Chapter 1
Introduction

“Every morning our newspapers could read, ‘More than 20,000 people perished yesterday of extreme poverty.’ How? The poor die in hospital wards that lack drugs, in villages that lack antimalarial bed nets, in houses that lack safe drinking water. They die namelessly, without any public comment. Sadly, sad stories rarely get written.”

So, what determines which stories get written and which do not? This dissertation project is an inquiry into the understanding of how development priorities are shaped, and how and why states respond to a specific development issue in certain fashion. I start by asking why do some health issues, such as HIV/AIDS, get considerable attention of the state whereas others such as diarrhea, dengue, malnutrition, childhood diseases, and a collapsing health system get very little? Given that there are several competing health proprieties in a resource-poor setting, what determines HIV/AIDS will get priority over the others? And what are the implications of such a development trajectory that a state takes? I examine this case with reference to India.

1.1. The nature of HIV/AIDS “industry”

The 2010 Human Development Report (HDR) published by UNDP ranked India at 119th out of 169 countries in terms of human development (p. 143). A country with over 1.2 billion people to feed, still suffers from mass structural poverty, hunger and malnutrition with over 40 percent of total population surviving on $1.25 per day. Diseases are endemic – every year malaria, dengue, diarrhoea, cholera and other communicable diseases kill millions of people most of whom are women and children. For example, in 2008 World Health Organization (WHO) reported that out of 988,000

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2 As per India’s national poverty line, this figure is 29 percent. Human Development Report 2010. New York: Palgrave McMillan. p. 162.
medically certified deaths\(^3\) in the country, 462,000 (47\%) died from communicable, maternal, and perinatal diseases whereas respiratory infection alone accounted for 107,000 (11\%) of total deaths.\(^4\) Under-five mortality rate hovered around 66 per thousand in 2009 that translated into 1.7 million deaths of children annually, which are largely preventable.\(^5\) Nationally, only 44 percent of children are fully immunized by age two\(^6\) resulting in millions of child-deaths every year from vaccine preventable diseases. About half of the children (47\%) below age 5 are moderately or severely underweight\(^7\). Maternal deaths are as high as 450 per 100,000 live births, compared to that of 11 of USA (HDR 2010: p. 156).

In terms of illiteracy, India falls behind Sub-Saharan Africa with more than 350 million illiterate populations (35\% of total). About 120 million people still lack safe drinking water (HDR 2010: p. 170); and nearly 70 percent of total population (more than double the total population of USA) do not have toilet and improved sanitation facility (\textit{ibid.}). National health achievements are low. Nearly 200 million people do not have access to basic health services. Social sector spending is about 6 percent of GDP (3\% on education) that almost remained constant over the last two decades (Yuko, 2005). Government spending on health is barely one percent of GDP (HDR, p. 204), whereas private spending is about 4 percent.

Let me now juxtapose this overall country scenario with HIV/AIDS epidemic in India. As of 2008, about 2.3 million people were living with AIDS virus giving an adult prevalence rate of 0.3 percent\(^8\). Total reported AIDS death stands at around 1,500 per

\(^3\) In India, overall, only 50\% of total death are recorded and captured through the death registration system, out of which medical certification takes place to only 15\% of total registered deaths (Mortality statistics, p. 28, chapter 3). Hence the actual figures of total deaths and disease specific deaths are likely to be 3–4 times higher.
In contrast, UN agencies estimate that around 117,000 maternal deaths occur in India every year, comprising 25 percent of total maternal deaths worldwide. Diarrhoea alone accounts for 1,600 deaths per day, whereas childhood illnesses and vaccine preventable diseases cause more than a million deaths of children per year. Yet, the government of India provides free universal antiretroviral treatment to AIDS patients, a “privilege” that hardly exists for any other disease, say, diarrhoea or dengue. In fact, “basic” medicines for common fever, cold, diarrhoea, antimalarial drugs, and life saving antibiotics are not available “free” from the government hospitals. HIV patients also get free diagnostic facilities and treatment of opportunistic infections, which does not exist for any other diseases, say cancer.

In 2008, the Indian government introduced employment guarantee scheme for India’s 2.5 million HIV–positive people to give them employment under National Rural Employment Guarantee Act (no other disease specific employment guarantee exist in India as of today). The government also declared that all HIV–patients who are receiving antiretroviral therapy would be treated as “below poverty line” that would enable them to receive 35 Kilograms of food grain per month (ibid.). Some Indian states such as Orissa and Rajasthan have introduced pension scheme for HIV patients, or other forms of economic support such as loans to establish small business in Andhra Pradesh, economic support for the spouse of the diseased, and orphan care and support in all the six high–prevalence states of India. To give the highest political priority to the disease, India has formed a Parliamentarians’ Forum on HIV/AIDS in 2001 consisting of elected members in the Parliament, which apparently has never existed for any other disease in history.

In India, HIV/AIDS constituted 2.1 percent of total disease burden as measured by DALY.\textsuperscript{13} This burden is about 5 times less than cardiovascular diseases (10 percent); 6 times less than maternal and perinatal conditions (11.6 percent); 4 times less than diarrhea (8.2 percent) and about 9 times less than other communicable diseases and acute respiratory tract infection\textsuperscript{14} (see Table 1.1). In another recent work, Sridhar and

<table>
<thead>
<tr>
<th>Diseases/ Health conditions</th>
<th>DALY’s lost (x1000)</th>
<th>Share in the total burden of disease (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Communicable, maternal &amp; perinatal conditions</td>
<td>49,517</td>
<td>18.4</td>
</tr>
<tr>
<td>Injuries</td>
<td>45,032</td>
<td>16.7</td>
</tr>
<tr>
<td>Maternal and perinatal conditions</td>
<td>31,207</td>
<td>11.6</td>
</tr>
<tr>
<td>Cardiovascular diseases</td>
<td>26,932</td>
<td>10</td>
</tr>
<tr>
<td>Mental illness</td>
<td>22,944</td>
<td>8.5</td>
</tr>
<tr>
<td>Diarrhoeal diseases</td>
<td>22,005</td>
<td>8.2</td>
</tr>
<tr>
<td>Other Non Communicable diseases</td>
<td>18,801</td>
<td>7</td>
</tr>
<tr>
<td>Childhood diseases</td>
<td>14,463</td>
<td>5.4</td>
</tr>
<tr>
<td>Cancers</td>
<td>8,992</td>
<td>3.4</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>7,577</td>
<td>2.8</td>
</tr>
<tr>
<td>HIV/AIDS*</td>
<td>5,611*</td>
<td>2.1*</td>
</tr>
<tr>
<td>Malaria and other vector-borne conditions</td>
<td>4,200</td>
<td>1.6</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Diseases and asthma</td>
<td>4,061</td>
<td>1.5</td>
</tr>
<tr>
<td>Blindness</td>
<td>3,699</td>
<td>1.4</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1,981</td>
<td>0.7</td>
</tr>
<tr>
<td>Oral diseases</td>
<td>1,247</td>
<td>0.5</td>
</tr>
<tr>
<td>Otitis media (middle ear infection)</td>
<td>475</td>
<td>0.1</td>
</tr>
<tr>
<td>Leprosy</td>
<td>208</td>
<td>0.1</td>
</tr>
<tr>
<td>All other diseases not listed in Communicable or non-communicable conditions</td>
<td>68,319</td>
<td>25.4</td>
</tr>
<tr>
<td><strong>All listed conditions</strong></td>
<td><strong>200,634</strong></td>
<td><strong>74.6</strong></td>
</tr>
</tbody>
</table>


Gomez (2010: p. 6) noted that if measured by age-standardized DALY rates, then cardiovascular disease was the most burdensome in India with a DALY rate at 3284. This was followed by neuropsychiatric disease at 3044, and respiratory conditions and unintentional injuries at 2913. In contrast the DALY rates for HIV/AIDS, TB and malaria were 1011, 869 and 69, respectively (see Table 1.3).

(Mis)Allocation of resources

The political priority to treat HIV/AIDS as a “special” disease was backed up by making increasing financial and other resources available for AIDS prevention. Since early 1990s till the end of 2010, India’s total budget from all sources for implementing National AIDS Control Program (NACP) has steadily gone up from US$19 million\textsuperscript{15} in 1989 to over $2.4 billion\textsuperscript{16} during 2007–12 for implementing the third phase of NACP. This has happened in a climate when overall health and social sector spending remained stagnant during 1990s till 2005 due to structural adjustment,\textsuperscript{17} or even, may have gone down as some studies indicate\textsuperscript{18}. The government of India’s approved plan outlay during the 11\textsuperscript{th} Plan (2007–2012) for implementing national AIDS control program was nearly $1.3 billion\textsuperscript{19} (MoHFW AR 2011: p. 52). During the same period, India’s total allocation for all Centrally Sponsored Programs for health was $5.2 billion, and total “health” allocation was $9.1 billion (MoHFW AR 2011: p. 52–58). Thus, with 0.3

\textsuperscript{17} Yuko (2005); Mooji and Dev (2004) among others.
\textsuperscript{18} See Gupta and Sarkar (1994); Prabhu (1994); Jalan and Subbarao (1995); Duggal, Nandraj and Vadair (1995); Prabhu (1999); Swaminathan and Rawal (1999); Basu (2000); Chandrashekhar and Gosh (2002).
\textsuperscript{19} An exchange rate of 45 = $1 is applied to calculate the equivalent dollar value. The Government of India reported this as 5,728 Crore (1 Crore = 10 million).
percent of adult infection rate, HIV/AIDS has come to consume 25 percent of all Centrally Sponsored Programs for health, and 15 percent of total health budget in India (See table 1.2). When compared to health systems strengthening which consumed 4 percent of total health allocations, HIV/AIDS alone received nearly 4 times more resources.

India is not unique that shows this pattern of expenditure on HIV/AIDS. Data from OECD’s Credit Reporting System shows that in low and middle-income countries, HIV/AIDS consumed more than 25 percent of total health aid with less than 5 percent of the disease burden as measured by disability-adjusted life years lost (DALYs) (England, 2007). The total HIV aid to the middle and low-income countries between 1999-2004 was 120 times higher than aid for safe drinking water projects in these countries.20 Within sub-Saharan Africa, HIV was the biggest single killer, contributing 17 percent of the burden of disease in 2001. But it received 40 percent of all health aid in 2004 (England, 2007: p. 344). Shiffman (2008) observed that HIV/AIDS’ relative share of health and population aid has risen rapidly over 1992–2003. In 1992, HIV/AIDS received 8 percent of donor health and population aid; by 2003 it received more than a third (35%) of all commitments (p. 97). Shiffman also noted that even in absolute terms, the funding for HIV/AIDS rose rapidly from 1992 to 2005 — In constant US dollars it increased more than 12-fold — from $213 million to $2.6 billion, an average annual growth rate of 42 percent (2008: p. 98), whereas over the same time-period, the number of adults living with HIV globally rose only by 3-fold from around 10 million to 33 million (UNAIDS revised estimate, 2010 Global Report, p. 24).

<table>
<thead>
<tr>
<th>Heads of expenditure</th>
<th>11th Plan Approved Outlay</th>
<th>Outlay for 2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RS (Crore)</td>
<td>Million US$</td>
</tr>
<tr>
<td>National AIDS Control Program</td>
<td>5728</td>
<td>1273</td>
</tr>
<tr>
<td>National Cancer Control Program</td>
<td>2400</td>
<td>533</td>
</tr>
</tbody>
</table>

Even in sub-Saharan Africa, “HIV funding is out of balance” (England, 2007: p. 344). In Ethiopia, for instance, with an HIV prevalence rate of 1.4 percent, donors committed $130 million for HIV/AIDS alone in 2005, whereas Ethiopia’s total national health budget in 2003 was $113 million. Commenting on this issue Rwanda’s Ministry of Finance and Economic Planning noted “a gross misallocation of resources” in the health sector caused by “development partners.” As an evidence of this “misallocation,” the Ministry pointed to, “$18 million earmarked for malaria (the biggest cause of mortality and morbidity) and just $1 million for the integrated

21 Similar trends were observed in Rwanda and Uganda — whereas Rwanda’s national health budget (2003) was only $37 million, donor commitment for HIV was $47 million. Similarly in Uganda, for a total national health budget of $121 million, donor’s commitment for HIV/AIDS alone was $167 million. See Shiffman (2008). p. 99.
management of childhood illnesses, compared to $47 million for HIV/AIDS, grossly disproportionate in a country with a 3% infection rate. At the global level, based on the country-defined targets for 2010, UNAIDS estimated that $25.1 billion would be required for the global AIDS response in 2010 for low-and middle-income countries. Of this, $13.7 billion was already invested in the AIDS response in 2008 alone. While health aid in other sectors largely stagnated in the developing countries during 1990s and 2000s, aid for HIV has claimed almost half of all health aid.

**The missing link**

Despite several worrying health conditions in India, AIDS received a significantly higher allocation than all the other health areas. For example, cardiovascular disease burden is five times higher (10%) than HIV/AIDS; yet it received 3.5 times fewer resources than HIV/AIDS in national health allocations. Similarly mental health with a disease burden of 9 percent, consumed 2 percent of all health allocations compared to 14 percent for HIV. Whereas childhood diseases constituted 5.4 percent of total disease burden (3 times more than AIDS), routine immunization received 2.5 times fewer resources than HIV/AIDS (See table 1.2). Thus, in India, the bulk of health problems people face are quite simple -- malnutrition, malaria, diarrheal diseases, maternal deaths, childhood illnesses, etc. – and they require quite simple solutions — food, nutrition supplement, mosquito control, clean water, and health system strengthening. Despite this, the government’s approach to public health was increasingly focused on vertical programs to tackle each disease instead of comprehensive healthcare. The allocation/spending on HIV was 4 times more than national TB control program, and national malaria control program. Moreover, whereas HIV experienced an exponential increase in spending from about $100 million in

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NACP-1, to $327 million in NACP-2, to $2.4 billion in NACP-3,\textsuperscript{25} other endemic conditions with much higher disease burden have experienced either a negative growth rate, remained stagnant over the years, or increased only marginally (see Fig. 1.1).

<table>
<thead>
<tr>
<th>Diseases/Conditions</th>
<th>DALYs</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular disease</td>
<td>3284</td>
<td>15.2</td>
<td>30.7</td>
<td>30.8</td>
<td>34.1</td>
<td>42.7</td>
<td>65.6</td>
</tr>
<tr>
<td>Neuropsychiatric disease</td>
<td>3044</td>
<td>0.93</td>
<td>5.6</td>
<td>5.8</td>
<td>6.3</td>
<td>7.5</td>
<td>9.5</td>
</tr>
<tr>
<td>Unintentional injury</td>
<td>2913</td>
<td>n.a.</td>
<td>n.a.</td>
<td>n.a.</td>
<td>6.67</td>
<td>8.9</td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>1011</td>
<td>37.5</td>
<td>41.3</td>
<td>42.7</td>
<td>48.4</td>
<td>99.3</td>
<td>134.9</td>
</tr>
<tr>
<td>TB</td>
<td>869</td>
<td>25.4</td>
<td>22.9</td>
<td>22.5</td>
<td>24</td>
<td>34.7</td>
<td>39</td>
</tr>
<tr>
<td>Malaria</td>
<td>69</td>
<td>36.1</td>
<td>40</td>
<td>37.2</td>
<td>40.1</td>
<td>58.1</td>
<td>73.1</td>
</tr>
</tbody>
</table>


The huge vertical (and expensive) infrastructure for AIDS created over the last 25 years does not compare with other “basic” yet crucial health concerns. For example, in a country of 1.2 billion, India doesn’t even have public urinals for women (UNDP HDR 2010, p. 170, noted that 70% of total population live without improved sanitation facility). And without clean water, women are especially vulnerable to genital and

\textsuperscript{25} Calculated from NACO/UNGASS (n.d.), UNGASS India Country progress report on the Declaration of Commitment on HIV/AIDS, various years. UN General Assembly Special Session on HIV/AIDS. New Delhi: Govt. of India. All estimates are in current prices.
reproductive tract infections, which make them vulnerable to HIV infection at the first place. Such important issues are glossed over because the health agenda is set by the well-off, who don’t die of childbirth, or whose women don’t have to use a public urinal. Moreover, what can any health program do where people go starving; or where 35 percent of total population remains illiterate? People’s resistance to illness depends on their immunity, which in turn depends on their food intake. Moreover, educational level of a group determines their health and treatment seeking behavior, and seeking treatment for sexually transmitted diseases (STDs) and reproductive tract infections (RTIs) is the first step of preventing HIV-infection.

To explicate the above link, I bring evidence from one of the best documentaries on HIV/AIDS in recent times having received 13 prestigious international awards, the House of Numbers (2009), directed by Brent Leung. It interviewed Luc Montagnier, a French virologist who was awarded a Nobel Prize in 2008 for his co-discovery of HIV in 1982. The following is a verbatim transcript from his interview.

Q: You talked about oxidative stress earlier. Is treating oxidative stress one of the best ways to deal with the African epidemic?

Luc: [T]his is one way to approach to decrease the rate of transmission... *We can be exposed to HIV many times* without being chronically infected. *Our immune system will get rid of the virus within a few weeks, if you have a good immune system.* And this is also the problem of African people. Their nutrition is not very equilibrated. They are in oxidative stress, even if they are not infected with HIV. So their immune system does not work well already, so its prone. It can allow HIV

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29 Oxidative stress is an imbalance between the production of reactive oxygen species and our body’s ability to detoxify the reactive agents or to repair the resulting damage.
to get in and persist. So there are many ways which are not the vaccine, the magic name — to decrease the transmission just by simple measure of nutrition — giving antioxidants, hygiene measure. They are not spectacular, but they could very well decrease the epidemic.

Q. So if you have a good immune system, then your body can naturally get rid of HIV?

Luc: YES… We should push for more antioxidants, nutrition advice, nutrition, fighting other infections, malaria, worm, parasitosis, and genital hygiene for women and men… water is important, water is key – very simple measure, which are not expensive, but which could do a lot… they are not very well funded… because there’s no profit! [Luc Montagnier, 2008 Nobel Prize winner in Physiology of Medicine for co-discovering HIV, in House of Numbers, 2009. Extended interview. Emphasis mine].

Instead of addressing these preventive factors for HIV-infection (such as addressing water problem for women that make them vulnerable to reproductive tract infection; addressing rural-urban migration; addressing problem of urban housing for migrant labors to bring their families for reducing the need to visit sex workers; or providing basic school education that makes people aware of the modes of HIV transmission), AIDS is addressed as a band-aid solution. It is in the same philosophy of when there is pollution, use a mask; so when there is AIDS, use a condom — but not addressing the root cause of “pollution” per se. The excessive funding on HIV has created the largest vertical program in history with its own staff, systems, and infrastructure (England, 2007). This is having deleterious effects not only by drawing away funds from other diseases (Shiffman, et.al., 2009; Shiffman, 2008), but also by separating HIV from sexual and reproductive health, and creating parallel infrastructure that constrain the development of health services (England, 2007). “AIDS-industry,” as a well-funded program, has also attracted qualified staffs from other health sectors creating chronic shortages in these areas.

1.2. Research Questions

By any empirical yardstick, it is obvious that combating HIV/AIDS has come to receive a disproportionate allocation of state and non-state resources. A question that warrants investigation is, in a global environment of reduced public spending on health
and social sector largely resulting from structural adjustment and globalization, why HIV/AIDS expenditure shows an opposing trend? What explains a sharp increase in HIV/AIDS expenditure both globally and in India? Is India merely following a global trend? Why endemic diseases and conditions such as poverty, illiteracy, malnutrition, ill health, potable water, and homelessness do not get enough public attention and priority in national and international development agenda but instead, a pandemic takes away lion’s share of available resources and public energy?

This dissertation investigates the factors that explain this disproportionate allocation of resources on HIV/AIDS, and what happens as a result? Throughout this dissertation, I examine two central questions: 1) Why, and under what circumstances did the Indian state behave/responded to the HIV/AIDS epidemic in this particular way? And 2) how such responses have come to animate vulnerable communities of sex workers and queer sexualities in their struggle for civil and political rights? While exploring these two central questions, this dissertation will look at: (a) factors that shaped the Indian state’s action to respond to HIV/AIDS epidemic in certain way or the other; (b) the role of non-governmental organizations (NGOs), international organizations (IOs), and transnational advocacy groups domestically and internationally in promoting the norms and mobilizing Indian state’s action; (c) [explore] the political-economy of national and international funding system and the reasons why it is seen as preferable by various stakeholders to focus attention on HIV epidemic rather than other preventable diseases responsible for higher mortality in India; and, (d) what are the implications of Indian state’s response to HIV/AIDS epidemic on various vulnerable communities and overall health sector in India.

1.3. The argument

To respond to the first central question, why did the Indian state behave in a particular way as far as HIV/AIDS is concerned, there could be several possible lines of explanation ranging from socio-medical and epidemiological theories, to political,
economic, and demographic theories. I have outlined some of these arguments to explain the state behavior in Chapter 2. However, no theory in isolation can adequately explain the complex nature of state response and how and why do states behave in certain ways to respond to a particular disease. As a political scientist myself, I found a mix of political-economy and International Relations (IR) theories extremely useful to explain the core questions I posed above. My choice of using a particular theoretical frame is therefore constrained by the “nature” of the questions I want to investigate. That “nature” of the central questions dictates that states learn to behave as a member of the international society to which they belong. Though what a state wants depends on how it is internally constituted31 (identity), that internal constitution, and what it wants (interests, preferences) do not exist just “out there,” so as a state will go and adopt them. They develop from existing 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). States are therefore, “socialized to want certain things by the international society in which they live” (Finnmore, 1996: p. 2, emphasis mine).

The process by which principled ideas (ideas about what is right and wrong) held by individuals becomes norms (collective expectation about proper behavior for a given identity32), which then lead to change in identities, interests and behavior is conceptualized as socialization (Finnmore, 1993; Ikenberry and Kupchan, 1990; Risse and Sikkink, 1999). Socialization is defined as a process of introducing the “new members into the ways of behavior that are preferred in a society” (Barnes, Carter and Skidmore, 1980: p. 35). Because a state’s identity emerges not in isolation but by interacting with other groups of states and non state actors, the concept of socialization is therefore useful in understanding how the international society transmits norms to its members.

31 See Wendt (1992); Walt, (1998); Katzenstein (1996a); Moravcsik (1997) among others.
Keeping this overall frame in mind, I have used social constructivist theories to the study of International Relations to explain state behavior (Katzenstein, 1996a; Kratochwil, 1989; Wendt, 1992). I argue that the Indian state’s behavior was re/shaped by a process of norm socialization, in which the state’s interests and preferences were reconstituted by internalizing the principled ideas, and norms of powerful HIV/AIDS regimes. Following Brysk (1993), Reich (2002), and Shiffman (2007), I argue that the Indian state and its preferences were reshaped/ reconstituted from three directions: “from above,” “from below,” and “from within.” After identifying important actors at these three levels and mapping out how they interact, this dissertation provides a model for norm socialization to explain the behavior of states.

To examine the second central question, this dissertation explores how norm socialization has affected two most important communities vulnerable to HIV/AIDS epidemic — sex workers and queer sexualities. I argue that norm socialization has had a boomerang effect — on the one hand, it led the state to change its existing human rights practices; and on the other, it produced varieties of fundamentalist resistance and discourses of “returns to culture.” In the first case, I examine the above propositions with respect to the political struggle of sex workers towards decriminalizing all aspects of sex work; and the societal resistance of considering sex work as “any other work”. In the second case, I examine India’s queer mobilization for civil and political rights fuelled by the AIDS-money; and how their collectivization has simultaneously produced homophobic discourses of nationalism and “returns to culture.” I conclude that AIDS has not only affected India’s health systems in diverse ways by reshaping the national development priorities, but also brought about progressive and modern social change in India.

1.4. Political-economy and norm socialization: A theoretical framework

A. Political economy

From a political economy perspective, any distribution of resources is likely to reflect imbalances in the distribution of political, economic and social power. Critiques
of political economy of India’s development have pointed out that resources allocated to specific development sectors reflect the “elitist” and “class” character of the Indian state (Bardhan, 1997; Kohli, 1986). The imbalances in political, economic and social power relationships created a system in which the benefits of development were enjoyed by the rich, politically powerful, proprietary class, and the ruling elites (Frankel, 1978; Bardhan, 1984; Rudolph and Rudolph, 1987). Throughout the world, HIV/AIDS has remained a cause of the elites, and the middle class championed by stars and celebrities, who do not die in childbirth, diarrhoea, or vaccine preventable diseases (England, 2007). Moreover, “HIV is a disease of poverty33”—argument was found to be baseless as systematic surveys from African countries, such as, Ethiopia, Kenya, and Tanzania showed that prevalence was highest among the middle classes and more educated people (England, 2008), who could afford purchase of sexual services. It is therefore likely that India’s policy response to HIV/AIDS will also reflect this elitist class bias.

A second explanation about why HIV/AIDS expenditure shows an unprecedented growth emerges from an international political economy (IPE) perspective. From this perspective, it is argued that HIV/AIDS can be located within a particular world order characterized by transnational neoliberalism (Lee and Zwi 1996; Altman, 1998, 1999; Patton, 2002). This world order defined by unprecedented growth of capital, production and exchange relations across state boundaries with unequal effects of globalization has not only created fertile conditions within which AIDS has spread, but also affected its prevention, treatment and care strategies in diverse ways. The material basis of this world order is “a global economic system dominated by large institutional investors and transnational firms which control the bulk of the world’s productive assets and are the principal influences in word trade and financial markets34.” Its institutional nucleus is comprised of the G-7 state apparatuses and transnational capital, giving rise to internationalization of authority and governance. Global governance is thus led by what Robert Cox called a “transnational managerial

class, and their institutional homes, such as Ministries of finance, health, trade and industry; the World Bank and IMF; the OECD and WHO, who increasingly shape policy-making on a global scale.

Thus, from an IPE perspective, there are four principal actors in the problem of HIV pandemic: states; international organizations (IOs); non-state actors (NGOs/CBOs, private corporate business and industries); and affected communities. The transnational neoliberal world order dictates that the role of states be limited to oversee the overall public health policy for a country, allowing for more private entrepreneurship, partnership and collaboration in the distribution of goods and services. The neoliberal ideology of “minimalist state” thus allows for more room for privatization of HIV/AIDS and development business resulting in mushrooming of thousands of private NGOs, CBO, foundations, research institutions, and advocacy groups. The role of the IOs (which may be bilateral governments as CIDA, DFID, USAID; or multilateral organizations as UNAIDS, WHO, IMF and World Bank) is to provide technical and financial assistance to countries for developing appropriate policy and program responses to HIV/AIDS epidemic. This financial support invariably comes with “conditions” that may include assistance in policy formulation and program development, and training of staff and organizational skill building (Grzybowski, 2000; Braveman, 2001; Farid and Benavides, 2003; Jones, 2004).

The non state actors may be of several kinds ranging from international NGOs having worldwide presence like CARE and Amnesty International, to smallest grassroots NGO in one remote corner of Africa or India. The nature of these actors is diverse: some provide direct prevention, care and treatment services to vulnerable people and affected communities; some are engaged in developing communication tools; some do advocacy with policy makers, or conduct research on HIV/AIDS; some are private foundations, corporate business, pharmaceutical companies largely acting as donors, but may also give direct prevention and care services; while some are purely philanthropic organizations, religious institutions and charities. Collectively, this group

acts as the most important pressure group for influencing policies and programs through direct advocacy and lobbying with the state apparatuses, political institutions and IOs.

Lastly, the infected and affected communities form the crucial link between all the three sets of actors mentioned above for whom the whole HIV/AIDS program runs. They consist of sex workers, drug users, men having sex with men (MSMs), truck drivers, migrant population, people living with HIV/AIDS, orphans, and other vulnerable populations and affected communities. They may or may not participate in the policy dialogue and program development; or may often be used as scapegoats for driving the infection and fundraising; or may be used as experimental guinea pigs for vaccine research and drug trial, or as objects for other biomedical and social interventions.

Swidler (2006) noted that the interaction among these different actors constitutes an extremely complex web. The grassroots NGOs/CBOs carry out HIV/AIDS prevention and care programs in the affected communities. Their activities are monitored and supervised by large, national-level NGOs, who in turn, get funding, supervision and technical support for HIV/AIDS projects from their global counterparts – international aid agencies, transnational advocacy groups, and bilateral and multilateral donors (Edwards and Sen, 2000; Kamat, 2002, 2003; Rau, 2006; Fernand, 2006). Generally, the State is the legal sovereign in its own territory and is free to devise any health policy or program that it may wish. The NGOs and IOs, generally, can not implement any HIV response strategies that are at odds with the State. While “theoretically” this is the case, more often than not the actions of the modern state get actively constrained by the norms of the international society in which it lives. What a state wants, and how it wants to realize its interests do not take place in a vacuum. The following section will make this connection clear.

**B. Norms in international politics**

As mentioned earlier, norm is a “collective expectation about proper behavior for a given identity” (Jepperson, Wendt, & Katzenstein, 1996: p. 54). To endorse a norm means that a state expresses its belief and also created an impetus for behavior
change consistent with that belief (Risse and Sikkink, 1999: p. 7). The very idea of a “proper” behavior presupposes the existence of a community able to pass judgment on the appropriateness. Thus once a state behave in any particular way, others are likely to make judgment about the identity of that state. As James Fearon argued that while rules take the form “Do X to get Y,” norms take a different form: “Good people do X.” Thus people follow norms not only to feel good about themselves, but also want others to think good about them (Fearon, 1999). In case of states, one of the incentives that drives norm adaptation is their desire to gain international legitimacy of not being branded in the category of “bad” states.36

How diffusion of norms leads to behavior change of actors has remained a matter of considerable interest to political scientists and IR theorists (See for example, Finnmore and Sikkink 1998; Finnmore, 1993, 1996a, b; Jepperson, Wendt and Katzenstein, 1996; Katzenstein 1996; Klotz 1995). Though some of them have explored this connection quite successfully with regard to human rights, banning of landmine, chemical weapons, apartheid, etc.37, few have actually investigated this case with regard to HIV/AIDS epidemic.38 Moreover, India, as a country with the third highest HIV-burden in the world after South Africa and Nigeria, remained conspicuously absent from these analyses. Therefore, using India as a case, I explore the linkage between norms of the HIV/AIDS regimes and changing state practices; and how inclusion of these norms in domestic practices produced a cascading effect on community mobilization, resistance and social change in India. So my primary questions under investigation — diffusion of AIDS norms — provide me an excellent opportunity, primarily because they challenge the established state norms, state sovereignty, and


38 See for example, Vierra (2007); Patterson (2007); Kim (2009); Boone and Batsel (2001); Mameli (1998); Mustapha (2006); and to some extent, Ruggie (2004).
cultural codes of sexuality and gender. The theory and analytical framework that I offer is useful in understanding the role of norms in international politics.

Finnmore and Sikkink (1998) identified three stages of norm life cycle: — norm emergence, norm cascade and norm internalization. Norm entrepreneurs are critical for norm emergence because they call attention to issues or even “create” issues by using language that names, interprets, and dramatizes them (p. 897). Social movement theorists refer to this process as “framing.” After norm has emerged, norm cascading occurs through a process of socialization, in which a group of states accept norms in their domestic practices.

Socialization is a process by which new members of the society are introduced to the ways of behavior that are appropriate and acceptable by its members (Barnes, Carter, and Skidmore, 1980: p. 35). The goal of socialization is for actors to internalize the norms so that external pressures are no longer needed to ensure compliance (Risse and Sikkink, 1999: p. 11). Norms that interfere with human rights, such as HIV/AIDS, have special status because they prescribe certain rules that help other states identify a member of their own community, usually liberal states (Katzenstein, 1996a, b; Kowert and Legro, 1996). Thus human rights norms have a constitutive effect because they help define the identity of adopting states.

This constitutive effect of norms draws on social constructivism. Actors’ interests and preferences do not take place outside of social interaction. The materialist (neorealist) theorists have argued that the material capacity of a state, such as military and economic conditions determines the basis of state identities, interests, and preferences (Ruggie, 1998). For the materialists, the interests and preferences are already given that exist even before states start to interact. In contrast, social constructivists emphasize that ideas and communicative processes determine at the first place which material factors are perceived as “important” and how they influence understanding of interests, preferences and political decisions.\textsuperscript{39} Material conditions

\textsuperscript{39} On this, see particularly, Adler (1991, 1997); Checkel (1998); Katzenstein (1996a, b); Kratochwil (1998); and Wendt (1992).
only matter through cognitive and communicative process by which states try to determine their identities and to develop a collective understanding of the situation. Therefore, identities and 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. Actors acquire identities—relatively stable, role-specific understanding and expectations about self—by participating in such collective meaning-making (Wendt, 1992: p. 397). State behavior is thus defined by identity and interest, which in turn, are defined by the norms of behavior embedded in the international society. The norms of international society are transmitted to states through a process of socialization that “teaches” the states what their interests should be.

Risse and Sikkink (1999) identified three types of causal mechanisms necessary for enduring internalization of norms — 1) process of instrumental adaptation and strategic bargaining; 2) process of moral consciousness raising, argumentation, persuasion; 3) and process of institutionalization and habitualization. In the first stage of socialization, norm violating governments adopt norms for instrumental reasons (examined in detail in Chapter 3), for example, to retain foreign aid, overcome international sanctions, etc. In the second stage, socialization involves process of shaming and denunciation aimed at changing minds by isolating or embarrassing the target. By shaming, a state is constantly reminded of its identity. When domestic NGOs use arguments to further their interests, the governments will start challenging them by counterarguments. The more they become engaged in arguments, the more they are likely to institutionalize human rights in domestic practices. If a state adopts norms for instrumental reasons, over time they come to believe what they say, particularly if the statements were made in public. In the third stage, human rights norms are incorporated as standard operating procedure of domestic institutions. Norms are implemented independently from moral consciousness – they are simply taken for granted that make the final stage of socialization process. This is called habitualization (Risse and Sikkink, 1999: pp. 11-17).

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One of the most elaborate models of norm socialization in IR literature in contemporary times has come from Risse and Sikkink in their “five phase spiral model” (Fig. 1.2) that causally explains how norm socialization takes place. They identified five phases in their spiral model — 1) repression and activation of network by state; 2) denial by the state as violation of norm is its “internal” matter; 3) tactical consideration and strategic bargaining; 4) prescriptive status by ratifying norms; 5) and rule consistent behavior as the final stage of socialization, in which compliance becomes a habitual practice. They claimed that their model can be used in many different socio-cultural and political contexts (p. 6). Though my objective is not to test their model in Indian case, I nonetheless take part of their analytical framework in developing my own model. I do this because, unlike their focus...
which is solely on establishing a causal mechanism for norm socialization, my model is more geared towards understanding how state interest and preferences are reshaped and reconstituted by discursive practices at the first place, that creates a precondition for norm socialization.

1.5. Organization of the work

This dissertation is a part of the growing literature on the role and impact of norms in international politics (Adler, 1987; Finnmore 1996; Katzenstein, 1996a; Klotz, 1995; Risse, Ropp and Sikkink, 1999), and I examine the role of AIDS regimes and norms in influencing domestic politics of the Indian state. Corresponding to the two central questions that I inquire, this dissertation is divided into two parts. In the first part, consisting of Chapters 2, 3, and 4, I explore the first central question – why did the Indian state behave in a particular way to respond to HIV/AIDS epidemic. The next two chapters, Chapter 5 and 6 examine the second central question – what implications such responses had on vulnerable communities. Both these two parts are intertwined within the broader argument of the dissertation — the influence of regimes and norms in international politics. I examine the conditions under which international HIV/AIDS regimes, and the norms, rules and principles embedded in them are internalized and implemented in domestic institutional practices.

Chapter 2 starts with a background information about India’s HIV/AIDS epidemic and its domestic political economy. This information is useful in conceptualizing the context in which AIDS has emerged and evolved in India. This chapter also lays the foundation for the next two chapters by exploring the politics of knowledge production resulting in the formation of HIV/AIDS regimes, which in turn influenced the behavior of states.

Chapter 3 provides the substance of my major argument to explain the behavior of the Indian state with respect to controlling HIV/AIDS epidemic. Throughout this chapter, I trace one central question: why did the Indian state behave in any particular
way to respond to the HIV/AIDS epidemic. My focus is therefore on the reasons and causal linkages that promoted specific state behavior. I explore how regimes and their norms reconstitute state preferences and behavior to reflect changes in domestic institutional practices. At the end of this chapter, I develop a theoretical model to explain the processes through which norm socialization and institutional changes took place in India. This explanatory model provides the foundation for the next substantive chapter.

Chapter 4 therefore focuses on the processes through which behavior change took place in domestic institutional practices in India. This chapter first explores the degree to which the norms promoted by the AIDS regimes were adopted in the Indian state’s domestic practices. The degree of compliance was examined 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, this chapter explores the mechanisms through which norm socialization took place in India, and how various actors reconstituted the Indian state’s preferences and behavior by influencing it “from above,” “from below” and “from within.”

In Chapter 5, I examine how, in what ways AIDS-norm socialization has affected the vulnerable communities of sex workers leading to their collectivization, and their political struggle towards redefining sex work as “any other work” and demanding workers’ rights. I then discuss how such discourses have resulted in societal resistance to normalize sex work and the broader implications of such AIDS-induced social movements on Indian society.

Chapter 6 examines the case of second most vulnerable group -- how norms led to the collectivization of queer sexualities and their legal and political battle for civil rights. This chapter explores India’s emerging sexual identity politics in a historical context and situates the role of norms and AIDS regimes in mobilizing queer sexualities to perform in certain ways. It also outlines how this mobilization was contested by various groups and argues that though norm socialization has had a liberating effect on
queer sexualities, it has simultaneously strengthened a homophobic discourses of heterosexist nationalism in India. This chapter then draws the general implications of AIDS induced queer mobilization on Indian society.

Finally, based on observations from each of these Chapters, I draw my conclusions. I conclude by outlining my specific contribution in this dissertation and in the growing body of IR literature and related fields. As with any intellectual endeavor, I raise more questions than answers, and I raise them at the end to provide future directions for research.

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