Chapter 2

Indian political economy and HIV/AIDS

This chapter provides background information about India’s political economy and the socio-cultural context in which HIV/AIDS epidemic had emerged, and how it catalyzed the responses of the state and non-state actors. The information presented here would be helpful to guide one through the rest of the dissertation. I first examine the broader political-economic contexts and how the Indian state initially responded to face the challenge of an emerging AIDS-epidemic. I then provide a brief introduction about the current status of the epidemic, and the strategies Indian government adopted to tackle the disease. In the final part I examine the politics of knowledge production — how AIDS has been talked and discussed about, and the effects of these discursive practices in the formation of regimes, which in turn, mobilized Indian state’s response.

2.1. Political economy and social context

Any discussion about India’s HIV/AIDS epidemic must be situated within the broader political-economic and social context of the country. India is a secular-democratic- republic comprising of 35 states and union territories and is the world’s largest democracy. Though it occupies only 3 percent of the world’s total land area, the country is home to about 18 percent of the world’s population, which in 2010 stood at about 1.2 billion.\footnote{Census of India. (2011). \textit{Provisional population totals: India, Paper 1.} New Delhi: Registrar General of India.} On various other economic development front, India accounts for 34 percent of the world’s poor living on less than US$1 per day; 20 percent of the world’s out-of-school children; 23 percent of the world’s child deaths; 25 percent of the world’s maternal deaths; 30 percent of the world’s deaths from poor access to water and sanitation\footnote{World Bank. (2004). \textit{Country assistance strategy for India.} Washington, DC. Retrieved September 18, 2009: http://siteresources.worldbank.org/}; and 50 percent of the world’s hungry.\footnote{World Food Program. (n.d.). \textit{Country Brief: India.} Retrieved September 17, 2009 from http://www.wfp.org/node/3485.} Religion, caste, and language are
the major determinants of sociopolitical organization. Despite economic liberalization and laws prohibiting discrimination against the lower castes, the caste-system remains an important source of social identification and a major factor in national politics.

Government spending on health as a percentage of total government spending, equaled 4 percent in 2004\(^4\) (1\% of GDP in 2009). In India, health is constitutionally a state responsibility. Hence, central government expenditure formed 23 percent of total government health spending, whereas state government expenditure was 77 percent (\textit{ibid.}). Despite controlling only 23 percent of the funds, central government sets the priorities in public health which are executed by the state governments\(^5\). The central government dominates financing of public health and family welfare activities as well as centrally sponsored communicable disease control programs like HIV/AIDS, TB and malaria. Thus central government’s priorities in public health thus provide an important indicator of state priorities in public health (Sridhar and Gomez, 2010).

After the economic liberalization of 1991, the government has reduced its role in health care delivery — privatization, decentralization, and public-private partnership are some of the preferred ways of delivering the health care threatening the safety nets for rural poor. With severe fiscal crisis of some of the state like West Bengal, the state government’s ability to provide even the basic health care services remains doubtful.\(^6\) The private medical sector remains the primary source of health care for the majority of households in both urban areas (70 percent) and rural areas\(^7\) (63 percent). Public health facilities suffer from poor management, low-quality of service, long waiting time, and 47 percent people do not use it because there is no nearby facility (\textit{ibid.}, p. 438). Even among poor households, only 34 percent normally use the public health facilities when a family member falls sick. The private sector remains virtually unregulated and has a


highly variable quality of care. While in government hospitals, 53 percent of pediatrician posts remained unfilled, and hospital staffs make use of patients severed legs for pillows, the private hospitals install heart valves and replace hips for “medical tourists” from developed countries.

Corruption in India is systematic. It significantly affects the government efficiency, fairness and legitimacy of the state with adverse distributive consequences (Bardhan, 1997). Transparency International in its Corruption Perception Index of 2010 has ranked India at 87 out of 178 countries. Pervasive corruption highlights the risk of “leakage” of funds allocated to HIV/AIDS, as well as the common practice of paying bribes and percentage cuts to government officials to expedite action on projects.

**Economic liberalization and after**

Right after 200 years of British colonial rule, when India got independence in 1947, it was viewed by the nationalist leaders that poverty and structural inequality was inherited due to colonialism (Roy, 2002). In 1947, this diagnosis of Indian poverty held that it was a product of *laissez faire*, exploitation by foreign capital, and noninterventionist stance of the Indian government under British Raj (Basu, 2004). In turn, such ideas supported two key planks of Indian development strategy – strong sentiment against foreign trade and investment and strong state control. Such an ideology of dirigiste planning and import substitution strategy of growth resulted in poor GDP growth performance of 3.5 percent per annum between 1950-51 to 1979-80 (Shastri, 2001). During 1950 to 1990, the per capita income growth was below 2

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51 As Basu (2004) pointed out, the actual policy regime that India followed after independence was thus, a precarious mixture of two competing and almost contradictory version – Soviet style planning but without state monopoly of control over resources; capitalism allowed to flourish, but a large bureaucratic control was nurtured; huge investments were made in basic industries but several sectors were protected as small scale sectors; capitalism was criticized but it was relied upon; socialism was almost never practiced but the rhetoric of socialism became manifested in nurturing a burgeoning bureaucracy (p. 19).
percent per annum which was less than half of all the developing countries of the world (Mukherjee, 2002). The economy was dominated by a huge public sector (Kesavan, 2001); the entry of foreign companies was strictly forbidden and domestic investment was regulated by instituting strong bureaucratic controls and license-permit-Raj (Bhagwati, 1993).

This kind of mixed economy has been termed by Krueger (2002) as “competitive rent seeking” society in which rents originate from quantitative restriction upon international trade; and by Bhagwati (1993) as “directly unproductive profit-seeking activities” in which enormous time and money gets wasted to procure licenses. The dirigiste policy thus created its own vested interests and three dominant groups, the industrialists, the bureaucrats and the politicians, all benefited from it. Domestic industry, which was already protected from foreign competition, had no incentives to be efficient as industrialists, traders, bureaucrats and politicians found it more profitable to seek rents rather than increase the efficiency production (Kelegama and Parikh, 2000).

From 1952-1989, Indian political scene was largely dominated by the Congress party typically controlling over 65 percent or more seats in the parliament52 (Rodden and Wilkinson, 2004). Indira Gandhi succeeded Jawaharlal Nehru who came to power by winning two successive elections in 1971 and 1972 and broadly followed the path of Nehruvian socialism inherited from her father. However, Indira was defeated in the general election of 1977 by a weak coalition of Janta Dal due to her notorious emergency rule in the preceding 18 months. Yet, she came back to power again in 1980 and continued her policies of centralization until her assassination in 1984. After Indira’s assassination, the enormous electoral victory of Rajiv Gandhi in 1984 freed his administration from various political pressures and he broadly followed the liberalization measures directed towards more growth. By the end of his rule, state control of entry into production (licence), corporate and personal taxes, and import

52 There were only two exceptions to this dominance. First, in the late 1960s, there was a serious split in the Congress Party between Nehru’s daughter Indira and more established party figures that created a divide between Congress (I) controlled by Mrs. Gandhi and the Congress government in many states. The second exception to Congress dominance was the 1977-79 Janata coalition – an unstable and heterogeneous group of parties that won a hastily called election after Indira Gandhi lifted her 18 months of emergency rule in 1977.
barriers and quotas were eased further (Kohli, 2006). It is during his time (1984-89), the Indian economy broke through its previous growth-path to a rapidly growing economy, though it was not sustained, which finally culminated in the severe economic crisis of 1991-92.

Post-reform political economy

By the beginning of 1990s, Indian economy came under severe strain with increasing budget deficit, falling foreign exchange reserve and shooting inflation of up to 17 percent per annum (Bhaduri and Nayyar, 1996). From November 1990 to March 1991, within four months there was a fall of two governments. In May 1991, while campaigning in Tamil Nadu, Prime Minister Rajiv Gandhi was assassinated by Tamil extremists from Sri Lanka. After Rajiv’s assassination, Narsimha Rao government came to power. Towards the end of June 1991, India’s foreign exchange reserve drastically fell to almost $1 billion less than sustaining 15 days of import bill. The IMF agreed to give loan and rescue the government out of financial crisis provided India accepts its structural adjustment program. Ravaged by severe economic depression, the government opened up the economy by adopting several economic reform measures.

The political scene of the 1990s also saw a shift in the dominant-party system. Both Congress and BJP were unable to win an election without pre-election alliances, and neither party has been able to win more than 35 percent of the total seats in the Parliament since 1991. There has also been a fundamental shift in favour of the regional parties that control more than 35 percent seats in the parliament compared to only 7 percent in 1977 (Rodden and Wilkinson, 2004). Most of these regional party leaders are perfectly willing to switch alliances from the BJP-led coalition to the Congress-led coalition if they feel it will advantage their party and their state.

The final months of the Rao-led government in 1996 were marred by several major political corruptions and scandals. From May 1996 general elections BJP emerged as the single-largest party but without a majority in Parliament. Under Prime Minister Atal Bihari Vajpayee, the BJP coalition was in power only for 13 days. From 1996-1999, there were fall of two short-lived governments one led by Janta Dal, and the
other led by BJP. In 1999, BJP formed the National Democratic Alliance with Atal Bihari Vajpayee as the Prime Minister, which completed its full-term of five years until 2004. In 2004, the Congress formed a coalition government, United Progressive Alliance headed by Prime Minister Manmohan Singh. But his government remained constrained by threats from Marxists and other coalition partners towards any move for further economic liberalization. In 2009 general election, BJP suffered a major setback which brought in Congress as the single largest political party. Manmohan Singh with support from its allies was reelected as the Prime Minister for the second consecutive term.

The overall impact of reform has been highly positive. Breaking away from a slow growth-path, Indian economy grew by 6 percent per annum during 1991-2004, with per capita income growth at 3.6 percent (Viramani, 2004). In fact, after 2003, growth rate increased dramatically to 8 percent per annum. The official poverty estimates decreased from 53 percent in the 1980s, to 26 percent in 2000, and a slight increase to 29 percent in 2009. Rapid economic growth resulted in better living condition among average Indians and per capita GDP growth gave rise to a burgeoning middle-class (Sridharan, 2004) whose number is somewhere between 200-300 million depending on the criteria used. Economic reform also created incentives for decentralization and the state governments actively seek FDI on sectors such as power or infrastructure.

Contrary to the belief that structural adjustment adversely affects social sector expenditure, Yuko (2005) from his study of 15 Indian states based on data from 1980 to 2000 finds that economic reform largely did not have a major negative impact on social sector expenditures. In fact, there was a positive impact on some states that received foreign aid. By the late 1990s, states spending more on the social sector

56 Cornia, Jolly and Steward (1987); Kakwani et.al. (1990); Saunders (1996); Jauch (1999); Simmons and Andrews (2000).
changed from states with a strong social commitment, such as Kerala and West Bengal to states having higher revenues, including aid from outside the country.

**Putting HIV in context**

It must be remembered that HIV/AIDS had emerged and evolved as a distinct clinical, bio-medical, social and political entity within this overall political economic context of the country. When the first case of AIDS was reported from Chennai in 1986, Rajiv Gandhi led Congress government was ruling at the center. The economy was fairly highly regulated — per capita income, degree of urbanization, and volume of rural-urban migration were less, compared to the decades following his rule. After economic liberalization of 1991, India experienced a rapid rate of economic development, especially in the southern states where prevalence of the HIV-epidemic is high. With rapid economic development, India has also experienced large inflow of foreign capital in industrial sector mostly in states of Maharastra, Adhra Pradesh, Tamil Nadu, Gujarat, and Karnataka, which again corresponds with high HIV-prevalence states.

Several consequences of this rapid development include increase in truck transportation, industrialization, growth in urban population and rural-urban migration. India has about 5 – 6 million truck drivers, about half of whom drive on long-distance routes traversing across state and national highways that keep them away from home for a month or more. Singhal and Rogers (2003) estimated that about 200,000 truck drivers entered Mumbai on a single day (p. 114). Commercial sex workers are found at every truck stop. The communities from which migrants emigrate are vulnerable to HIV for several reasons. First, the returning migrant labors, who during their long period of absence from family had purchased sexual services from prostitutes, may infect their wives or other sex-partners in their villages. On the other hand, when male partners are away for long periods, and if they do not send regular remittances, some women may rely on sex work to supplement family income (Ekstrand, et.al., 2003: p. 8). This pattern

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is typically found in the villages of Andhra Pradesh and Tamil Nadu where migrant laborers returning from Mumbai bring HIV with them and infect their wives and children. Along with the rise of middle class, India has also experienced a substantial increase in the number of NGOs. NGO-activism on HIV/AIDS has put tremendous pressure on the national government, and shaped national policies and programs in particular ways.

**Initial response**

While in the United States the first AIDS case was discovered in 1980 among a group of gay men in Los Angeles, in India it was discovered six years later (1986) among a group of sex workers in Chennai, Tamil Nadu. In India, the first case of HIV was detected by Dr. Jacob John and Suniti Solomon (microbiologists in a government medical college), who identified 10 HIV-positive samples out of a group of 102 female sex workers in Chennai.\(^{58}\) In the initial years, the general hysteria and panic among medical community and in the media, labeled AIDS as a “foreign disease” and women in prostitution were thought to be the reservoir and vectors of the epidemic (Dube, 2000). The Indian government went through a period of denial and moralistically proclaimed that AIDS could not affect India since it is a family-centric society. During this initial period of the epidemic, several lynching of HIV-positive men occurred in Tamil Nadu and other states. The state Health Minister of Tamil Nadu asserted publicly that there were no prostitutes in the state though AIDS control officials promptly introduced him to 2,000 sex workers from his hometown (Singhal and Rogers, 2003: p. 359). Some feminist activists in the state claimed that sex workers should be “eliminated,” or rather sex work should be abolished. Dube (2000) reports that between 1986-1991 about 500,000 Indians got infected because of the collective failure and denial of Indian politicians, bureaucrats and health authorities.\(^{59}\) AIDS epidemic did not get a place in the national agenda as many officials felt that it was being hyped.


\(^{59}\) This figure by AIDS-activists like Siddharth Dube must be read with caution because in the initial years, due to general hysteria and panic (coupled with unscientific methods of estimation), the numbers were greatly inflated. The revised estimates of UNAIDS in 2006 (considered to be the most scientific
In 1986, the Indian Council of Medical Research (ICMR) in collaboration with the Directorate General of Health Services (DGHS) and individual state governments initiated a national program of serological surveillance (Asthana, 1996). This provided the springboard for the National AIDS Control Program that was formally launched in 1987. Since 1986, the government treated HIV/AIDS as a “law-and-order” problem (and not epidemiological) because it is those “criminals,” mostly sex workers, homosexuals and drug users who get it and then infect others. Thus the policy option was: such criminals must be detected, forcibly tested, quarantined if found HIV-positive, and thus be prevented from infecting innocent people (Dube, 2000). This approach was formally laid down in National AIDS Control Policy of 1989 when Prime Minister Rajiv Gandhi’s government passed the AIDS Prevention Bill that not only outlined forced testing, but also gave government unprecedented power to intervene in private lives. Those who were found HIV-positive, were thus quarantined or jailed. In 1989, the Maharrastra government deported several hundred Tamil sex workers from Mumbai to Chennai. In the same year, Dominic de Souza (a swimmer, a gay and WWF employee on whose life Bollywood film My Brother Nikhil 2005 was made) was kept in solitary confinement for over a month. To justify this, Goa government passed a law on Mandatory testing of any “suspect” and quarantining those if found positive. Also following this repressive policy, the state government of Tamil Nadu in 1990 forcibly tested hundreds of sex workers in Chennai and locked up 800 HIV positive women for several months (Dube, 2000: p. 27).

Many other state and city governments also forcibly tested sex workers who were later freed only after sustained campaign by NGOs and civil rights activists. During 1987-91, the government took a medium term loan of $19 million from the World Bank to implement HIV-program which consisted of blood screening, and moderate level of awareness building, with virtually no component of condom promotion, intervention with “criminals”, or STD treatment. Dube (2000) noted that the “middle class morality” of the Indian officials felt that everybody (which includes

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method based on population blood samples) has put the number of India’s HIV infection to less than half. Dube’s number of 500,000 should be read in this light. On the politics of inflating AIDS-numbers, see Chin, 2008; and Pisani, 2008, also award winning video documentary, House of numbers (2009).
morally good people) is threatened by transfusion of blood, and only those “worthless” people get it from sex. The AIDS awareness campaign during the initial years proclaimed that AIDS is a disease spread by the *veshyas* (whores), while the official HIV prevention program categorized them as the “highest-risk-groups” (Chattopadhyay, 2003). Thus while in the public discourse the prostitutes were conceived as “criminals” and charged with the offence of infecting “innocent people” with deadly HIV, the customers who used sex workers were in no place despised or condemned. In fact, Maharastra government proposed in 1994 to mark the infected prostitutes with indelible ink (Dube, 2000: p. 29).

Following the detection of the first AIDS case in 1986, the National AIDS Committee was constituted within the Ministry of Health and Family Welfare. As the epidemic spread, the National AIDS Control Organization (NACO) was established in 1992 – later State AIDS Control Societies were constituted in all states and union territories to implement the program activities locally. Accordingly, the strategic plan for prevention and control of AIDS in India was developed for the period 1992-97, which is called the first phase of the NACP. This phase was extended to 1999 when it was realized at the end of the project (1997) that NACO could barely utilize only 54 percent of total budgeted funds during the period 1992-99, and out of the 54 percent that was used, a major proportion of the budget was spent for holding expensive conferences, seminars and workshops.60 India’s AIDS control program was initially supported by a few key officials, including the Secretary of the Health Ministry. But the national government and most state governments continued to accord relatively low priority to AIDS through the mid-1990s. In 1994, the Union Minister of Health and Family Welfare, B. Shankaranand forcefully claimed that HIV/AIDS was not a problem in India61.

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The final estimated cost of NACP-1 was $27.5 million from the government of India, $2.2 million from WHO, and international development assistance (IDA) credit of $84.2 million from the World Bank. The foremost condition of the IDA loan was to withdraw the previous AIDS Control Bill of 1989 and adopt a more liberal, rights based perspective of HIV/AIDS prevention (Dube 2000, p. 86; Singhal and Rogers 2003, p. 118). For developing this new rights-based policy, technical support was imported from abroad and organizations like WHO helped India developing such a policy. Thus though sex work, drug use and homosexuality remained criminalized, “targeted interventions” were launched among “high-risk groups” across many cities. The government adopted a double-standard of morally and legally disapproving despised sexualities, but simultaneously funding collectives of sex workers and MSMs for implementing national HIV/AIDS programs.

The first attempt in the post-reform period was to decentralize HIV/AIDS prevention efforts by forming AIDS Control Societies at the State level. Conforming to the neoliberal mantra of participatory development through NGOs, the government started withdrawing from service provision and instead let the NGOs provide direct services in the community. These included prevention services such as raising awareness, condom promotion, and STD treatment; and care components such as drug detoxification, terminal care, and in recent years, antiretroviral therapy. In the post reform period, there is a significant change in government attitude in that it now views NGOs as a supportive partner in development process. The successive coalition governments at the centre did not do much to treat HIV as a national emergency. Political commitment among India’s top leaders was sporadic and spearheaded by certain individuals rather than based on broad consensus and commitment throughout the government (Policy Project, 2005). Some of the political leadership included former President Abdul Kalam, former Prime Minister Atal Bihari Vajpayee, and Congress President Sonia Gandhi, and the current Prime Minister Manmohan Singh. Other than giving few public speeches at high-level meetings affirming India’s commitment to

contain the epidemic, most political leaders remained preoccupied with maintaining a fragile coalition government at the center and failed to sustain the AIDS rhetoric.

Today India has a National Committee on AIDS which is headed by the Prime Minister to give the highest political commitment and priority on the disease. There is also a Parliamentarian’s Forum on HIV/AIDS (PFA) launched in 2002 consisting of elected representatives. Former Health Secretaries are now recruited by the international NGOs to exert their influence on the Ministry of Health. A national curriculum on sex education is being implemented in schools through NCERT. Several state governments (Assam, Maharashtra, Andhra Pradesh and Goa) have proposed to adopt a mandatory premarital HIV testing policy to reduce the vulnerability of women. However, due to intense protest from the activists and since it contradicts the national policy, such a bill was not passed. HIV/AIDS is now addressed through all government Departments and Ministries following donor recommendation of developing intersectoral linkages and “mainstreaming.” This made it extremely difficult to track the total flow of resources on HIV/AIDS.

2.2. Current epidemiological situation

It is important to keep an overall perspective about India’s HIV-epidemic in mind while exploring the political economy of the disease. India’s HIV epidemic is now 25 years old. In 2008, about 2.3 million Indians were living with HIV with an estimated adult HIV prevalence rate of 0.3 percent. This made India behind Nigeria and South Africa in terms of total number of HIV infected people, though the prevalence rate in those two African nations remains high — 4 percent in Nigeria, and 18 percent in South Africa.63 The UNAIDS Report on the Global AIDS Epidemic 2010 (p. 20) estimated that about 33 million people globally were living with HIV/AIDS in 2009, out of which Sub-Saharan Africa alone had 23 million (70%). In some of the African countries such as Botswana, Swaziland, and Lesotho HIV prevalence among adults remained well over 20 percent; whereas South Africa, Namibia, Mozambique, Zambia and Zimbabwe had a

prevalence rate of 12-18 percent (ibid., p. 181). Overall prevalence in Asian countries remained very low — from 0.3 – 0.9 percent.

India’s HIV epidemic follows a “concentrated pattern” that is concentrated among certain high risk groups consisting of sex workers, men having sex with men (MSMs), injecting drug users (IDUs), the clients of sex workers, and partners of IDUs. This is quite different from a generalized pattern of HIV epidemic in Sub-Saharan Africa, where epidemic has spread beyond “high risk” population groups.

Not everyone in India has the same level of risk of acquiring or transmitting HIV. Those at the highest risk, such as sex workers, MSMs and drug users first infect their clients, sexual partners, or injecting partners. The clients of sex workers, and sexual partners of IDUs and MSMs often consisting of migrant laborers and truckers (or anyone purchasing sexual services from these groups) are called the “bridge population.” They serve as a bridge/carrier of infection from the highest risk groups to the general population by infecting their low risk wives, and children though gestation, breast milk or both (Fig. 2.1). As per national Behavioral Sentinel Surveillance Survey in 2006, 2.4 percent of adult males had visited commercial sex worker in the year prior to the survey (UNGASS CPR, 2010: p. 23).

The overall HIV prevalence among different population groups in 2008 also showed a concentrated pattern of epidemic — the highest prevalence was found among the IDUs, 9 percent followed by MSMs, 7 percent, and female sex workers, 5 percent.
In the general population, the antenatal clinic attendees (a proxy for general population) had a prevalence rate of 0.5 percent.64

Heterosexual route of transmission accounts for 87 percent of total HIV cases detected, whereas parent to child transmission accounts for 5 percent, injecting drug use 2 percent, and MSM another 2 percent of total HIV transmission in the country (NACO, 2010: p. 2). India’s HIV epidemic is highly heterogeneous. Geographically it is concentrated in four southern states (Maharashtra, Tamil Nadu, Andhra Pradesh and Karnataka); and two north-eastern states (Manipur and Nagaland) — collectively called as high-prevalence states. Available evidence of HIV prevalence shows signs of stabilization of HIV epidemic at the national level. This means, India has now started to reverse the spread of the epidemic showing a downward trend (Fig. 2.2). The declining trend is also observed in 6 high prevalence states, indicating possible impact of a sustained intervention program. These six states with high HIV-prevalence account for nearly 66 percent of the HIV burden of the country (UNGASS, CPR, 2010: p. 17). Among the population sub-groups, while there is a decline in the epidemic among female sex workers in south Indian states, rising trends are observed in the North East where the epidemic is primarily driven by both IDU and sexual transmission. The highest prevalence amongst sex workers is observed in the state of Maharashtra, 18 percent. The highest HIV prevalence amongst drug users was reported in Amritsar, Punjab at approximately 30 percent (ibid., p. 3). Injecting drug use is the principal driver of the HIV epidemic in the north-eastern states of Manipur, Nagaland, and Mizoram. NACO estimated that about 57 percent of total HIV positive persons were living in rural areas (NACO AR 2010, p. 17).

Given the model of concentrated epidemic (Fig. 2.1), it is most effective and efficient to target prevention at the source — that is to keep the HIV prevalence as low as possible among the high risk groups to reduce transmission to the bridge population. India’s response therefore has been “targeted interventions” among high risk population as well as the bridge population. The prevention activities with these groups consist of

behavior change communication, awareness generation, providing STI services, provision of condoms, linkages to care and support services, needle-syringe exchange program, and opioid substitution therapy.

A major success of the national AIDS control program is reflected through the high level of condom use reported by sex workers, especially in the high prevalence states. Levels of reported condom use with last paying client reached 100 percent in Andhra Pradesh, and exceeded 99 percent in Karnataka and Maharashtra (UNGASS CPR, 2010: p. 24). To prevent HIV in the general population the government ensures safety of all blood and blood products, provides free voluntary counseling and testing services, provides nevirapine drugs for preventing mother to child transmission of HIV, and carries out high-profile awareness generation and mass media campaigns. A national level awareness campaign includes Red Ribbon Express, a specially designed train painted with HIV-messages, and coaches carrying exhibition and personnel to provide information, counseling and testing. Other radio programs like Babli boli (Babli talked); 5 down mohabbat express (5 down love express); and Kitne door, kitne pass (how far, how close) were launched by NACO, targeting rural women, youth and aspiring urban migrants.

While Chapter 4 deals with part of the program components vis-a-vis norms of the HIV/AIDS regimes, a detail description about India’s AIDS control program itself is clearly not the focus of this dissertation. Yet, it was hoped that the brief information provided above will nonetheless be useful to situate the epidemic within the broader theoretical context. I use this information as a springboard for scrutinizing the political economy of knowledge production — how HIV/AIDS has been talked and discussed about, and in what ways it affected the state and non-state actors in mobilizing their actions.

2.3. Understanding AIDS numbers

An important component of the politics of knowledge production about AIDS, was the production of “numbers,” that were deployed to win the support of states in
favor of AIDS control. As Elizabeth Pisani (2008) described, until mid-1990s, little funding was available for global HIV/AIDS prevention, and many governments in the countries of Asia and Africa silently watched as their epidemic grew. Pisani, who worked as a short-term consultant for UNAIDS, reported that the dimension and potential for global HIV/AIDS epidemic was deliberately hyped to mobilize more resources for HIV prevention programs. As a consultant, her job was to mobilize more resources for AIDS by engaging in the politics of knowledge production. The knowledge that were produced under the institutional weight of UNAIDS, WHO, and Family Health International, sought to classify potential areas for the epidemic, predict the nature and future of epidemic in such areas, develop public consciousness about AIDS as a devastating pandemic, and propagate the myth that AIDS will soon infect the “general population” (Pisani, 2008: p. 28), and that “everyone is at risk” (ibid., p. 158) – In short, to produce a regime of “truths and norms” about HIV/AIDS by simply “cooking up an epidemic.”

Pisani (2008) says that in journalistic language, this is called “beating up,” an exercise of making a mountain out of a molehill, “making a big, interesting, dramatic story out of something that may actually be rather mundane” (p. 22). Thus in the initial period, global estimates of HIV infected individuals were inflated, and there was a deliberate attempt to present the statistics in their worst light that induces horror and panic. Similarly, other epidemiologists like James Chin (2008) argued that UNAIDS has systematically exaggerated the size and trend of the pandemic, as well as hyped the potential for HIV epidemics in general populations to keep it high on the political agenda. These estimates in most cases were actually “guesstimates.” Pisani called these as “executive decisions,” which were often made after midnight over a couple of beers (2008: p. 24).

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Thus several accounts of an AIDS catastrophe looming over Asia were produced by the UNAIDS, World Bank, US National Intelligence Council, FHI and other bilateral organizations and aid agencies. In fact, it was widely propagated by the UNAIDS that Asia will soon follow an African path of AIDS epidemic that will wipe-out its adult population. Pisani, and other epidemiologists (Caldwell, 2006) knew that AIDS in Asia will not be a generalized epidemic because people do not weave sexual networks similar to Africa. But they went on perpetuating the myth through an apocalyptic language that “everyone is at risk.” While this depiction has pulled in much needed resources for AIDS prevention, it has resulted in billions of dollars of unnecessary and misdirected spending (Chin, 2008), and has also become a hindrance in building up effective prevention response. This is because money has also drawn in people like homophobes, conservatives, ideologues, religious clerics, etc. who would happily accept AIDS-money but won’t talk about sex, drugs, prostitutes, condoms, and anal sex.

But Pisani acknowledged, “We weren’t making anything up, but once we got the numbers, we were certainly presenting them in their worst light. We did it consciously” (2008: p. 28). In an earlier book, Chin (2007) had accused UNAIDS of inflating the global HIV estimates and labeled the epidemic as a “disease with political correctness.” After Chin’s book was published, UNAIDS came up with a press statement disclaiming that “UNAIDS secretariat and WHO data are not influenced by political or fundraising agendas” (emphasis mine). This is in total contradiction to Pisani’s claim who authored several “cookbooks” for UNAIDS and proclaimed (2008: p. 22) that the task of UNAIDS-“epi-nerds” like her was to mobilize funds by writing “stories.”

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India also passed through two distinct stages in which the epidemic was “made” by deliberate hyping and exaggerating the numbers, and then “unmade” in the second phase due to intense critique. More numbers of HIV-positive people meant more money into the HIV/AIDS funding-machine\textsuperscript{70}. Since the first case of HIV was identified in 1986, the Indian government and NGO have claimed that HIV spread very rapidly in some parts especially in southern states. In the early 1990s (1986-91), it was reported that 300 Indians contract HIV every day (Dube, 2000: p. 14-15). This figure rose to 1,400 by 1999, and 5,000 by 2002 (Singhal and Rogers, 2003: p. 115). Similarly, many individuals and institutions projected India’s total number of AIDS cases with grossly misleading figures. In 2001 for example, while the government claimed that there were about 4 million total AIDS cases, some statisticians reported it as 19 million that is expected to rise to 62 million by 2016.\textsuperscript{71} Similarly, UNAIDS and CIA estimates suggest that India will have 20-25 million infection by 2010;\textsuperscript{72} World Bank estimated it as 20 million by 2005 (Singhal and Rogers, 2003: p. 113); yet some other estimate suggests it as 50 million by 2025.\textsuperscript{73} In 2005, UNAIDS claimed that India had the world’s largest HIV population with an estimated 5.2 to 5.7 million infections with approximately 0.91% of India’s adult population infected.

The fact these estimates were a part of an overall political project came into light with more accurate estimates and population based surveys. For example, a population based survey in Guntur district of South India revealed that “sentinel surveillance method” to arrive at HIV/AIDS figures overestimates the burden by 2-3 times than population based data.\textsuperscript{74} A more authentic population based data, National Family Health Survey conducted

\textsuperscript{73} Kumar, Rajesh et.al. (2005), HIV-1 Trends, Risk Factors and Growth in India, in Government of India. (2005). \textit{Burden of Disease in India.} pp. 58-73.
\textsuperscript{74} The reasons for this overestimation are due to addition of unnecessary HIV estimates from STI clinics; common practice of referral of HIV positive and suspect patients by private practitioners to public hospitals; and a preferential use of public hospitals by lower socioeconomic strata used in sentinel surveillance method. See Dandona, Lalit et.al. (2006), Is the HIV Burden in India being Overestimated? \textit{BMC Public Health, 6}(308).
under international (US) financing and supervision endorsed the above fact. This estimate reduced India’s total HIV-numbers from 5.7 million to 2.3 million (0.9 percent to 0.3 percent of adult population). In view of this, UNAIDS reduced India’s HIV estimates for all previous years. Similar trends were observed in Africa where population based surveys led the UNAIDS to gradually reduce the estimated number of infected people country by country. For example, when Kenya was carefully surveyed in 2004, its prevalence rate dropped by more than half from 15 percent UNAIDS’ estimate of 2001 to 6.7 percent (ibid.). As Daniel Halperin, an HIV-expert at the Harvard School of Public Health said:

“If the total number of cases in the world is half of what you’ve been saying, that’s a bitter pill to swallow… AIDS-fighting agencies have such a stake in portraying the epidemic as an approaching Armageddon that they are hesitant to make significant downward revisions in estimates… So every year they lower the numbers a little bit, and retroactively change the estimates of what it used to be” [c.f. McNeil, 2007, ibid.].

Halperin’s above statement about AIDS as an approaching Armageddon would be fully understood from the following section about how HIV was portrayed and represented in public discourses.

2.4. Representing AIDS: What’s in an “epidemic?”

The naming of AIDS as an “epidemic” or “pandemic” was a first major disjunction raising several conceptual problems not only about the disease, but also about the field of epidemiology. The word epidemic according to the New Shorter Oxford English Dictionary is a disease “normally absent or infrequent in a population but liable to outbreaks of greatly increased frequency and severity;” or a “temporary but widespread outbreak of a particular disease [emphasis mine]. Another standard dictionary, Webster’s New Collegiate, gives a second definition: “affecting or tending to affect a dis-proportionately large number of individuals within a population, community, or region at the same time;” or “excessively prevalent” [emphasis mine].

Similarly, a dictionary of epidemiology defines epidemic as the “occurrence in a community or region of cases of an illness, specified health behavior, or other health-related events clearly in excess of normal expectancy; the community or region, and the time period in which cases occur, are specified precisely.” In contrast, a pandemic is defined as an epidemic “occurring over a wide geographic area and affecting an exceptionally high proportion of the population [emphasis mine].

If I go by these definitions, none would make HIV/AIDS qualify as either an epidemic or a pandemic. For example, if I go by the first definition, the liability (or potential) of AIDS to outbreak in greatly increased frequency is itself a contested notion and not endorsed by researchers and epidemiologists. The liability is a function of several factors that are structural, socio-cultural, and economic, and that varies greatly across the globe making different populations liable to varying levels of outbreaks. Secondly, how much exactly constitutes “greatly increased;” what “frequency” qualifies as great; what level of incidence makes it “severe;” how long is “temporary;” and what exactly is “widespread” remain undefined in the conception of the epidemic. AIDS is here since last three decades and likely to be permanent: is it temporary?

If I go by the second definition, what is “disproportionately large” and “in excess of normal expectancy” remain a subjective interpretation. It will make “consumption” in America as a disease and an epidemic. “Dis-proportionately,” by definition, is a “proportion” out of the total, and “dis” and “large” would possibly mean anything above one-third (33%) as epidemic. Nowhere in the world, AIDS has affected a “disproportionately” large number of individuals. Is it still an epidemic? Similar conceptual problem arises from phrases like “exceptionally high” in the definition of

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pandemic. For example, the prevalence of HIV-infection is less than one percent in many countries of Western Europe, USA, and Asia. And yet, AIDS in these countries is both labeled as an “epidemic,” and “pandemic.” Textbooks of epidemiology and virology, including WHO, remain ambiguous about when and in which contexts to use these terms.78

Portraying AIDS

However we may call it, epidemic or pandemic, AIDS has drawn the worldwide attention of governments, NGOs, international donors, scholars, activists and networks, and has come to occupy the center stage of development programs since late-1980s. UNAIDS has systematically propagated the myth that “AIDS is everyone’s problem,” and “HIV/AIDS is a development problem” instead of saying AIDS is a problem of sex and drugs (Pisani, 2008). Since then, HIV was conceived as the “biggest public health threat in India” (NIC, 2002; Chattopadhyay, 2003; Mitra 2004). Images of a doomed India in the African epidemic model and a wiped-out adult population abound the literature produced by activists, NGOs, research organizations, and national and international donor agencies (World Bank, 1999; Kadiyala and Barnett, 2004; Williams, 2005; Godbole and Mehendale, 2005; Potts and Walsh 2006).

Since the beginning of HIV epidemic in India in late 1980s, the portrayal and representation of HIV epidemic in popular discourses remained alarmist, creating an image of fear and horror among minds of planners, policy makers, academicians, researchers and general population (Pandav et.al., 1997; Salunke et.al., 1998; Dube, 2000; Singhal and Rodgers, 2003; Willams, 2005). For over last two decades, such fears were constantly reinforced through discourses of the epidemic using a fear-mongering language. For example, India’s HIV epidemic was labeled as a “ticking time bomb” that would “explode” if not given urgent attention (Williams, 2005). It was argued that it will cause “millions of death” (Kadiyala and Barnett, 2004) with “disastrous consequences” on health sector (Gupta, 1998; Oja and Pradhan, 2006); and economy, business and

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78 Green, Manfred, et.al. (2002). When is an epidemic an epidemic? The Israel Medical Association Journal, 4. pp. 3-5.
industries (Hira, Gupta and Godwin, 1998; Mahal, 2004). AIDS was labeled as a “national emergency,” reaching an “epidemic” proportion and is “out of control” (UNAIDS, 2003; Chandrasekaran, 2006). The United Nations Special Envoy on HIV/AIDS referred to it as “a termite attack, invisible at first, catastrophic in the end” (Williams, 2005). US Intelligence Agencies (CIA) have said that the problem is “getting worse” and India is entering into the “next wave of AIDS epidemic” (Mitra, 2004; NIC, 2002). Others have noted that India is doing a “huge mistake that could prove fatal” (Williams, 2005), and hence predicted that India’s “booming economy would come crashing back to earth” in the next 10-15 years due to AIDS.

The executive director of the Global Fund for AIDS, TB and Malaria warned that India needs to “wake up and take the problem seriously, as the epidemic is out of control and there is nothing happening in India that is big or serious enough to prevent
International development agencies have also labeled HIV epidemic in India as the “major health emergency” having a devastating effect on human development (UNDP 1999; UNAIDS 2003). It was termed not only as the “greatest global public health disaster,” (Whiteside and Wall 2004) but also the “greatest development challenge” in human history (Ruger 2004; Ruxrungtham et. al. 2004; Poku and Whiteside 2006; Barnett 2006; World Bank 2006).

Even in official awareness campaigns, public education and outreach materials, AIDS was periodically portrayed as a lethal disease that is highly contagious and deadly, reinforcing the stereotype that AIDS means death. The “AIDS equals death” theme remained a part of the awareness campaigns by some grassroots NGOs in India, which I have experienced during my fieldwork in 2006. Use of images such as a skeleton, skull and bones, effigy of a monster, or a dragon with messages that deeply

Fig. 2.4. Hero or zero? Uttar Pradesh State AIDS Control Society in collaboration with UNICEF placed large hoardings across five cities with several stigmatizing messages. The hoarding reads, Hero or Zero? How wise are you? Reinforcing the stereotype that if you contract AIDS, you are “zero.” Photo: UP State AIDS Control Society, India.

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reinforce fear is used in public awareness campaigns. To cite an example, even in 2009 (that is almost after 25 years of AIDS-activism), NGOs organizing awareness campaigns by gathering college students in Chandigarh, Punjab, reinforced the same AIDS equals death stereotype through face painting competition (Fig. 2.3) that was widely circulated in the media, and later used in 2009 Bali International Congress on AIDS in Asia and the Pacific.

Similarly, in 2006, Uttar Pradesh State AIDS Control Society in collaboration with UNICEF had put up several large hoardings across five cities with the message “Hero or zero?” (Fig. 2.4). Similar hoardings also used phrases from popular Bollywood movies like “Khiladi or anadi?” (skilled or novice?); and Kal ho na ho! (There may not be tomorrow!). Though these hoardings were later taken down due to protest from PLHA groups, they reinforced the stereotype that once an individual contract AIDS, there’s no tomorrow as someone will possibly die; or once you contract AIDS, you are a “zero,” or an “anadi”. Besides being factually wrong, messages such as these has been highly stigmatizing for people living with HIV/AIDS. I have never come across a message that read: “AIDS is a manageable chronic illness;” and that “one can live indefinitely by taking medicines.”

Outside India, a horrifying European AIDS prevention campaign to celebrate World AIDS Day 2009 made worldwide news. The campaign featured posters of Adolf Hitler, Saddam Hussein, and Joseph Stalin engaging in unprotected sexual intercourse (See Fig. 2.5) to emphasize the campaign’s tagline, “AIDS is a mass murderer”. But the advertisement fails to convey “use a condom” or even a positive message like, “AIDS does not necessarily leads to death.”

The Indian Network for People Living with HIV/AIDS (INP*) has observed that the amount of media coverage on various aspects of HIV/AIDS has increased noticeably during the last decade, but there has been little change in the images of the epidemic that are conveyed by the media. Media coverage of AIDS “continues to dwell on disempowering images of death, despair, stigma, abandonment of marginalized groups, or mismanagement of funds or programs. Though the presence of sensitized
media persons is increasing, sensation is still the keyword ruling coverage. Stereotyped reporting patterns and stereotyped sources continue to cause further discrimination of PLWHA."

**AIDS “exceptionalism”**

The above representation of AIDS as a “deadly,” “lethal” pandemic significantly influenced its exceptionality argument — the argument that was used to promote HIV/AIDS over other diseases resulting in the formation of powerful AIDS regimes. In view of the “lethal” nature of the epidemic having no cure, activists and international bodies have repeatedly argued that HIV/AIDS cannot be treated like other conventional diseases, and it requires an exceptional response (Smith and Whiteside, 2010). AIDS exceptionalism therefore demanded a preferential treatment that AIDS prevention, treatment and care, AIDS research and education must receive priority above other deadly global diseases, and higher amount of resources must be made available for this purpose. UNAIDS Executive Director, Peter Piot remained a champion of this stance — AIDS needs to be exceptionalized in order to gain control over its’ spreading. In fact the creation of UNAIDS — a separate UN body for a specific disease outside the leadership of WHO was justified on the ground that HIV is exceptional (England, 2008). The exceptionality argument was used to raise international political commitment and large sums of money — UNAIDS called for a massive increase of funds from $9 billion in 2008 to $42 billion by 2010, and $54 billion by 2015 to combat the disease.

However, in recent years, accurate population based estimates endorsed by UNAIDS from various African countries and Asia have lowered the number of infected

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population nearly by half. For example, India’s population reduced from UNAIDS’ estimate of 5.2 million in 2006 to 2.3 million in 2007; and Kenya’s prevalence rate dropped from 15 percent to 6.7 percent. Similar trends were observed in Uganda, Zimbabwe, Zambia, Mali, Botswana and other Sub-Saharan African countries, except South Africa. An increase in the allocation of resources may be explained by a simultaneous increase in the number of infected people. But if the estimated numbers of infected people were not as many in the last 20 years (as the recent estimates suggest), then how HIV/AIDS warranted so much expenditure? Where did all the money go in whose name it was raised that never existed at the first place?

Thus, the exceptionalism argument came under stress in recent years. England (2007) argued that AIDS exceptionalism has displaced national health priorities by receiving too much money. AIDS interventions are expensive, and the current disease burden does not justify the present level of funding. Similarly, Chin (2008), and Pisani (2008) focusing on the Asian experience, suggested that scientists, UNAIDS and AIDS activists accept certain myths about HIV epidemiology to maintain the political profile of AIDS, and their own jobs. They suggested that the epidemic was overstated, and resources were being deployed in situations where HIV would not spread anyway. Pisani offered the example of East Timor, where only for seven known HIV-infected individuals, a sum of $2 million was poured in to design an HIV prevention program (Pisani, 2008: p. 288).

AIDS exceptionalism also fails to capture that AIDS is a “manageable chronic illness” like diabetes, asthma, or chronic low back pain, which one can “manage” by taking medicines throughout lifetime. With the invention of antiretroviral (ARV) drugs, one can remain healthy throughout lifetime, and viral load in the blood drops down to undetectable level even by using most advanced tests (Singhal and Rogers, 2003:

84 Of course it gave a headache to the East Timorese government about how to use the money where the potential for HIV infection at the first place remained low due to little prostitution and low drug use. This also made the East Timor a country where more organizations were working on AIDS than people infected (Pisani, 2008: p. 288). Pisani’s exposition corroborates Bala’s statement I mentioned in the Preface: “more people are living on AIDS than living with the virus.” See also, Kole, Subir (2010). Book Review. Elizabeth Pisani. The wisdom of whores: Bureaucrats, brothels and the business of AIDS. Asian Politics & Policy 2(1). pp. 141-144.
Chapter 3). It remains therefore doubtful whether a person with no traceable HIV in the blood can infect other people by regular sexual contact. Therefore, HIV is in no way exceptional as it is made out to be. As England (2008) noted: AIDS exceptionalism has created too many single-issue NGOs in the world, and the UNAIDS must be disbanded because its presence is wrong and harmful for the health system.

**Donor prioritization**

One important effect of this exceptionalism is reflected in the donor prioritization of the disease. Donors preferred HIV over other endemic diseases because endemic conditions are mostly structural and too complex a problem to solve quickly (for example, solving potable drinking water problem to reduce diarrhea). The donors prefer to fund for a development program that yields visible, measurable results within 3-5 years. Thus targeting the pandemic (AIDS) instead of endemic (potable water) provided a quick-fix type solution.

While visible, measurable, and quick results are still possible to achieve by funding potable drinking water or malnutrition projects, there are clearly other factors at work that may partly explain donor preference for HIV over other diseases. One may be the bandwagon effect — donors allocate aid by simply following what other donors are doing. This makes the allocation of aid easier, as well as less risky. It also brings legitimacy for the donor, as it conforms to the actions of other, usually more important donors. Bandwagon effect thus reinforces the political objectives of the main donors.85

The bandwagon effect gave rise to the formation of HIV/AIDS regimes (explained in Chapter 3), which gained strength over the years and promoted global norms embedded in them. Throughout the history of international development, regimes of these kinds have created a peak-and-trough pattern of aid-allocation on “issues.” Globally, in the development history, new issues have periodically emerged to take the center-stage of NGO activism. They have drawn worldwide attention of activists, planners, policy makers, and researchers, and then dwindled after some period of

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intense activism. This is called an issue burn-out — something that no more remains “in fashion”. Examples are: concerns for overpopulation, family planning, poverty alleviation and the basic needs in the 1970s; global warming, environment and forestry, gender and development in the 1980s; and sexual rights, reproductive health rights and adolescent health in the 1990s. And quite following the same trajectory in the development history, AIDS has now become the latest fashion among development partners, and international development establishments.

Another reason why endemic diseases received less attention is because, over time, people get desensitized to endemic conditions as a way of life — there is some degree of brutalization of consciousness, an attitude of non-feeling resulting from repeatedly experiencing deaths from endemic diseases. Instead, HIV pandemic is something new, fashionable, modern and progressive to talk about than age-old problems of poverty, illiteracy or homelessness. This shifting of donor’s focus from endemics to pandemics affected the dynamics of the disease, because structural conditions like clean water, poverty, illiteracy, and homelessness have a causal effect — they provide a fertile ground on which HIV can spread at the first place.

**The ripple effect**

So what has been the overall effect of representation, exceptionalism, and donor prioritization of HIV/AIDS?

**Fist, it mobilized state actions.** The exact mechanism of why, how and to what extent the AIDS-regimes and their norms mobilized state actions in particular ways are examined in Chapter 3 and Chapter 4. But it is sufficient to state here that the initial representation, exceptionalism and bandwagon effect created a panic among activists, NGOs, national and international donors, researchers, and policy makers (O’neill, 1990), resulting in the creation of regimes and promotion of global norms through these regimes. The member/recipient states in the developing countries internalized the regimes’ norms through a process of norm socialization and focused their attention to combat AIDS at various levels. The overall effect of norm socialization remained positive as reflected in growing awareness about HIV among general population (Lal
et.al. 2000; NACO, 2006); reduced infection rate (Rao 2007; NACO AR, 2010); reducing stigma and discrimination in employment and health care (Mahendira et.al. 2006); and improvement in quality of life of people infected and affected (UNGASS, CPR 2010).

And second, norm socialization has produced varieties of resistances both from venerable communities and the Indian society in general — but both directed against the state. For instance, there is a growing concern that the modalities of HIV/AIDS prevention programs are breaking into cultural norms around sex and sexuality, which are fought with fierce resistance by local communities, NGO-workers, policy makers, politicians and development practitioners themselves (Kandiyala and Barnett, 2004). To take an example, despite 37 percent of total new HIV infections occurring in the age group of 15-24 years, the proposal to introduce sex education in schools by Government of India was fiercely resisted by 11 Indian states. Though condom use is extremely low, the introduction of throbbing ribbed condom by Hindustan Latex Ltd. for increasing its popularity, faced with harsh political resistance and banned by various Indian states terming it as “sex toy,” and “against Indian culture” (Times of India, June 23, 2007). In addition, despite prostitution and commercial sex contributing to more than 80 percent of total new HIV infection in India (Jain, et.al., 1994; Venkataramana and Sarada, 2001; NACO AR 2010), prostitutes continue to be criminalized, stigmatized, face violence from pimp-police-customers, and their civil and political rights denied (Sleightholme and Sinha, 1996; Abiala, 2006). And finally, though gay men, men having sex with men (MSMs), hijras, kothis and other transgender groups remained at the high risk of HIV infection, the proposal to decriminalize same-sex sexual relationship faced with 15 years of legal battle at the

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Delhi High Court and Supreme Court of India (Fernandez 2002; Narain and Bhan 2005).

**Summing up**

These two interconnected issues, norms mobilizing state actions on the one hand, and simultaneously producing resistances on the other remain the central theme of this dissertation. In the next two chapters, Chapter 3 and 4, the first idea is explored — how and why the Indian state responded to HIV/AIDS epidemic in particular ways focusing on the role of regimes and norms in international politics. In Chapter 5 and 6, I explore the second central idea — what has been the effect of such responses on vulnerable communities focusing on the role of norms in producing varieties of resistances against the state.

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