rights issue. Hence <em>appropriate</em> prevention, treatment, and care and support services must be made available for infected, affected and vulnerable communities.</td>
<td>Positive</td>
</tr>
<tr>
<td>Resource provision</td>
<td>From Above</td>
<td>Provision of financial resources and technical support by international agencies, and transnational advocacy networks to combat HIV/AIDS.</td>
<td>Positive</td>
</tr>
<tr>
<td>Ideological cohesion among NGOs and domestic policy community</td>
<td>From Below/From within</td>
<td>The degree to which national HIV/AIDS policy advocates consisting of both the grassroots activists and government bureaucrats coalesced as a political force pressurizing the government to act.</td>
<td>Positive</td>
</tr>
<tr>
<td>Political champions</td>
<td>From within</td>
<td>The presence of respected and capable national political leaders willing to promote and champion the cause of HIV/AIDS.</td>
<td>Positive</td>
</tr>
<tr>
<td>Credible indicators</td>
<td>From Below</td>
<td>The availability and strategic deployment of clear evidence and field-based indicators to demonstrate that a particular problem exists and that needs urgent attention.</td>
<td>Positive</td>
</tr>
<tr>
<td>Large scale focusing events</td>
<td>From below/From above</td>
<td>The organization of international conferences, seminars, events championed by stars and celebrities, observing special days to generate attention of the national policy making community for the cause.</td>
<td>Positive</td>
</tr>
</tbody>
</table>
### Table 4.5 Contd…

<table>
<thead>
<tr>
<th>Factors</th>
<th>Category</th>
<th>Description</th>
<th>Influence on norm socialization: Positive or negative?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offering clear policy solutions</td>
<td>From below/ From above</td>
<td>The availability of clear policy solutions based on research and field intervention to demonstrate that a particular program has worked and that the problem can be solved.</td>
<td>Positive</td>
</tr>
<tr>
<td>Network building and establishing linkage with actors from above, below and within</td>
<td>All levels</td>
<td>The degree to which the actors at all levels develop network and professional linkage among themselves and with others, across all levels.</td>
<td>Positive</td>
</tr>
<tr>
<td>Political and bureaucratic change</td>
<td>From within</td>
<td>Regime change based on political ideology such as Marxism, liberalism, socialism or cultural nationalism positively or negatively affects AIDS norm socialization.</td>
<td>Positive or Negative</td>
</tr>
<tr>
<td>Structural change</td>
<td>From within</td>
<td>Economic and structural transformation, global economic integration, and the degree to which domestic economy adopts neoliberal economic principle and market based growth.</td>
<td>Positive</td>
</tr>
</tbody>
</table>

### C. Globalization/liberalization

I have examined this case in detail in the next two chapters (Chapter 5 and 6) with respect to sex workers’ and queer mobilization. I have also mentioned earlier that following the economic liberalization of 1991, India witnessed an NGO-boom with dramatic increase in foreign funds received by NGOs. Globalization thus facilitated a global exchange of ideas. The global civil society got connected through cheap telecommunication technology, fax, and internet. Issue based advocacy networks grew both in number and strength. This global interconnection and exchange of ideas...
between policy makers and activists provided a conducive environment for norm socialization. The next two chapters will make this connection explicitly clear.

4.3. Summing up

In this Chapter, I have provided a generalized model for norm socialization and demonstrated how the Indian state’s interests and preferences were reshaped/reconstituted by various actors from above, from below and from within. In the process of absorbing the norms, the Indian state developed, embraced, re/de(fined), and asserted its liberal-democratic identity. Following the social constructivist theories (Finnmore, 1996; Katzenstein, 1996a; Adler, 2002; Checkel 2004), I have demonstrated that state’s interests and preferences are not static — rather, they are fluid and are highly malleable that develop from existing discursive practices and social processes. Whereas materialist theorists have argued (Walt, 1998) that it’s the identity that defines interests and actions (behavior), this dissertation does not have any preconceived idea about which leads to what. Yet, as per constructivist position, norm-guided identity formation is a causal mechanism that seemed most appropriate to me. Identities, as interests, are not just “out there” so as a state will go and adopt them — they develop from social interaction between states, and in relation to others in which the presence of ideas, norms, institutions, and regimes play a significant role in state’s definition and construction of its own interests (Keohane 1984: pp. 100-06). As Martha Finnmore noted, “States are socialized to want certain things by the international society in which they… live” (Finnmore, 1996: p. 2). In this Chapter, I have provided a causal explanation about how the Indian state was socialized to want/adopt the norms of the HIV/AIDS regimes in its domestic institutional structures.

My theoretical model shows that it can be used to explain the norm socialization process in various socio–economic–political–cultural settings. However, in other contexts, say for example, in Brazil, or Peru some of the actors and their roles may change, but that will not alter the validity of this overall explanatory framework.
Finally a few words about the actors from above: International development agencies can influence the health priorities in poor countries. At the global level, they shape norms. Often they impose their priorities upon developing countries without considering local needs and national priorities. For example, Bill Gates came to India with $258 million and said, I want to implement an AIDS prevention project. Now Indian government could very well told him that, we don’t want AIDS here — for us, diarrhea or cholera is a problem. But Bill Gates wouldn’t give his money for safe drinking water or mosquito net.

It would be a rare precedence that a donor comes with millions of dollars and a resource poor country refuses him. So Bill Gates did what he wanted — Established expensive corporate style management structures, paid huge salaries to its staff; created huge infrastructures, and now telling the Indian government to take over all that because, my job is over! Though Indian government fiercely resisted the idea of taking over such a gigantic white-elephant because it is expensive, unsustainable, and misfit. For Bill Gates, his job was only to “initiate,” setting-in-motion the process. And in the meantime, while tussles were going on between the two, all the norms that Bill Gates brought with him were absorbed in the Indian domestic institutional structures.

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